STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075312	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wadsworth Glen Health Care and Rehabilitation Cent	30 Boston Rd Middletown, CT 06457

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021 Based on clinical record reviews, review of facility documentation, review of facility policy and interviews for four of six sampled residents (Residents #8, #9, #10, and #12) reviewed for a potential allegation of verbal abuse, the facility failed to ensure the residents were treated in a dignified and respectful manner when a staff member used insensitive language when speaking to a resident and a staff member yelled in front of a resident. The findings include: 1. Resident # 8's diagnoses included overactive bladder, bipolar disorder, and paroxysmal atrial fibrillation. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #8 was cognitively intact and required extensive assistance of one (1) staff person for most Activities of Daily Living. The Facility Reported Incident report dated 7/22/21 at 10:00 AM indicated Resident #8 alleged a staff member called Resident #8 a liar and turned off the call bell without toileting Resident #8. The report identified the facility substantiated that the charge nurse told Resident #8 that he/she used the bathroom too frequently and the nurse may have shut the call light off. The report indicated this caused emotional distress to Resident #8. The investigation identified the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #2, spoke in an undignified manner and used insensitive language toward Resident #8 when LPN #2 told Resident #8 that he/she used the bathroom too frequently and called Resident #8 a liar. The summary report dated 7/28/21 identified employment with LPN #2 was terminated. Interview and review of the Facility Reported Incident report with the Director of Nursing (DON) on 7/3/24 at 10:54 AM indicated although he was not at the facility at the time of the incident, based upon the facility documentation reviewed, the outcome of the investigation determined LPN #2 did not speak to Resident #8 in a respectful manner. The DON identified it was the expectation for all staff to treat all residents with respect while providing the care a resident needed. 2. Resident #9's diagnoses included osteoarthritis, bipolar disorder, and anxiety. The annual Minimum Data Set assessment dated [DATE] identified Resident #9 was cognitively intact and required limited one (1) person assistance with dressing and personal hygiene. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident report dated 11/17/23 identified NA #5 was in the hallway yelling at other staff. The report indicated Resident #9 became visibly upset by the behavior of NA #5 and was seen crying and shaking. Interview and review of the Facility Reported Incident report with the Administrator on 7/3/24 at 9:35 AM identified an investigation was conducted and determined NA #5 was in the hallway yelling at other staff about Resident #9's grievance and Resident #9 became upset by the behavior of NA #5. The Administrator identified NA #5 was not permitted back to the facility following the incident. 3. Resident #10's diagnoses included unsteadiness, need for assistance with personal care, and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #10 was cognitively intact and required limited one (1) staff person assistance with bed mobility, transferring, toileting, and personal hygiene. The Facility Reported Incident report dated 8/9/23 identified Resident #10 reported a nurse aide yelled at him/her on 8/8/23 on the 11PM-7AM shift after Resident #10 went to the bathroom on his/her own without waiting for assistance from a staff member. The investigation identified NA #6 communicated with Resident #10 in a manner that was unacceptable and not respectful of Resident #10. The report indicated NA #6 answered Resident #10's call bell on 8/8/23 on the 11PM-7AM shift, questioned Resident #10 why resident needed assistance and commented to Resident #10 that I was just in here ten (10) minutes ago. Interview and review of the Facility Reported Incident report dated 8/9/23 with the Director of Nursing (DON) on 7/3/24 at 10:58 AM identified although he was not at the facility at the time of the incident, based upon the facility documentation reviewed, the outcome of the investigation determined NA #6 did not speak to Resident #10 in a respectful manner. The DON identified it was the expectation that all staff members treat residents with dignity and speak to residents in a respectful manner. Review of the facility Resident's [NAME] of Rights dated 7/2021 directed residents had the right to be treated with consideration, respect, and full recognition of his/her dignity and individuality. 4. Resident #12's diagnoses included dementia and muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #12 rarely made decisions regarding tasks of daily life, required substantial to maximum assistance with toileting, partial to moderate assistance with ambulating, utilized a wheelchair for mobility, was occasionally incontinent of bowel and bladder, and has a history of falls. The Resident Care Plan dated 1/29/24 identified Resident #12 was at risk for falls. Interventions directed to toilet early on first rounds, to provide frequent toileting throughout shift, keep wheelchair by the bed, and call bell within reach. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 2/3/24 at 11:30 PM identified Resident #12 was found on the bathroom floor sitting on his/her buttock in front of the toilet and Resident #12 stated I had to go to the bathroom. The Facility Reported Incident form dated 2/4/24 identified Resident #12 sustained a fall in the bathroom without injury on 2/3/24. The report indicated the nurse aide upset with another staff member entered Resident #12's room using profanity in front of Resident #12. The investigation identified the 11PM-7AM nurse aide, Nurse Aide (NA) #7, and the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #3, had an argument at the nurse's station which carried into Resident #12's room when NA #7 went to assistance with getting Resident #12 up and off the floor. In an interview with the Administrator on 7/3/24 at 10:54 AM identified Resident #12 had fallen around the change of shifts, and LPN #3 asked NA #7 where she was and why Resident #12 had not been checked. The Administrator indicated the conversation took place at the nurse's station and NA #7 was swearing, NA #7 went into Resident #12's room and continued swearing, Resident #12 apologized to NA #7 for being an inconvenience and falling. The Administrator identified at the conclusion of the investigation NA #7 was terminated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #1) who were reviewed for the implementation of the care plan, the facility failed to ensure Resident #1 was transferred with the assistance of two (2) staff members. The findings include: Resident #1's diagnoses included fracture of the lateral condyle of the right tibia (lower leg), fracture of the left calcaneus (heel), unspecified head injury and arthritis. The nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time and required assistance of two (2) staff members with toileting, transferring, and ambulation with the use of a walker (a device to assist with ambulation) with partial weight bearing restrictions. The Resident Care Plan dated 8/27/21 identified a risk for activities of daily living deficit related to recent hospitalization for fall with fractures and non-weight bearing to the left lower extremity and toe touch weight bearing to the right lower extremity, impaired mobility, and pain. The care plan identified a left calcaneus fracture and right lateral tibial plateau fracture repaired with open reduction internal fixation (ORIF) and at risk for falls. Interventions directed to keep the call bell within reach, Occupational and Physical therapy evaluations and treatment as ordered, assist with position changes as needed, encourage elevation of fracture site, monitor circulatory motor sensation, non-weight bearing to the left lower extremity, toe touch weight bearing to the right lower extremity, orthopedic follow up as ordered, instruct in proper use of appliance and device to aid with balance/ and transfers and encourage use, and instruct to ask for assistance prior to attempting to transfer or ambulate as needed. A physician's order dated 8/28/21 directed the activity orders out of bed to chair as tolerated, ambulation with rehabilitation only, assist of two (2) staff members for transfers from bed to chair with rolling walker, assist of two (2) staff members to transfer to bedside commode for toileting, and assist of one (1) staff member for activities of daily living at bed or wheelchair level to resident's preference with precautions of non0weight bearing to left lower extremity and toe touch weight bearing to right lower extremity. The resident care card, undated, directed for transfer status with assist of two (2) staff members with toe touch weight bearing to the right lower extremity and non-weight bearing to the left lower extremity with pivot on right lower extremity. Interview and picture review with Person #4 on 7/3/24 at 7:57 AM identified Resident #1 was observed being transferred with only one (1) staff member. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, review of complainant pictures and clinical record review with the Director of Nursing (DON) on 7/3/24 at 11:03 AM identified the physician's order directed for Resident #1 to be out of bed to chair as tolerated, ambulate with therapy only, assist of two (2) staff members bed to chair with rolling walker, assist of two (2) staff members to bedside commode for toileting, assist of one (1) staff member for activities of daily living at bedside or wheelchair level with toe touch weight bearing to right lower extremity and non-weight bearing to left lower extremity. The DON identified there was also an order that directed for right lower extremity toe touch weight bearing, can use pivot with assistance of two (2) staff members. Although requested, a policy on weight bearing status was not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #1) who were reviewed for pain management, the facility failed to ensure the hospital discharge order for ice to the lower extremities five (5) times a day for twenty (20) minute intervals was implemented. The findings include: Resident #1's diagnoses included fracture of the lateral condyle of the right tibia (lower leg), fracture of the left calcaneus (heel), unspecified head injury and arthritis. The nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time and required assistance of two (2) staff members with toileting, transferring, and ambulation with the use of a walker (a device to assist with ambulation) with partial weight bearing restrictions. The Resident Care Plan dated 8/27/21 identified a risk for activities of daily living deficit related to recent hospitalization for fall with fractures and non-weight bearing to the left lower extremity and toe touch weight bearing to the right lower extremity, impaired mobility, and pain. The care plan identified a left calcaneus fracture and right lateral tibial plateau fracture repaired with open reduction internal fixation (ORIF) and at risk for falls. Interventions directed to keep the call bell within reach, Occupational and Physical therapy evaluations and treatment as ordered, assist with position changes as needed, encourage elevation of fracture site, monitor circulatory motor sensation, non-weight bearing to the left lower extremity, toe touch weight bearing to the right lower extremity, orthopedic follow up as ordered, instruct in proper use of appliance and device to aid with balance/ and transfers and encourage use, and instruct to ask for assistance prior to attempting to transfer or ambulate as needed. Review of the hospital discharge summary dated 8/27/21 directed for Resident #1 to keep the extremities elevated and to apply ice five (5) times a day for twenty (20) minute intervals. A physician's order dated 8/27/21 directed to monitor pain every shift using the zero to ten (0-10) pain scale. Interview and clinical record review with the Director of Nursing (DON) on 7/3/24 at 11:03 AM identified the hospital discharge summary included an order to ice the lower extremities five (5) times a day for twenty (20) minute intervals, but this was not reflected in the physician orders or care plan. Review of the facility policy titled, Pain Management, dated April 2015, directed, in part, the facility will, to the extent possible, develop and implement interventions/approaches to pain management, both pharmacological and non-pharmacological.