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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075317	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilton Meadows Health Care Center	439 Danbury Rd, Route 7 Wilton, CT 06897

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure a resident was free from abuse resulting in a fracture. The findings include: a. Resident #1 had diagnoses that included dementia with other behavioral disturbance, depression, and anxiety. The significant change Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of six (6) indicative of severely impaired cognition, was occasionally incontinent of bowel and bladder, required moderate assistance with transfers, and required supervision with ambulation. The Resident Care Plan (RCP) dated 2/26/2025 identified treatment with antipsychotic medication related to anxiety, depression, and dementia. Interventions directed to evaluate the effectiveness and side effects of medications for possible decrease or elimination, observe mood and behavior, refer to psych for medication and behavior management, and observe interactions with others for appropriateness. The physician's order dated 3/1/2025 directed to monitor behaviors of agitation and resistiveness every shift. b. Resident #2 had diagnoses that included dementia, anxiety, adjustment disorder with mixed anxiety and depressed mood, restlessness and agitation. The physician's order dated 2/3/2025 directed to monitor behaviors of restlessness and agitation every shift. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP dated 2/4/2025 identified Resident #2 had a new diagnosis of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Interventions directed to engage in friendly conversations to help h/her feel welcomed and comfortable in the new environment, observe for signs of anxiety or distress if noted, provide additional support such as adjusting h/her environment, offering companionship, or notifying nursing staff for further intervention, offer access to preferred calming music through a radio, CD player, or digital device during relaxation times, ensure music is available in h/her room as per h/her request, and encourage family members to visit regularly and stay involved in her care to promote emotional well-being, and assist in coordinating visits. APRN #1's service note dated 2/6/2025 identified Resident #2 was seen for an initial encounter and was restless and wandering in the halls, with h/her son, discussing leaving. The note indicated staff denied increased behaviors and would continue to monitor. The admission MDS dated [DATE] identified Resident #2 had a Brief Interview for Mental Status score of five (5) indicative of severely impaired cognition, rejection of care behavior that occurred one to three days weekly, was frequently incontinent of bowel and bladder, required moderate assistance with transfers, and independent of with ambulation. SW #2's service note dated 2/11/2025 identified Resident #2 was alert to people only, pleasant, and cooperative and further identified an anxious and agitated mood. The note identified Resident #2 informed her that h/she was waiting for h/her son to take h/her home and that it was unclear if Resident #2 would be staying at the facility long term. APRN #1's service note dated 2/13/2025 identified behavioral concerns of restlessness with moderate severity. The note identified Resident #2 stated h/she was in good spirits and looking forward to going home and that, per staff, Resident #2's family decided not to tell Resident #2 that h/she was staying at the facility for long term care. A nurse's note dated 2/16/2025 at 2:30 A.M. by LPN #2 identified Resident #1 was restless through the night, continued to get out of bed and was redirected without a positive effect. The note identified Resident #2 removed h/her top and refused to put it back on, and further identified multiple attempts to redirect Resident #2 back to h/her room and Resident #2 refused. The note identified Resident #2 developed aggressive behaviors, the supervisor was notified, and a note was left in the APRN book. APRN #1's service note dated 3/3/2025 identified she was asked to evaluate Resident #2 with pertinent diagnoses of dementia, anxiety, and insomnia. The note identified Resident #2 was in the hall at the nurse's station crying, very upset, wanted to go home and Resident #2 was having increased moments of tearfulness and anxiety and was difficult to redirect. The note identified Resident #2 was more restless and agitated and APRN #1 ordered a onetime dose of Seroquel and would start Rexulti (a medication used to treat depression and agitation associated with dementia) 0.5 milligrams (mg) at bedtime. Physician's orders dated 3/3/2025 directed to administer Seroquel (a medication used to treat agitation, aggressive behaviors, hostility, and psychosis) 25 mg one time only and administer Rexulti 0.5 mg one time per day at 9:00 P.M. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW #2's note dated 3/5/2025 at 11:53 A.M. identified Resident #2's mood was depressed and Resident #2 appeared anxious due to confusion. A nurse's note dated 3/15/2025 at 6:24 P.M. by LPN #1 identified Resident #2 was confused, occasionally agitated and restless. APRN #3's telehealth visit note dated 3/16/2025 at 3:04 P.M. identified she was notified by RN #1 that Resident #2 assaulted another resident. APRN #3 identified that RN #1 reported Resident #2's behaviors had been escalating, and Resident #2 was evaluated by psych with changes made to h/her psychotropics. APRN #3 identified that Resident #2 struck another resident in the face and is being hostile towards nursing staff, Resident #2 is not redirectable, and requires transfer to the emergency department. The facility accident and incident report dated 3/16/2025 at 5:00 P.M. identified a resident-to-resident abuse incident with injury occurred on 3/16/2025 at approximately 3:00 P.M. Resident #2 was witnessed by a nurse aide (NA) leaving Resident #1's room, then the NA observed Resident #1 sitting on his/her room floor with an abrasion to h/her right eye lid, and both residents were transferred to the hospital for further evaluation. A review of Resident #1's emergency department documents dated 3/16/2025 identified that an X-ray of Resident #1's nasal bones identified cortical irregularity in the nasal bone suspicious for fracture and Resident #1 was diagnosed with a nasal fracture. The facility reportable event summary dated 3/19/2025 identified that at approximately 3:00 P.M. on 3/16/2025 Resident #1 was calling for help from h/her room, staff responded immediately, observed Resident #2 exiting Resident #1's room, and observed Resident #1 on the floor with a 0.5 centimeter periorbital abrasion with minor nasal bleeding. Resident #1 reported that Resident #2, who appeared to be confused, entered h/her room, claimed the room belonged to h/her, and became aggressive. Resident #1 alleged that Resident #2 punched h/her in the face and pushed h/her to the floor. The incident was unwitnessed. The attending physician was notified, and both residents were sent to the hospital. Resident #1's radiology report indicated a cortical irregularity in the nasal bone and Resident #2 underwent a psychiatric evaluation and was cleared to return to the facility. Resident #1 was relocated to a different unit. Resident #2 was re-evaluated by psych with medication adjustments and initiation of increased monitoring of aggression and behavioral changes was implemented. Interview with LPN #1 on 4/2/2025 at 9:20 A.M. identified on 3/16/2025 at approximately 2:30 P.M. she was sitting at the nurse's station completing her charting when she heard Resident #1 yelling 'help.' LPN #1 identified she observed Resident #1 was sitting on the floor in h/her room with NA #1 standing next to h/her, and Resident #2 was exiting the room. LPN #1 identified she notified RN #1 and directed NA #1 to stay one to one with Resident #2 until Resident #2 went to the hospital. Interview with NA #2 on 4/2/2025 at 10:20 A.M. identified during the morning of 3/16/2025 she attempted to provide personal care to Resident #2 and Resident #2 became combative and struck out in an attempt to hit her. NA #2 indicated she notified LPN #1 of the behavior. NA #2 identified that if Resident #2 did not want personal care h/she would usually say 'don't touch me.' Review of the clinical record identified there was no update to the RCP or further interventions after the combative incident with NA #2 on the morning of 3/16/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/2/2025 at 12:00 P.M. identified that prior to 3/16/2025 Resident #2 had behaviors which included agitation and anxiety. The DNS identified when Resident #2 returned to the facility after the 3/16/25 incident, h/she was monitored hourly for 48 hours and stop signs were placed on various resident doorways as a precaution. The DNS indicated she was not made aware of the combative incident between Resident #2 and NA #2 on 3/16/25. Review of facility policy titled, Abuse Prevention dated December 2016 identified as part of the resident abuse prevention the administration will protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.