| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075295 | A. Building<br>B. Wing | 11/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meriden Health and Rehab | 360 Broad Street, Ste 1<br>Meriden, CT 06450 |

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) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021<br><br>Based on clinical record reviews, review of facility policy, review of facility documentation, and staff interviews for three (3) sampled residents (Residents #1, #2, and #3) who were reviewed for an allegation of neglect, the facility failed to ensure the residents were fed and provided incontinent care by the assigned staff during the 3-11PM shift. The findings include:<br><br>1. Resident #1's diagnoses included dementia, generalized idiopathic epilepsy, and restlessness and agitation.<br><br>The annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, required setup or clean-up assistance with eating, was frequently incontinent of bowel and bladder, and dependent on staff for toileting hygiene.<br><br>The Resident Care Plan dated 11/11/24 identified Resident #1 needed assistance with activities of daily living. Interventions directed to assist with eating and to provide incontinent care after each episode of incontinence.<br><br>The nurse's note dated 11/11/24 at 3:06 PM identified the Staff Development Coordinator was notified of allegations of neglect. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #1 did not have any ill effects and all parties were notified.<br><br>2. Resident #2's diagnoses included dementia and adult failure to thrive.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily life, was dependent on staff for eating, toileting hygiene, transferring and repositioning in bed, always incontinent of bowel, and had a urinary catheter.<br><br>The Resident Care Plan dated 8/31/24 identified Resident #2 was incontinent of bowel. Interventions directed to assist with turning and repositioning every two (2) hours and as needed and to provide pericare after each incontinent episode.<br><br>(continued on next page) |

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 |
|---|---|---|

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The nurse's note dated 11/11/24 at 3:08 PM identified the Staff Development Coordinator was notified of allegations of neglect at 10:45 AM. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #2 did not have any ill effects and all parties were notified.<br><br>3. Resident #3's diagnoses included chronic obstructive pulmonary disease (COPD), restlessness and agitation, and vascular dementia.<br><br>The MDS assessment dated [DATE] identified Resident #3 rarely or never made decisions regarding tasks of daily life, dependent on facility staff for toilet use, bed mobility and eating, and was incontinent of bowel and of bladder.<br><br>The Resident Care Plan dated 11/2/24 identified Resident #3 has the potential for impairment of skin integrity related to incontinence of bowel and bladder. Interventions directed to provide incontinent care after each episode.<br><br>The nurse's note dated 11/11/24 at 4:40 PM identified the Staff Development Coordinator was notified of allegations of neglect at 10:45 AM. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #3 did not have any ill effects and all parties were notified.<br><br>The Facility Reported Incident forms dated 11/11/24 identified on 11/10/24 facility staff alleged Residents #1, #2, and #3 were not fed dinner and not provided care by the nurse aide assigned to them during the 3-11PM shift on 11/10/24.<br><br>The investigation identified the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, received complaints from facility staff on the memory care unit that a nurse aide, Nurse Aide (NA) #1, sat at the nurse's station charting without seeing residents, NA #1 left the facility at 8:00 PM on a break and did not return until 8:45 PM, and did not fed or provide incontinent care to Residents #1, #2, and #3. Upon notification the residents were assigned to a different nurse aide on the unit prior to the end of the 3-11PM shift, and incontinent care was provided, and the residents were fed.<br><br>Interview and review of the facility report incident reports dated 11/11/24 with the Administrator on 11/22/24 at 12:15 PM reflected there was a delay in care provided to Residents #1, #2 and #3 on 11/10/24 during the 3-11PM shift. The Administrator indicated NA #1 was sent home during shift and all residents assigned to NA #1 were re-assigned and provided care at 9:00 PM.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the 3-11PM Nursing Supervisor, RN #1, on 11/22/24 at 1:05 PM identified she first received an allegation of neglect related to NA #1 not performing her job duties for the assigned residents on the memory care unit when another nurse aide on 11/10/24 at 5:00 PM came to the office. RN #1 indicated she went to the unit between 6:00-7:00 PM and realized NA #1 was not on the unit. RN #1 identified the charge nurse, Licensed Practical Nurse (LPN) #1, expressed concern that NA #1 had spent time charting at the nurses' station and not doing work with residents. RN #1 indicated she sent a text message to NA #1, received a response from NA #1 that she, NA #1 had left the facility to go to the store, and she requested NA #1 return to the facility. RN #1 reported NA #1 came back ten (10) minutes later. RN #1 indicated she checked on the residents assigned to NA #1 and had observed NA #1 go into a few resident rooms but did not observe what NA #1 did. RN #1 identified although she contacted the covering Director of Nursing (DON) and Administrator and notified them of the allegations of neglect, she could not recall the time. RN #1 identified she was directed to send NA #1 home and NA #1 left the facility at 9:15 PM.<br><br>Interview with NA #1 on 11/22/24 at 1:30 PM identified it was her first time at the facility on 11/10/24, was not familiar with the residents or the facility policies and felt she was misinformed about the needs of the residents she was assigned.<br><br>Interview with NA #2 on 11/22/24 at 1:40 PM identified she was assigned to Resident #2 at 9:30 PM. NA #2 identified when she went into Resident #2's room, she observed Resident #2 in the fetal position in bed with dried feces that appeared to be there for a while. NA #2 identified she provided care and fed Resident #2.<br><br>Review of the facility Reporting Abuse to Facility Management Policy dated 04/2024 directed abuse and neglect was not condoned by the facility. |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021<br><br>Based on clinical record reviews, review of facility policy, review of facility documentation, and staff interviews for three (3) sampled residents (Resident #1, Resident #2, and Resident #3) who were reviewed for an allegation of neglect, the facility failed to ensure the allegation was reported immediately to the Administrator and/or designee and to the State Agency within two (2) hours after the allegation was identified. The findings include:<br><br>1. Resident #1's diagnoses included dementia, generalized idiopathic epilepsy, and restlessness and agitation.<br><br>The annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, required setup or clean-up assistance with eating, was frequently incontinent of bowel and bladder, and dependent on staff for toileting hygiene.<br><br>The Resident Care Plan dated 11/11/24 identified Resident #1 needed assistance with activities of daily living. Interventions directed to assist with eating and to provide incontinent care after each episode of incontinence.<br><br>The nurse's note dated 11/11/24 at 3:06 PM identified the Staff Development Coordinator was notified of allegations of neglect. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #1 did not have any ill effects and all parties were notified.<br><br>2. Resident #2's diagnoses included dementia and adult failure to thrive.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily life, was dependent on staff for eating, toileting hygiene, transferring and repositioning in bed, always incontinent of bowel, and had a urinary catheter.<br><br>The Resident Care Plan dated 8/31/24 identified Resident #2 was incontinent of bowel. Interventions directed to assist with turning and repositioning every two (2) hours and as needed and to provide pericare after each incontinent episode.<br><br>The nurse's note dated 11/11/24 at 3:08 PM identified the Staff Development Coordinator was notified of allegations of neglect at 10:45 AM. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #2 did not have any ill effects and all parties were notified.<br><br>3. Resident #3's diagnoses included chronic obstructive pulmonary disease (COPD), restlessness and agitation, and vascular dementia.<br><br>The MDS assessment dated [DATE] identified Resident #3 rarely or never made decisions regarding tasks of daily life, dependent on facility staff for toilet use, bed mobility and eating, and was incontinent of bowel and of bladder.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Resident Care Plan dated 11/2/24 identified Resident #3 has the potential for impairment of skin integrity related to incontinence of bowel and bladder. Interventions directed to provide incontinent care after each episode.<br><br>The nurse's note dated 11/11/24 at 4:40 PM identified the Staff Development Coordinator was notified of allegations of neglect at 10:45 AM. The Supervisor from the evening shift on 11/10/24 reported a nurse aide did not render care on Resident #1 during her shift. The note identified Resident #3 did not have any ill effects and all parties were notified.<br><br>The Facility Reported Incident forms dated 11/11/24 identified on 11/10/24 during the 3-11PM shift facility staff alleged Residents #1, #2, and #3 were not fed dinner and not provided care by the nurse aide assigned to them during the 3-11PM shift on 11/10/24. The report indicated the State Agency was notified on 11/11/24 at 11:45 AM.<br><br>The investigation identified the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, received complaints from facility staff on the memory care unit that a nurse aide, Nurse Aide (NA) #1, sat at the nurse's station charting without seeing residents, NA #1 left the facility at 8:00 PM on a break and did not return until 8:45 PM, and did not fed or provide incontinent care to Residents #1, #2, and #3. Upon notification the residents were assigned to a different nurse aide on the unit prior to the end of the 3-11PM shift, and incontinent care was provided, and the residents were fed.<br><br>Interviews and review of the facility report incident reports dated 11/11/24 with the Administrator on 11/22/24 at 12:15 PM identified he was the person responsible for conducting the investigations related to the allegations of neglect and was first informed about the allegations of neglect for Residents #1, #2, and #3 on 11/10/24 at 9:00 PM by the Staff Development Coordinator.<br><br>Interview with the Staff Development Coordinator on 11/22/24 at 12:30 PM identified she was the covering Director of Nursing on 11/10/24, was informed by RN #1 about the allegations of neglect on 11/10/24 a few minutes before 9:00 PM, and immediately notified the Administrator. The Staff Development Coordinator indicated the notification received from RN #1 was not considered timely and the expectation was for nursing staff to report any allegations of neglect immediately to the supervisor.<br><br>Interview with the 3-11PM Nursing Supervisor, RN #1, on 11/22/24 at 1:05 PM identified she first received an allegation of neglect related to NA #1 not performing her job duties for the assigned residents on the memory care unit when another nurse aide on 11/10/24 at 5:00 PM came to the office. RN #1 indicated she went to the unit between 6:00-7:00 PM and realized NA #1 was not on the unit. RN #1 identified the charge nurse, Licensed Practical Nurse (LPN) #1, expressed concern that NA #1 had spent time charting at the nurses' station and not doing work with residents. RN #1 indicated she sent a text message to NA #1, received a response from NA #1 that she, NA #1 had left the facility to go to the store, and she requested NA #1 return to the facility. RN #1 reported NA #1 came back ten (10) minutes later. RN #1 indicated she checked on the residents assigned to NA #1 and had observed NA #1 go into a few resident rooms but did not observe what NA #1 did. RN #1 identified although she contacted the covering Director of Nursing (DON) and Administrator and notified them of the allegations of neglect, she could not recall the time. RN #1 identified she was directed to send NA #1 home and NA #1 left the facility at 9:15 PM.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility Reporting Abuse to Facility Management Policy dated 4/2024 identified abuse was not condoned by the facility and directed any staff member or person affiliated with the facility who witnessed or believed a resident was a victim of abuse or neglect should immediately report the incident of abuse, or suspected abuse, to the Director of Nursing Services or the Administrator. |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>49021<br><br>Based on review of employee personnel files, review of facility policy, facility documentation, and interviews for one (1) of four (4) sampled staff (NA #1) who was employed by an outside agency, the facility failed to ensure the agency staff member was provided orientation and education prior to beginning the shift for the first time in accordance with facility policy. The findings include:<br><br>Review of facility documentation for the completion of agency employee orientation and education reflected a nurse aide, Nurse Aide (NA) #1, was not provided orientation and training prior to working for the first time at the facility on 11/10/24.<br><br>Interview with NA #1 on 11/22/24 at 1:30 PM identified it was her first time at the facility on 11/10/24 and indicated she was not provided with orientation or education on facility policies, including the facility abuse and neglect policy, prior to beginning the 3-11PM shift.<br><br>Interview and review of facility documentation with the Director of Nursing (DON) on 11/22/24 at 2:04 PM identified although the facility had a policy and procedures for orientation and providing education on facility policies, including the facility abuse policy, to all agency staffing personnel prior to beginning the first shift at the facility, the facility documentation reflected orientation and education was not provided to NA #1 prior to working at the facility on 11/10/24. The DON indicated the Nursing Supervisor was responsible for conducting the agency staff orientation and education prior to working on the floor. The DON indicated she was unsure why NA #1 was not provided with the orientation and education.<br><br>Review of the facility policy on Agency Orientation and Acknowledgement directed all agency staff have minimum facility orientation and are able to meet basic needs of facility's residents prior to beginning the first shift at facility and for a copy of the current facility abuse and neglect policy to be reviewed and provided by the facility for all staffing agency personnel. |