

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Jefferson House		STREET ADDRESS, CITY, STATE, ZIP CODE  1 John H Stewart Dr Newington, CT 06111	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460</b></p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from mistreatment. The findings include:</p> <p>Record review identified Resident #1 was admitted to the skilled nursing facility during 5/2024 and had an emergency contact listed as a Durable Power of Attorney (POA).</p> <p>Resident #1's diagnoses included depression, anxiety and cerebral infarction (stroke). The annual Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, and required assistance with ADLs. The Resident Care Plan (RCP) dated 8/27/2024 identified a risk for loneliness due adjustment to change in living situation related to placement for long term care. Interventions directed to allow to express feelings, and visits with social services.</p> <p>Review of facility Reportable Event form dated 11/18/2024 at 2:00 PM identified that the DNS was contacted by an officer from the local police department regarding misappropriation of Resident #1's funds by NA #1. The form indicated NA #1 was suspended and a locked drawer was provided for Resident #1's valuables storage.</p> <p>The facility summary dated 11/20/2024 identified the POA reported suspected larceny to the local police. The local police notified the facility that Resident #1's banking information (routing number and account number) was used to pay debt in the name of NA #1; between \$1400 and 1500 was misappropriated.</p> <p>Review of the Administrator timeline summary of investigation identified the following:</p> <p>On 11/18/2024 the local police notified the facility of fraudulent use of Resident #1's bank account for NA #1's bills totaling around \$1,900.00 during the end of September/early October 2024.</p> <p>The police indicated family had left a blank check with Resident #1 for approximately four (4) days.</p> <p>NA #1 did not work on Resident #1's unit, denied the allegation when staff questioned her, and was suspended.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Jefferson House		STREET ADDRESS, CITY, STATE, ZIP CODE  1 John H Stewart Dr Newington, CT 06111	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>NA #1 informed the facility she had documentation to show she paid the bills in question.</p> <p>The police informed the facility, NA #1 had documentation to show she paid the bills in question after the bills were paid using Resident #1's account and they were flagged by the bank fraud department.</p> <p>Interview, clinical record review and facility documentation review on 12/4/2024 at 2:17 PM with the Administrator and ADNS identified that Resident #1's family member brought in a blank check that was in Resident #1's drawer for four (4) days before another family member came to collect it. NA #1 knew Resident #1 from another area of the campus prior to admission to the skilled nursing section (SNF), and although NA #1 worked in the SNF part of the campus, she did not work on Resident #1's unit and had never floated to that unit to work. Interview identified Resident #1's responsible party had indicated Resident #1 had a history of leaving his/her checkbook out at the other area of campus prior to admission to the SNF, where NA #1 worked in another role.</p> <p>Interview on 12/5/2024 at 9:30 AM with Police Officer (PO #1) identified although NA #1 denied the accusation, PO #1 stated Resident #1's account was used to pay bills for NA #1. Further PO #1 stated the case was pending court and prosecutor review regarding any arrest warrant.</p> <p>Although several attempts were made, an interview with NA #1 not obtained during the survey.</p> <p>Review of facility Resident [NAME] of Rights directed in part, the facility must take reasonable care in protecting your property from loss or theft and the right to be from misappropriation of property.</p> <p>Review of facility Abuse, Neglect, Mistreatment, Exploitation, Misappropriation of Resident Property directed in part, to prohibit misappropriation of property.</p> <p>Additional information provided by the Administrator on 12/16/2024 identified NA #1 did work two (2) of the days when the blank check was alleged to be in the facility, although NA #1 was not scheduled on Resident #1's unit on either of the days she worked.</p>		