

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42117</p> <p>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #87 and #378) reviewed for pressure ulcers, the facility failed to notify the physician and resident representative when new open areas were identified and 1 of 2 residents (Resident #274) reviewed for admission, the facility failed to notify the physician when a 2 glaucoma medications were not available and when a resident was admitted to the facility with an implanted cardiac defibrillator which required a bedside monitor. The findings include:</p> <p>1. Resident #87 was admitted to the facility in December 2021 with diagnoses that included dementia and osteoporosis.</p> <p>The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition, required maximum assistance with personal hygiene, and was totally dependent for transfers and rolling left to right. Additionally, Resident #87 was at risk to develop a pressure ulcer but did not have any pressure ulcers.</p> <p>The care plan dated 8/14/24 identified Resident #87 was at risk for skin breakdown. Interventions included to monitor skin when putting on and off compression stockings to bilateral lower extremities and position resident to offset pressure areas while awake.</p> <p>The nurse's note written by LPN #7 dated 9/10/2024 at 6:21 AM identified this writer was informed by a nurse's aide of a wound to the resident heel. This writer cleansed the wound site, offloaded the heel with pillow, and updated physicians book for the heel to be evaluated for a treatment.</p> <p>Review of the nurse's and physician's progress notes dated 9/10/24 to 9/11/24 failed to reflect the physician, APRN or resident representative had been notified of the new wound on the resident right heel.</p> <p>A progress note, written by MD #1 dated 9/12/24 at 2:48 PM indicated that staff reports a new right heel ulcer. Resident #87 is alert, confused and disoriented. There is a 4.5cm unstageable ulcer on the right heel with no exudate or tenderness. There is + 2 - 3 right pedal edema with no other clinical changes. MD #1 ordered a wound consult, bilateral heel boots, and a daily dressing with Santyl for chemical debridement.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/7/24 at 9:13 AM indicated that when a new pressure ulcer is noted, the nurse must notify the APRN or physician and resident representative that day and document the notification in the clinical record. After clinical record review, the DNS indicated the physician and resident representative were not notified until 9/12/24, 2 days later. The DNS it is not acceptable practice to place a notation of a new wound in the communication book for the physician.</p> <p>Interview with LPN #7 on 10/7/24 at 1:10 PM indicated that on 9/10/24 the nurse aide had informed him that the resident had an open area on the right heel. LPN #7 indicated he went and looked at it, cleansed it with normal saline, and placed a boarder gauze dressing over it. LPN #7 indicated that he had placed a notation of the wound in MD #1's book. LPN #7 indicated that he did not call the APRN, MD, or resident representative, or notify the RN supervisor because he had placed it in the physician book.</p> <p>Interview with MD #1 on 10/7/24 at 10:45 AM indicated that he had seen Resident #87 on 9/12/24 for his/her monthly visit. MD #1 indicated that he does not recall on that day how he learned about the new pressure ulcer and indicated that he would have expected someone to call him on 9/10/24 to let him know so he could have put a treatment in immediately.</p> <p>The policy on pressure injury risk assessment directed that the facility should notify the physician and resident representative if any new skin alternations were noted.</p> <p>2. Resident #274 was admitted to the facility in September 2024 with diagnoses that included cardiomyopathy, ventricular tachycardia, and Glaucoma.</p> <p>a. The physician's order dated 9/23/24 identified to administer Brimonidine Timolol drops 0.2 -0.5%, 1 drop in each eye daily and Bimatoprost drops 0.01% administer 1 drop to both eyes every other day for Glaucoma.</p> <p>The care plan dated 9/24/24 identified Resident #274 had vision impairment. Interventions included to report any concerns or changes to the physician and resident representative as needed.</p> <p>Review of the September 2024 MAR identified from 9/24/24 through 9/27/24, 4 days, Brimonidine Timolol drops 0.2 - 0.5% was documented as not available (4 doses). Additionally, from 9/24/24 through 9/30/24, 7 days the Bimatoprost drops 0.01% were documented as not available (4 doses).</p> <p>Review of the physician and nurse's notes dated 9/23/24 through 9/30/24 failed to reflect that the physician had been notified that the glaucoma medications, Brimonidine Timolol and Bimatoprost and were not available.</p> <p>Interview with Resident #274 and Person #1 on 10/6/24 at 10:08 AM indicated they were upset that Resident #274 did not receive the 2 eye drops during for 4 - 7. Resident #274 indicated that he/she was not informed why the facility could not get them from the pharmacy. Person #1 indicated that he/she had brought in the eye drops when the nurse informed them that they were not available from the pharmacy and Person #1 offered again to bring in the eye drops from home and the nurse informed Person #1 that the facility could not use them. Person #1 indicated that he/she had brought in the vials with the pharmacy labels on them and showed them to a nurse, and was informed again that the facility could not use the resident's bottles of eye drops. Person #1 indicated that subsequently, Resident #274 miss 4 - 7 days of the eye drops when that was not necessary.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/7/24 at 7:07 AM indicated that if a medication is not available from the pharmacy the nurses could use the resident's personal medication with a pharmacy label on it, until the pharmacy medication arrives. The DNS indicated that the charge nurse should have notified the supervisor, and she would have expected the supervisor to call the pharmacy for a stat order for the 2 eye drops and if the medication was still not available to notify the physician. The DNS indicated that the supervisor could have received an order from the physician that Resident #274 could have used own medications until available from the pharmacy. The DNS indicated that the physician should have been notified immediately upon admission that the medications were not available and for each day that medications were missed. The DNS indicated that there were no nurse's notes that the supervisor or charge nurse had notified the pharmacy or the APRN/MD that the medications were not given because they were not available.</p> <p>b. The hospital discharge summary dated 9/23/24 identified Resident #274 had an implanted cardiac defibrillator.</p> <p>The physician's orders and progress notes and the nurse's notes dated 9/23/24 to 10/6/24 did not reflect that Resident #274 had an implanted cardiac defibrillator with a continuous monitor at the bedside.</p> <p>The care plan dated 9/30/24 did not reflect that Resident #274 had an implanted cardiac defibrillator with a continuous monitor.</p> <p>Observation 10/6/24 at 8:00 AM identified Resident #274 was lying in bed with a white box plugged into the wall on the nightstand within 2 feet from resident.</p> <p>Observation on 10/6/24 at 10:08 AM identified Resident #274 had a raised area on the left chest wall.</p> <p>Interview with Person #1 on 10/6/24 at 10:08 AM indicated that he/she had informed the nurse on day of Resident #274's admission and the day after admission that she had brought in and plugged in the implanted cardiac defibrillator monitor and it was sitting on the bedside table doing the continuous transmission. Further, Person #1 showed had placed the owner's manual for implanted cardiac defibrillator monitor in the top draw of the nightstand in the resident's room.</p> <p>Interview with LPN #16 on 10/6/24 at 10:30 AM indicated she was responsible for Resident #274's care today. LPN #16 indicated that she was not aware Resident #274 had a cardiac monitor or a defibrillator.</p> <p>Interview with the DNS on 10/9/24 at 8:33 AM indicated that after review of the clinical record, since admission on 9/23/24 until today 10/9/24 the cardiologist had not been updated about Resident #274's admission, nor was the primary physician at the facility notified that Resident #274 had an implanted cardiac defibrillator that required a monitor, which was at the bedside. The DNS indicated that this should have been done on the day of admission. The DNS directed RN #4 to call the cardiologist and the resident's primary physician for direction regarding the cardiac device and the monitor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After surveyor inquiry, interview with RN #4 on 10/9/24 at 9:20 AM indicated that she called the cardiologist and was informed the monitor must be at least 10 feet away from Resident #274 when resident is sleeping and frequent checks to make sure the monitor is on and functioning. RN #4 indicated that she put the order in place and was waiting for the cardiologist to fax over more information. RN #4 indicated that she would call MD #1 to notify him of the cardiac device and monitor once she received more information from the cardiologist today.</p> <p>The physician's order dated 10/9/24 directed to check cardiac monitor at 8:00 PM and 11:00 PM daily. Ensure the monitor is plugged in and functioning properly and at least 10 feet away from resident when sleeping.</p> <p>Review of the medication administration times policy indicated that medications were to be administered at the determined times per the physicians orders.</p> <p>Although requested, a facility policy for notification to physician when medications are not available from the pharmacy was not provided.</p> <p>Although requested, a facility policy for implanted cardiac devices with monitors was not provided.</p> <p>46040</p> <p>3. Resident #378 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, edema, and gout.</p> <p>The physician's order dated 9/17/24 directed to complete Braden scale and weight every week on the 1st shower day of the week (Monday 3:00 PM - 11:00 PM shift) for 4 weeks and then once monthly, update wound management weekly (every Tuesday) with measurements and details of the right upper back site and document a progress note every shift including reason for admission, treatments in progress, response to treatments, and any other pertinent information.</p> <p>The physician's order dated 9/19/24 directed to complete body audits every week on the 1st shower day of the month (Monday 3:00 PM - 11:00 PM shift) with special instructions to please check and update resident wound management observations.</p> <p>The care plan dated 9/19/24 identified Resident #378 was at risk to develop pressure ulcers. Interventions included to complete skin evaluations.</p> <p>A wound APRN note dated 10/3/24 identified Resident #378 was seen for wound follow up to the medial back. The note identified Resident #378 had 3 new areas assessed at this visit and included: a new penile wound identified as a laceration, measuring 4 cm x 5 cm x 0.3 cm with a small amount of serosanguinous drainage; a new coccyx wound, identified as a stage 3 pressure ulcer, measuring 4 cm x 1 cm x 0.2 cm with a moderate amount of serosanguinous drainage; and a new left buttock wound, classified as a stage 3 pressure ulcer, measuring 5 cm x 2.5 cm x 0.2 cm with a moderate amount of serosanguinous drainage. The treatment plan included bacitracin and zinc to the penile wound and calcium alginate to the 2 newly identified pressure ulcers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with MD #1 on 10/7/24 at 10:52 AM identified that weekly body audits and Braden scales were standard orders and were usually done on a resident's shower day and that if anything was discovered going on with a resident's skin, the nurse aide should notify the nurse caring for the resident, and if the issue was related to a newly identified wound, the nurse should notify the wound nurse, as well as the APRN or MD to know that the next steps should be, and that the notification should happened the same day.</p> <p>Interview with LPN #4 on 10/9/24 at 8:35 AM identified that she was notified of a new open area on Resident #378's penile area and left sacrum on 9/29/24. LPN #4 identified she documented a nurses note but did not notify the RN supervisor or the resident representative. LPN #4 identified that the penile area previously had excoriation, and the left sacrum appeared to be a skin shear injury, however she did not assess either site any further. LPN #4 identified that she entered a request for wound care evaluation in the wound care communication book, which is what the facility used to notify the wound care APRN a resident needed to be seen. LPN #4 also identified that the facility's wound care nurse, RN #1, also made rounds on the units and was supposed to review the book for any issues.</p> <p>Interview with DNS on 10/9/24 at 10:10 AM identified that the facility did utilize a communication book but the licensed nurses, but newly identified wounds require direct notification to the resident's family, the APRN or the on-call provider or using the Third Eye (telehealth) providers to assess the resident for the next steps with treatments.</p> <p>The policy on acute condition changes directed that the nursing staff would contact the physician based on the urgency of the situation, that the nurse and physician would discuss possible causes of the condition change, and the physician would help identify and authorize appropriate treatments.</p> <p>The policy on pressure injury risk assessment directed that the facility should notify the MD and resident representative if any new skin alternations were noted.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37293</p> <p>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Resident #24, 39 and 87) reviewed for abuse and pressure ulcers, the facility failed to protect Resident #24 from physical abuse by Resident #19, who had a history of resident to resident altercations, failed to protect Resident #39 from physical abuse by Resident #24, who had a history of resident to resident altercations and the facility a failed to ensure the Resident #87 was not neglected when staff did not complete a daily dressing change to a pressure ulcer on the resident's heel for 4 consecutive days despite documenting that the dressing change had been done. The findings include:</p> <p>1. Resident #24 was admitted to the facility in September 2022 with diagnoses that included dementia with behavioral disturbance, anxiety disorder, psychotic disturbance, and depressive episodes.</p> <p>The care plan dated 11/26/22 identified Resident #24 had physical aggression. Interventions included to report any verbal, physical, sexual or aggressive expressions to the charge nurse immediately three times a day on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift.</p> <p>The physician's order dated 3/1/23 - 3/31/23 directed to monitor behavior for aggression and angry outburst on every shift night, day, and evening.</p> <p>The quarterly MDS dated [DATE] identified Resident #24 had moderately impaired cognition and required extensive assistance with personal hygiene. Additionally, Resident #24 had no behaviors of physical or verbal directed toward others.</p> <p>The reportable event form dated 3/16/23 at 5:00 PM identified staff witnessed Resident #19 throwing water at Resident #24 after having a verbal argument. Both residents were immediately separated, and an RN assessment identified Resident #24 had no injuries. Psychiatrist and social service consult requested. The resident representative, police, the physician, and the Administrator were notified, and an investigation was initiated.</p> <p>The nurse's note dated 3/16/23 at 10:33 PM by RN #9 identified at 5:00 PM a staff member reported that Resident #19 threw water at Resident #24.</p> <p>A written statement by NA #3 dated 3/16/23 identified she saw Resident #19 and Resident #24 fighting, and LPN #17 was between them, and she went to assist.</p> <p>A written statement by LPN #17 dated 3/16/23 identified she witnessed Resident #19 throwing water on Resident #24 which led to an altercation. LPN #17 indicated she and other staff were able to separate the two residents from each other.</p> <p>The nurse's note dated 3/17/23 at 1:08 AM by LPN #17 identified an altercation began between Resident #24 and Resident #19. LPN #17 witnessed Resident #19 throwing water at Resident #24 and a brief altercation took place. The residents were immediately separated. RN #9 was notified immediately.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A written telephone interview (with no date) by the DNS with LPN #17 identified on 3/16/23 at 5:00 PM LPN #17 indicated she witnessed Resident #19 and Resident #24 having a verbal disagreement. LPN #17 indicated she heard one of the residents asking the other resident to move, however she was not sure who exactly said it. LPN #17 indicated she was walking towards the residents and observed Resident #19 throw water at Resident #24. LPN #17 indicated Resident #24 was angry and verbal towards Resident #19, however he/she did not retaliate. LPN #17 immediately intervened and separated the residents. The nursing supervisor was notified, and Resident #19 was placed on 1:1 monitoring.</p> <p>The social service note dated 3/17/23 at 12:02 PM identified Resident #24 indicated (Resident #19 threw a couple of punches at me, but it is no big deal). Resident #24 indicated he/she was not hurt and identified he/she has been to places with bigger guys/girls than him/her. Resident #24 indicated he/she was not scared and Resident #19 was a punk, and he/she should be scared. No emotional distress noted. Psychiatrist consult is schedule for today. Social service will continue to monitor.</p> <p>The psychiatrist note dated 3/17/23 identified Resident #24 had a recent alleged resident altercation with Resident #24 and tossed water at the resident. Resident #24 was alert and oriented times two, and brief response. Resident #24 was confused and preoccupied in finding a way to return back into the community. Resident #24 denies any harm, distress or concerns related to the negative interaction with Resident #19. Resident #24 noted feeling safe at the facility. Resident #24 was not in any distress/stable mood. Continue to monitor and support.</p> <p>The care plan dated 3/17/23 identified Resident #24 had physical aggression and attempted to move another resident's wheelchair. Interventions included to monitor for any signs of aggressive behavior. Report any behaviors to the charge nurse immediately. Social services and psychiatric consult requested post altercation with peer. Every shift night, day, and evening.</p> <p>A written statement by the Administrator dated 3/20/23 identified on 3/16/23 at 4:30 PM he was at the nurse's station and heard LPN #17 down the hallway yelling for help. The Administrator indicated he immediately went down the hallway and observed Resident #24 and Resident #19 getting close and yelling at each other. The Administrator indicated the residents started swinging, but he did not witness any physical contact. The Administrator indicated the staff separated the two residents. Resident #19 was placed on 1:1 monitoring. The police were notified and interviewed both residents. The Administrator indicated he notified the State Agency.</p> <p>A written report by the DNS, undated, identified Resident #19 had severely impaired cognition. On 3/16/23 at 5:00 PM LPN #17 observed Resident #19 and Resident #24 having a verbal argument. LPN #17 witnessed Resident #19 throwing water at Resident #24. LPN #17 immediately intervened and separated both residents and notified RN #9. Resident #19 was placed on 1:1 monitoring. An RN assessment revealed no physical injuries to either resident. A psychiatrist and social service consult was requested for both residents. Resident #19 was seen by the psychiatrist and 1:1 was discontinued. Resident #19 was seen by the physician with new orders obtained. Resident #19's care plan was updated to monitor for increase in agitation, confusion, paranoia, and aggressive behavior and to notify licensed staff immediately. Resident #24 was seen by the psychiatrist and was not in any distress/stable mood.</p> <p>Interview with Resident #24 on 10/6/24 at 11:25 AM identified he/she was not happy when Resident #19 threw the water at him/her. Resident #24 indicated he/she was angry when it happened. Resident #24 indicated he/she is not afraid of Resident #19.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Although attempted, an interview with the Previous DNS and LPN #17 was not obtained.</p> <p>Interview and review of the clinical record with RN #5 on 10/8/24 at 1:55 PM identified Resident #19 was placed on 1:1 immediately until cleared by the psychiatrist. RN #5 indicated with each incident a behavior specific care plan was initiated or revised to prevent further behavioral issue. RN #5 indicated the staff were in-serviced. RN #5 indicated Resident #24 was seen by the psychiatrist and a behavioral care plan was initiated.</p> <p>2. Resident #39 was admitted to the facility in July 2021 with diagnoses that included hemiplegia, hemiparesis affecting left -non-dominant side, anxiety disorder, major depressive disorder, and adjustment disorder.</p> <p>The quarterly MDS dated [DATE] identified Resident #39 had intact cognition and required extensive assistance with personal hygiene. Additionally, Resident #39 had no behaviors of physical or verbal directed toward others.</p> <p>The reportable event form dated 5/8/23 at 4:30 PM identified Resident #39 was alert and oriented, calm, and cooperative. Resident #39 approached LPN #13 and reported that he/she was self-propelling in the wheelchair when Resident #24 exited his/her room, also in a wheelchair, and accidentally hit Resident #39's wheelchair. As they were attempting to untangle the wheelchairs, Resident #24 hit Resident #39 on the head and threaten to kill him/her. The residents were immediately separated and Resident #24 was placed on 1:1 and transferred to the hospital for psychiatric evaluation. Both residents were interviewed by SW #1. Resident #39 was seen by the psychiatrist APRN. The police, physician, psychiatrist APRN, the Administrator, and the resident representative were notified.</p> <p>The social service note dated 5/8/23 at 5:13 PM by SW #1 identified Resident #39 was alert and oriented times four. SW #1 was called to the unit by nursing to meet with Resident #39. Resident #39 indicated he/she was going down the hallway when Resident #24 came out and bumped into Resident #39 wheelchair. Resident #39 indicated the wheelchairs got stuck and he/she touched Resident #24's arm while trying to get away and that is when Resident #24 punched Resident #39 in the head. Resident #39 indicated Resident #24 threaten to kill him/her if they ever passed each other in the hallway again. Resident #39 was seen by the psychiatric APRN. SW #1 indicated she notified RN #9, the DNS, and LPN #13. No emotional distress was noted, and Resident #9 indicated he/she does not feel threaten or unsafe at this time.</p> <p>The nurse's note dated 5/8/23 at 7:11 PM by RN #9 identified at 4:50 PM the psychiatrist, APRN, and SW #1 reported that Resident #39 indicated Resident #24 punched him/her and threaten to kill him/her. Resident #39 indicated he/she was attacked by Resident #24 when he/she was coming down the hallway in the wheelchair. Resident #39 indicated he/she stopped to blow his/her nose and Resident #24 came out of his/her room and banged into Resident #39's wheelchair and they got stuck. Resident #24 blamed Resident #39 and punched Resident #39 on the right side of the head and later on threaten to kill Resident #39. An RN assessment was completed with no injury noted. The police, and the physician were notified. Message left for resident representative.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated 5/8/23 at 11:43 PM by LPN #13 identified Resident #39 came to the nursing station this afternoon and reported that he/she was in the hallway in Resident #24 bumped into his/her wheelchair when trying to get by. Resident #39 indicated Resident #24 got upset and punched him/her in the back of the head and threaten to kill him/her if this happens again. The incident was immediately reported to social service, the supervisor, and the psychiatrist APRN. Resident #39 was escorted to his/her room and assessed.</p> <p>A written statement by NA #5 dated 5/8/23 identified Resident #39 came to the nursing station and was very upset. NA #5 indicated Resident #39 reported that he/she was trying to get by when Resident #24 punched him/her on the head. NA #5 indicated she reported it to LPN #13 immediately.</p> <p>The psychiatrist APRN note dated 5/8/23 identified Resident #39 was seen after he/she approached the nursing station and stating that Resident #24 hit him/her on the head. Resident #39 is currently not a danger to self or others. Resident #39 appeared to be in behavioral control at this time. Will ask psychologist to see Resident #39 as a follow-up. No changes in medication.</p> <p>The care plan dated 5/8/23 identified Resident #39 was at risk for emotional distress and anxiety related to altercation with peer. Interventions included to monitor resident for any emotional or negative behavioral changes. Report to charge nurse or supervisor with any findings. Provide resident with emotional support.</p> <p>Although attempted, an interview with the Previous DNS, LPN #13, and NA #5 was not obtained.</p> <p>Interview with Resident #39 on 10/6/24 at 11:27 AM identified Resident #24's wheelchair and his/her wheelchair bumped into each other. Resident #39 indicated while trying to detangle the wheelchairs Resident #24 hit him/her on the head. Resident #39 indicated he/she was afraid when Resident #24 threaten to kill him/her. Resident #39 indicated the psychiatric APRN and SW #1 was right on the issue of making sure that he/she felt safe. Resident #39 indicated LPN #13, and the staff made sure that he/she was always safe from Resident #24. Resident #39 indicated he/she feel safe at the facility.</p> <p>Interview and review of the clinical record with the RN #5 on 10/8/24 at 1:55 PM identified Resident #24 was placed on 1:1 immediately, seen by the psychiatrist APRN, and was transferred to the hospital for psychiatric evaluation. RN #5 indicated with each incident a behavior pacific care plan was initiated to prevent further behavioral issue. RN #5 indicated the staff were in-service. RN #5 indicated Resident #39 was seen by the psychiatrist and a care plan was initiated</p> <p>Review of the facility abuse policy identified that each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's symptoms. It is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe environment.</p> <p>Abuse - means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.</p> <p>Willful - means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verbal Abuse - is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Physical abuse - includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.</p> <p>Resident to Resident altercation - is defined as a physical or verbal act between two residents with or without resulting injury. For altercations where the aggressor is cognitively impaired</p> <p>42117</p> <p>3. Resident #87 was admitted to the facility in December 2021 with diagnoses that included dementia and osteoporosis.</p> <p>Physician's monthly orders for September 2024 (originally dated 8/19/23) directed to apply skin prep to bilateral heels daily on the 3:00 PM to 11:00 PM shift.</p> <p>The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition, required maximum assistance with personal hygiene and bathing, and was totally dependent for transfers and rolling left to right. Additionally, Resident #87 was at risk to develop a pressure ulcer, did not have any current pressure ulcers, and had a pressure reducing device on the bed.</p> <p>The care plan dated 8/14/24 identified Resident #87 was at risk for skin breakdown. Interventions included to monitor skin when putting on and off compression stockings and position resident to offset pressure areas while awake.</p> <p>The Wound Assessment Report written by the Wound APRN, (APRN #2), on 9/26/24 identified a first evaluation of pressure ulcer to the right heel with measurements of 2.5 cm by 5.0 cm by 0.2 cm with 25 - 49% slough, 50 - 74% granulation tissue, moderate amount of serosanguineous drainage and a mild odor. Recommendations included to cleanse with normal saline, apply Santyl, Calcium Alginate, skin prep to the peri wound, dry clean dressing and off load boots.</p> <p>A physician's order dated 9/27/24 directed to cleanse the unstageable right heel pressure ulcer with normal saline, apply Santyl, Calcium Alginate, skin prep around the peri wound, secure with a dry clean dressing daily and as needed.</p> <p>A Wound Management Report, written by the Infection Control/Wound Nurse (RN #1) dated 10/4/24 (late entry for 10/3/24) identified the right heel pressure ulcer measured 2.5cm x 5.0 cm by 0.2 cm with slough in the wound bed and no tunneling.</p> <p>Review of the October 2024 TAR dated 10/3/24 to 10/8/24 identified the treatment to the right heel was signed as done on the following days by the following staff.</p> <p>10/4/24 LPN #14 documented she completed the treatment to the right heel.</p> <p>10/5/24 LPN #12 documented she completed the treatment to the right heel.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/6/24 LPN #6 documented she completed the treatment to the right heel.</p> <p>Further, on 10/7/24 LPN #15 did not document if the treatment was completed as per the order on the (7:00 AM - 3:00 PM shift) and documented the treatment was not done on the 3:00 PM - 11:00 PM shift because it is scheduled for 7:00 AM to 3:00 PM shift.</p> <p>Interview with MD #1 on 10/7/24 at 10:45 AM indicated that his expectation was the nurses follow the physician's orders.</p> <p>Observation on 10/8/24 at 2:00 PM with LPN #14 identified when she removed the old dressing from Resident #87's right heel it was dated as 10/3/24, 5 days prior, and there were no initials to identify who completed the treatment on 10/3/24.</p> <p>Interview with LPN #14 at that time identified the treatment to the resident right heel is ordered to be done daily.</p> <p>Interview with the DNS and the VP of Clinical Operations (RN #5) on 10/8/24 at 3:00 PM indicated that Resident #87's had a wound on the right heel and the treatment was ordered to be done daily. Further, RN #5 identified the nurses are responsible to complete the dressing change daily, and date and initial the dressing itself, and sign their initials on the TAR. RN #5 indicated she would investigate to find out why the treatment was not done since 10/3/24.</p> <p>A written statement by LPN #14 dated 10/8/24 identified that on 10/4/24 she was orienting a new nurse, and that nurse was using her log in for the electronic medical record (EMR). There might have been a time that the dressing change to Resident #87's right heel was clicked off in the EMR as having been done but wasn't done yet. LPN # 14 indicated the dressing to the right heel was not changed on 10/4/24.</p> <p>An email from LPN #6 dated 10/8/24 identified she worked Sunday 10/6/24. LPN #6 identified she intended to do the dressing change to Resident #87's right heel but due to an overwhelming layer of pressure and distraction, she inadvertently overlooked the dressing change to Resident #87's right heel.</p> <p>LPN #6 did not identify why she documented on the TAR that the dressing change to Resident #87's right heel had been done.</p> <p>An email dated 10/9/24 from LPN #12 identified she worked 10/5/24 during the 7:00 AM -3:00 PM and she is not as familiar with that unit. LPN #12 indicated she inadvertently clicked the treatment to Resident #87's right heel as being done.</p> <p>A written statement dated 10/8/24 by LPN #15 who worked on 10/7/24 during the 7:00 AM - 3:00 PM shift identified at the end of her shift, she realized she did not have the time to complete the wound care.</p> <p>A statement by the ADNS identified LPN #15 did not document or complete dressing change to Resident #87's right heel and she left it for the following shift. This was an omission.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/9/24 at 6:42 AM identified LPN #15 forgot to notify the oncoming 3:00 PM - 11:00 PM nurse, LPN #9, that she had not done the dressing change. Further, LPN #9 did not do the dressing change because it was due on the 7:00 AM - 3:00 PM shift.</p> <p>Interview with the DNS on 10/9/24 at 6:42 AM indicated that all dressing changes are to be completed, and if they are not able to be completed, the nurses should not be documenting that they have been done. Further, the DNS indicated if a dressing change is not done, they are responsible to write a note as to why it wasn't done, and they should notify the supervisor because the supervisor can come and assist. The DNS indicated that the APRN/MD must be notified immediately if a dressing change is not done.</p> <p>Observation and interview with the DNS and RN #4 on 10/9/24 at 7:55 AM identified Resident #87's right heel pressure ulcer had an odor prior to removing the old dressing. The wound measured 2.1 cm by 1.2 cm by 0.4 cm with tunneling 0.6 cm from 9 o'clock to 1 o'clock. The wound bed was 75% slough and 25% purple color.</p> <p>Review of the Abuse Policy identified neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Any form of mistreatment or neglect is to be thoroughly investigated and reported.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42117</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #7) reviewed for hospitalization, the facility failed to convey appropriate information when the resident was sent to the hospital on 8/26/23. The findings include:</p> <p>Resident #7 was admitted to the facility in June 2023 with diagnoses that included dementia, acid reflux, and diabetes.</p> <p>The admission MDS dated [DATE] identified Resident #7 had moderately impaired cognition and required total assistance with transfers, bed mobility, dressing and toileting.</p> <p>The nurses note dated 8/26/23 at 5:34 PM identified Resident #7 was refusing to let the Intravenous (IV) technician insert an IV line for intravenous fluids the physician had ordered due to abnormal labs from this morning. Resident #7 continued to refuse IV insertion. The APRN was notified and Resident #7 was sent to the emergency room for evaluation.</p> <p>The facility transfer form dated 8/26/23 identified Resident #7 was being transferred to emergency room for abnormal labs. Resident #7 had refused an IV.</p> <p>The hospital emergency documentation dated 8/26/23 identified Resident #7 was brought to the emergency room per facility paperwork for abnormal labs. EMS reported concern for high potassium. ER charge nurse will call facility. At 7:15 PM the ER nurse called the facility, and nurse was unable to specify what lab work was abnormal but would fax lab results. At 7:25 PM ER nurse recontacted facility and nurse stated they do not have the lab work results that were reported as abnormal. They reported only having lab work from 8/17/23 and the results were on 8/23/23. At 8:00 PM received lab work from facility from 8/23/23 and potassium level was 4.3 (normal range 3.5 - 5.1 mmol/L), sodium of 159 (normal range 136 to 145 mmol/L), BUN of 23 (normal range HIGH), creatinine 1.01 (normal range .59 to 1.04 mg/dl), and normal LFT's. Gave 1 liter lactate ringers via IV in emergency room and transferred back to facility.</p> <p>Review of labs in chart dated 8/21/23, 8/23/23 and 9/27/23.</p> <p>Interview with RN #8 on 10/8/24 at 10:18 AM indicated that she does not recall transferring Resident #7 to the emergency room on [DATE]. RN #8 indicated that she would send with the resident to the emergency room their diagnosis list, current medication list, and call emergency room to inform them the reason for the transfer. RN #8 indicated she would write a progress note regarding who she spoke with at the ER. RN #8 indicated that she did not recall what the abnormal labs were but if she had the completed labs, she would have sent it with the paperwork. RN #8 indicated that there should be a copy of what was sent in the resident's medical record.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/8/24 at 11:40 AM indicated it is the responsibility of the charge nurse and supervisor to provide the hospital with the exact reason for the transfer to the hospital. After clinical record review, the DNS indicated the discharge paperwork dated 8/26/23 from the facility to the hospital does not identify the reason for transfer by just saying abnormal labs. The DNS indicated that her expectation was the nurse would have sent a copy of the labs and documented on the w-10 what the abnormal lab was. The DNS indicated that the nurse could have called the lab to get the results. The DNS indicated that the hospital should not have had to call the facility many times to try to get the labs or the reason for the transfer. The DNS indicated that she was not able to find labs dated 8/26/23 in the medical record and it was not in the MD or nurses progress notes if they had received a verbal from the lab of a critical lab. The DNS indicated she was not able to identify what was the abnormal labs were.</p> <p>Although requested a policy for hospital transfer documentation was not provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>42117</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #274) reviewed for admission, the facility failed to ensure the baseline care plan was completed upon admission and included interventions related to the residents implanted cardiac defibrillator. The findings include:</p> <p>The hospital discharge summary dated 9/23/24 identified Resident #274 had an implanted cardiac defibrillator.</p> <p>Resident #274 was admitted to the facility in September 2024 with diagnoses that included cardiomyopathy and ventricular tachycardia.</p> <p>The baseline care plan, undated, was labeled with Resident #274's name, date of birth, physician name, and room number was not filled out.</p> <p>Observation 10/6/24 at 8:00 AM identified Resident #274 was lying in bed with a white box plugged into the wall on the nightstand within 2 feet from resident.</p> <p>Observation on 10/6/24 at 10:08 AM identified Resident #274 had a raised area on the left chest wall.</p> <p>Interview with Person #1 on 10/6/24 at 10:08 AM indicated that he/she had informed the nurse on day of Resident #274's admission and the day after admission that he/she had brought in and plugged in the implanted cardiac defibrillator monitor and it was sitting on the bedside table doing the continuous transmission. Further, Person #1 had placed the owner's manual for implanted cardiac defibrillator monitor in the top draw of the nightstand in the resident's room.</p> <p>Interview with the DNS on 10/7/24 at 6:49 AM indicated charge nurse or supervisor on the shift of admission was responsible to start the baseline care plan and the MDS coordinator was responsible to complete the baseline care plan the next business day. After review of the clinical record the DNS indicated the baseline care plan was blank, and did not reflect the implanted cardiac defibrillator.</p> <p>Although requested, a facility policy for baseline care plans was not provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37293</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #30 and 100) reviewed for Activities of Daily Living (ADL), the facility failed to ensure the residents were provided a shower on scheduled shower days. The findings include:</p> <p>1. Resident #30 was admitted to the facility in September 2024 with diagnoses that included heart failure, depressive episodes, and anxiety disorder.</p> <p>The physician's order dated 9/14/24 directed to provide a weekly body audit every week on the first shower day of the week. If the resident refuses shower or body audit update the supervisor and document in the progress notes. Shower once a day on Tuesday on the 7:00 AM - 3:00 PM shift.</p> <p>The care plan dated 9/14/24 identified Resident #30 had an Activity Daily Living (ADL's) functional deficit and needs assistance with mobility and self-care needs related to: weakness, dorsalgia, and advanced age. Interventions included to provide assistance and provide privacy to the extent needed. Allow extra time to perform tasks as needed.</p> <p>The unit shower &amp; body audit schedule form identified Resident #30's shower days were Wednesday and Saturday on the 7:00 AM - 3:00 PM shift.</p> <p>The admission MDS dated [DATE] identified Resident #30 had intact cognition and required total assistance with shower.</p> <p>Review of the nurse aide flowsheet dated 9/14/24 - 9/30/24 failed to reflect documentation that Resident #30 had been provided a shower on his/her scheduled day Tuesday 9/17/24 during the 7:00 AM - 3:00 PM shift.</p> <p>Review of the nurse's note dated 9/14/24 through 9/23/24 failed to reflect documentation that Resident #30 had been provided a shower on his/her scheduled day Tuesday 9/17/24 during the 7:00 AM - 3:00 PM shift.</p> <p>The physician's order dated 10/1/24 directed to provide weekly body audit every week on the first shower day of the week. If resident refuses shower or body audit update the supervisor and document in the progress notes. Shower once a day on Tuesday on the 7:00 AM - 3:00 PM shift.</p> <p>Review of the nurse aide flowsheet dated 10/1/24 - 10/7/24 failed to reflect documentation that Resident #30 had been provided a shower on his/her scheduled day Tuesday 10/1/24 during the 7:00 AM - 3:00 PM shift.</p> <p>Review of the nurse's note dated 10/1/24 - 10/7/24 failed to reflect documentation that Resident #30 had been provided a shower on his/her scheduled day Tuesday 10/1/24 during the 7:00 AM - 3:00 PM shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse aide care card failed to reflect documentation that Resident #30 shower days were scheduled for Tuesday during the 7:00 AM - 3:00 PM shift.</p> <p>Interview with Resident #30 on 10/6/24 at 11:40 AM identified he/she had not had a shower since she has been at the facility. Resident #30 indicated he/she had refused one shower in the month of September 2024 because he/she was not feeling well. Resident #30 indicated ever since that day the staff has not offer him/her a shower. Resident #30 indicated he/she was told his/her shower day are on Tuesdays on the 7:00 AM - 3:00 PM shift. Resident #30 indicated he/she has asked for a shower multiple times and the nurse aides have not given her a shower. Resident #30 indicated the nurse aides would say they are short of staff. Resident #30 indicated all he/she wants is a shower on his/her schedule shower day.</p> <p>Interview with the Administrator on 10/8/24 at 7:00 AM identified he was not aware that Resident #30 had not been receiving showers. The Administrator indicated that all nursing staff will be in-service regarding showers.</p> <p>Interview and review of the clinical record with RN #4 on 10/8/24 at 11:55 AM identified she was not aware that Resident #30 had not been receiving showers. RN #4 indicated Resident #30 has not complained to her that he/she has not received showers. RN #4 indicated going forward she will be in-servicing the nursing staff.</p> <p>Interview and review of the clinical record with the DNS on 10/8/24 at 1:49 PM identified she was not aware that Resident #30 had not been receiving showers. The DNS indicated the nurse aides should have provided Resident #30 with a shower on his/her schedule shower days. The DNS indicated the assigned nurse aide should have reported to the charge nurse if a shower was not given. The DNS indicated the assigned nurse aide should have documented if the shower was given or not. The DNS indicated that all nursing staff will be in-service regarding showers and documentation.</p> <p>Interview with LPN #15 on 10/11/23 at 1:34 PM identified she is a float nurse and works Per Diem only. LPN #15 indicated she signed the MAR on 10/1/24 on the 7:00 AM - 3:00 PM shift which indicated she performed a body audit and Braden scale. LPN #15 indicated she does not know if the nurse aide gave the resident a shower and she does not know when the residents shower day is and did not document whether Resident #30 had a shower or not. LPN #15 indicated being a float makes it very difficult to know the residents and their routine.</p> <p>Although attempted, an interview with LPN #14, and NA #3 was not obtained.</p> <p>2. Resident #100 was admitted to the facility in July 2023 with diagnoses that included severe morbid obesity, atrial fibrillation, and chronic obstructive pulmonary disease.</p> <p>The unit shower &amp; body audit schedule form dated 6/5/24 identified Resident #100 shower days were Tuesday and Friday on the 3:00 PM - 11:00 PM shift.</p> <p>The physician's order dated 8/1/24 directed to provide a body audit every week on the first shower day of the week. If the resident refuses shower or body audit update the supervisor and document in the progress notes. Once a day on Tuesday 3:00 - 11:00 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The quarterly MDS dated [DATE] identified Resident #100 had intact cognition and required supervision or touching assistance with shower/bathing, and personal hygiene.</p> <p>The care plan dated 8/28/24 identified Resident #100 would like to be offered and assisted with a shower on Tuesday and Friday on the 3:00 PM - 11:00 PM shift. Intervention included staff will offer Resident #100 a shower on Tuesday and Friday on the 3:00 PM - 11:00 PM shift.</p> <p>Review of the nurse's notes and nurse aide flowsheet dated 8/1/24 - 8/30/24 failed to reflect documentation that Resident #100 had been provided a shower on his/her scheduled day Tuesday 8/6/24, 8/13/24, 8/20/24 and 8/27/24 during the 3:00 PM - 11:00 PM shift. Friday 8/2/24, 8/9/24, 8/16/24, 8/23/24, and 8/30/24 during the 3:00 PM - 11:00 PM shift.</p> <p>The physician's order dated 9/1/24 directed to provide body audit every week on the first shower day of the week. If resident refuses shower or body audit update the supervisor and document in the progress notes. Once a day on Tuesday 3:00 - 11:00 PM.</p> <p>Review of the September 2024 MAR and TAR reflected documentation that Resident #100 had a body and Braden scale audit performed on his/her scheduled shower day Tuesday 9/3/24, 9/10/24, 9/17/24 and 9/24/24 during the 3:00 PM - 11:00 PM shift. Friday 9/6/24, 9/13/24, 9/20/24, and 9/27/24 during the 3:00 PM - 11:00 PM shift.</p> <p>Review of the nurse's notes and nurse aide flowsheet dated 9/1/24 - 9/30/24 failed to reflect documentation that Resident #100 had been provided a shower on his/her scheduled day Tuesday 9/3/24, 9/10/24, 9/17/24 and 9/24/24 during the 3:00 PM - 11:00 PM shift. Friday 9/6/24, 9/13/24, 9/20/24, and 9/27/24 during the 3:00 PM - 11:00 PM shift.</p> <p>The physician's order dated 10/1/24 directed to provide body audit every week on the first shower day of the week. If resident refuses shower or body audit update the supervisor and document in the progress notes. Once a day on Tuesday 3:00 - 11:00 PM.</p> <p>Review of the October 2024 MAR and TAR reflected documentation that Resident #100 had a body and Braden scale audit performed on his/her scheduled shower day Tuesday 10/1/24 and Friday 10/4/24 during the 3:00 PM - 11:00 PM shift.</p> <p>Review of the nurse's notes and nurse aide flowsheet dated 10/1/24 - 10/7/24 failed to reflect documentation that Resident #100 had been provided a shower on his/her scheduled day Tuesday 10/1/24 and Friday 10/4/24 during the 3:00 PM - 11:00 PM shift.</p> <p>Interview with Resident #100 on 10/6/24 at 11:19 AM identified he/she has not had a shower since he/she moved from the 2nd floor to the 1st floor in October 2023. Resident #100 indicated he/she was told his/her shower day are Tuesday and Friday on the 3:00 PM - 11:00 PM shift. Resident #100 indicated when he/she asked the nurse aides about his/her shower the nurse aide would say they are short. Resident #100 also indicated the staff would tell him/her that they have to transfer him/her with a hooyer and they had too many resident with hoyers to take care of.</p> <p>Interview with the Administrator on 10/8/24 at 7:00 AM identified he was not aware that Resident #100 had not been receiving showers. The Administrator indicated that all nursing staff will be in-service regarding showers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and review of the clinical record with RN #4 on 10/8/24 at 11:55 AM identified she has only been with the facility for approximately 1 month. RN #4 indicated she was not aware of Resident #100 had not been receiving showers. RN #4 indicated Resident #100 has not complained to her that he/she has not received showers. RN #4 indicated going forward she will be in-servicing the nursing staff.</p> <p>Interview and review of the clinical record with the DNS on 10/8/24 at 1:49 PM identified she was not aware that Resident #100 had not been receiving showers. The DNS indicated the nurse aides should have provided Resident #100 with a shower on his/her schedule shower days. The DNS indicated the assigned nurse aide should have reported to the charge nurse if shower was not given. The DNS indicated the assigned nurse aide should have documented if the shower was given or not. The DNS indicated that all nursing staff will be in-service regarding showers and documentation.</p> <p>Interview with LPN #13 on 10/8/24 at 3:30 PM identified she was aware Resident #100 refused showers. LPN #13 identified Resident #100 shower is on Tuesday and Friday on the 3:00 PM - 11:00 PM shift and indicated Resident #100 refuses care and showers. LPN #13 indicated on 9/10/24 on the 3:00 PM - 11:00 PM she had worked, and Resident #100 had refused to take a shower that day. LPN #13 indicated she did not document in the nurse's note that Resident #100 had refused his/her shower. LPN #13 indicated she signed the MAR on 9/10/24 because she had performed the body and Braden scale on Resident #100. LPN #13 indicated Resident #100 will allow the nurses to perform the body and Braden scale audit but will refuse the shower. LPN #13 indicated she had offered Resident #100 a shower on 9/19/24 on the 7:00 - 3:00 PM shift and Resident #100 had refused the shower. LPN #13 indicated she had documented in the nurse's note. LPN #13 indicated she does not know if Resident #100 has a care plan reflecting refusal of care.</p> <p>Interview with LPN #2 on 10/8/24 at 3:50 PM identified she was aware of Resident #100 not receiving his/her showers. LPN #2 indicated Resident #100 shower day are on Tuesday and Friday on the 3:00 PM - 11:00 PM shift. LPN #2 indicated Resident #100 refuses to take a shower on schedule shower days. LPN #2 indicated she signed the MAR because she did perform the body audit and Braden audits every Tuesdays on the resident schedule shower day. LPN #2 identified signing the MAR it indicated that the body audit was performed not that Resident #100 had a shower. LPN #2 indicated she thought she had documented when Resident #100 had refused his/her showers. LPN #2 indicated going forward she will document in the resident clinical record when Resident #100 refuses shower. LPN #2 indicated that she assists the nurse aides with hoyer transfers if needed.</p> <p>Subsequent to surveyor inquiry, Resident #100 was provided a shower on 10/8/24 on the 3:00 PM - 11:00 PM shift.</p> <p>Although attempted, an interview with NA #4 was not obtained.</p> <p>Review of the facility bath, shower/tub policy identified the purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.</p> <p>Documentation:</p> <p>The date and time the shower/tub bath was performed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The name and title of the individual who assisted the resident with shower/tub bath.</p> <p>All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath.</p> <p>If the resident refused to the shower/tub bath, the reasons.</p> <p>Reporting:</p> <p>Notify the supervisor if the resident refuses the shower/tub bath.</p> <p>Review of the facility activities of daily living policy identified residents will receive services to optimize their level of independence with activities of daily living and the assistance they need to complete activities of daily living.</p> <p>The resident will receive assistance daily with hygiene, dressing, bathing, feeding, transfer, ambulation, and elimination as necessary.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42117</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interview for 5 residents (Resident #13, 26, 32, 274 and 378) the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices.</p> <p>For 1 resident (Resident #13) reviewed for choices, the facility failed to ensure the resident was walked daily per the physician's order, for 1 of 3 residents (Resident #26) reviewed for nutrition, the facility failed to obtain daily weights per the physician's order and failed to document education and interventions when the resident refused the weights, for 1 resident (Resident #32) reviewed for a specialized medical treatment, the facility failed to ensure a medication was restarted following a medical procedure, for 1 resident (Resident #274) reviewed for new admission, the facility failed to administer two different glaucoma medications and subsequently the resident missed 4 doses of each, and failed to include an implanted cardiac defibrillator on the nursing admission assessment, and failed to obtain physician's orders for the implanted cardiac defibrillator, and for 1 of 3 residents (Resident #378) reviewed for pressure ulcers, the facility failed to ensure that a nursing assessment was completed following admission and readmission, failed to obtain weights as ordered, and failed to implement interventions following a weight loss. The findings include:</p> <p>1. Resident #13 was admitted to the facility with diagnoses that included diabetes and a lower extremity amputation with prosthetic.</p> <p>The quarterly MDS dated [DATE] identified Resident #13 had intact cognition and required maximum assistance with transfers, walking 50 feet with 2 turns, and walking 150 feet in the corridor/hallway. Additionally, Resident #13 had no behaviors or rejection of care.</p> <p>The care plan dated 8/19/24 identified Resident #13 needs assistance with activities of daily living. Interventions included to walk the resident daily with a limited assist of 1 staff, a 2 wheeled walker and prosthetic using a gait belt with wheelchair to follow on the 3:00 PM to 11:00 PM shift. Special instructions to ensure assigned nurse aide walks the resident daily.</p> <p>The August 2024 monthly physician's order (original date 4/11/24) directed nursing staff to walk the resident (assist of 1) using a rolling walker, a gait belt with the wheelchair to follow, in the hallways, 150 feet. Special instructions: Ensure the assigned nurse aide on the 3:00 PM to 11:00 PM shift walks the resident daily.</p> <p>Review of nurse's notes dated 8/20/24 to 10/8/24 failed to reflect that Resident #13 had been offered to walk and had refused to walk.</p> <p>The treatment administration history report dated 8/20/24 to 10/8/24 identified that Resident #13 had been walked daily by the assigned nurse aide during the 3:00 PM to 11:00 PM shift.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #13 on 10/6/24 at 11:58 AM identified that staff do not walk him/her, and have not walked him/her in months because they are afraid he/she will fall. Resident #13 indicated when he/she asks staff to walk him/her, staff will tell him/her that they don't want to, and they don't. Resident #13 indicated that he/she has reported to the nurses and the social worker that staff are not walking him/her. Resident #13 indicted that the only time he/she gets walked to end of the hallway or to the nurse's station is when his/her resident representative comes in to visit. Resident #13 indicated that he/she was afraid to lose the ability to walk because the staff won't walk him/her in the hallway every day.</p> <p>Review of the 14-day administration history indicated that between 9/26/24 to 10/8/24, LPN #9 (who worked 8 out of the 13 shifts) documented Resident #13 had been walked.</p> <p>Interview with the DNS on 10/9/24 at 10:30 AM indicated she found out yesterday that Resident #13's had spoken with SW #1 about not being walked by nursing staff and that Resident #13 was upset that only his/her representative walks him/her when he/she visits.</p> <p>Interview with NA #6 on 10/9/24 at 1:19 PM, (a full-time nurse aide during the 3:00 PM - 11:00 PM shift on the resident's unit frequently responsible for the care of Resident #13) indicated that she does not walk Resident #13. NA #6 was not able to identify why she does not offer or walk Resident #13.</p> <p>Interview with LPN #11 on 10/9/24 at 1:21 PM identified that for Resident #13, there is a physician's order (put in the computer by the Previous DNS) to walk the resident 150 ft in the hallway daily on the 3:00 PM - 11:00 PM shift by the nurse aide. Further, LPN #11 identified that the nurse on duty must see the walking occur and sign off in the TAR that it occurred. LPN #11 identified that the Previous DNS did not enter the physician's order to walk Resident #13 correctly, and subsequently, the number of feet that the resident actually walked during the 3:00 PM - 11:00 PM shift could not be recorded. Further, after reviewing the 14-day administration history, LPN #11 indicated that the nurses between 9/26/24 to 10/8/24 documented that Resident #13 had walked every evening on 3:00 PM to 11:00 PM shift.</p> <p>Interview with LPN #9 on 10/9/24 at 1:45 PM (the full-time nurse on the 3:00 PM - 11:00 PM shift responsible for the care of Resident #13) indicated that he was aware there was a physician's order for Resident #13 to walk 150 feet daily on the 3:00 PM to 11:00 PM shift, but his understanding of the order is to encourage the resident to walk on the 3:00 PM to 11:00 PM shift. LPN #9 indicated that he does not encourage Resident #13 to walk, but rather, he tells the nurse aides to encourage the resident to walk. Further, although between 9/26/24 to 10/8/24, LPN #9 (who worked 8 out of the 13 shifts) documented Resident #13 had been walked, LPN #9 identified he could not remember the last time he saw Resident #13 walk in the hallway with the nurse aide.</p> <p>Interview the DNS on 10/9/24 at 2:08 PM identified her expectation was that the nurses document on the TAR if Resident #13 had been walked by the nurse aides, and if Resident #13 was not walked by the nurse aide there would be a nurse's note explaining why because she would expect the nurses to document accurately. The DNS indicated that the physician's order was clear that Resident #13 was to be walked, and not just encouraged. The DNS indicated that if Resident #13 had refused to walk, that refusal would be documented on the TAR and in a nurse's note. The DNS indicated that after review of the clinical record dated 9/1/24 to 10/9/24, she did not see a nurses note that indicated Resident #13 had refused to walk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the SW #1 on 10/9/24 at 2:12 PM indicated that at the care plan meeting on 8/19/24 Resident #13 and his/her representative indicated that the nursing staff do not walk the resident. SW #1 indicated that she thinks she reported Resident #13's concern about not being walked at morning report. SW #1 indicated that on 9/19/24 she met with Resident #13's representative who reported that Resident #13 was still not being walked by nursing. SW #1 identified that she did report the concern to someone in the nursing department about Resident #13 not being walked but she does not recall who she informed. SW #1 indicated that she did not fill out a grievance, and she did not document the residents or the resident representatives concerns about the resident not being walked.</p> <p>Review of the Documentation Guidelines Policy identified the purpose of documentation is to promote quality and coordination of care. The understanding is that all standards of care have been met with a normal or expected response unless documented otherwise. When documentation is required include the date and time, write clearly, be concise, be factual, no opinions, no assumptions, and no conclusions, be actual record only what you observe or who reported to you, and avoid impressions.</p> <p>Although requested, a facility policy for physician orders and walking was not provided.</p> <p>2. Resident #26 was admitted to the facility in June 2023 with diagnoses that included congestive heart failure (CHF), chronic kidney disease, chronic respiratory failure, cerebral infarction, and dementia.</p> <p>A physician's order dated 6/12/23 directed to notify the physician or APRN of any abnormal findings: more than a 5-pound weight gain, rales, wheezes, shortness of breath or orthopnea.</p> <p>A physician's order dated 8/3/23 directed to compete daily weight before breakfast, special instructions: resident has CHF.</p> <p>The annual MDS dated [DATE] identified Resident #26 had severely impaired cognition, was dependent for chair/bed-to-chair transfers and toileting hygiene, and had received a high-risk medication, diuretic (a drug that increases the amount of water excreted from the body), in the last 7 days.</p> <p>The care plan dated 8/27/24 identified Resident #26 had the potential for decreased cardiac output/distress related to: hyperkalemia, hypertension, atrial fibrillation, congestive heart failure, and history of a cerebral vascular accident. Interventions included monitoring vital signs and as ordered and as needed and following the CHF protocol per the physician's orders: monitor weight as ordered, complete pulmonary and peripheral edema assessments, observe, document, and report any signs and symptoms of fluid overload to the physician, such as sudden weight gain, peripheral edema, shortness of breath, and lung congestion. The care plan further identified Resident #26 had refused to get out of bed and at times refused to be weighed. Interventions included documenting episodes being resistive, and reapproach as needed, reminding the resident of the importance of getting out of bed and being weighed.</p> <p>Review of the Vital Signs: Weight document dated 8/1/24 through 9/30/24 failed to identify documentation that daily weights were completed on 59 of 61 days: daily weights were documented only on 8/14/24 and 9/7/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MAR dated 8/1/24 through 9/30/24 failed to identify documentation that daily weights were completed on 60 of 61 days: a daily weight was documented only on 9/6/24. The August/September 2024 MAR identified the following weight documentation:</p> <p>Not administered: refused on 8/1 - 8/8, 8/10, 8/11, 8/14 - 8/17, 8/21 - 8/23, 8/27 - 8/31, 9/2, 9/4, 9/9 - 9/13, 9/15 - 9/17, 9/20, 9/23 - 9/24, 9/27, and 9/28/24.</p> <p>Late administration: charted late on 9/5/24.</p> <p>Weight: not taken on 8/9, 9/8, and 9/25/24.</p> <p>Not administered: not done on this shift on 8/26, 9/14, and 9/29/24.</p> <p>Not administered: on hold on 9/18/24.</p> <p>The nurses note dated 8/6/24 at 7:18 AM identified Resident #26 refused to be weighed during the shift. The nurse's note dated 8/1/24 through 8/5/24 and 8/7/24 through 9/30/24 failed to identify that daily weights were completed per the physician's order or documentation that Resident #26 had refused daily weights.</p> <p>Interview and review of the clinical record review with LPN #5 on 10/9/24 at 10:48 AM identified that daily weights were typically completed by the nurse aide or charge nurse on the 11:00 PM - 7:00 AM shift, but that it had been reported to her, during morning report, that Resident #26 has refused daily weights. LPN #5 further identified that Resident #26 would frequently refuse to be weighed when she reapproached him/her, and while she could not recall if she had documented the resident's refusals, LPN #5 indicated that she should be documenting the resident's refusals in the clinical record. LPN #5 further indicated that she would expect Resident #26's weight refusals to be communicated to the APRN through the communication log; review of the APRN communication log dated 9/1/24 through 9/30/24 failed to identify the daily weight refusals were documented.</p> <p>Although attempted an interview with APRN #1 was refused.</p> <p>Interview with the Nursing Supervisor (RN #4) on 10/9/24 at 8:20 AM identified that the charge nurse was responsible for ensuring daily weights were completed, per the physician's order. RN #2 further identified that if Resident #26 refused care, she would expect the charge nurse to re-approach the resident and provide education. RN #2 indicated that if the daily weight was not obtained by the end of the shift, the charge nurse should communicate the refusal to the next shift; if Resident #26 continued to refuse throughout the day, which he/she has that the right to refuse, then the nurse is expected to document in the clinical record the date and time that he/she was reapproached and educated, and notify the provider and resident representative of the refusals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and review of the clinical record with the DNS on 10/9/24 at 11:03 AM failed to identify Resident #26's daily weights were completed, per the physician's order and failed to identify that instances of refusals of care were documented in the clinical record. The DNS indicated that she had worked at the facility for 7 weeks, and she had identified weight monitoring as an area for improvement, and the facility was in the process of implementing new measures to ensure weights were completed per the physician's order. The DNS further indicated that it was the responsibility of the charge nurse to ensure daily weights were completed, and while a resident has the right to refuse care, if a resident refuses a treatment or medication, or is out of the building and misses a treatment or medication, she would expect documentation in the clinical record to reflect why the treatment or medication was missed, interventions that were implemented, and notifications to the physician or APRN and the resident representative.</p> <p>The Heart Failure protocol directs the physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc) to monitor, when to report finding to the physician, etc. The physician will prescribe treatments for residents with heart failure that are consistent with relevant guidelines and protocols.</p> <p>The Documentation Guidelines policy directs that documentation shall be done by inclusion and/or exception. Documentation by inclusion is done on a regular basis, does not indicate any deviation from standards or norms of care, and includes such areas as: weekly or monthly summaries, routine vital signs, weights, behavior monitoring, medication charting, treatment charting, intake and output, etc. Documentation by exception is done when significant findings or exceptions to standards or norms of care are observed.</p> <p>3. Resident #32 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, osteomyelitis, and atrial fibrillation.</p> <p>A physician's order dated 7/24/24 directed to administer Eliquis (a medication used to prevent blood clot formation) 5 mg tablet daily.</p> <p>The care plan dated 7/25/24 identified Resident #32 was at risk for cardiopulmonary complications due to multiple diagnoses including atrial fibrillation. Interventions included to administer medication as ordered.</p> <p>The admission MDS dated [DATE] identified Resident #32 had intact cognition, was frequently incontinent of bowel and bladder and was dependent on staff to assist with dressing, toileting and substantial staff assistance with bathing. The MDS also identified Resident #32 took a daily anticoagulant and required dialysis treatments.</p> <p>A new physician's order dated 9/26/24 directed to administer Eliquis 5 mg tablet twice daily at 9:00 AM and 5:00 PM.</p> <p>The October 2024 MAR identified that on 10/3/24 Resident #32 received 5 mg Eliquis at 9:00 AM.</p> <p>The physician's order dated 10/3/24 directed to discontinue Eliquis 5 mg twice daily.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An order dated 10/3/24, entered by APRN #1, directed the following: Please evaluate and review when Resident #32 should restart Eliquis 5 mg twice daily after the angiogram procedure. Please alert and update provider. Please d/c when completed. The order was for every shift and with no end date (open ended).</p> <p>A nurse's note dated 10/3/24 at 11:20 PM identified Resident #32 was scheduled for an angiogram procedure on 10/4/24 at 10:30 AM and had orders to have nothing by mouth after midnight prior to the procedure.</p> <p>A consultation report dated 10/4/24 identified that Resident #32 underwent a right leg angiogram on 10/4/24, and that post procedure instructions included to resume all meds and diet.</p> <p>Review of the clinical record failed to identify documentation related to Eliquis being restarted on 10/4/24 - 10/7/24.</p> <p>Review of the October 2024 MAR dated 10/4/24 - 10/8/24 during the 11:00 PM - 7:00 AM shift identified licensed staff documented as done the order to the (evaluate and review Eliquis), with LPN #1 documented as done the order to the (evaluate and review Eliquis) on 10/8/24 during the 11:00 PM - 7:00 AM shift.</p> <p>Interview with RN #4 (7:00 AM - 3:00 PM supervisor) on 10/8/24 at 7:14 AM identified she was working on 10/4/24 when Resident #32 left the facility for the angiogram and had an order in place to hold the Eliquis pending return to the facility. RN #4 identified Resident #32 returned to the facility after her shift ended. A review of Resident #32's orders was then completed with RN #4, who identified that Resident #32's Eliquis order was discontinued. RN #4 also identified the order placed by APRN #1 on 10/3/24 to evaluate and review for Eliquis restart was not an order she had ever seen before, as the nurses on the unit would not determine when to restart medications. RN #4 identified she would contact APRN #1 to determine what the order meant, and indicated APRN #1 was in the facility almost daily during the week.</p> <p>Interview with the DNS on 10/8/24 at 7:45 AM identified that her understanding of the order to evaluate and review when Resident #32 should restart Eliquis would mean that the nursing staff were to monitor Resident #32 for bleeding, excessive bruising, and that once these items had been reported to the APRN, the APRN would assess when it was appropriate for Eliquis to be restarted.</p> <p>Interview with LPN #1 on 10/8/24 at 8:36 AM identified she had signed as done in the MAR related to evaluation of Eliquis restart. LPN #1 identified her understanding was that she was being kept in the loop and to make sure everyone was aware that the Eliquis needed to be restarted at some point. LPN #1 was unable to identify what this meant, but identified it involved checking the APRN communication book. LPN #1 did not answer if she had checked the APRN communication book.</p> <p>Interview with APRN #1 and RN #4 identified that Resident #32's consultation report had been placed in Resident #32's paper chart but should have been placed along with a note in the APRN communication book. APRN #1 identified wrote the order to evaluate and review Eliquis restart so the nursing staff would notify her when Resident #32 returned to the facility and to notify her of the consultation report findings as this was the primary way the nurses notified her of issues with residents of the facility. APRN #1 identified Resident #32 took Eliquis due to atrial fibrillation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Subsequent to surveyor inquiry, APRN #1 placed an order to restart Eliquis 5 mg twice daily beginning at 5pm on 10/8/24.</p> <p>Interview with MD #1 on 10/9/24 at 9:53 AM identified that Resident #32 was on Eliquis 5 mg twice daily and that the nursing staff should have communicated the need to restart the medication following the angiogram on 10/4/24. MD #1 identified that while Resident #32 should have restarted the medication after returning to the facility, he felt that up to 3 - 5 days from the last dose would have been acceptable regarding Eliquis administration. MD #1 identified that staff should have put a copy of the consultation form and a note in the APRN and MD communication books after the procedure. MD #1 identified that while Resident #32 was on Eliquis 5 mg twice daily for atrial fibrillation and that being off of the medication placed Resident #32 at risk for stroke due to clot formation, he felt the risk based on the timeframe the medication was not restarted was minimal.</p> <p>Interview with the DNS on 10/9/24 at 10:10 AM identified that multiple consultation sheets had been found in Resident #32's chart from outside providers. The DNS identified during morning report, each resident going out to an appointment would be reported on, and the consult sheets from the prior day's appointments would also be reviewed during report to ensure anything including medication restarts, discontinuations, new medications, and any treatment orders were reconciled timely.</p> <p>The Anticoagulation policy directed that the facility staff and physician would identify situations where an individual was not anticoagulated but required anticoagulation, including atrial fibrillation. The policy further directed that the staff and physician would assess for evidence of subtherapeutic drug levels for residents who were being anticoagulated.</p> <p>The facility policy on admission assessments and follow-up directed that nursing staff were to reconcile medications from the previous institution.</p> <p>The facility policy on medication orders directed that treatment orders should specify a duration of the order.</p> <p>4. Resident #274 was admitted to the facility in September 2024 with diagnoses that included cardiomyopathy, ventricular tachycardia, and glaucoma.</p> <p>a. The physician's order dated 9/23/24 identified to administer Brimonidine Timolol drops 0.2 -0.5%, 1 drop in each eye daily and Bimatoprost drops 0.01% administer 1 drop to both eyes every other day for Glaucoma.</p> <p>The care plan dated 9/24/24 identified Resident #274 had vision impairment. Interventions included to report any concerns or changes to the physician and resident representative as needed.</p> <p>Review of the September 2024 MAR identified from 9/24/24 through 9/27/24, 4 days, Brimonidine Timolol drops 0.2 - 0.5% was documented as not available (4 doses). Additionally, from 9/24/24 through 9/30/24, 7 days the Bimatoprost drops 0.01% were documented as not available (4 doses).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #274 and Person #1 on 10/6/24 at 10:08 AM indicated they were upset that Resident #274 did not receive the 2 eye drops during for 4 - 7. Resident #274 indicated that he/she was not informed why the facility could not get them from the pharmacy. Person #1 indicated that he/she had brought in the eye drops when the nurse informed them that they were not available from the pharmacy and Person #1 offered again to bring in the eye drops from home and the nurse informed Person #1 that the facility could not use them. Person #1 indicated that he/she had brought in the vials with the pharmacy labels on them and showed them to a nurse, and was informed again that the facility could not use the resident's bottles of eye drops. Person #1 indicated that subsequently, Resident #274 miss 4 - 7 days of the eye drops when that was not necessary.</p> <p>Interview with the DNS on 10/7/24 at 7:07 AM indicated that if a medication is not available from the pharmacy the nurses could use the resident's personal medication with a pharmacy label on it, until the pharmacy medication arrives. The DNS indicated that the charge nurse should have notified the supervisor, and she would have expected the supervisor to call the pharmacy for a stat order for the 2 eye drops and if the medication was still not available to notify the physician. The DNS indicated that the supervisor could have received an order from the physician that Resident #274 could have used own medications until available from the pharmacy. The DNS indicated that the physician should have been notified immediately upon admission that the medications were not available and for each day that medications were missed. The DNS indicated that there were no nurse's notes that the supervisor or charge nurse had notified the pharmacy or the APRN/MD that the medications were not given because they were not available.</p> <p>b. The hospital discharge summary dated 9/23/24 identified Resident #274 had an implanted cardiac defibrillator.</p> <p>The physician's orders and progress notes and the nurse's notes dated 9/23/24 to 10/6/24 did not reflect that Resident #274 had an implanted cardiac defibrillator with a continuous monitor at the bedside.</p> <p>The care plan dated 9/30/24 did not reflect that Resident #274 had an implanted cardiac defibrillator with a continuous monitor.</p> <p>Observation 10/6/24 at 8:00 AM identified Resident #274 was lying in bed with a white box plugged into the wall on the nightstand within 2 feet from resident.</p> <p>Observation on 10/6/24 at 10:08 AM identified Resident #274 had a raised area on the left chest wall.</p> <p>Interview with Person #1 on 10/6/24 at 10:08 AM indicated that he/she had informed the nurse on day of Resident #274's admission and the day after admission that she had brought in and plugged in the implanted cardiac defibrillator monitor and it was sitting on the bedside table doing the continuous transmission. Further, Person #1 showed had placed the owner's manual for implanted cardiac defibrillator monitor in the top draw of the nightstand in the resident's room.</p> <p>Interview with LPN #16 on 10/6/24 at 10:30 AM indicated she was responsible for Resident #274's care today. LPN #16 indicated that she was not aware Resident #274 had a cardiac monitor or a defibrillator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/9/24 at 8:33 AM indicated that after review of the clinical record, since admission on 9/23/24 until today 10/9/24 the cardiologist had not been updated about Resident #274's admission, nor was the primary physician at the facility notified that Resident #274 had an implanted cardiac defibrillator that required a monitor, which was at the bedside. The DNS indicated that this should have been done on the day of admission. The DNS directed RN #4 to call the cardiologist and the resident's primary physician for direction regarding the cardiac device and the monitor.</p> <p>After surveyor inquiry, interview with RN #4 on 10/9/24 at 9:20 AM indicated that she called the cardiologist and was informed the monitor must be at least 10 feet away from Resident #274 when resident is sleeping and frequent checks to make sure the monitor is on and functioning. RN #4 indicated that she put the order in place and was waiting for the cardiologist to fax over more information. RN #4 indicated that she would call MD #1 to notify him of the cardiac device and monitor once she received more information from the cardiologist today.</p> <p>The physician's order dated 10/9/24 directed to check cardiac monitor at 8:00 PM and 11:00 PM daily. Ensure the monitor is plugged in and functioning properly and at least 10 feet away from resident when sleeping.</p> <p>Interview with DNS on 10/7/24 at 6:49 AM indicated that as part of the nursing admission assessment, she would expect the RN to note and document an implanted device in the resident's chest wall. After review of the admission nursing assessment the DNS indicated that although Resident #274 had an implanted cardiac defibrillator, it had not been documented within the nursing admission assessment.</p> <p>The manufacturer manual for the Medtronic patient monitor identified this monitor is an electronic device that provides an easy way for your doctor to obtain information about your heart's device. The monitor gathers and sends information to allow your doctor to manage your care. This automatic wireless communication between your heart device and the monitor. The monitor must remain plugged into a power outlet. The monitor is an external electronic device that interfaces with your compatible implanted heart device and the telecommunications connect to transmit stored implanted heart device data to the physician or clinic. Do not use the monitor within 6.5 feet of the television, computer monitor or screen, or wireless communications equipment such as wireless home network devices, mobile phones, and cordless phones. Using your monitor near these devices could interfere with communication between your implanted heart device and the monitor.</p> <p>5. Resident #378 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, edema, and gout.</p> <p>Review of the clinical record identified on 9/17/24, during the admission process to the facility, Resident #378 was observed to have gross hematuria with blood and clots in an indwelling catheter bag and was subsequently sent to the hospital for evaluation and treatment. Further review of the record identified Resident #378 returned to the facility on [DATE] at some point during the 11:00 PM - 7:00 AM shift.</p> <p>Review of the clinical record failed to identify an admission nursing assessment had been completed on 9/17/24, or that a readmission assessment was completed on 9/18/24.</p> <p>The physician's orders dated 9/17/24 directed to weigh the resident on the 1st shower day of the week (Monday 3:00 PM - 11:00 PM shift) for 4 weeks and then once monthly.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record failed to identify any nursing documentation related to Resident #378's readmission to the facility on [DATE].</p> <p>A nurse's note by LPN #4 on 9/19/24 at 2:53 PM identified Resident #378 had been seen by the wound care nurse that morning and an order was in place for the upper back. The clinical record failed to identify any documentation regarding the upper back area prior to this date.</p> <p>The care plan dated 9/20/24 identified that Resident #378 was at risk for alternated nutritional status due to new admission and decreased intake. Interventions included obtain weights as ordered.</p> <p>The admission MDS dated [DATE] identified Resident #378 had severely impaired cognition, was always incontinent of bowel, utilized an indwelling catheter for bladder and was dependent on staff assistance with toileting, bathing and required supervision with meals. The MDS also identified Resident #378 was not known to have had a weight loss of 5% or greater in the 6 months prior to admission to the facility.</p> <p>An initial nutritional assessment completed by Dietitian #1 on 9/20/24 identified Resident #378's admission weight was pending, and the hospital discharge weight was 221.8 lbs. The note also identified that Resident #378 was at risk for malnutrition and unintended weight loss due to decreased appetite and at risk for pressure ulcers due to decreased mobility. The nutritional plan included leaving a note for the APRN to change to a liberalized no added salt diet and supplement.</p> <p>Review of the APRN communication book identified on 9/20/24 a note was placed for Resident #378 with the following: (Resident requesting supplement. Had Ensure in the hospital. Recommend 240 cc daily. Consider discontinuing renal restrictions and change to no salt added diet. Decreased appetite, at risk for malnutrition).</p> <p>Review of the clinical record failed to identify any documentation related to orders for nutritional supplements or a liberalized no added salt diet for Resident #378 on or after 9/20/24.</p> <p>Review of the APRN communication book identified on 9/27/24 a was note placed for Resident #378 with the following: (Poor appetite. Continue to recommend discontinue renal diet restriction and change to no salt added and add Ensure plus 240 cc twice daily. At risk for malnutrition). Further review of the note identified a sign off made with the initials of APRN #1.</p> <p>The September 2024 MAR identified Resident #378 was documented as refusing weights on 9/23/24. The clinical record failed to identify any progress notes or documentation related to the refusal.</p> <p>Review of the clinical record failed to identify any documentation related to orders for nutritional supplements or a liberalized no added salt diet for Resident #378 on or after 9/27/24.</p> <p>A nutrition follow up note dated 9/30/24 at 8:33 AM by the Dietitian identified that Resident #378 had refused a weekly weight per the MAR and had overall poor intake. The note identified no weights were available and a request [TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117</b></p> <p>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 residents (Resident #26, 87 and 378) reviewed for pressure ulcers, for Resident #26 the facility failed to ensure weekly skin audits were completed per the physician's order, and failed to ensure a complete and accurate nursing assessment was documented, upon identifying a new skin issue, and for Resident #87 the facility failed to ensure weekly body audits and Braden scales were completed per physician's order, failed to complete a RN assessment of a newly identified pressure ulcer, failed to immediately obtain a treatment order for a newly identified pressure ulcer, failed to perform weekly pressure ulcer assessments, failed to notify the dietitian timely of new pressure ulcer, and complete treatments daily per the physician's order and for Resident #378 the facility failed to ensure that an initial nursing skin assessment was completed upon the resident's admission and readmission to the facility, failed to ensure that an RN assessment was completed when the resident developed new pressure ulcers, and failed to ensure that weekly body audits and Braden scales were completed per physician's order. The findings include:</p> <p>1. Resident #26 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), type 2 diabetes mellitus, anemia, vitamin D deficiency, and dementia.</p> <p>The annual MDS dated [DATE] identified Resident #26 had severely impaired cognition, was dependent for toileting hygiene, was always incontinent of bowel, frequently incontinent of bladder, and was at risk for developing pressure ulcers.</p> <p>The care plan dated 6/1/24 identified Resident #26 was at risk for skin breakdown and pressure ulcers related to incontinence of bowel, decreased mobility, and choosing not to participate in bladder program. Interventions included inspecting skin for signs and symptoms of breakdown during care and completing a weekly body audit.</p> <p>A physician's order dated 7/29/24 directed to complete a body audit every week on the first shower day of the week, Tuesday; 7:00 AM-3:00 PM, special instructions: please check and update resident wound management observations, if resident refuses shower or body audit update supervisor and document in the progress notes.</p> <p>Review of the Weekly Body Audit documentation dated 7/1/24 through 8/31/24 failed to identify 4 of 9 weekly skin audits were completed; audits were not completed during the weeks of: 7/1/24, 7/14/24, 8/4/24, and 8/18/24.</p> <p>The nurse's note dated 8/1/24 through 8/7/24 failed to identify documentation that a newly identified skin issue had been assessed and reported to the physician or APRN.</p> <p>The Wound Specialist note dated 8/8/24 identified that Resident #26 was seen as a consultation for the evaluation of their wound(s). The wound assessment identified Wound #1 presented as scattered areas on the sacrum with a primary etiology of moisture associated skin damage. Wound status identified this was the first evaluation of the existing wound by the new provider and the wound measured 0 cm x 0 cm x 0cm.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Weekly Body Audit document dated 8/13/24 indicated no new skin issues were identified.</p> <p>The Wound Specialist note dated 8/15/24 identified that Resident #26 was seen as a consultation for the evaluation of their wound(s). The wound assessment identified Wound #1 presented as scattered areas on the sacrum with a primary etiology of moisture associated skin damage. Wound status was identified as stable, and the wound measured 0 cm x 0 cm x 0cm. Wound #2, located on the coccyx was a stable stage 2 pressure wound measuring 2 cm x 1.5 cm x 0.2 cm.</p> <p>Interview with the Wound Nurse (RN #1) on 10/08/24 at 7:56 AM identified that she had only worked at the facility for one month, was unaware of Resident #26's stage 2 pressure ulcer and was unable to speak to its onset, progress, or resolution. RN #1 further identified that she would expect skin audits to be completed weekly by the nurse and documentation to be reflected in the clinical record upon the identification of a new skin issue.</p> <p>Interview with the Nurse Supervisor (RN #4) on 10/09/24 at 8:20 AM identified that skin audits were expected to be completed by the charge nurse, weekly. RN #4 was unsure why some of Resident #26's weekly skin audits were not being completed, as she had only worked for the facility for a few weeks. RN #4 indicated that she identified missed weekly skin audits as an area for improvement and had already begun revamping the process and adding resident's shower/skin audit days to the nurse's assignment sheet, instead of relying on charge nurses checking the list of daily showers that is located behind the nurse's station. RN #4 indicated that if a nurse identifies a new skin issue, she would expect the Nurse Supervisor, physician or APRN, and resident representative to be notified and documentation to be included in the resident's medical record including the nurse's assessment, appropriate notifications, and the updated plan of care.</p> <p>Interview with LPN #5 on 10/09/24 at 10:46 AM identified that the charge nurse is responsible for completing weekly skin audits, and she did not believe that she had missed any skin audits for Resident #26, during her shifts. LPN #5 indicated that at the beginning of the shift, she would communicate to the nurse aide assigned to the resident to notify her at the time of the shower or bed bath, so she could complete the full body skin assessment. LPN #5 further indicated that if, at any time, a new area of concern was identified, she would notify the Nurse Supervisor, the Wound Nurse, and the medical provider (via call or in person) during her shift, and she would document in a progress note her findings, who was notified, and any intervention or treatments ordered.</p> <p>Interview and clinical record review with the DNS on 10/09/24 at 11:06 AM failed to identify that documentation of weekly skin audits were completed on Resident #26 during the weeks of 7/1/24, 7/14/24, 8/4/24, and 8/18/24. The DNS identified that weekly skin audits were signed off in the Medication Administration Record, but her expectation was that the Weekly Body Audit documentation would also be completed. The DNS further identified that skin assessments were expected to be completed weekly by the charge nurse, per the physician's order, and if a new skin issue or pressure ulcer was identified the nurse was expected to document that the physician, Nursing Supervisor, and resident representative were notified. The DNS indicated that she would also expect a progress note, not only from the charge nurse note, but also the Nurse Supervisor detailing the assessment of the area: location, wound base, drainage, odor, measurements, and peri wound area.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Body Audit policy directs that residents will have a body audit performed weekly and will be scheduled to coincide with shower days. The body audit will be completed by the licensed nurse assigned to that unit and will be signed as done on the Body/Oral Check form. The policy further directs that any area(s) of skin that is not intact or is impaired will be followed up on per the facility protocol.</p> <p>The facility's Pressure Ulcers/Skin Breakdown policy directs the nursing staff and practitioner to assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue, pain assessment, mobility status, current treatments, and active diagnoses.</p> <p>2. Resident #87 was admitted to the facility in December 2021 with diagnoses that included dementia and osteoporosis.</p> <p>A Braden scale dated 6/22/24 identified Resident #87 was at high risk to develop a pressure ulcer.</p> <p>The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition, required maximum assistance with personal hygiene, bathing, and eating and was totally dependent for transfers and rolling left to right. Additionally, Resident #87 was at risk to develop a pressure ulcer but did not have any pressure ulcers.</p> <p>The care plan dated 8/14/24 identified Resident #87 was at risk for skin breakdown. Interventions included to monitor skin when putting on and off compression stockings and position the resident to offset pressure areas while awake.</p> <p>a. The September 2024 monthly order (originally dated 8/19/23) directed to apply skin prep to the bilateral heels daily on the 3:00 PM to 11:00 PM shift. Additionally, the September 2024 monthly order also directed to complete a body audit and Braden scale weekly (original date 10/1/22) on Saturdays during the 3:00 PM to 11:00 PM shift.</p> <p>A nurse's note dated 9/10/24 identified Resident #87 had a new wound to the right heel.</p> <p>A progress note, written by MD #1 dated 9/12/24 identified Resident #87 had a new unstageable right heel pressure ulcer that measured 4.5cm.</p> <p>Review of the clinical record between 1/1/24 - 10/7/24, 9 months, identified the body audits, which were ordered to be completed weekly, were done 5 times in 9 months, with the last body audit being completed on 6/22/24, over 3 months ago. Further, the Braden scales, which were ordered to be completed weekly, were done 4 times in 9 months.</p> <p>Interview with the DNS on 10/7/24 at 9:13 AM indicated that the nurses should be checking the resident ' s skin weekly to ensure it ' s intact. Further, the DNS indicated that body audits should have been done every Saturdays during the 3:00 PM to 11:00 PM shift and documented in the clinical record. After review of the clinical record the DNS indicated that between 1/1/24 - 10/7/24, 9 months, the body audits were done 5 times, with the last body audit done on 6/22/24. The DNS indicated that there was an order for a Braden scale to be done weekly and after clinical record review, the Braden scale was only done 4 times in 9 months.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Body Audit Policy identified residents will have a body audit performed weekly to ensure that skin is intact and without impairment. The body audit will be performed by the licensed nurse and documented and signed as done on the body audit form. Any areas of skin that are not intact will be followed up on per the facility protocol.</p> <p>Review of the Pressure Injury Risk Assessment (Braden Scale) Policy identified the purpose is to identify residents at risk of developing a new pressure injury or worsening of existing pressure injuries. The purpose of a pressure injury risk assessment is to identify all risk factors and then determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify.</p> <p>b. The nurse's note written by LPN #7 dated 9/10/24 at 6:21 AM identified Resident #87 has a wound to right heel which was cleansed, and offloaded heel with pillow. LPN #1 added a notation of the new right heel wound to the physician ' s book to be evaluated for a treatment.</p> <p>The MD #1 note dated 9/12/24 at 2:48 PM indicated Resident #87 has a 4.5cm unstageable pressure ulcer to the right heel. MD #1 ordered a wound care consult, bilateral heel boots, and a daily dressing with Santyl for chemical debridement.</p> <p>Review of the clinical record identified the first RN assessment of the resident ' s new right heel pressure ulcer was not done until 9/26/24, 16 days.</p> <p>Interview with the DNS on 10/7/24 at 9:13 AM indicated that when a new pressure ulcer is found, the charge nurse must notify the RN supervisor, who is responsible to perform an RN assessment right away. The DNS indicated that the assessment must include the stage, appearance, the measurements length by width, by depth, the wound bed, the surrounding wound bed, if there was any drainage, and any odor. The DNS indicated that the APRN or MD must be notified that day to get a treatment in place. After clinical record review, the DNS indicated there was only an LPN note on 9/10/24 and an MD note on 9/12/24 but no RN assessment of the wound.</p> <p>Interview with LPN #7 on 10/7/24 at 1:10 PM indicated that on 9/10/24 the nurse aide had informed him that the resident had an open area on the right heel. LPN #7 indicated he looked at the wound, cleansed it with normal saline, and placed a boarder gauze dressing over it. LPN #7 indicated that he had placed a notation of the new wound in the MD #1's book and requested a treatment. LPN #7 indicated that he did not call the APRN or MD or notify the RN supervisor because he had placed the notation in the book. LPN #7 indicated he did not measure the wound, but it was open. LPN #7 indicated that the wound bed was purplish, and the edges were black, there was a slight odor, and the surrounding tissue was dry and flaky.</p> <p>Review of the Pressure Ulcer Breakdown Protocol identified the nurse, and practitioner will examine the newly identified skin for evidence of pressure ulcer or other skin condition. In addition, the nurse shall describe and document the full assessment of a pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue, pain assessment, resident's mobility status, current treatments, and all active diagnosis.</p> <p>c. Review of the September 2024 TAR identified although a new pressure ulcer was identified on 9/10/24, a physician ordered treatment was not initiated until 9/12/24, 2 days later.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/7/24 at 9:13 AM indicated that when a new pressure ulcer is found, the charge nurse notifies the supervisor who is responsible to notify the APRN or MD that day, to get a treatment in place. After clinical record review, the DNS indicated there were no treatment orders in place for the right heel from 9/10/24 until 9/12/24 when resident was seen by MD #1.</p> <p>Review of the Pressure Injury Risk Assessment Policy directed if a new area is identified staff must notify the supervisor, notify the physician and notify the resident representative.</p> <p>d. The Wound Assessment Report, written by the Wound APRN (APRN #2) on 9/26/24 identified a first evaluation of the existing pressure ulcer to the right heel that measured 2.5 cm by 5.0 cm by 0.2 cm with 25 - 49% slough and 50 - 74% granulation tissue. Wound had moderate amount of serosanguineous drainage with a mild odor. Recommendation to cleanse with normal saline, apply Santyl, Calcium Alginate, skin prep peri wound and dry clean dressing. Implement off load boots.</p> <p>Review of the clinical record between 9/10/24 - 9/26/24 identified RN assessments of the wound were not done until 9/26/24, 2 weeks.</p> <p>Interview with the DNS on 10/7/24 at 9:13 AM indicated that when a new pressure ulcer is found, the charge nurse must complete an RN assessment at the time of identification and then weekly including the stage, appearance, measurements length by width by depth, the wound bed, the surrounding wound bed, drainage and odor. The DNS indicated that an RN must do weekly wound rounds, and RN #1, is responsible to do the assessments weekly. After clinical record review the DNS indicated there was not a complete assessment of the new right heel pressure ulcer until the APRN #2 had seen it on 9/26/24. The DNS indicated that the Infection Control Nurse, RN #1 oversees wounds and should have looked at it.</p> <p>Interview with RN #1 on 10/7/24 at 11:13 AM indicated she was responsible to do the weekly wound rounds and measurements with the wound APRN on Thursdays. RN #1 indicated that she was aware that the nurses were not informing her of any new skin conditions or wounds so last week she started a communication book for new wounds. RN #1 indicated that the wound measurements must be done by an RN weekly. RN #1 indicated she does not know when Resident #87 first was identified with the pressure ulcer to the right heel, but she was first notified on 9/27/24 and had seen it on 9/27/24. RN #1 indicated that she was not aware of the wound until 9/27/24 so the weekly RN assessments were not done. RN #1 indicated she should have been notified and put her eyes on the wound.</p> <p>e. Review of the clinical record identified the dietitian did not assess Resident #87 until 9/25/24, 15 days after the pressure ulcer was identified.</p> <p>The dietitian note dated 9/25/24 indicated Resident #87 has a pressure ulcer to right heel with recommendations to add ProSource 30 ml daily.</p> <p>Interview with the DNS on 10/7/24 at 6:50 AM indicated that when a new pressure ulcer is identified, the dietitian should be notified, and the dietitian should see the resident the next time she is in the facility. The DNS indicated that she did not know the process for the dietitian notification.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Dietitian on 10/7/24 at 1:24 PM indicated that she works at the facility 3 days per week on Mondays, Wednesday ' s, and Friday's and attends morning report with the management team. The Dietitian indicated that she sees all residents quarterly and annually and also addresses issues when doing rounds. The Dietitian indicated that she would learn about a new wound during morning report or word of mouth on the unit. The Dietitian indicated there was not a communication system like a communication book or a slip of paper that she receives. The Dietitian indicated that when a resident has a new pressure ulcer, she would check the resident's weight and any orders for supplements. The Dietitian indicated that Resident #87 was on fortified cereal. The Dietitian indicated that when a resident develops a new pressure ulcer, her expectation was that nursing would notify her right away and she would see and evaluate the resident that day or the next day she comes in. The Dietitian indicated that she was not aware that Resident #87 had a new right heel pressure ulcer until 9/25/24 (15 days later) when she spoke with the APRN and added ProSource (protein supplement). The Dietitian indicated that even if she had numerous admissions, she would prioritize a new wound as top priority.</p> <p>f. Physician's monthly orders for September 2024 (originally dated 8/19/23) directed to apply skin prep to bilateral heels daily on the 3:00 PM to 11:00 PM shift.</p> <p>The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition, required maximum assistance with personal hygiene and bathing, and was totally dependent for transfers and rolling left to right. Additionally, Resident #87 was at risk to develop a pressure ulcer, did not have any current pressure ulcers, and had a pressure reducing device on the bed.</p> <p>The care plan dated 8/14/24 identified Resident #87 was at risk for skin breakdown.</p> <p>Interventions included to monitor skin when putting on and off compression stockings and position resident to offset pressure areas while awake.</p> <p>The Wound Assessment Report written by the Wound APRN, (APRN #2), on 9/26/24 identified a first evaluation of pressure ulcer to the right heel with measurements of 2.5 cm by 5.0 cm by 0.2 cm with 25 - 49% slough, 50 - 74% granulation tissue, moderate amount of serosanguineous drainage and a mild odor. Recommendations included to cleanse with normal saline, apply Santyl, Calcium Alginate, skin prep to the peri wound, dry clean dressing and off load boots.</p> <p>A physician's order dated 9/27/24 directed to cleanse the unstageable right heel pressure ulcer with normal saline, apply Santyl, Calcium Alginate, skin prep around the peri wound, secure with a dry clean dressing daily and as needed.</p> <p>A Wound Management Report, written by the Infection Control/Wound Nurse (RN #1) dated 10/4/24 (late entry for 10/3/24) identified the right heel pressure ulcer measured 2.5cm x 5.0 cm by 0.2 cm with slough in the wound bed and no tunneling.</p> <p>Review of the October 2024 TAR dated 10/3/24 to 10/8/24 identified the treatment to the right heel was signed as done on the following days by the following staff.</p> <p>10/4/24 LPN #14 documented she completed the treatment to the right heel.</p> <p>10/5/24 LPN #12 documented she completed the treatment to the right heel.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/6/24 LPN #6 documented she completed the treatment to the right heel.</p> <p>Further, on 10/7/24 LPN #15 did not document if the treatment was completed as per the order on the (7:00 AM - 3:00 PM shift) and documented the treatment was not done on the 3:00 PM - 11:00 PM shift because it is scheduled for 7:00 AM to 3:00 PM shift.</p> <p>Interview with MD #1 on 10/7/24 at 10:45 AM indicated that his expectation was the nurses follow the physician's orders.</p> <p>Observation on 10/8/24 at 2:00 PM with LPN #14 identified when she removed the old dressing from Resident #87's right heel it was dated as 10/3/24, 5 days prior, and there were no initials to identify who completed the treatment on 10/3/24.</p> <p>Interview with LPN #14 at that time identified the treatment to the resident right heel is ordered to be done daily.</p> <p>Interview with the DNS and the VP of Clinical Operations (RN #5) on 10/8/24 at 3:00 PM indicated that Resident #87's had a wound on the right heel and the treatment was ordered to be done daily. Further, RN #5 identified the nurses are responsible to complete the dressing change daily, and date and initial the dressing itself, and sign their initials on the TAR. RN #5 indicated she would investigate to find out why the treatment was not done since 10/3/24.</p> <p>A written statement by LPN #14 dated 10/8/24 identified that on 10/4/24 she was orienting a new nurse, and that nurse was using her log in for the electronic medical record (EMR). There might have been a time that the dressing change to Resident #87's right heel was clicked off in the EMR as having been done but wasn't done yet. LPN # 14 indicated the dressing to the right heel was not changed on 10/4/24.</p> <p>An email from LPN #6 dated 10/8/24 identified she worked Sunday 10/6/24. LPN #6 identified she intended to do the dressing change to Resident #87's right heel but due to an overwhelming layer of pressure and distraction, she inadvertently overlooked the dressing change to Resident #87's right heel.</p> <p>LPN #6 did not identify why she documented on the TAR that the dressing change to Resident #87's right heel had been done.</p> <p>An email dated 10/9/24 from LPN #12 identified she worked 10/5/24 during the 7:00 AM -3:00 PM and she is not as familiar with that unit. LPN #12 indicated she inadvertently clicked the treatment to Resident #87's right heel as being done.</p> <p>A written statement dated 10/8/24 by LPN #15 who worked on 10/7/24 during the 7:00 AM - 3:00 PM shift identified at the end of her shift, she realized she did not have the time to complete the wound care.</p> <p>A statement by the ADNS identified LPN #15 did not document or complete dressing change to Resident #87's right heel and she left it for the following shift. This was an omission.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 10/9/24 at 6:42 AM identified LPN #15 forgot to notify the oncoming 3:00 PM - 11:00 PM nurse, LPN #9, that she had not done the dressing change. Further, LPN #9 did not do the dressing change because it was due on the 7:00 AM - 3:00 PM shift.</p> <p>Interview with the DNS on 10/9/24 at 6:42 AM indicated that all dressing changes are to be completed, and if they are not able to be completed, the nurses should not be documenting that they have been done. Further, the DNS indicated if a dressing change is not done, they are responsible to write a note as to why it wasn't done, and they should notify the supervisor because the supervisor can come and assist. The DNS indicated that the APRN/MD must be notified immediately if a dressing change is not done.</p> <p>Observation and interview with the DNS and RN #4 on 10/9/24 at 7:55 AM identified Resident #87's right heel pressure ulcer had an odor prior to removing the old dressing. The wound measured 2.1 cm by 1.2 cm by 0.4 cm with tunneling 0.6 cm from 9 o'clock to 1 o'clock. The wound bed was 75% slough and 25% purple color.</p> <p>Review of the Abuse Policy identified neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Any form of mistreatment or neglect is to be thoroughly investigated and reported.</p> <p>Interview with MD #1 on 10/7/24 at 10:45 AM indicated that he had seen Resident #87 on 9/12/24 for a monthly visit. MD #1 indicated that the wound must not have been clean because he ordered Santyl to debride it. MD #1 indicated that he ordered the heel lift boots and a consult with the wound APRN/MD. MD #1 indicated that his expectation was the wound MD/APRN would see the resident 's right heel on the next weekly visit and then weekly. MD #1 indicated that the wound RN in the facility should have seen the wound on 9/10/24 if not then no later than 9/11/24 and followed it weekly with the wound MD/APRN. MD #1 indicate that he would have expected someone to call him on 9/10/24 to let him know about the wound so he could have put a treatment in place at that time. MD #1 indicated that body audits and the Braden scales are put in the physician's orders by the facility, not him. MD #1 indicated if the order says weekly then the nurses should be done weekly. MD #1 indicated that the dietitian should have been notified the next day she was working so she could do an assessment within a few days.</p> <p>Review of the Pressure Ulcer Breakdown identified nutritional assessment to identify if resident was maintaining a stable weight or has poor nutritional status associated with increased risk of pressure ulcer development, no specific nutritional interventions clearly prevent or heal pressure ulcers. Providing approximately 1.2 to 1.5 grams per kilogram of protein daily, there are no routine pressure ulcer specific nutritional measures for those at risk for developing a pressure ulcer. Any nutritional supplement should be based on realistic appraisal of an individual's current nutritional status and minimizing any factors affecting appetite and weight.</p> <p>3. Resident #378 was admitted to the facility in 9/17/24 with diagnoses that included chronic kidney disease, edema, and gout.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the clinical record identified on 9/17/24, during the admission process to the facility, Resident #378 was observed to have gross hematuria with blood and clots in his/her indwelling catheter bag and was subsequently sent to the hospital for evaluation and treatment. Further review of the record identified Resident #378 returned to the facility at some point during the 11:00 PM - 7:00 AM shift on 9/18/24.</p> <p>Review of the clinical record failed to identify an assessment of the resident's skin had been done on 9/17/24 when the resident was first admitted to the facility, or on 9/18/24 when the resident returned from the hospital. Further, the body audit dated 9/18/24 was documented as not done.</p> <p>The physician's orders dated 9/17/24 directed to complete a Braden scale on the 1st shower day of the week (Monday 3:00 PM - 11:00 PM) for 4 weeks and then once monthly.</p> <p>The physician's orders dated 9/19/24 directed to complete body audits every week on the 1st shower day of the month (Monday 3:00 PM - 11:00 PM) with special instructions to please check and update resident wound management observations. The orders also directed to update the supervisor and document in a nurses note if the resident refused the shower or body audit.</p> <p>The care plan dated 9/19/24 identified Resident #378 was at risk to develop pressure ulcers. Interventions included to complete skin evaluations upon admission and per facility policy, and to report any skin issues when noted.</p> <p>The body audit dated 9/19/24 was documented as not done.</p> <p>The admission MDS dated [DATE] identified Resident #378 had severely impaired cognition, was always incontinent of bowel, utilized an indwelling catheter for bladder, was dependent on staff assistance with toileting, bathing and required supervision with meals. The MDS also identified Resident #378 was at risk to develop pressure ulcers and was not known to have had a weight loss of 5% or greater in the 6 months prior to admission to the facility.</p> <p>Review of the clinical record identified a Braden scale and body audit were completed on 9/23/24, 6 days after admission. The Braden scale identified Resident #378 was at moderate risk to develop pressure ulcers and the body audit identified Resident #378 had no new skin issues.</p> <p>A nurse's note by LPN #4 on 9/29/24 at 3:01 PM identified Resident #378 had a new area on the left sacrum and that a note was left for the APRN.</p> <p>Review of the clinical record failed to identify any interventions implemented related to the newly identified skin area on 9/29/24.</p> <p>The September 2024 MAR identified on 9/30/24 Resident #378 refused a body audit and Braden scale. The clinical record failed to identify any nurse's notes or documentation related to refusal.</p> <p>Review of the unit wound referral sheet identified Resident #378's name was added 9/30/24 and 10/1/24 for wound evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's note dated 10/1/24 at 2:15 PM by RN #6 identified that Resident #378 was found to have 2 open areas to the buttocks, one measuring 5.5 cm x 4.5 cm, the second 4 cm x 0.5 cm and that APRN #1 and Resident #378's resident representative was notified.</p> <p>A nurse's note dated 10/1/24 at 3:59 PM by RN #4 (7:00 AM - 3:00 PM supervisor) identified she was called to evaluate an open area. Resident #378 has an open area to the coccyx and right buttock. The note identified treatment orders included alginate and border foam to the open areas.</p> <p>A wound APRN note dated 10/3/24 identified Resident #378 was seen for wound follow up to the medial back. The note identified Resident #378 had a new coccyx wound, identified as a stage 3 pressure ulcer, measuring 4 cm x 1 cm x 0.2 cm with a moderate amount of serosanguinous drainage; and a new left buttock wound, classified as a stage 3 pressure ulcer, measuring 5 cm x 2.5 cm x 0.2 cm with a moderate amount of serosanguinous drainage. The treatment plan included calcium alginate to the 2 newly identified pressure ulcers.</p> <p>Review of the clinical record on 10/7/24 failed to identify any documentation that the Dietitian was notified of Resident #378's newly identified pressure ulcers.</p> <p>Although the MAR dated 10/7/24 identified staff documented a body audit had been done, the clinical record failed to identify any documentation related to the audit findings.</p> <p>Interview with MD #1 on 10/7/24 at 10:52 AM identified that a weekly body audit and Braden scale were standard orders and were usually done on a resident's shower day. If anything was discovered with a resident's skin, the nurse aide should notify the nurse caring for the resident, and if the issue was related to a newly identified wound, the nurse should notify the wound nurse, as well as the APRN or MD for next steps, and that notification should happen the same day. MD #1 identified that the Dietitian should also be notified of any new wounds to allow her to follow up with the resident during her next visit to the facility.</p> <p>Interview with LPN #4 on 10/9/24 at 8:35 AM identified that she was notified of the left sacral area on 9/29/24. LPN #4 identified she documented a progress note but did not notify the RN supervisor or the resident representative. LPN #4 identified the left sacrum appeared to be a skin shear injury, however she did not assess either site any further. LPN #4 identified that she entered a request for wound care evaluation in the wound care communication book, which is what the facility used to notify the wound care APRN a resident needed to be seen. LPN #4 also identified that the facility's wound care nurse, RN #1, also made rounds on the units and was supposed to review the book for any issues.</p> <p>Interview with the DNS on 10/9/24 at 10:10 AM identified that Resident #378 should have had a full assessment by an RN on admission to the facility, and in the event Resident #378 required to be sent out and returned to the facility, a readmission nursing assessment should have been completed to ensu [TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040</b></p> <p>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #56) reviewed for nutrition, the facility failed to ensure weights were obtained per the physician's order; failed to notify the physician of a significant weight loss and failed to implement interventions following a significant weight loss. The findings include:</p> <p>Resident #56 was admitted to the facility in September 2024 with diagnoses that included spinal fracture at T11 - T12, prostate cancer, and urinary retention.</p> <p>The physician's orders dated 9/4/24 directed to weigh the resident every week on the 1st shower day of the week (Monday 3:00 PM - 11:00 PM shift) for 4 weeks and then once monthly.</p> <p>Review of the clinical record identified Resident #56 weighed 275 lbs. at admission on 9/4/24.</p> <p>The care plan dated 9/9/24 identified that Resident #56 was at risk for alteration in nutritional status due to new admission and decreased intake. Interventions included obtain weights as ordered.</p> <p>A nutritional assessment completed on 9/9/24 by the Dietitian identified Resident #56 was at risk for malnutrition.</p> <p>The admission MDS dated [DATE] identified Resident #56 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with bathing, toileting and dressing. The MDS also identified Resident #56 was not known to have had a weight loss of 5% or greater in the 6 months prior to admission to the facility.</p> <p>The September 2024 MAR identified Resident #56 was documented as refusing weights on 9/9/24 and 9/16/24. The clinical record failed to identify any progress notes or documentation related to the refusal.</p> <p>Review of the clinical record identified Resident #56 weighed 255.2 lbs. on 9/23/24, a 19.8 lbs. loss or 7.2% weight loss over 20 days.</p> <p>Review of the clinical record failed to identify any documentation that the physician was notified of Resident #56's significant weight loss on or after 9/23/24 or that any nutritional assessments or dietary interventions had been implemented related to Resident #56's significant weight loss.</p> <p>The September 2024 MAR identified Resident #56's weight was not obtained on 9/30/24. The clinical record failed to identify any progress notes or documentation related to why.</p> <p>The MAR for October 2024 identified Resident #56's weight was not obtained on 10/7/24. The clinical record failed to identify any progress notes or documentation related to why.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Dietitian on 10/8/24 at 2:15 PM identified she was not aware of Resident #56's weight loss until the time of this interview. The Dietitian indicated she was the only dietitian for the facility which contained 148 beds, and only worked 3 days a week. The Dietitian identified she manually tracks all weights for the facility residents herself, and the nursing staff do not notify her regularly of weight loss. The Dietitian reported she had enough time with her workload to conduct a manual review of all resident weights twice a month at most, but if she was not notified of a weight loss, she was not aware the resident required any additional interventions. The Dietitian also identified that the facility recently had a changeover in the administrative management and that prior to the change, the facility had weekly at-risk meetings to discuss residents with weight loss, new wounds, etc. but that the meeting had not been held for over a month. The Dietitian also identified that APRN #1 was also in the building regularly and had access to the weights in the clinical record. The Dietitian identified Resident #56's weight loss would be considered significant given it was almost one pound a day, and she would have expected to be notified to provide recommendations.</p> <p>Interview with the DNS on 10/9/24 at 10:10 AM identified that weights were to be done as part of the physician's orders, and her expectation is that the staff were are responsible to ensure the physician's orders were carried out. The DNS identified if the orders were unable to be carried out (due to refusals, etc.) that a progress note was documented and that the APRN/MD were notified of the issue. The DNS identified she was unable to identify why Resident #56 did not have weight documented as ordered, or why Resident #56's weight loss was not addressed, and that it should have been addressed by the nursing staff notifying the APRN and Dietitian. The DNS identified that the nursing staff may have documented the APRN notification in the communication book on the unit.</p> <p>Review of the communication book on the unit failed to identify any communication for Resident #56 related to weight loss for 9/2024 or 10/2024.</p> <p>Although attempted, an interview with APRN #1 regarding Resident #56 was not obtained.</p> <p>The facility policy on acute condition changes directed that the nursing staff would contact the physician based on the urgency of the situation, that the nurse and physician would discuss possible causes of the condition change, and the physician would help identify and authorize appropriate treatments.</p> <p>The policy on care plan directed that the resident's care plan would be individualized and would be revised with any change or new development in the resident's plan of care.</p> <p>The policy on documentation guideline directed that documentation by including should be done on a regular basis and included areas such as weights and treatment charting. The policy also directed that documentation by exception should be done when significant findings or exceptions to standards of care were observed and could include weight loss.</p> <p>The policy on weighing and measuring a resident directed that the purpose of the policy was to determine the resident's height and weight, to provide a baseline and an ongoing record of the resident's body weight and an indication of nutritional status and medical condition of the resident. The policy also directed that a weight loss of greater than 5% over one month was considered severe, and that significant weight gain/loss and refusals of weight were to be reported to the nursing supervisor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0692  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	The policy on nutrition-unplanned weight loss directed facility staff would report any significant weight loss to the physician. The policy further directed that facility staff, and the physician would identify pertinent interventions, and that the physician would authorize appropriate interventions.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457</b></p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews the facility failed to ensure nursing staff had completed the required annual skill competencies as identified through the facility assessment and for the only sampled resident (Resident #77) reviewed for enteral feeding, the facility failed to ensure an agency nurse had the required competencies to replace a feeding tube. The findings include:</p> <p>1. Interview and review of facility documentation (Competency Book 2023) with the Staff Development Nurse (RN #2) on 10/8/24 at 8:19 AM failed to identify that the nursing staff had the required annual skills and competencies assessed in 2023. The Competency Book 2023 identified documentation supporting that hand hygiene and medication administration competencies were completed for a portion of the nursing staff. RN #2 further indicated that she was not employed at the facility in 2023 and began her role as the Staff Development Nurse in March of 2024. RN #2 indicated that on 7/18/24 she hosted a mandatory annual in-service which provided the nursing staff with the required annual education, in a poster board format, but did not include skill competencies. RN #2 further indicated that she is planning another mandatory in-service fair to evaluate skill competencies before the end of the year, for nursing staff.</p> <p>Interview with the DNS on 10/9/24 at 11:35 AM identified that she had worked at the facility for 7 weeks and was not aware that annual skill competencies for licensed nurses and nurse aides had not been evaluated in 2023, and she would expect specific skill competencies to be evaluated annually. The DNS further identified that since she began working at the facility, in collaboration with the Staff Development Nurse, they have completed 2 mock codes, planned an upcoming skills fair where nurses will demonstrate hands on assessments and treatments, and have planned monthly educational in-services/skill assessments on specific topics that relate to the patient population.</p> <p>The facility's Staffing policy directs that the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the resident care plans and the facility assessment.</p> <p>The Facility Assessment directs the following annual skill competencies for nurse aides: peri-care, turning and repositioning, mechanical lifts, donning and doffing personal protective equipment, electronic blood pressures, hand hygiene, and foley catheter care. The Facility Assessment further directs the following annual skill competencies for licensed staff: wound care and assessment, management of IV sites (for certified staff only), medication administration, and glucometer checks, cleaning, and testing.</p> <p>2. Resident #77 was admitted to the facility on [DATE] with diagnoses that included tracheostomy status, gastrostomy status, restlessness and agitation.</p> <p>The quarterly MDS dated [DATE] identified Resident #77 had intact cognition, had no range of motion functional limitations to his/her upper body, and had a feeding tube while a resident, at the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The care plan dated 5/13/24 identified Resident #77 had the potential for an alteration in nutritional status related to tube feeding and hospital return. Interventions included administering tube feedings as ordered, checking placement every shift, and flushing tube feed, per order.</p> <p>The nurse's note dated 5/17/24 at 8:14 AM, written by LPN #19, identified Resident #77's feeding tube came out with the balloon inflated, the nursing supervisor was made aware and re-inserted the tube, placement was verified via auscultation, flushing was done with no issue, abdomen soft, non-tender, no respiratory distress noted.</p> <p>Review of the nurse's notes dated 5/17/24 failed to identify documentation from the nursing supervisor identifying the time and date of the procedure and the condition of the treatment area.</p> <p>Interview with LPN #19 on 10/8/24 at 9:42 AM identified that on 5/17/24 during the 11:00 PM-7:00 AM shift she entered Resident #77's room to flush the feeding tube and found the tube was dislodged and laying on top of Resident #19's abdomen. LPN #19 further identified that she called the nursing supervisor (RN #12), who was an agency nurse, to assess the area; RN #12 reinserted the feeding tube, confirmed placement via auscultation, and looked for a return. LPN #19 indicated that after placement was confirmed, she was told by RN #12 that the feeding tube could be used. Resident #77 was not scheduled for a tube feed during her shift, but the flush was completed.</p> <p>Although attempted an interview with RN #12 was not obtained.</p> <p>Interview with the DNS on 10/9/24 at 1:17 PM identified that she had been working at the facility for 7 weeks and was not the DNS at the time the feeding tube was replaced at the bedside, and she was not yet familiar with the facility's policy and procedure for a nurse to replace a feeding tube at the facility. The DNS further identified that she would expect that a licensed nurse replacing a dislodged feeding tube would have documentation of education and skill competency for the procedure on file. RN #12 was an agency nurse so education and competency validation would have been completed by the agency. The DNS indicated that she had reached out to the agency that employs RN #12 and was told that they did not have documentation that RN #12 had received education or demonstrated competency with feeding tube replacement. The DNS further identified, in the future, all agency nurses and nurse aides must arrive to the facility with a competency check list in hand, prior to starting their shift.</p> <p>The facility's G-Tube/PEG Tube: Replacement policy directs a G-tube replacement is performed by a licensed nurse to allow for the continuation of g-tube feedings/medication administration as per physician order. The policy further directs that the nurse document the time, date of procedure, and condition of treatment area.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>47457</p> <p>Based on review of facility documentation, facility policy, and interviews for 5 of 5 certified nurse aide personnel files (NA #1, 2, 6, 7, and 8), the facility failed to ensure nurse aide performance evaluations were completed annually. The findings include:</p> <p>Review of NA #1's personnel file identified that she was hired on 10/25/2011 and failed to identify documentation that an annual performance evaluation was completed in the year of 2023 or to date, in 2024.</p> <p>Review of NA #2's personnel file identified that she was hired on 10/24/22 and failed to identify documentation that an annual performance evaluation was completed in the year of 2023 or to date, in 2024.</p> <p>Review of NA #7's personnel file identified that she was hired on 6/5/23 and failed to identify documentation that an annual performance evaluation was completed to date, in 2024.</p> <p>Review of NA #8's personnel file identified that she was hired on 8/2/04 and failed to identify documentation that an annual performance evaluation was completed in the year of 2023 or to date, in 2024.</p> <p>Review of NA #9's personnel file identified that she was hired on 6/17/13 and failed to identify documentation that an annual performance evaluation was completed in the year of 2023 or to date, in 2024.</p> <p>Interview and facility documentation review with the Payroll Manager on 10/9/24 at 12:45 PM identified that she had been working at the facility for approximately 3 weeks and that she was unable to locate any 2023 or 2024 annual performance evaluations for licensed nurses or nurse aides.</p> <p>Interview with NA #1 on 10/9/24 at 1:25 PM identified that she could not recall the last time her annual performance evaluation was completed. NA #1 indicated that performance evaluations were usually completed every year, but the facility had not completed them in the recent years.</p> <p>Interview with the DNS on 10/9/24 at 1:36 PM identified that she had worked at the facility for 7 weeks; after searching the prior DNS's paper files and hard drives she was unable to locate documentation identifying the 2023 and 2024 nurse aide annual performance evaluations were completed. The DNS indicated that she would expect nurse aide performance evaluations to be completed annually and stored in the employee's personnel file, copies would also be retained by the DNS and Human Resources.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Annual Employee Evaluation policy directs that the purpose of the policy is to establish a standardized process for the annual evaluation of all employees, ensuring their performance aligns with the facility's goals and regulatory requirements, and to promote continuous improvement in job performance. The policy further directs that all employees will undergo an annual performance evaluation, which must be completed by the employee's anniversary date or a designated time frame (e.g., every calendar year by a certain date) and all evaluation forms, ratings, and any supporting documentation will be stored in the employee's personnel file in accordance with confidentiality guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42117</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #28 and 66) reviewed for unnecessary medications, the facility failed to ensure pharmacy recommendations were responded to by the physician or APRN. The findings include:</p> <p>1. Resident #28 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, type 2 diabetes mellitus, and bipolar disorder.</p> <p>The quarterly MDS dated [DATE] identified Resident #28 had intact cognition and had received medications from the following high-risk drug classes in the last 7 days: antidepressant, opioid, and hypoglycemic.</p> <p>The care plan dated 4/26/24 identified Resident #28 was taking psychotropic medications daily related to bipolar disorder and adjustment disorder with depression and anxiety. Interventions included administering medications as ordered and decrease dosage of psychotropic medications as ordered. The care plan further identified Resident #28 had type 2 diabetes mellitus and was on insulin. Interventions included monitoring blood sugars as ordered, administering medication per the physician's order, monitoring labs as ordered, and reporting abnormal values to the physician.</p> <p>a. The Pharmacy Medication Regimen Monthly Review dated 5/23/24 identified Resident #28 received Tolterodine and Paroxetine HCL 40 mg by mouth daily and may be at risk for experiencing adverse effects related to the anticholinergic properties of this medication. The following signs/symptoms were documented in the resident's medical record: dry mouth on Biotene twice daily. The report further identified the following recommendation: please reevaluate the ongoing use of Tolterodine and Paxil. The report failed to identify signatures from the DNS and physician or APRN, acknowledging that the recommendations had been reviewed.</p> <p>The APRN progress note dated 6/16/24 at 12:15 AM identified in review of pharmacy recommendations and patient evaluation and discussion, discontinue Meclizine and Mucinex at this time, pharmacy request approved, and forms completed.</p> <p>b. The Pharmacy Medication Regimen Monthly Review dated 6/23/24 identified Resident #28 had an as needed (PRN) order for an anxiolytic, which had been in place for greater than 14 days without a stop date: Lorazepam 0.5mg since 6/3/24 (not used). The report further identified the following recommendation: please reevaluate use and add an intended duration to the order if the order is to remain. The report failed to identify signatures from the DNS and physician or APRN, acknowledging that the recommendations had been reviewed.</p> <p>Review of the physician and APRN progress notes dated 6/23/24 through 7/27/24 failed to identify documentation that the Pharmacy Medication Regimen Monthly Review recommendations from the report dated 6/23/24 were addressed.</p> <p>The Pharmacist Drug Regimen Review dated 7/28/24 identified no recommendations.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Pharmacy Medication Regimen Monthly Review dated 8/22/24 identified Resident #28 received Atorvastatin Calcium and did not have a fasting lipid panel documented in the medical record in the previous 12 months to evaluate effectiveness and to assist in adjusting medication therapy. The report further identified the following recommendation: please monitor a fasting lipid panel on the next convenient lab day and every 12 months thereafter. The report failed to identify signatures from the DNS and physician or APRN, acknowledging that the recommendations had been reviewed.</p> <p>Review of the physician and APRN progress notes dated 8/22/24 through 9/21/24 failed to identify documentation that the Pharmacy Medication Regimen Monthly Review recommendations from the report dated 8/22/24 were addressed.</p> <p>The LTC Facilities Receiving Pharmacy Products and Services From Pharmacy policy directs the facility to encourage physician/prescriber or other responsible parties receiving the medication regimen review (MRR) and the DNS to act upon the recommendations contained in the MRR, for those issues that require physician/prescriber intervention, the facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. The policy further directs the attending physician should document in the residents health record that the identified irregularity has been reviewed and what if any action has been taken to address it, if the attending physician/prescriber has decided to make no change in the medication, the attending physician should document the rationale in the resident's health record. The policy directs the facility should alert the medical director where MRRs are not addressed by the attending physician in a timely manner and the attending physician/prescribers should address the consultant pharmacist recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations.</p> <p>2. Resident #66 was admitted to the facility December 2023 with diagnoses that included dementia and psychotic and mood disturbances.</p> <p>Physician's orders dated 12/11/23 directed to administer Seroquel (antipsychotic) 50 mg at bedtime, and monitor behaviors of anxious, agitation, restless, and aggressive.</p> <p>The quarterly MDS dated [DATE] identified Resident #66 had severely impaired cognition and received antipsychotic and antidepressant medication daily during the 7 day assessment period.</p> <p>The care plan dated 3/27/24 identified Resident #66 is at risk for adverse reactions related to antipsychotic medications. Interventions included psychiatric group to evaluate appropriateness for gradual dose reduction (GDR) on an ongoing basis.</p> <p>A Pharmacy Medication Regimen Monthly Review dated 5/28/24 recommended to attempt a gradual dose reduction (GDR) of the Seroquel. Resident #66 has received Seroquel since admission in December 2023 without a gradual dose reduction trial. Antipsychotics should be evaluated at least quarterly with documentation regarding continued clinical appropriateness. Dose reductions should occur in modest increments over adequate periods of time to minimize withdrawal symptoms and to monitor reassurance. GDR is attempted in 2 separate quarters, with at least 1 month between attempts within the first year in which an individual is admitted on an antipsychotic medication or after the prescriber has initiated such medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Pharmacy Medication Regimen Monthly Review was not signed or dated by the physician or APRN.</p> <p>Physician's orders for August 2024 (original order date 12/11/23) directed to give Seroquel (antipsychotic) 50 mg at bedtime, and monitor behaviors of anxious, agitation, restless, and aggressive.</p> <p>Interview with the ADNS on 10/8/24 at 10:34 AM indicated that the Pharmacy Medication Regimen Monthly Review dated 5/28/24 had not been addressed by the APRN or MD. The ADNS indicated that she had reviewed all physician and APRN notes and the GDR had not been done. The ADNS indicated there should have been a signed and dated copy of the Pharmacy Medication Regimen Monthly Review dated 5/28/24 in the clinical record and she did not know why it was not there and why it was not addressed.</p> <p>Interview with the DNS on 10/8/24 at 11:58 AM indicated she receives the pharmacy monthly recommendations via email, and she prints them out and puts the psychiatric recommendations in the psychiatric book and all others go in the APRN book. The DNS indicated that she keeps a complete copy. The DNS indicated that once the APRN or MD completes the pharmacy recommendations, she checks to make sure all were completed with a signature and date and faxes them back to the pharmacy. The DNS indicated that the APRN/MD must check that they agree or disagree and a rational with their signature and date. The DNS indicated that the MD/ADNS have 2 weeks to complete them.</p> <p>Review of the facility Pharmacy Medication Regimen Monthly Review identified the consultant pharmacist will conduct a clinical record review for each resident monthly. The facility should ensure the medical record is complete including lab results, physician progress notes, nursing notes, medication administration records, and other documents to assist the pharmacist as to whether irregularities exist in the medication regimen. The pharmacy consultant will provide required report to the DNS. Facility staff will ensure the physician, medical director, and DNS are provided with copies of the reports. The physician intervention, facility should encourage the physician to either accept or reject the recommendation and provide an explanation as to why if rejected in the clinical record. The facility should maintain readily available copies of the recommendations on file and as part of the resident's permanent record.</p> <p>47457</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46040</p> <p>Based on observations, facility documentation, facility policy, and interviews, the facility failed to ensure that testing supplies used to ensure chemical sanitizing solution was at recommended concentration levels were not expired; and failed to ensure that the chemical sanitizing solution was maintained at the recommended sanitation level; and failed to ensure a policy was in place regarding testing and changing chemical sanitizing solution; and failed to ensure that unit nourishment refrigerators were maintained to the proper temperatures; failed to ensure that food items stored in the resident nourishment refrigerators were dated and labeled. The findings include:</p> <p>1. Observations during a tour of the kitchen on [DATE] at 9:13 AM with the Dietary Supervisor identified that the chemical sanitizing solution used for cleaning and sanitizing kitchen surfaces, was being checked for proper levels with testing strips that were out of date. The Dietary Supervisor conducted a check of the sanitizer level with a test strip. The test strip appeared to be a blue tinged color upon removal from the test strip container and became a slightly darker shade of blue after submersion in the chemical sanitizer, which the Dietary Supervisor identified was the proper sanitizer level by referring the test strip bottle indicator label. The Dietary Supervisor identified that the square identifying ,d+[DATE] parts per million (PPM) was the test strip result. This observation also identified that the test strips used expired [DATE].</p> <p>Interview with the Dietary Supervisor immediately following this observation identified that the chemical sanitizer was changed once daily at 6:00 AM, and at that time the sanitizer was checked with the test strips to ensure it was at the proper level by the Dietary Director. The Dietary Supervisor identified it was the responsibility of the Dietary Director to change the solution, check the levels, and log the results on the daily log sheets for the kitchen.</p> <p>Observation of the chemical sanitizer solution dispenser and test strips on [DATE] at 9:30 AM identified the facility utilized 'Smartpower Sink and Surface Cleaner Sanitizer' as the chemical sanitizing solution for the kitchen area and was a 2 chemical solution using DDBSA and Lactic Acid as the sanitizing components. The instructions on the sanitizer bottle identified that the sanitizer should be diluted for DDBSA to be between , d+[DATE] PPM and Lactic Acid to be between ,d+[DATE] PPM. A review of the test strip bottle indicator label identified a large square around the target test colors for these ranges, and the test strip color previously identified by the Dietary Supervisor was below and outside these ranges.</p> <p>Review of the daily logs for the kitchen identified the chemical sanitizer was checked with test strips twice daily (AM/PM) and the sanitizer level should be between 200 - 400 PPM, and all documentation reviewed from [DATE] to [DATE] identified all test results were 400 PPM.</p> <p>Follow up observation on [DATE] at 7:04 AM identified the chemical test strips in the kitchen available for use were expired ,d+[DATE] and appeared to be the test strips from the [DATE] observation.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with the Dietary Director on [DATE] at 8:15 AM identified that he was not typically responsible for changing or testing the chemical sanitizer in the morning, and that the staff member who arrived at 6:00 AM typically took care of this, but that he did test and change the solution sometimes. The Dietary Director identified that the solution was supposed to be changed every 2 hours, and that the facility used a quat (quaternary ammonium) based solution for sanitizing the kitchen. The Dietary Director identified he was not aware that the kitchen was using a lactic acid/DDBSA based solution, could not identify what the sanitizing ranges for this type of solution was, how often to change this type of solution, or why the test strips were expired. The Dietary Director identified that the facility had recently changed companies who provided the chemical sanitizer, and that the strips on hand were provided by the company at the beginning of the year, but he did not check the expiration date on the strips, and that the bottle on hand was the only test strips he had available but he had requested for a technician from the chemical sanitizer company to come to the facility regarding the solution and test strips. A request was then made for a policy regarding sanitization of the kitchen including testing of the sanitizer and when to change the sanitizer solution.</p> <p>Subsequent to surveyor inquiry, the Dietary Director provided in-service education on [DATE] at 2:21 PM regarding sanitizer buckets. The in-service documentation identified a policy effective date of [DATE] related to sanitizer bucket change and identified the buckets should be changed every 2 hours.</p> <p>Interview with the Dietary Director on [DATE] at 2:30 PM identified that the kitchen did not have any policies related to the chemical sanitizer buckets, testing, or changing of the solution prior to the survey team's entrance to the facility on [DATE]. The Dietary Director identified that the facility would be changing the chemical sanitizer solution from the DDBSA/lactic acid based to a quat based solution, which had sanitizer ranges from 200 - 400 ppm.</p> <p>A follow up observation and interviews on [DATE] at 1:10 PM identified the Dietary Director with Ecolab Technician #1 was onsite to change the chemical sanitizer solution. Person #2 identified that all sanitizer products for the kitchen would be quat based and he was also posting signage regarding instructions of dilution levels and test strips ranges near the solution dispenser in the kitchen.</p> <p>Review of the manufacturer recommendations for Smartpower Sink and Surface Cleaner Sanitizer identified that the solution concentration should be between 272 - 700 PPM for DDBSA and 704 -1875 PPM for Lactic Acid, and that the solution should be checked with every change out. The recommendations also identified that the solution should be changed when it was visibly dirty or when the solution tested below the concentration range. The instructions also identified the test strips had a shelf life of 2 years.</p> <p>The facility policy on Sanitizer Bucket Change Protocol, effective [DATE], directed the purpose of the policy was to ensure the safety and cleanliness of the food service areas by maintaining effective sanitizing solutions and prevent cross contamination. The policy further directed that the sanitizer buckets must be changed every 2 hours to ensure the sanitizing solution remained effective and to minimize the risk of cross contamination. The policy also directed that staff were required to monitor the time of the sanitizing bucket preparation and the preparation would be according to the manufacturer's instructions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Interview with the Dietary Director on [DATE] at 8:15 AM identified that the resident nourishment refrigerators were maintained by the nursing staff of the facility, including temperature logs and labeling. The Dietary Director identified that the dietary staff provided nourishment snacks and juices to the units and the kitchen items were labeled with use by dates.</p> <p>Observations conducted on [DATE] at of the resident nourishment refrigerators identified the following:</p> <p>Initial observation of the nourishment room located in the Deerfield unit was conducted at 1:59 PM. Review of the log located attached to the refrigerator door identified no logging of freezer temperatures, and observation of the freezer did not contain a thermometer. The log also included documented temperatures through 11:00 PM on [DATE] (a future time). The refrigerator contained three 2-quart clear pitchers, each half full, what appeared to be apple, orange and cranberry juices, however there were no labels on the pitchers. The refrigerator also contained a 48-ounce bottle of almond milk, a large container of microwavable prepacked macaroni and cheese; a clear plastic container with a white substance; partially full 20 oz water bottle, and large black and plastic white polka dotted lunch carrier taking up half of the bottom shelf. The freezer contained a second large black plastic lunch carrier and a partially full ice cream carton. All items observed had no labels to identify the date, item contained within the container, the resident the item belonged to, or the use by date.</p> <p>Observation of the Maple unit resident nourishment refrigerator located within the first floor lounge area was conducted at 2:03 PM. Review of the log located attached to the refrigerator door identified no logging of freezer temperatures, and the freezer did not contain a thermometer. The refrigerator contained three 2 quart clear pitchers, ,d+[DATE] full, what appeared to be apple, orange and cranberry juices, however there were no labels on the pitchers. The refrigerator also contained partially full container of [NAME] cream cheese, 6 containers of Chobani yogurts, a Walgreens brand protein drink with an expiration date of ,d+[DATE], and a probiotic yogurt bottle with an expiration date [DATE]. The freezer contained 13 freezer pops, an opened 5 lb. box of mozzarella sticks, and a partially full ice cream carton. All items observed had no labels to identify the date, item contained within the container, the resident the item belonged to, or the use by date.</p> <p>Observation of the Birchwood unit resident nourishment refrigerator located within the first floor lounge area was conducted at 2:39 PM. Review of the log located attached to the refrigerator door identified no logging of freezer temperatures, and the freezer did not contain a thermometer. The thermometer located within the refrigerator, on the top shelf near the door, had an observed temperature of 26 degrees F. The items observed in the refrigerator were not frozen or partially frozen during this observation. The refrigerator contained a 2 quart clear pitcher, ,d+[DATE]th full with what appeared to be orange juice. The refrigerator also contained partially full container of muscle milk protein drink. The freezer contained one small cup of ice cream. The items observed had no labels to identify the date, item contained within the container, the resident the item belonged to, or the use by date.</p> <p>Observation on all 3 refrigerators identified a large yellow sign with the following: This refrigerator is for Resident food only. Staff food must be stored in employee break rooms or staff development classroom.</p> <p>Review of the temperature logs for the Deerfield unit for ,d+[DATE] identified the following dates/times with no documentation:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[DATE] no AM or PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>(continued on next page)</p> <p>Review of the temperature logs for the Deerfield unit for ,d+[DATE] identified the following dates/times with no documentation:</p> <p>[DATE] no AM or PM temp</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM temperature.</p> <p>[DATE] no AM or PM temperature.</p> <p>[DATE] no AM temperature.</p> <p>Interview with RN #1 (Infection Preventionist) on [DATE] at 2:48 PM identified that the dietary staff was responsible for all resident nourishment refrigerators, including cleaning and temperature logs.</p> <p>Interview with RN #2 (Staff Development) on [DATE] at 3:00 PM identified she believed the RN supervisor on 11:00 PM - 7:00 AM was supposed to check the nourishment refrigerators but was unsure if the logs included checking the freezer temperatures.</p> <p>Interview with the DNS identified on [DATE] at 3:02 PM identified that she was aware of an issue with the nourishment room temperature logs being maintained but was not aware the logs did not track the freezer temperatures. The DNS identified she only recently began employment at the facility, and in her review of the temperature logs, she was only able to locate one unit (Deerfield) of previous logs, and only going back to , d+[DATE]. The DNS identified that the logs were an issue, and that the food in the refrigerators should be labeled with what the item was, the resident, and the use by date. The DNS also identified that the freezers should be checked along with the cooler portion of the refrigerator every shift. The DNS was unable to identify who was responsible for the cleaning of the refrigerators, but identified it was the responsibility of nursing staff to label the food items from outside the facility and to check the temperatures.</p> <p>Although requested, the monthly refrigerator logs for all resident nourishment refrigerators from ,d+[DATE] to ,d+[DATE] were not obtained.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy on food brought by family/visitors directed that food items in the refrigerator would be labeled with the resident's name, item, and use by date. The policy further directed that the nursing staff would discard any perishable items on or before the use by date, and that the nursing and/or food service staff would discard any prepared foods for the resident that showed obvious signs of potential foodborne danger including mold and past package expiration dates.</p> <p>The facility policy on preventing foodborne illness directed that federal standards required that refrigerated foods be stored below 41 degrees and that freezers keep frozen food solid.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117</b></p> <p>Based on observation, review of the clinical record, facility documentation, facility policy, and interviews the facility failed to ensure the infection preventionist, (IP) conducted environmental rounds at least quarterly per the facility policy, and for 1 of 3 residents (Resident #87) reviewed for pressure ulcer, the facility failed to use appropriate infection control practices when providing wound care, and for 1 of 3 residents (Resident #374) reviewed for transmission-based precautions, the facility failed to ensure that nursing staff maintained proper infection control techniques and hand hygiene for a resident with a highly contagious bacteria, and failed to ensure that resident nourishment areas were maintained in a clean and sanitary manner. The findings include:</p> <p>1. Interview with RN #1 on 10/7/24 at 11:40 AM indicated that she was responsible to do the environmental rounds monthly. RN #1 indicated that she looks daily at the environment but does not write anything down. RN #1 indicated that she did not have any environmental rounds documented in her office from 2023 or 2024.</p> <p>Interview with LPN #19 on 10/7/24 at 11:41 AM indicated that environmental rounds were to be monthly with the corrective action forms filled out for any items that needed to be addressed. LPN #19 indicated that she was not able to find the environmental rounds for 2023 and 2024. LPN #19 indicated that she would check in the DNS office.</p> <p>Interview with the DNS on 10/7/24 at 1:30 PM indicated that she did not find any environmental rounds.</p> <p>Interview with the DNS on 10/8/24 at 12:30 PM indicated the environmental rounds found for April, May, June, and July 2024 had no corrective action forms. The DNS indicated they were not able to find any environmental rounds for 2023 to April 2024 and from July 2024 to present. The DNS indicated that she and the ADNS started to do the environmental rounds this morning for October 2024. The DNS indicated that yesterday after surveyor inquiry LPN #19 had informed her that RN #1 had not done environmental rounds for September or October 2024, so she started them today.</p> <p>Review of the Environmental Rounds Policy identified it is the policy that the infection preventionist or his/her designee, charge nurse, or supervisors complete nursing unit rounds on a regular basis but at least quarterly. The focus of this program is to observe practices carried out by nursing personnel that increase the risk of infection or pose a residents safety concern. Departmental environmental rounds are to be done at least quarterly. The department heads will submit completed environmental rounds to the infection preventionist. The infection preventionist will generate reports identifying areas of noncompliance. This report and a corrective action form will be distributed to the supervisors of each area. The corrective action form will be completed by the supervisor and will outline the corrective action taken and the anticipated completion dates. The infection preventionist will ensure follow up is completed.</p> <p>2. Resident #87 was admitted to the facility in December 2021with diagnoses that included dementia and osteoporosis.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition and required maximum assistance with personal hygiene, bathing, and totally dependent for transfers and rolling left to right. Additionally, Resident #87 has an unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar.</p> <p>The care plan dated 9/12/24 identified at right heel pressure ulcer. Interventions included wound consult as indicated and treatment as ordered.</p> <p>A physician's order dated 9/27/24 directed to cleanse pressure ulcer to right heel with normal saline, apply Santyl (a debridement cream), Calcium Alginate, secured by a dry clean dressing daily and as needed. Apply skin prep to peri wound. Apply off-loading boots.</p> <p>Wound Management Report written Infection Control/Wound Nurse by RN #1 dated 10/4/24 identified the right heel pressure ulcer to the right heel measurements 2.5cm x 5.0 cm by 0.2 cm. Wound bed was slough. No tunneling.</p> <p>Observation on 10/8/24 at 2:00 PM identified LPN #14 went into Resident #87's room with dressing supplies and placed them on the top sheet of the bed. LPN #14 went into the bathroom and removed the trash can and placed it in the room near Residents #87 right foot. LPN #14 put on 2 pairs of gloves without the benefit of washing her hands after touching the trash can. LPN #14 proceeded to remove the old dressing which was saturated in dry brown drainage and moderate amount of yellow drainage and was dated 10/3/24, 5 days prior. LPN #14 was observed to remove one pair of gloves, placed normal saline on the 2 by 2 stack of gauze pads and tapped the bottom of the resident's right heel a few times with the wet gauze pad. LPN #14 took a skin prep pad and wiped around the bottom of the resident's right heel area and Resident #87 cried out in pain. LPN #14 applied a small amount of Santyl on top of a piece of Calcium Alginate and placed on the right heel wound area. LPN #14 removed the 2nd pair of gloves and washed her hands.</p> <p>Interview with LPN #14 on 10/8/24 at 2:30 PM indicated that she wore multiple layers of gloves and will peel off the gloves when going from the dirty dressing to the start of the clean dressing. LPN #14 indicated that she had put gloves on, so the gloves were clean to remove the old dressing dated 10/3/24, and she removed a set of gloves to perform the clean dressing and then after she removed the last set of gloves she washed her hands. LPN #14 indicated that she had placed all the new supplies on the Resident #87's bed because there was not a bedside table to use.</p> <p>Interview with the DNS on 10/9/24 at 7:45 AM indicated that LPN #14 should not put any treatment supplies on a resident's bed, she should have placed a clean towel on the overbed table and placed the supplies on the overbed table. The DNS indicated that LPN #14 should have washed her hands prior to putting on a pair of gloves to remove the old dressing. The DNS indicated that a nurse is not to wear more than one pair of gloves at any time. The DNS indicated that LPN #14 after removing the old dressing should have removed her gloves and washed her hands before touching the clean supplies.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Clean Dressing Change Policy identified to assemble equipment and supplies. Date and initial all jars upon opening. Frist step clean bedside stand to establish a clean field. Place the clean supplies on the clean field. Place a bag tapped to the bedside stand or a garbage can below the clean field. Position resident and adjust clothing to provide access to the affected area. Wash and dry your hands thoroughly. Put on clean gloves. Remove soiled dressing. Pull the glove over the soiled dressing and discard into the garbage. Wash and dry your hands thoroughly. Open dry, clean dressing by pulling corners of the exterior wrapping, touching only the exterior surface. Label and date the dressing with date and initials. Place onto clean field. Using clean technique open the other products. Wash and dry hands thoroughly. Put on clean gloves. Assess wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. Cleanse the wound with ordered cleaner. If using gauze, use clean gauze for each stroke. Clean from the least contaminated to the most contaminated area. Use dry gauze to pat wound dry. Apply the ordered dressing and secure with tape or bordered dressing. Discard disposable items into garbage. Remove disposable gloves and discard. Wash and dry your hands thoroughly. Clean the bedside stand. Wash and dry your hands thoroughly. Reposition the bed covers and make resident comfortable. Document the following information the date and time the dressing was changed. Wound appearance, including the wound bed, edges, and presence of drainage. How the resident had tolerated the procedure.</p> <p>3. Resident #374 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the left foot and ankle, sepsis, and hypertension.</p> <p>The 5 day MDS dated [DATE] identified Resident # 374 had intact cognition, was always continent of bowel and bladder and required moderate assistance from staff with transfers, bathing, and toileting.</p> <p>The care plan dated 9/23/24 identified Resident #374 required IV antibiotics for osteomyelitis. Interventions included evaluate for effectiveness of the medications.</p> <p>Review of the clinical record identified Resident #374 was admitted to the hospital from 9/29/24 - 9/30/24 for urinary retention and confirmed Clostridium Difficile (C. Diff) infection.</p> <p>Observation on 10/6/24 at 7:58 AM identified a PPE cart on the floor directly to the right side of the hallway entering Resident #374's doorway along with a sign that identified Contact Precautions and 2 signs regarding donning and doffing PPE located attached to the doorframe.</p> <p>Review of the clinical record failed to identify any physician's orders or care plans related to transmission-based precautions due to C. Diff for Resident #374 on 10/6/24.</p> <p>A physician's order dated 10/8/24 directed Resident #374 required contact precautions for C. diff beginning on the 11:00 PM - 7:00 AM shift.</p> <p>Observation beginning 10/9/24 at 8:25 AM identified LPN #3 standing in Resident #374's room assisting with his/her IV. LPN #3 was observed to have a pair of gloves on, however did not have any other PPE donned. At 8:31 AM, LPN #3 discarded her gloves in a trash bin located within the room, exited, and then proceeded to use the alcohol-based hand sanitizer located outside of the room in the unit hallway.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview immediately following this observation identified LPN #3 was not aware Resident #374 was any type of transmission-based precautions or the reason. LPN #3 identified she didn't realize that Resident #374 was on contact precautions and did not notice the 3 signs or PPE cart located at the doorway entrance. LPN #3 further identified that Resident #374 was on contact precautions due to an IV being in place and identified he/she did not have any active infections, including C. Diff, that could be transmitted by contact. LPN #3 also identified that although she did not don a gown, she did dispose of her gloves and use hand sanitizer after leaving Resident #374's room, and that going forward, she should also have a gown on.</p> <p>Interview with the DNS on 10/9/24 at 9 AM identified that Resident #374 was on contact precautions for active C. Diff infection and all staff entering his/her room were required to don gloves and a gown as well as handwashing with soap and water. The DNS identified that LPN #3 was an agency nurse, and that the facility did not provide any in services or competencies related to infection control as the expectation was the agency already addressed these. A request was then made to the DNS for LPN #3's in-services and competencies for the last year from her agency.</p> <p>Subsequent to surveyor inquiry, the facility provided an in-service sign off sheet dated 10/8/24 (a day prior) at 9:50 AM that identified a mandatory in-service completed. The sign off sheet identified the topic as C. Diff is contact precautions. When entering the threshold full PPE is required. Hand Hygiene with soap and water is needed. PPE to be on prior to entering the room and removed before leaving. The in-service sign off included LPN #3's signature.</p> <p>Interview with MD #1 on 10/9/24 at 9:53 AM identified that Resident #374 was on contact precaution for C. Diff and that all staff entering the room should don appropriate PPE. MD #1 also identified that he was unsure how staff would have entered the room without the signs on the doorway.</p> <p>The facility policy on C. Diff directed that the purpose of the policy was to ensure that precautions were taken while caring for residents with C. Diff to prevent transmission to other residents, that primary reservoirs for the infection were infected people and surfaces, and that C. Diff was transferred via fecal-oral route. The policy also directed when caring for residents with C. Diff, staff should maintain vigilant hand hygiene, and that handwashing with soap and water was superior to alcohol-based hand rub (ABHR) for the mechanical removal of C. Diff spores from the hands.</p> <p>The facility policy on Isolation-Transmission Based Precautions directed that residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. The policy further directed PPE for contact precautions included donning gloves and gown when entering the resident's room, removal of these items before leaving the room, and performing hand hygiene. The policy also identified that after gown removal and hand hygiene, staff should not allow any clothing, or hands to contact any potentially contaminated environmental surfaces or items in the resident's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Observation on 10/8/24 at 3:10 PM of the resident nourishment room located in the Deerfield unit identified food items located in the cabinet above the microwave including a Styrofoam container containing rice with red beans and a meat item with brown sauce and a Styrofoam cup located on a highest shelf in the same cabinet. A brownish grey gelatinous material was identified in the cup which was approximately halfway full, and the top of the material had multiple large areas of green and white mold type matter. The cabinet containing both containers also had dried brown areas and loose food remnants located in the lowest shelf of the cabinet that included cereal and raisins. The nourishment room also had multiple personal items including a grey jacket, large black duffel bag, purse, and large brown tote bag on the counter area directly next to the resident ice dispenser. The countertops also had a clear reusable water bottle and an open fruit soda beverage, as well as large areas of brown dried liquid observed on multiple areas of the countertop. The cabinet under the ice dispenser also had a black personal bag and a large black backpack inside.</p> <p>Interview with the DNS identified on 10/8/24 at 3:18 PM identified that the Deerfield resident nourishment room should not contain any staff personal items and that the cup and food items found in the cabinet should not be in a resident area. The DNS identified she would provide in-service education to the staff asap and all personal items, including meals, were to be in the facility staff break areas and not in the nourishment rooms. The DNS identified that the cup with mold type material should never be in a resident care area, and she would ensure that this was taken care of.</p> <p>Although requested, the facility failed to provide any policies related to the cleanliness and sanitation of the resident nourishment rooms.</p> <p>46040</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/09/2024
NAME OF PROVIDER OR SUPPLIER  Wilton Meadows Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>42117</p> <p>Based on review of facility documentation and interviews the facility failed to have a qualified infection preventionist (IP). The findings include:</p> <p>Review of RN #13's employee file (previous IP) identified a hire date was 3/13/23. RN #13 no longer was employed by the facility effective 8/5/24.</p> <p>Review of facility documentation identified RN #1 was hired on 9/3/24 in the role of IP.</p> <p>Interview with RN #1 on 10/7/24 at 11:28 AM indicated she started at the facility on 9/3/24 as the IP. RN #1 indicated that she had taken the IP course online but she realized she only completed 92% of the course work and did not take and pass the post test for completion.</p> <p>Interview with the DNS on 10/8/24 at 6:20 AM indicated that she and the ADNS have not taken and are not certified as an IP. The DNS indicated that she assumed RN #1 had been certified in IP.</p> <p>Review of the facility infection control nurse job description identified the qualifications of a graduate of accredited school of nursing, bachelor's degree a plus, a current licensure as a registered nurse in the state of Connecticut, and working knowledge of applicable local, state, and federal regulations and standards.</p>