STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075309	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwich Woods Rehabilitation	1165 King Street Greenwich, CT 06831

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 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. Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for wound care, the facility failed to ensure wound treatment recommendations were implemented. The findings include: Resident #1 had diagnoses that included metastatic malignant neoplasm of breast, fungating mass (tumor has broken through the skin) of right breast, secondary malignant neoplasm of bone, severe protein-calorie malnutrition, and adult failure to thrive. The nursing admission body audit dated 11/14/24 at 4:37 P.M. completed by RN #3 (wound nurse) identified Resident #1 has alterations in skin integrity with a cancerous wound to h/her right breast that is erythematous (red)with sanguineous drainage (clear fluid mixed with blood). A physician's order dated 11/14/24 directed to cleanse the right breast cancer wound with Dakins 0.125 % (an antimicrobial cleanser) , pat dry, apply Xeroform 4x4 gauze (a non adhesive dressing), cover with dry gauze, and abdominal pad secure with large stockinette like tube top change daily while awake on the 11:00 P.M.- 7:00 A.M. shift. The care plan dated 11/15/2024 identified Resident #1 has impaired skin integrity with interventions that directed to provide treatment as ordered, weekly skin assessment per facility protocol, monitor for healing process and notify MD and responsible party if no improvement, and change treatment as indicated. Review of APRN #2's (wound APRN) note dated 11/19/24 at 9:48 A.M. identified Resident #1 was seen today for evaluation and management of wounds. APRN #2 identified Resident #1 has a full thickness wound to h/her right breast from carcinoma that measures 14.0 centimeters (cm) in length by 12.0 cm in width, with a depth of 0.2 cm, and a moderate amount of sanguineous drainage. APRN #2 identified on 11/19/24 for Resident #1's right breast the wound treatment recommendation directed to cleanse with 0.125 % Dakins, apply xeroform, calcium alginate with silver to base of the wound (absorbs excess moisture), secure with an abdominal pad, change daily and as needed. Review of the physician's orders dated 11/19/24 to 11/24/24 failed to reflect that APRN #2's wound treatment recommendation for Resident #1's right breast were implemented. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Treatment Administration Record (TAR) from 11/19/24 to 11/24/24 identified the wound treatments for Resident #1's right breast cancer directed to cleanse the right breast cancer wound with Dakins 0.125 %, pat dry, apply Xeroform 4x4 gauze, cover with dry gauze, and abdominal pad secure with large stockinette like tube top change daily while awake not before 5:00 A.M. and did not include APRN #2's wound treatment recommendations dated 11/19/24 that directed to apply calcium alginate with silver to base of wound. An interview with APRN #2 (wound APRN) on 12/19/24 at 3:25 P.M. identified on 11/19/24 she was consulted to evaluate Resident #1's wounds. APRN #2 identified Resident #1's right breast carcinoma wound had a moderate amount of sanguineous drainage. APRN #2 identified based on the amount of drainage from Resident #1's right breast she changed the wound treatment and added calcium alginate with silver to be applied to the base of the wound. APRN #2 identified on 11/19/24 her wound treatment recommendation for Resident #1's right breast wound directed to cleanse the right breast with 0.125 % Dakin's solution, apply xeroform, apply calcium alginate with silver to base of the wound, secure with an abdominal pad, change daily and as needed. APRN #2 identified on 11/19/24 Resident #1's wound treatment recommendations for the right breast should of been implemented. Interview with the DNS on 12/19/24 at 3:45 P.M. identified on 11/19/24 RN #3 (wound nurse) was on vacation and on the charge nurses of each unit conducted wound rounds with APRN #2. The DNS identified the charge nurses are responsible for implementing APRN #2's wound treatment recommendations. The DNS was unable to provide documentation to reflect that on 11/19/24 APRN #2's wound treatment recommendations for Resident #1's right breast was implemented. The DNS identified her expectation is the charge nurses implement APRN #2's wound treatment recommendations. The DNS further identified on 11/19/24 APRN #2's wound treatment recommendation for Resident #1's right breast should have been implemented. Review of facility undated wound treatment and wound care policy identified that there are scheduled wound observation rounds (same day each week) with observation of resident's skin (head to toe) and documentation of meetings will be kept to include recommendations as appropriate, new treatments, and progress of wounds.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for wound treatments, the facility failed to ensure the clinical record was complete and accurate to reflect wound treatments were administered. The findings include: Resident #1 had diagnoses that included metastatic malignant neoplasm of breast, fungating mass of right breast (the mass has broken through the skin), pressure-induced deep tissue damage of sacral region, pressure-induced deep tissue damage to right and left buttock, secondary malignant neoplasm of bone, severe protein-calorie malnutrition, and adult failure to thrive. The nursing admission body audit dated 11/14/24 at 4:37 P.M. completed by RN #3 (wound nurse) identified Resident #1 has alterations in skin integrity with a cancerous wound to h/her right breast that is erythematous (red) with sanguineous drainage (drainage mixed with blood). RN #3 identified Resident #1 has ulcers to lower right lateral leg, right medial leg, and lower left medial leg and pressure ulcers 'injury' to h/her right buttock and left buttock. a. A physician's order dated 11/14/24 directed to cleanse bilateral lower leg wounds with normal saline, pat dry, apply calcium alginate with silver gauze (absorbs wound drainage), cover with dry gauze, followed by rolled gauze daily change while awake before 5:00 A.M. Review of Resident #1's Treatment Administration Record dated identified Resident #1's wound treatments to h/her bilateral lower leg wounds were not administered per the physician's order on 11/15/24 during the 11 P.M. - 7 A.M., on 11/19/24 during the 11 P.M.- 7 A.M. shift, and on 11/20/24. Further review of Resident #1's TAR identified on 11/16/24 at 7:34 A.M. LPN #4 noted he did not administer Resident #1's wound treatment to h/her bilateral lower leg wounds because Resident #1 was sleeping, on 11/20/24 at 7:58 A.M. RN #1 noted she did not administer Resident #1's wound treatment to h/her bilateral lower leg wounds because Resident #1 refused, and on 11/21/24 at 8:14 A.M. RN #1 noted she did not administer Resident #1's wound treatment to h/her bilateral leg wounds because Resident #1 refused. Interview with RN #1 on 12/19/24 at 8:45 A.M. identified on 11/19/24 and 11/20/24 during the 11 P.M. - 7 A.M. shifts Resident #1 refused the wound treatments to h/her bilateral leg wounds. RN #1 indicated she notified RN #2 (7 A.M. -3 P.M. shift) when she came in to relieve her at 7 A.M. on 11/20/24 and 11/21/24. Interview with RN #2 (7 AM -3 PM shift) on 12/19/24 at 12:35 P.M. identified on 11/16/24 the 11:00 P.M. - 7:00 A.M. nurse LPN #4 reported to her that he did not administer Resident #1's wound treatment to h/her bilateral leg wounds because Resident #1 was sleeping. RN #2 indicated on 11/16/24 she administered Resident #1's wound treatment to h/her bilateral lower leg wounds per the physician's order. RN #2 identified on 11/20/24 and 11/21/24 RN #1 reported that she did not administer Resident #1's wound treatments to h/her bilateral leg wounds because Resident #1 refused. RN #2 indicated on 11/20/24 and 11/21/24 she administered Resident #1's wound treatments to h/her bilateral leg wounds. RN #2 identified on 11/16/24, 11/20/24, and 11/21/24 she forgot to document that she did administer Resident #1's wound treatments to h/her bilateral leg wounds. RN #2 identified she is expected to write a nurse note whenever she administers wound treatments. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although attempted an interview with LPN #4 was not obtained. b. A physician's order dated 11/14/24 directed to cleanse the right breast cancer wound with Dakins 0.125 %, pat dry, apply Xeroform 4x4 gauze, cover with dry gauze, and abdominal pad secure with large stockinette like tube top change dressing daily and as needed, cleanse the bilateral buttocks with normal saline, pat dry, apply calcium alginate, cover with dry clean dressing daily and as needed, and cleanse the on 11:00 P.M. - 7:00 A.M. change dressing while awake not before 5:00 A.M. The care plan dated 11/15/2024 identified Resident #1 has impaired skin integrity with interventions that directed to provide treatment as ordered, weekly skin assessment per facility protocol, monitor for healing process and notify MD and responsible party if no improvement, and change treatment as indicated. Review of Resident #1's Treatment Administration Record dated 11/19/24, 11/22/24, and 11/23/24 identified Resident #1's right breast cancer wound treatments were not administered per the physician's order. On 11/20/24 at 7:58 A.M. RN #1 documented noted Resident #1 refused, on 11/22/24 at 8:14 A.M. RN noted Resident #1 refused, and on 11/24/24 at 8:29 A.M. RN noted not administered due to condition. A nurse's note dated 11/24/24 at 8:00 A.M. written by RN #1 identified Resident #1's breast cancer dressing was found with old blood, supervisor notified. RN #1 identified an assessment was done by the supervisor RN #5 and RN #5 said she will take care of Resident #1's dressing. Interview with RN #1 on 12/19/24 at 8:45 A.M. identified on 11/19/24 and 11/22/24 during the 11 P.M. - 7 A.M. shifts when Resident #1 refused wound treatment to h/her right breast wound she reported it to RN #2 the 7 A.M. - 3 P.M. nurse who relieved her. RN #1 indicated on 11/23/24 during the 11 P. M. to 7 A.M. shift when Resident #1 refused wound care to h/her right breast she notified RN #5 the day shift supervisor. RN #1 indicated RN #5 came down to assess Resident #1 and told her she would take care of Resident #1's dressing. Interview with RN #5 on 12/19/24 at 10:30 A.M. identified she could not recall if on 11/24/24 RN #1 notified her that during the 11 P.M. - 7 A.M. shift on 11/23/24 Resident #1 refused h/her wound treatment to the right breast. RN #5 indicated she could not recall if she had assessed Resident #1, but RN #5 indicated if RN #1 documented that she did it was possible that she did. Interview with RN #2 (7 AM -3 PM shift) on 12/19/24 at 12:35 P.M. identified on 11/20/24, 11/23/24, and 11/24/24 when she came on duty to relieve RN #1 (11 P.M. - 7 A.M. shift) RN #1 reported that Resident #1 refused h/her right breast wound treatments. RN #2 indicated on 11/20/24, 11/23/24, and 11/24/24 she administered Resident #1's right breast wound treatments per the physician's order. RN #2 identified on 11/20/24, 11/23/24, and 11/24/24 she forgot to document that she did Resident #1's right breast wound treatments. RN #2 identified she is expected to write a nurse's note whenever she administers wound treatments. c. A physician's order dated 11/19/24 directed to cleanse right buttock and coccyx with normal saline, pat dry, apply Santyl and calcium alginate cover with a dry clean dressing daily and as needed once per day change dressing while awake not before 5:00 A.M. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's TAR dated 11/22/24 identified the wound treatment to Resident #1's right buttock and coccyx was not administered. RN #1 noted on 11/23/24 at 8:14 A.M. the wound treatment was not done because Resident #1 refused. Interview with RN #1 on 12/19/24 at 8:45 A.M. identified on 11/22/24 during the 11 P.M. - 7 A.M. shift Resident #1 refused the ordered wound treatment to h/her right buttock and coccyx. RN #1 indicated on 11/23/24 when RN #2 (7 AM - 3 PM) came in to relieve her she reported to RN #2 that Resident #1 refused the wound treatment to h/her right buttock and coccyx. Interview with RN #2 (7 AM - 3 PM shift) on 12/19/24 at 12:35 P.M. identified on 11/24/24 during report RN #1 communicated to RN #2 that Resident #1 refused the wound treatment to h/her right buttock and coccyx during the 11 P.M.- 7 A.M. shift on 11/23/24. RN #2 indicated on 11/24/24 she administered Resident #1's wound treatment to h/her right buttock and coccyx per the physician's order. RN #2 identified on 11/24/24 she forgot to document that she did Resident #1's wound treatment. RN #2 identified she is expected to write a nurse's note whenever she administers wound treatments. An interview with the DNS on 12/19/24 at 1:05 P.M. identified whenever a nurse administers an as needed wound treatment, she expects a nurse's note to be written in the resident's medical record. The DNS identified when RN #2 administered Resident #1's wound treatments because Resident #1 was asleep or when Resident #1 refused RN #2 should have written a nurse's note to identify that RN #2 administered Resident #1's wound treatments. Review of the facility charting and documentation policy dated 2023, in part, identified all services provided to the resident shall be documented in the resident's medical record and the following information is to be documented in the resident medical record treatments or services performed.