STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075306	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Manor	52 Missionary Rd Cromwell, CT 06416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 50177 Based on interviews, review of the clinical record and facility policy for 1 of 4 residents (Resident #454) reviewed for accidents, the facility failed to include in the Resident Baseline Care Plan interventions to prevent falls for a resident who sustained a fall with injury prior to admission and for 1 of 3 residents (Resident #554) reviewed for pressure ulcers, failed to initiate a Resident Baseline Care Plan for a resident admitted with an unstageable pressure ulcer. The findings include: 1. Resident #454 was admitted to the facility on [DATE] with diagnoses that included a displaced fracture of the anterior wall of the left acetabular (broken hip), dementia, and difficulty walking. A physician's order dated 3/25/24 directed no ambulation and to transfer using a mechanical lift with a two person assist. The Resident, Baseline Care Plan dated 3/25/24 identified that Resident #454 was a fall risk and had weight bearing restrictions with goals to maintain safety and to be free from falls/injury, however, did not identify any interventions to prevent falls. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #454 was severely cognitively impaired and required total dependence with all mobility utilizing his/her wheelchair. Walking was not attempted due to Resident #454's medical condition or safety concerns. Additionally, the MDS identified that Resident #454 had a fall within the last month and a fracture related to a fall within the last 6 months prior to admission. A nurse's note dated 3/29/24 at 10:34 PM identified that Resident #454 was found on the floor at 8:35 PM with an open, bleeding laceration on the back of his/her head and was sent to the hospital for further evaluation. A computed tomography (CT) scan of the pelvis completed at the hospital and dated 3/29/24 identified that the previous fractures (from Resident #454's fall prior to admission) demonstrated increased displacement when compared with the previous scan. A CT scan of the head dated 3/29/24 identified no acute intracranial hemorrhage (brain bleed). (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Nursing Services (DNS) on 4/22/24 at 11:25 AM identified that the admitting nurse supervisor at the time of admission was responsible for completing the Baseline Care Plan and if it was not completed, the DNS was responsible to ensure completion. Further, the DNS indicated that the Baseline Care Plan was to be completed within 48 hours and should have included interventions to prevent falls. The DNS stated that the facility was working with their Quality Assurance and Performance Improvement program to improve care plans. 2. Resident #554's diagnoses included hemarthrosis (bleeding into the joint cavity) of the right hip, unsteadiness on feet, and intervertebral disc disorder with radiculopathy (pinching of a nerve in the spinal column). Review of the Resident #554's care card (care plan) signed by nursing on 4/8/24 at 6:50 PM failed to identify any directives regarding a wound or a pressure relieving mattress (care card is blank). Physician's orders dated 4/9/24 directed the use of a pressure relieving mattress on the bed, and to cleanse the coccyx wound with normal saline, apply Medi honey and cover with foam dressing daily and as needed, and to monitor dressing to coccyx every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #554 was cognitively intact and was dependent on staff for bed mobility and toileting. Additionally, the MDS indicated the resident was admitted to the facility on [DATE] with an unstageable community acquired pressure ulcer. Interview and clinical record review with RN #4 (MDS Coordinator) on 4/23/24 at 11:38 AM identified that Resident #554 did not have a baseline or comprehensive person-centered care plan developed for his/her community acquired pressure ulcer. RN #4 identified that she was new to her role and that she worked with the DNS to develop the care plans, but that ultimately it was her job to initiate and review/revise care plans. She reported the care plan was missed and that she would initiate one. Subsequent to surveyor inquiry, a care plan was added for Resident #554 on 4/23/24 to identify an unstageable coccyx pressure ulcer. Review of the Baseline Care Plan policy dated 3/2022 directed, in part, that a baseline care plan is developed for each resident within 48 hours of admission to meet the resident's immediate health and safety needs. Additionally, the Baseline Care Plan includes instructions needed to provide effective, person-centered care of the resident that meets the professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #304) reviewed for accidents, the facility failed to assess the resident's neurological status and failed to complete a fall assessment following a fall with head injury per the facility policy. The findings include: Resident #304 's diagnoses included dementia, anxiety, history of a transient cerebral ischemic attack (TIA), atrial fibrillation, and blindness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #304 was severely cognitively impaired and required extensive assistance for bed mobility, transfers, and personal hygiene. Additionally, Resident #304 had balance issues during transitions when moving from a seated to standing position, and surface to surface transfers between the bed and chair or wheelchair. Review of the Resident Care Plan (RCP) in effect from 5/1/23 through 5/31/23 identified that Resident #304 was at risk for falls and required assistance with Activities of Daily Living (ADL's). Interventions included arranging personal items within reach, monitoring for safety, placing a floor mat to the right side of the bed, and providing the assistance of 1 staff for bed mobility, bathing, dressing, hygiene, and toileting. A nurse's note dated 5/31/23 at 2:13 PM identified that Resident #304 was receiving incontinent care by a NA and rolled off the side of the bed and sustaining a bleeding laceration to the right backside of his/her head and which required a pressure dressing. The note identified that vital signs were obtained but failed to indicate any neurological or fall assessments. Review of the facility's Accident and Incident (A&I), investigation information, and clinical record identified Resident #304 had fallen on 5/31/23. A Neurological Checks form was with the documentation which read: To be done following a head injury, TIA, active seizure, unwitnessed fall, or any other situation which may alter neurological status and that neurological checks were to be completed every 15 minutes for the first hour. The first line of the table on the form was time stamped on 5/31/23 at 11:45 AM but failed to document the level of consciousness, right and left pupil reactions, or the strength and sensation of both the right and left extremity (indicating neurological checks). Additional review of the clinical record (paper or electronic) failed to indicate a nurse's note indicating neurological signs or that a post fall assessment had been completed prior to Resident #304's transfer to the hospital on 5/31/23 at 11:51 AM. Interview with RN #3 (RN Supervisor) on 4/22/24 at 8:59 AM identified that according to the facility policy, after either an unwitnessed fall or a fall with a head injury, both neurological and fall assessments were to be conducted by the RN Supervisor. RN #3 indicated that previously the electronic health record had a Fall Assessment section, but due to a computer issue, the section was no longer available and both the neurological and fall assessments were to be conducted on paper and a nurse's note written. RN #3 was unable to locate assessments that Neurological Checks and a Fall Assessment had been completed following Resident #304's fall and she was unable to explain the lack of assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/22/24 at 10:30AM identified that no fall assessment was conducted (paper or the EHR) following Resident #304's fall with injury on 5/31/23, but that fall assessments should be conducted following any resident fall. Review of the Neurological Assessment policy dated 10/2010 directed, in part, that neurological assessments are indicated following a fall or other accident/injury involving head trauma and the nurse should check vital signs (temperature, pulse, respirations, and blood pressure), pupil reaction, determine motor ability, determine sensation in extremities, assess the gag reflex, and check eye opening, verbal and motor responses using the Glasgow Coma Scale. All assessment data obtained should be documented in the resident's medical record. Review of the Falls- Clinical Protocol policy dated 3/2018 directed, in part, that the nurse shall document/report on a change in cognition or level of consciousness, neurological status, and the frequency and number of falls since last physician visit. The staff and practitioner will review each resident's risk factors for falling and document in the medical record. The physician will identify medical conditions affecting fall risk and the risk for significant complications of falls.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on review of the clinical record, and interviews for the only sampled resident (Resident #19) reviewed for a change in condition, the facility failed to correctly transcribe physician's orders for a medication, Synthroid. The findings include: Resident #19 's diagnoses included hypothyroidism, metabolic encephalopathy, and Vascular Dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #19 was moderately cognitively impaired and required, maximal assistance with bed mobility, moderate assistance with eating and was dependent with toileting hygiene. The Resident Care Plan dated 4/6/22 identified issues with Activities of daily living. Interventions included providing all nourishment and medication through the G-Tube. Interview with Person #3 on 4/17/24 at 1:40 PM indicated that in 2022 Resident #19 had been receiving Synthroid 125 mcg, however, should have received Synthroid 62.2 mcg (one half of the 125 mcg dose). Person #3 reported the facility had requested to change the time of administration, to which they consented. After receiving Resident #19's laboratory result in November 2022 (5 months following the change in time of administration) Resident #19's blood level was noted to be abnormally low. Person #3 indicated that s/he believed Resident #19's Synthroid dosage had been doubled. A readmission hospital W10 dated 4/30/22 directed Resident #19 was to receive Synthroid, 125mcg (62.5 mcg total) tablet via PEG tube daily on empty stomach. A nurse's note dated 4/30/22 at 11:23 PM identified Resident #19 returned to the facility from the hospital, the APRN was notified, and verified the readmission orders. A physician's order dated 5/2/22 directed to give 125 mcg of Synthroid once daily, give one half tablet. Review of the Medication Administration Records (MAR) from 5/3/22 through 6/10/22 directed that Synthroid 125 micrograms (mcg) one half tablet (62.5 mcg) had been given every morning. On 6/10/22 the MAR indicated Synthroid 125 mcg (give 1/2 tab) had been discontinued. A time of administration change was noted on the MAR and the order for Synthroid 125 mcg was rewritten but lacked the indication that one half tablet (62.5 mcg) should be administered. A physician's order sheet dated 11/30/22 directed to discontinue the Synthroid. A Quality Assurance reporting form dated 3/15/23 indicated that a mediation administration and documentation error had occurred. Further, the form indicated the staff who had changed the time of administration had been reeducated on the 5 rights of medication administration (right route, right dose, right resident, right time, right medication). Although requested, the facility failed to provide a policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50250

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility policy, facility documentation, and interviews for 3 of 3 residents (Resident #554) reviewed for pressure ulcers, the facility failed to ensure a low air loss mattress was set at the appropriate setting for Resident #554's weight, and failed to assess and measure a community acquired pressure ulcer on admission. The findings include: Resident #554's diagnoses included hemarthrosis (bleeding into the joint cavity) of the right hip, unsteadiness on feet, and intervertebral disc disorder with radiculopathy (pinching of a nerve in the spinal column). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #554 was cognitively intact and was dependent on staff for bed mobility and toileting. Additionally, the MDS indicated the resident was admitted to the facility on [DATE] with an unstageable community acquired pressure ulcer. Review of discharge summary paperwork from Hartford Hospital dated 4/8/24 identified that resident was followed by wound care, but did not indicate where the wound was located, the measurement, or the treatment to the wound. Review of the Nursing Admission Evaluation dated 4/8/24 identified that Resident #554 was admitted with a wound but did not include an assessment of the wound or provide measurements of the wound on admission. Review of nursing progress notes dated 4/8/24 failed to identify a wound. Physician's orders dated 4/9/24 directed to monitor the dressing to the coccyx every shift, and cleanse the coccyx wound with normal saline, then apply Medihoney and cover with foam dressing daily and as needed. Review of nursing progress notes from 4/9/24 through 4/17/24 identified a wound to the coccyx but failed to identify wound measurements. A physician's note dated 4/10/24 failed to mention a wound on Resident #554. A wound physician note dated 4/15/24 identified Resident #554 with an unstageable pressure wound to the coccyx and included a wound evaluation and measurements of 6 cm x 3 cm x 0.1 cm. Interview with LPN #1 on 4/18/24 at 9:32 AM identified that the facility was aware prior to admission on 4/8/24 that Resident #554 had a wound to her coccyx and stated they were also alerted when they received report by phone from Hartford Hospital. A late entry nursing progress note on 4/18/24 at 12:35 PM identified that Resident #554 was seen by the wound physician on 4/15/24. The note included the measurements, assessment of the wound, and the treatment that was ordered and administered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #1 on 4/22/24 at 12:22 PM identified that no wound evaluation or measurements were done on admission for Resident #554. She indicated that it is facility policy that a community acquired wound is assessed and documented on admission by an RN in the Nursing Admission Evaluation, and identified the wound was not measured until she saw the resident with the wound physician on 4/15/24. She was unable to identify if the coccyx wound had increased in size or changed in appearance from 4/8/24 through 4/15/24. Review of the Prevention of Pressure Injuries policy dated 4/2020 directed, in part, to conduct a comprehensive skin assessment upon admission. During the skin assessment inspect for the presence of erythema, temperature of the skin and soft tissue, and edema. Evaluate, report, and document potential changes in the skin.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, review of facility documentation, and interviews for 4 of 5 residents (Resident #304) reviewed for accidents, the facility failed to appropriately supervise a resident resulting in a fall with a major injury. The findings include: Resident #304 's diagnoses included dementia, anxiety, history of a transient cerebral ischemic attack (TIA), atrial fibrillation, and blindness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #304 was severely cognitively impaired and required extensive assistance for bed mobility, transfers, and personal hygiene. Additionally, Resident #304 had balance issues during transitions when moving from a seated to standing position and surface to surface transfers between the bed and chair or wheelchair. Review of the Resident Care Plan (RCP) in effect from 5/1/23 through 5/31/23 identified that Resident #304 was at risk for falls and required assistance with Activities of Daily Living (ADL's). Interventions included arranging personal items within reach, monitoring for safety, placing a floor mat to the right side of the bed, and providing the assistance of 1 staff for bed mobility, bathing, dressing, hygiene, and toileting. Review of physician's orders in effect from 5/1/23 through 5/31/23, identified Resident #304 had been on Eliquis (a blood thinner) 5 milligrams (mg) twice daily and was at increased risk for bleeding. A nursing progress note dated 5/31/23 at 2:13 PM identified Resident #304 was in bed, receiving incontinent care from NA #1, and had rolled out of the bed. Resident #304 sustained a head laceration to the right back of his/her head, was bleeding, and complained of back pain. Pressure was applied to the area of bleeding, the APRN was notified, and the resident was transferred to the emergency room for an evaluation on 5/31/23 at 11:51 AM. Review of the hospital Discharge Summary dated 5/31/24 identified Resident #304 was on an anticoagulant (blood thinner) and was complaining of a fall out of bed while being changed. Resident #304 indicated that s/he struck the back of his/her head, reported a mild headache, and had pain between his/her shoulder blades. Resident #304 had a 2 centimeter laceration on the right back side of his/her head, received 3 staples, and underwent Computer Aided Tomography (CT) scans of the head, chest, and cervical and thoracic spine. The resident was given Tylenol 650mg (a pain reliever) with good effect. A nursing progress note dated 5/31/23 at 5:26 PM identified Resident #304 returned from the hospital, had 2 staples placed to the back right of his/her head, and had a hematoma (an area of blood pooling below the surface of the skin) noted. Review of the staff education sheet dated 5/31/23 identified that staff were to ensure all supplies were on hand and never to leave residents unattended, but if staff must leave, to ensure the resident was in a safe position with the call bell in reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #304's NA care card (care plan), updated 6/1/23, directed the assistance of 2 staff when providing care and for bed mobility. Interview and review of facility documentation on 4/17/24 at 11:46 AM with the DNS identified that NA #1 had left Resident #304 unattended. According to facility documentation, NA #1 was performing incontinent care on Resident #304, placed him/her on their side unsecured. NA #1 then left the resident on their side, unattended to obtain water from the resident's bathroom. While NA #1 was in the bathroom, Resident #304 verbalized s/he was sliding and was going to fall, but NA #1 was unable to reach the resident in time to prevent him/her from falling to the floor. NA #1 was educated to have supplies ready to perform care and not to leave resident's unattended on their side in the bed. Additionally Resident #304 should have been rolled onto his/her back prior to NA #1 leaving to obtain water from the resident's bathroom. Interview and clinical record review with PT #1 on 4/17/24 at 1:22 PM identified that Resident #304 had last been seen prior to his/her fall in June of 2022. At that time, Resident #304 had been made an assist of 1 for bed mobility and personal care, with a second staff to assist with transfers, the resident was non-ambulatory, used a specialized wheelchair, and had remained at the same functional status since the previous screening. Following Resident #304's fall on 5/31/23 PT received a request to screen the resident. Resident #304 was screened on 6/5/23 but was not not picked up for services as there had been no change from the previous screen in June 2022. Additionally, PT #1 identified that Resident #304 required partial to moderate assistance of 25-50% and anyone requiring any level of assistance with care is hands on and should not be left alone during care. She identified that staff leaving the resident in a side lying position to go the bathroom for water was not acceptable for safety reasons. She also indicated that Resident #304 had a balance deficit for sitting and standing. Resident #304 had not been assessed during the screen for bed mobility and PT #1 was unsure how capable Resident #304 would have been to stop him/herself from falling using the bed frame or mattress as Resident #304 did not have siderails on his/her bed to utilize for repositioning. PT #1 was unable to identify if Resident #304 required siderails for bed mobility as she had not assessed the resident for siderail use. Further review of the clinical record failed to identify if Resident #304 had his/her fall care plan intervention, a fall mat on the right side of the bed, in place as no post fall assessment had been conducted. Attempts to contact NA #1 were unsuccessful. Although requested, a facility policy for accidents and resident supervision and safety was not provided. Review of the facility Falls policy dated 3/2018 directed, in part, the staff and physician would identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on observation, interviews, review of the clinical record and facility policy for the only sampled resident (Resident #13) reviewed for respiratory care, the facility failed to provide oxygen therapy consistent with professional standards of practice. The findings include: Resident #13's diagnoses included chronic obstructive pulmonary disease, acute respiratory failure, and shortness of breath. A physician's order dated 3/19/24 directed to administer oxygen at 6 liters (L) via nasal cannula. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was without cognitive impairment and required partial/moderate assistance with toileting, showering, dressing, and personal hygiene. Walking was not attempted due to Resident #13's medical condition or safety concerns. Additionally, the MDS identified that Resident #13 received oxygen therapy. The Resident Care Plan dated 3/27/24 identified a problem with respiratory status. Interventions included to assess and monitor respiratory status and signs/symptoms of complications, medications and vital signs as ordered, and oxygen to maintain therapeutic oxygen level. Observation and interview with Resident #13 on 4/18/24 at 1:55 PM identified that he/she had returned to the unit after his/her portable oxygen tank was noted to be empty while attending a lunch group with recreation in an area of the complex requiring transportation via a wheelchair van. Resident #13 identified that he/she was without oxygen for approximately 2 minutes and he/she still felt shaky. Interview with LPN #1 on 4/18/24 at 2:14 PM identified that Resident #13 received 6 L of oxygen and that a portable oxygen tank would last about 1 hour for someone receiving 6 L of oxygen, therefore 2 tanks were typically supplied when Resident #13 left the unit. Additionally, LPN #1 identified that she did not administer or set the portable oxygen on Resident #13 when the resident left the unit and Resident #13 left the unit with only 1 tank. Interview with the Recreation Director (Life Enrichment Supervisor) on 4/18/24 at 2:19 PM identified that she had applied and set the portable oxygen on Resident #13. Additionally, the Recreation Director identified that she confirmed the oxygen setting of 6 L with LPN #1. The Recreation Director identified that she was unaware Resident #13 typically brought 2 portable oxygen tanks with him/her off the unit and connected only 1 tank. An additional interview with LPN #1 on 4/18/24 at 2:25 PM identified that she was in the hallway when the Recreation Director inquired on the liter flow of Resident #13's oxygen, however was not aware that the Recreation Director was applying oxygen to Resident #13. A nurse's note dated 4/18/24 at 3:36 PM identified Resident #13 went to a luncheon with recreation via wheelchair van, the portable oxygen tank was low and a Nurse Aide brought a new portable oxygen tank to Resident #13. Resident #13 then returned to the unit with the Nurse Aide in no distress. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 4/22/24 at 11:25 AM identified that only nurses are allowed to administer and set oxygen. Additionally, the DNS advised that staff would be retrained on who can apply oxygen to a resident. Review of the Oxygen Administration policy identified the steps to complete safe oxygen administration, including review of the physician's orders, completion of assessments before and during administration, and documentation. The Oxygen Administration policy was retrieved from the Nursing Services Policy and Procedure Manual for Long-Term Care. Subsequent to surveyor inquiry, a retraining dated 4/23/24 was provided identifying that only nurses can perform oxygen administration.