STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075318	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomperaug Woods Health Center	80 Heritage Rd Southbury, CT 06488

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 sampled resident (Resident #22) reviewed for resident rights, the facility failed to honor a resident's food preference. The findings include: Resident #22 had diagnoses that included type II diabetes and chronic kidney disease. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 was cognitively intact and independent with eating. The Resident Care Plan dated 8/13/24 identified Resident #22 had impaired cognition or thought process related to dementia with confusion. Interventions directed to implement an approach to maximize involvement with daily decision making. Physician orders dated 8/30/24 directed a regular, diabetic, low potassium renal diet. An interview with Resident #22 on 10/11/24 at 12:30 PM identified she/he was supposed to receive fresh potatoes at mealtimes, but the facility repeatedly provided instant potatoes. Resident #22 further identified she/he discussed the matter with the Director of Nursing (DNS) who ensured it would not happen again. An interview and observation with Nurse Aide (NA) #4 on 10/11/24 at 12:30 PM identified she was delivering a bowl of fresh mashed potatoes to Resident #22's room. NA #4 identified Resident #22 preferred fresh mashed potatoes but at times was served instant mashed potatoes instead. NA #4 further identified that Resident #22 was initially served instant mashed potatoes with lunch, and she was delivering fresh mashed potatoes as a replacement. An interview with Dietary Aide (DA) #1 on 10/11/24 at 12:50 PM identified he was aware Resident #22 should receive fresh potatoes and that Resident #22 was served instant potatoes with lunch by another dietary staff member. An interview with DA #2 on 10/11/24 at 12:57 PM identified residents complete menus that include daily preferences which are then transcribed onto meal tickets. DA #2 indicated he was aware Resident #22 preferred fresh potatoes rather than instant potatoes and excluded his/her preference for fresh potatoes. Additionally, DA #2 plated Resident #22's meal at lunchtime and did not serve Resident #22 fresh potatoes as an oversight. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 10/11/24 at 1:08 PM identified he did not recall any conversations regarding fresh potatoes as a preference, but efforts were made to ensure Resident #22 was comfortable. An interview with the Food Service Director on 10/11/24 at 2:30 PM identified staff were responsible for checking meal tickets when plating meals and Resident #22 should have been served fresh potatoes according to preference. A review of the Resident [NAME] of Rights directed a resident has the right to self-determination and to make choices about all aspects of life in the facility that are significant to the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 5 sampled residents (Resident #2) reviewed for accidents, the facility failed to report an injury of unknown origin to the overseeing state agency. The findings include: Resident #2 had diagnoses that included dementia and osteoarthritis. The Minimum Data Set assessment dated [DATE] identified Resident #2 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14) and required a 2 person assist with bed mobility, transfers and toileting. The Resident Care Plan dated 8/30/23 identified Resident #2 had impaired cognition and an activity of daily living (ADL) deficit. Interventions directed to explain procedures prior to beginning and provide an assist of 2 with transfers and toileting. A facility Event Report dated 11/3/23 at 9:00 AM identified a 6.5cm by 4cm bruise was observed, on Resident #2's left upper thigh, during care. An Investigation Summary/Root Cause Analysis and Final Action Plan form dated 11/7/24 identified Resident #2 had a bruise to the left upper thigh. The form identified Resident #2 denied any mistreatment, used a mechanical lift during nighttime hours due to fatigue, and complained of discomfort with use of the mechanical lift. The mechanical lift was evaluated by nursing and deemed the appropriate size. The mechanical lift company provided onsite education for staff to prevent further injury. An interview with the Director of Nursing (DNS) on 10/15/24 at 3:09 PM identified he was responsible for overseeing abuse allegations. The DNS identified the resident and staff would be interviewed, for any injury of unknown origin, to determine what may have occurred. The DNS indicated, if abuse was suspected, he would report to the overseeing state agency. Despite the bruise location of the left upper thigh, the DNS identified he did not report the injury as he did not feel it met criteria for reporting. A review of the facility Abuse Prevention Policy dated 4/20/23 directed all alleged violations of abuse including injuries of an unknown source are to be reported immediately, not to exceed (2) hours after discovery, to members of the community and other officials in accordance with state and federal laws through established procedures. Injuries of unknown source are when the following conditions are not met: The source of the injury was not observed, or the source could not be explained by the resident and the injury is suspicious because of the extent of the injury, location (the injury is not located in an area generally vulnerable to trauma), the number of injuries at one point in time or incidence of injuries over time.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on record review and staff interviews for 1 of 5 residents reviewed for unnecessary medications (Resident #16), the facility failed to ensure accurate transcription of a physician's order for a newly ordered psychotropic medication. The findings include: Resident #16 was admitted to the facility on [DATE] with diagnoses that included a history of fainting, falls, and a cervical fracture. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 was cognitively intact and had not exhibited behaviors directed toward others. A Psychiatrist note dated 10/2/24 identified Resident #16 exhibited delusions, hallucinations, and behaviors of yelling. The Psychiatrist note indicated that Risperdal (an antipsychotic medication) would be started. The note further indicated that the dose and frequency for Risperdal was 0.25 milligrams (mg) every evening at 8:00 PM. A facility Physician's Order dated 10/2/24 by the psychiatric provider, Medical Doctor (MD) #2, identified a handwritten order directing to administer Risperdal 0.25 mg by mouth every evening at 8:00 PM. An electronic Physician's order dated 10/2/24 directed the administration of Risperdal 0.25 mg by mouth every 8 hours. A review of the Electronic Medication Administration Record (EMAR) identified that Resident #16 was administered Risperdal 0.25 mg by mouth every 8 hours from 10/3/24 to 10/15/24 (a total of 13 days). A Nursing note dated 10/15/24 indicated that a new order for Risperdal was received from MD #2 on 10/2/24 and was transcribed as Risperdal 0.25 mg every 8 hours rather than Risperdal 0.25 mg every evening at 8:00 PM. On 10/16/24 at 11:36 AM, an interview with RN #2 indicated that providers usually input orders directly into the EMAR, but MD #2 handwrites orders which then require transcription into the EMAR by the nursing supervisor. RN #2 indicated that the handwritten Risperdal order looked unclear, but he thought the order was written as Risperdal 0.25 mg every 8 hours as needed. RN #2 indicated that he did not contact any staff member or providers for order clarification. On 10/16/24 at 12:25 PM, an interview with the Director of Nursing (DNS) identified that RN #2 brought the order discrepancy to his attention on 10/15/24. The DNS indicated that the facility was still investigating the incident, but that Resident #16 did not have an adverse effect from the medication error. The DNS indicated that staff do a 24-hour chart review every day to look for new orders and ensure orders look okay. The DNS further indicated that the 24-hour chart review does not serve as a check for the order transcription process. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 12:35 PM, an interview with MD #2 identified on 10/2/24 she ordered Risperdal 0.25 mg every evening at 8:00 PM, she did not order Risperdal 0.25mg every 8 hours. MD #2 indicated that she found discrepancies between what she ordered and what was being administered when she reviewed Resident #16's medications on 10/15/24. MD #2 identified that Risperdal was a new medication for Resident #16. MD #2 indicated that potential adverse effects of a higher dose or frequency of Risperdal included oversedation, falls, and low blood pressure. MD #2 identified that Resident #16 had a history of falls prior to starting Risperdal and was not aware of any falls or other adverse effects while receiving Risperdal. MD #2 further indicated that she would expect to be called or emailed if orders needed clarification. The facility policy titled Physician Order Transcription states, in part, orders written on the physician's order sheet by a prescriber will be entered in the electronic health record (EHR) after verification by a licensed nurse.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 3 of 5 sampled residents (Resident #26, Resident #2 and Resident #10) reviewed for accidents, the facility failed to follow the plan of care resulting in a fall with major injury (Resident #26) and failed to ensure a transfer was provided according to physician order (Resident #2) and failed to implement interventions according to the plan of care resulting in falls (Resident #10). The findings include: 1. Resident #26's diagnoses included dementia, cognitive communication deficit, history of falls, and traumatic subdural hemorrhage. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3) and required moderate assistance with transfers, bed mobility and sitting to standing. The MDS further identified Resident #26 required moderate assistance with dressing and supervision with toileting, had two or more previous falls and was always incontinent of bowel and bladder. The facility Morse Fall Scale evaluation dated 11/15/23 identified Resident #26 as a high fall risk. The Resident Care Plan dated 11/22/23 identified Resident #26 as at risk for falls, at risk for incontinence and at risk for impaired communication related to dementia and a hearing deficit. The RCP included interventions of applying gripper socks at bedtime, placing a call light within reach, offering toileting every 2 hours, and checking Resident #26 every 2 to 3 hours and as needed for toileting needs. Review of the facility Event Report dated 11/22/23 by RN #2 identified that on 11/22/23 at 9:30 PM, Resident #26 was found on the floor in front of his/her bathroom, sitting upright, with both lower extremities curled towards his/her back. The Event Report identified Resident #26 stated he/she hit his/her head on the floor and Resident #26 was transferred to the hospital for further evaluation. The Event Report further identified Resident #26 was barefoot when discovered and his/her shoes were located at the bed side. The Event Report indicated Resident #26 did not put his/her shoes on prior to getting out of bed and did not request assistance for toileting. Review of a statement dated 11/22/23 by NA #8, who was assigned to provide care for Resident #26 during the 3 PM to 11 PM shift on 11/22/23, identified NA #8 changed (referring to incontinent care) Resident #26 at around 2 PM then further identified Resident #26 was in his/her bed at around 7:30 PM to 8 PM, wearing pajamas, and indicated Resident #26 changed into pajamas by his/herself. The statement did not indicate toileting was provided every 2-3 hours according to the plan of care or indicate if footwear was on prior to or at the time of the incident. Review of a statement dated 11/22/23 by LPN #1, who was assigned to provide care for Resident #26 during the 3 PM to 11 PM shift on 11/22/23, identified no indication of Resident #26's status prior to the fall incident. The statement did not identify the last time Resident #26 was toileted or if footwear was on at the time of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a statement dated 11/22/23 by NA #1 who worked during the 3 PM to 11 PM shift on 11/22/23 identified no indication of Resident #26's status prior to the fall incident and no indication of care or toileting provided to Resident #26 prior to the fall incident. Review of an email correspondence on 11/23/23 between the Director of Nursing (DNS) and RN #2 indicated RN #2 interviewed NA #1, who also worked during the 3 PM to 11 PM shift on 11/22/23, regarding the fall incident, and that NA #1 stated she did not toilet Resident #26 at all during the 3 PM to 11 PM shift on 11/22/23 and that Resident #26 frequently toilets him/herself and does not require assistance. Review of the hospital discharge summary dated 11/27/23 identified a 5-day hospital admission with a transfer to the surgical intensive care unit for hourly neuro monitoring from 11/22/23 to 11/24/23. Resident #26 was then transferred to the hospital floor for further monitoring until discharge back to the facility on [DATE]. Hospital diagnoses related to the fall incident on 11/22/23 are as follows: a primary diagnosis of trauma secondary to a ground level fall with multiple subarachnoid hemorrhages (SAH) and several other diagnoses to include Bifrontal SAH anteriorly/inferiorly extending superiorly along the left, subtle right parietal SAH, subtle right temporal/occipital SAH, small anterior falx subdural hematoma extending to the right frontal convexity, nondisplaced occipital bone fracture extending to foramen magnum, right occipital hematoma. Interview with NA #8 on 10/11/24 at 11:48 AM identified Resident #26 often exhibited wandering behaviors and once awake would begin to walk. NA #8 identified Resident #26 dressed him/herself at bedtime on 11/22/23. NA #8 identified she saw Resident #26 in bed with pajamas on and did not provide any further care for Resident #26 once he/she was observed in bed. NA #8 identified she did not pull the blankets back to check that gripper socks were in place as directed in the plan of care. 2. Resident #2 had diagnoses that included dementia and osteoarthritis. The Minimum Data Set assessment dated [DATE] identified Resident #2 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 12) and required a 2 person assist with bed mobility, transfers and toileting. The Resident Care Plan dated 5/20/24 identified Resident #2 had impaired cognition, an ADL deficit and was at risk for falls. Interventions directed to explain procedures prior to beginning and to provide an assist of 2 with transfers and toileting. Physician orders dated 5/21/24 directed an assist of 2 with toileting at wheelchair level during the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and to provide transfers using a Hoyer lift (mechanical device used to move residents with limited mobility) during the 11:00 PM to 7:00 AM shift. A Nurse's note dated 7/10/24 at 11:03 PM identified Resident #2 was assisted to the floor in the bathroom by his/her assigned Nurse Aide (NA #1). Resident #2 was unable to hold weight in a panic and was assisted to the floor. The assessment further identified Resident #2 had no change in mobility status, did not hit his/her head, was stable, and cognition was at baseline. A facility Reportable Event Investigation Statement dated 7/10/24 completed by NA #1 identified that at 10:45 PM, Resident #2 was being transferred from the toilet to his/her wheelchair when he/she started to panic and fell . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with the Director of Rehabilitation (DOR) on 10/15/24 at 11:18 AM identified prior to the incident, Resident #2 required an assist of 2 for transfers to the toilet during the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts and Hoyer lift transfers during the 11:00 PM to 7:00 AM shift. The DOR further identified Resident #2 should have been transferred from the toilet to his/her wheelchair with an assist of 2. Resident #2 was provided an elevated toilet seat after the incident. An interview with NA #1 on 10/15/24 at 1:44 PM identified she was assigned to provide care for Resident #2 during the 3:00 PM to 11:00 PM shift on 7/10/24. NA #1 identified she knew Resident #2 required an assist of 2 with transfers, however, demonstrated that Resident #2 could stand with an assist of 1 while utilizing the grab bar to perform duties and then transfer back to the wheelchair. NA #1 identified that on 7/10/24, she began independently transferring Resident #2 to his/her wheelchair. NA #1 identified Resident #2 panicked, and NA #1 placed her foot behind Resident #2's body, pushed the wheelchair out of the way and eased him/her to the floor. An interview with NA #3 on 10/15/24 at 2:02 PM identified she was also assigned to provide care for Resident #2 during the 3:00 PM to 11:00 PM shift on 7/10/24. NA #3 identified she was aware Resident #2 required an assist of 2 with transfers. NA #3 further identified that there was no request for assistance with Resident #2 on 7/10/24 and that she was only made aware that Resident #2 had fallen when she heard NA #1 call for help. An interview with the Director of Nursing on 10/15/24 at 3:09 PM identified Resident #2 required an assist of 2 at the time of the fall and that Resident #2's transfer status was reviewed after the fall with no changes. 3. Resident #10 had diagnoses that included left femur fracture, dementia, repeated falls and restlessness and agitation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), required partial/moderate assistance with toileting, personal hygiene and transfers. The MDS identified Resident #10 occasionally experienced urinary incontinence. The Resident Care Plan (RCP) dated 5/24/24 identified Resident #10 as a fall risk related to cognition, diagnosis of dementia, ADL decline, history of repeated falls, incontinence and attempts to get up on his/her own. Interventions included offering toileting every hour while awake and to remain with Resident #10 near the bathroom while toileting. The RCP identified Resident #10 had urinary incontinence and included an intervention to check Resident #10 every 2 to 3 hours for toileting needs. The Resident Care Card (RCC) identified Resident #10 as a high fall risk with a history of a hip fracture and directed incontinence care every 2-3 hours, to offer toileting every half hour while awake and not to leave Resident #10 alone in the bathroom. a. Review of the Reportable Event form dated 6/3/24 identified Resident #10 was observed sitting on the bathroom floor at 7:40 PM. Review of a written statement by LPN #2 dated 6/3/24 identified Resident #10 was incontinent of stool at the time he/she was found on the bathroom floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a written statement by NA #1 dated 6/3/24 identified she was the NA assigned to care for Resident #10 during the 3 PM to 11 PM shift on 6/3/24. The statement written by NA #1 did not include information about toileting or any care provided for Resident #10 throughout the shift. During an interview with NA #1 on 10/16/24 at 11:11 AM, NA #1 indicated she remembered the fall incident that occurred on 6/3/24 and she remembered writing her statement. NA #1 identified she did not toilet Resident #10 prior to the fall in the bathroom and stated her reason for not toileting Resident #10 was because most of the time he/she goes to the toilet on his/her own. NA #1 further identified Resident #10 forgets to use the call bell when he/she needs help and indicated it is difficult to keep an eye on Resident #10 because there are other residents who need tending to. NA #1 indicated that even if Resident #10 is brought to the bathroom, he/she will still go on his/her own and further stated this is not someone you can keep tabs on, even if you toilet him/her every 2 hours, he/she will still go by himself/herself. b. Review of the facility Post Fall Evaluation by RN #2 dated 10/14/24 identified Resident #10 fell in the bathroom at 8:52 PM while attempting to self-transfer to the toilet and was incontinent at the time of the fall. Review of the Reportable Event Investigation Statement form by NA #5 dated 10/14/24 identified the last time care was provided to Resident #10 prior to the incident was at 3:30PM and further down the form identified Resident #10 was last toileted at 7:30 PM. Interview with NA #5 on 10/15/24 at 9:32 AM identified she was assigned to provide care for Resident #10 on 10/14/24 during the 3 PM to 11 PM shift. NA #5 indicated Resident #10 was more anxious and agitated than usual. NA #5 further identified Resident #10 was hyper focused on having his/her wanderguard bracelet (wearable alert device for residents who are at risk for wandering) removed and was arguing with another resident at the nurse's station for most of the shift. NA #5 identified that prior to the fall in the bathroom at 8:52 PM, she last brought Resident #10 to the bathroom at 3:30 PM. NA#5 identified she did not bring Resident #10 to the bathroom at 7:30 PM but, instead, asked Resident #10 if she needed to go to the bathroom. Interview with the Director of Nursing (DNS) on 10/15/24 at 11:47 AM indicated that although Resident #10 is severely cognitively impaired, at times Resident #10 knows when he/she needs use the bathroom. The DNS further identified that Resident #10 may not always answer questions appropriately or be able to make decisions based on his/her severe cognitive impairment and Resident #10 should be toileted according to a schedule. The facility Fall Prevention and Management policy states, in part, residents who are identified as a fall risk will be care planned and individualized interventions and precautions will be noted to avoid falls. The policy directed a safe environment with the least restrictive measures while promoting the highest possible independence. The Facility policy titled Urinary Incontinence - Clinical Protocol states, in part, based on assessment, staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence patterns. The facility Accidents and Incidents - Reporting and Investigating policy states, in part, all accidents, incidents, or events involving residents shall be reported and investigated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48792 Based on observation, staff interviews, and facility documentation, the facility failed to maintain refrigerator and dishwasher temperature logs and failed to ensure storage containers were clean. The findings include, Tour and observation of the kitchen on 10/10/24 at 9:40 AM with the Culinary Director identified the following: 1. Temperature logs for the refrigerators, freezers and dishwasher were completed through 9/30/24, however none were completed for 10/1/24 to 10/10/24. Subsequent to surveyor inquiry, on 10/10/24 at 10:16 AM, temperature logs were produced for the month of October, however the log was postdated with temperatures through 10/10/24 at 5 PM. 2. Four 50-pound storage containers used for flour, sugar, oatmeal and rice had a brown sticky substance around the outside of the tops of the containers. Subsequent to surveyor inquiry, the containers were cleaned. Interview on 10/10/24 at 9:40 AM with the Culinary Director identified the storage containers were not clean and that he does not have a cleaning schedule or log. Interview on 10/10/24 at 10:16 AM with the Culinary Director confirmed that the temperature logs were postdated through 5PM on 10/10/24. He identified that the manager logs both daily temperatures at 10:30 AM and then checks the temperature at 5 PM to ensure the documented temperatures are accurate. Although requested, policies for temperature maintenance and cleaning equipment were not provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37721 Based on review of facility documentation, facility policy and interviews the facility failed to implement appropriate plans of action to correct quality deficiencies once identified through Quality Assurance and Performance Improvement (QAPI). The findings include: A review of the facility QAPI program identified the following: 1.QAPI Committee Minutes dated 3/21/24 identified a bed safety program was being initiated for entrapment checks prior to bed changes for residents who choose to use bed rails as a mobility enabler. QAPI Committee Minutes dated 6/19/24 identified a bed safety program was completed and that bed checks were being performed by maintenance. A review of facility documentation failed to reflect documentation of measurable goals, step by step interventions to correct the problem or how the facility was to monitor progress over time. 2.QAPI Meeting Minutes dated 3/21/24, beginning February 2024, identified a plan for mechanical lifts and sling quality control was being initiated to ensure all slings were safe for use and sizing appropriate according to manufacturer guidelines. A review of the QAPI meeting Minutes dated 7/17/24 identified the mechanical lift sling and quality control project was completed and that all residents had (2) slings in rotation and inspection as part of a daily practice. A review of facility documentation failed to reflect documentation of measurable goals, step by step interventions to correct the problem or how the facility was to monitor progress over time. An interview with the Director of Nursing identified he was unable to provide an explanation for lack of documentation related to the QAPI initiatives. A review of the facility policy for QAPI Plan dated 2/3/2019 directed Performance Improvement Projects take a systemic approach to improve care and services that identify problems, document performance improvement/trends and conduct periodic measurement and review to ensure new action is adopted and performed consistently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075318	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomperaug Woods Health Center	80 Heritage Rd Southbury, CT 06488

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46046 Based on observation and interview, the facility failed to ensure staff were provided Personal Protective Equipment (PPE) gowns while sorting and washing soiled linens. On 10/15/2024 at 11:00 AM interview and observation with Laundry Aide (LA) #1 identified PPE gowns had never been used to handle soiled linen. An interview on 10/16/24 at 9:35 AM with the Director of Laundry (DOL) identified she/he was new to the position and did not know when PPE gowns should be utilized while processing laundry. An observation and interview with LA #1 and the DOL on 10/16/24 at 9:35 AM identified PPE gowns were never used with the handling of soiled linens. Observation with the DOL identified no PPE gowns were stored in the laundry area. Further observation identified contamination of LA #1's clothing with the handling of soiled linens and subsequent handling of clean linens. On 10/17/2024 at 11:30 AM the facility Administrator indicated laundry staff should utilize PPE gowns when handling soiled linen. Subsequent to surveyor inquiry, PPE gowns were stocked in the laundry area and staff were educated regarding the use of PPE gowns. The facility policy labeled Departmental (Environmental Services)-Laundry and Linen indicated, in part, employees sorting and washing linen must wear a gown and gloves and a mask may be worn if aerosolization is expected.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50890 Based on observations, review of facility policy, and interviews, the facility failed to store personal care items in a clean and sanitary manner in rooms with a shared bathroom. The findings include: Observation on 10/10/24 at 9:43 AM identified unlabeled personal care items on the left side of the bathroom countertop, shared by Resident #16 and Resident #24, to include a hairbrush, comb, used disposable razor, open 1/2 full shampoo bottle, blue soap dish containing a yellow used bar of soap, kidney shaped basin containing a used toothbrush, and a plastic cup laying on its side containing 2 used toothbrushes (1 white and 1 blue). Observed on the right side of the countertop were unlabeled items to include a denture cup, barrier cream and 2 electric razors. Also on the right side of the countertop was a kidney shaped basin, labeled with the last name of Resident #16, containing a used white toothbrush, toothpaste and comb. Observation on 10/10/24 at 10:01 AM identified unlabeled personal care items on the left side of the bathroom countertop, shared by Resident #27 and Resident #336, to include a kidney shaped basin containing a used toothbrush, toothpaste, hairbrush and comb. Interview with NA #6 on 10/10/24 at 10:07 AM in the shared bathroom belonging to Resident #16 and Resident #24 indicated she would not know what personal care items belonged to the residents so she would throw the items away. She further indicated both Resident #16 and Resident #24 were confused and would use whatever items were on the countertop without giving it a second thought. Interview with NA #7 on 10/10/24 at 10:23 AM identified both Resident #16 and Resident #24 used the shared bathroom and when asked how someone would know what items belonged to each resident, she indicated the items should be labeled. Observations on 10/15/24 at 10:02 AM identified unlabeled personal care items remained on the bathroom countertop belonging to Resident #16 and Resident #24. Unlabeled items observed on the left side of the countertop included 1 electric razor and a kidney shaped basin containing a used white toothbrush, comb and denture cup. Unlabeled items observed on the right side of the countertop included a comb, blue soap dish containing a yellow used bar of soap and 2 used toothbrushes (1 white and 1 blue), 1 electric razor and a comb. Observation on 10/15/24 at 10:04 AM identified unlabeled personal care items remained on the bathroom countertop belonging to Resident #27 and Resident #336. A kidney shaped basin was observed upside down on the left side of the countertop, when picked up, unlabeled items to include a used toothbrush, toothpaste, hairbrush and comb were observed laying directly on the countertop. Interview and observation with RN #1 on 10/15/24 at 10:17 AM identified the personal care items in the bathrooms shared by Resident #16 and Resident #24 and Resident #27 and Resident #336 should be labeled with resident identifiers and stored in the facility provided shelving units that hang in the bathrooms and are labeled with either door or window. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry, RN #1 used a label maker to label all personal care items in the shared bathrooms observed. Interview with the Director of Nursing (DNS) on 10/15/24 at 11:15 AM identified the facility did not have staff competencies or in-services related to storage and labeling of personal care items and further identified he was working on creating one. The DNS indicated personal care items in shared resident bathrooms should be kept separated and labeled with resident identifiers. The facility policy titled, Homelike Environment, states, in part, the facility staff maximizes facility characteristics to reflect a personalized, homelike setting to include a clean, sanitary and orderly environment.