STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #8) reviewed for urinary tract infections (UTI ' s) and 2 of 3 residents (Resident #8 and Resident #36) reviewed for weight changes, the facility failed to notify a provider of a medication omission for treatment of a UTI and failed to notify a provider of a significant weight gain for a resident with congestive heart failure (CHF) and failed to notify a provider of significant weight changes per facility policy. The findings include: 1. Resident #8 was admitted to the facility in December of 2024 and had diagnoses that included cellulitis of left lower limb, CHF, and UTI. The Clinical Admission assessment dated [DATE] at 3:51 PM identified Resident #8 was alert, disoriented, and confused with incoherent unclear speech that can sometimes be understood. Resident #8 required assistance with meals, used a walker and manual wheelchair, had a limb prosthesis due to amputation with lower extremity range of motion impairment on one side, had an unsteady gait with poor balance and was bedfast all or most of the time. The Resident Care Plan (RCP) dated 12/13/2024 identified Resident #8 was at risk for infection related to chronic illness, and a history of bacteremia and cellulitis. Interventions included encouragement and assistance with good hand hygiene, and social distancing as indicated. A Provider order dated 1/6/2025 directed to administer ciprofloxacin 500 mg (antibiotic) by mouth 2 times a day for 7 days related to a UTI. A nursing progress note by RN #7 on 1/6/2025 at 8:29 PM identified that ciprofloxacin 500mg was not available for administration in the Omnicell (automated medication dispensing system used to ensure the availability of certain medications) or medication cart. The progress note failed to identify that the provider had been notified. Interview with MD #1 on 1/10/2025 at 12:08 PM identified that she was not notified of the missed dose of ciprofloxacin 500 mg scheduled to be administered on 1/6/2025 at 8:00 PM. (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
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Policy on Physician's Orders identified if a medication is not available the provider will be notified. 2. Resident #8 was admitted to the facility in December of 2024 and had diagnoses that included cellulitis of left lower limb, CHF, and UTI. The Clinical Admission assessment dated [DATE] at 3:51 PM identified Resident #8 was alert, disoriented, and confused with incoherent unclear speech that can sometimes be understood. Resident #8 required assistance with meals, used a walker and manual wheelchair, had a limb prosthesis due to amputation with lower extremity range of motion impairment on one side, had an unsteady gait with poor balance and was bedfast all or most of the time. The Resident Care Plan (RCP) dated 12/13/2024 identified Resident #8 was at risk for fluid overload, dehydration and electrolyte abnormalities related to CHF and use of a diuretic. Interventions included assessment for dependent edema, administration of diuretics per provider order, and to obtain daily weights and report a weight gain greater than 2 pounds (lbs.) in a day to the provider. A Provider order dated 12/13/2024 directed to obtain a daily weights. A provider order dated 12/17/2024 directed to administer bumetanide (diuretic) 1 milligram (mg) by mouth 1 time a day related to CHF and to administer bumetanide 1 mg by mouth 1 time a day as needed (PRN) if Resident #8's weight increased 2 lbs. in one day or 5 lbs. in one week and to notify the provider. A Nursing progress note by RN #2 on 1/6/2025 at 3:06 PM identified she notified MD #1 of a 3 lb. weight gain in 1 day for Resident #8. A Nursing progress note by RN #2 on 1/6/2025 at 3:08 PM identified she received instructions from MD #1 to utilize the PRN bumetanide order for Resident #8. Review of the Weights and Vitals Summary report identified the following weight entries: 130.8 lbs. on 12/14/2024 132.6 lbs. on 12/17/2024: weight gain of 2.6 lbs. since the last weight entry 12/14/2024 136.0 lbs. on 12/18/2024: weight gain of 3.4 lbs. in 1 day 137.0 lbs. on 12/20/2024: weight gain of 6.2 lbs. in 6 days (from 12/14/2024) 137.8 lbs. on 12/22/2024 140.4 lbs. on 12/23/2024: weight gain of 2.6 lbs. in 1 day 139.6 lbs. on 12/24/2024 140.4 lbs. on 12/26/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	143.4 lbs. on 12/29/2024: weight gain of 3 lbs. since the last weight entry 12/26/24 Review of the clinical record failed to identify documentation of provider notification of weight gains on 12/18/2024, 12/20/2024, and 12/22/2024. of 2 lbs. in 1 day or 5 lbs. in 1 week Interview with RN #3 on 1/8/2025 at 12:50 PM identified Resident #8 had a weight increase of 2.6 lbs. on 12/23/2024 and it was her understanding that the facility policy directed to report a weight gain of 3 lbs. in 1 day or 5 lbs. in 1 week to the provider. RN #3 identified she was unaware Resident #8 had a PRN order which instructed to update the provider of a weight increase of 2 lbs. in 1 day or 5 lbs. in 1 week. RN #3 indicated there was no instruction in the daily weight order regarding reporting parameters and if she knew about the instructions in the PRN order she would have notified the provider of the 2.6 lb. weight gain in 1 day. Subsequent to surveyor inquiry, a Provider order dated 1/8/2025 directed daily weights and included instructions that directed to administer an extra dose of bumetanide 1 mg if Resident #8's weight increased 2 lbs. in 1 day or 5 lbs. in 1 week, and to notify the provider. Interview with RN #2 on 1/9/2025 at 3:00 PM identified that she follows parameters ordered by the provider for reporting of weight gains for residents with CHF, and these parameters are usually included within the order for daily weights. RN #2 identified that on 1/6/2025 she updated MD #1 of a 3 lb. weight gain in one day because she knew MD #1 used these parameters, and that at the time of her call she was not aware there was an active PRN order for bumetanide 1 mg for an increased weight of 2 lbs. in one day or 5 lbs. in one week. RN #2 further identified that she did not notify MD #1 on 12/20/2024 of a 6.2 lb. weight gain in 6 days because 3 different scales were used to obtain the weights and subsequently she questioned the accuracy of the weights. RN #2 identified she should have notified MD #1 of the weight changes even if she were uncertain of the accuracy and that moving forward she would do so. Interview with RN #4 on 1/10/2025 at 11:00 AM identified that she usually included parameters for reporting weight gain within the daily weight orders for residents with CHF. RN #4 identified that there were parameters for reporting weight gain in Resident #8's bumetanide 1 mg PRN order but she could not identify why the parameters were not included in the daily weight order or how nurses would know to look at the PRN order for further instructions. RN #4 identified the daily weight order had been revised to include instructions with weight gain parameters for reporting to the provider. Review of the Congestive Heart Failure policy identified weights will be obtained daily and a weight that has increased 3 lbs. in one day or 5 lbs. in one week will be reported to the provider. 3. Resident #36 was admitted to the facility in October of 2024 with diagnoses that included hypertension, hypo-osmolarity and hyponatremia (low sodium level in blood), chronic kidney disease, and diabetes. Review of the hospital Discharge Summary document dated 10/17/24 identified that Resident #36 was discharged on [DATE] and a weight of 199.0 pounds (Lbs) was obtained on 10/17/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Dietary/Nutrition Profile note dated 10/20/24 at 9:44 AM by the Dietician identified that Resident #36 was at risk for altered nutrition due to abnormal labs, diabetes with Hemoglobin A1C (average blood sugars in blood during the past 2 to 3 months) of 7.0 (normal range: below 5.7%) and hyponatremia (low blood sodium level) which improved upon being discharged from the hospital. The note identified a reweight request which was not reflected in the clinical record. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required maximum assistance for toileting, bed mobility and transfers and moderate assistance for personal hygiene. The MDS further identified that Resident #36 used a walker and wheelchair for mobility. A Resident Care Plan dated 10/21/24 identified Resident #36 was at risk for nutritional deficit. Interventions included administering a carbohydrate consistent diet, dietary counseling as needed, monitoring blood sugar as ordered, monitoring for digestive complaints as needed, monitoring labs as needed, monitoring weights per physician order, seeing resident for meal preferences, and skin checks as ordered. Review of the Weights and Vitals Summary identified the following weights: 10/18/24: 181.2 pounds (Lbs.), 10/30/24: 181.2 Lbs., 11/14/24: 181.2 Lbs., 12/2/24: 226.2 Lbs., 12/3/24, 227.9 Lbs., and 12/16/24, 226.4 Lbs. Resident #36's weights for 10/30/24 (181.2 Lbs.) and 11/14/24 (181.2Lbs.) were struck out on 12/9/24 by RN #6 as incorrect documentation. Review on Nursing Progress notes dated 10/18/24 through 12/20/24 failed to identify nursing documentation that physician was notified of significant weight loss of 17.2 Lbs. (8.94%) in one day between 10/17/24 (199 Lbs.) and 10/18/24 (181.2 Lbs.) and significant weight increase of 27.2 Lbs. (13.67%) in less than 2 months between 10/17/24 (199.0Lbs) and 12/2/24 (226.2 Lbs.). Interview and clinical record review with RN #6 on 1/9/25 at 1:35 PM, identified that she documented weights on 10/30/24 and 11/14/24 in the Electronic Medical Record (EMR). RN #6 indicated that on 12/9/24 she struck out the 10/30/24 and 11/14/24 weights because she thought the weights were incorrect based on a significant weight gain reflected on 12/3/24. RN #6 was unable to explain why Resident #36 was not weighed weekly for 4 weeks post admission to the facility or why Resident #36 was not reweighed on 10/18/24 due to the discrepancy between hospital discharge weight and the facility admission weight. Interview and clinical record review with the DNS on 1/9/25 at 3:20 PM, identified Resident #36 should have been weighed on admission and then weekly for 4 weeks according to the facility weight policy. The DNS identified that NA ' s are responsible for obtaining weights under the direction of the unit manager. The DNS identified licensed nurses are responsible for ensuring weights are documented in the EMR and for updating the provider, family and dietician of weight changes. The DNS was unable to explain why a reweight was not obtained subsequent to the facility admission weight reflecting a significant weight loss of 17.8 Lbs (8.94%) between 10/17/24 (199 Lbs.) and 10/18/24 (181.2 Lbs.) or why a reweight was not obtained on 10/20/24 as directed by the dietician. The DNS was unable to explain why Resident #36 ' s weights were obtained and documented on 10/30/24 as 181.2 Lbs. and on 11/14/24 as 181.2 Lbs. then struck out 1 month later (on 12/9/24) by RN #6 with a documented reason of: inaccurate documentation. The DNS was unbale to provide documentation that interventions were initiated for Resident #36 due to a significant weight increase of 27.2 Lbs. (13.67%) between 10/17/24 (199.0Lbs) and 12/2/24 (226.2 Lbs.). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry, the EMR was updated to reflect the following late entry weights: 10/28/24: 215.2 Lbs. and 11/25/24: 189.3 Lbs. Interview with MD #1 on 1/10/25 at 10:35AM, identified that physician weight notifications are documented in a physician's notification book which is usually with the unit manager and could not identify if she had been notified of the weight changes without referencing the notification book. Interview and clinical record review with the Unit Nurse Manager (RN#4) on 1/10/25 at 11:30 AM, identified that all weights should have been documented in EMR after Resident #36 was weighed and further indicated that if weights were not documented, it means they were not done. RN #4 was unable to identify if the physician was notified when Resident #36 experienced significant weight increase and loss. Review of facility policy titled, Policy and Procedure for Weights/Re-weights, identified in part, that, each Health Center resident will be weighed upon admission and then once weekly for four weeks, then monthly on bath day unless specified by the physician. When a significant weight loss or gain occurs (5 Lbs.), the following measure will be implemented. a). Resident will be reweighed to ensure accuracy. If weight loss is confirmed, Dietician will be notified. b) Consultant dietician will reassess during the next visit. c) Physician and family will be notified by nursing staff as appropriate. d). Documentation in nurses notes that weight loss has taken place, and the physician, Dietician and family have been notified. Weights are recorded in the EMR. Supervisor/designee will review weights weekly and report concerns. 51183

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50250 Based on clinical record review, facility documentation, facility policy, and interviews for the only sampled resident (Resident #36), reviewed for abuse, the facility failed to report an allegation of abuse to the State Agency (SA) within 2 hours of the alleged violation. The findings include: Resident #36 was admitted to the facility in October of 2024 with diagnoses that included hypertension, chronic kidney disease and diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required maximum assistance for toileting, bed mobility and transfers, moderate assistance for personal hygiene and was dependent for bathing. The MDS further identified Resident #36 was always incontinent of urine and bowel. The Resident Care Plan dated 12/6/24 identified Resident #36 had a functional ability decline. Interventions included set up assistance for eating, assist of 2 for bathing, toileting hygiene and dressing, notifying the nurse of refusals and physical, occupational and speech therapies to evaluate and treat per physician's order. A Reportable Event form dated 12/24/24 at 12:30 PM by the DNS identified that during the medication pass Resident #36 reported to RN #2 that Nurses Aid (NA) #1 touched him/her inappropriately while performing personal care. The form identified that Resident #36 described NA #1 as a Hispanic NA with short straight hair and that Resident #36 requested NA #1 no longer provide care for him/her. The form identified that Resident #36 reported that he/she spoke in Spanish to NA #1 and when he/she stopped speaking in Spanish to NA #1, NA #1 got mad. Additionally, Resident #36 reported that NA #1 also offered to stay with him/her if he/she rented a room. The form further identified that the physician, family, administrator and law enforcement agency were notified of the incident, and an investigation was initiated on 12/24/24 and concluded on 1/2/24 with no findings. The form identified that the allegation was reported by the DNS to the overseeing SA on 12/31/24 at 11:30 AM. Interview with Resident #36 on 1/8/25 at 9:30 AM, identified that he/she reported the incident to the facility and spoke to the DNS about the incident 2 weeks prior and did not want to further discuss the incident. Interview with NA #2 on 1/10/24 at 9:30 AM identified that she was not assigned to provide care for Resident #36 on 12/24/24 but was later assigned to provide care for Resident #36 by the Unit Manager (RN #4), after an allegation of abuse by Resident #36 was made towards NA #1. NA #2 identified that she assisted Resident #36 with personal care and did not have any issues providing care for Resident #36 during her shift. Interview with RN #2 on 1/10/24 at 9:45 AM identified that Resident #36 reported NA #1 touched him/her inappropriately while providing personal care. RN #2 identified that Resident #36 requested that NA #1 no longer provide care for him/her. RN #2 identified that she immediately reported the abuse allegation to RN #4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #1 on 1/10/24 at 10:30 AM identified that she was assigned to provide care for Resident #36 on 12/24/24 during the 7:00 AM to 3:00 PM shift. NA #1 identified that she was not feeling well during her shift and left the facility around 10:20 AM. NA #1 identified that she did not provide personal care to Resident #36 during the shift, but only provided apple juice when she passed out drinks to residents. NA #1 further identified that it was not until after she left the facility that RN #4 contacted her via phone to enquire about an allegation of abuse by Resident #36. NA #1 identified that she reported back to work on 12/27/24 from sick leave and had not provided care for Resident #36 since. In addition, NA #1 identified that she has long hair and does not speak Spanish. Interview with RN #4 on 1/10/24 at 11:20 AM identified she was informed by RN #2 that Resident #36 reported an allegation of abuse. RN #4 identified that she spoke with Resident #36 who was upset and then contacted NA #1 by phone to enquire about the allegation since NA #1 already left the facility. RN #4 updated the physician, DNS and Human Resources Manager and an investigation was initiated. Interview with the DNS on 1/10/25 at 11:30 AM identified that she did not report Resident #36's allegation of abuse, within 2 hours of the allegation, to the SA. The DNS identified that the Administrator and the DNS were responsible for reporting incidents to the SA. The DNS identified that Resident #36 had a history of making allegations and recanting his/her allegations. The DNS indicated that she did not immediately report the abuse allegation because she was not sure if Resident #36 would recant the allegation as he/she had previously done. The DNS reported the allegation of abuse to the overseeing SA on 12/31/2024 at 11:30 AM. Review of facility policy titled, Abuse Prevention Program, identified, in part, all allegations of abuse will be reported to the Administrator immediately and to the State Department of Health and residents' representative immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on review of the clinical record, facility policy and interviews for 1 sampled resident (Resident #8) reviewed for edema and 1 of 3 residents (Resident #36) reviewed for skin conditions, the facility failed to utilize an as needed (PRN) medication according to provider order for a resident with congestive heart failure (CHF) and the facility failed to complete preventative weekly skin assessments according to facility policy. The findings include: 1. Resident #8 was admitted to the facility in December of 2024 and had diagnoses that included cellulitis of left lower limb, CHF, and dementia. The Clinical Admission assessment dated [DATE] at 3:51 PM identified Resident #8 was alert, disoriented, and confused with incoherent unclear speech that could sometimes be understood. Resident #8 required assistance with meals, used a walker and a manual wheelchair, had a limb prosthesis due to an amputation with lower extremity range of motion impairment on one side, had an unsteady gait with poor balance and was bedfast all or most of the time. The Resident Care Plan (RCP) dated 12/13/2024 identified Resident #8 was at risk for fluid overload, dehydration and electrolyte abnormalities related to CHF and use of a diuretic. Interventions included assessment for dependent edema, administration of diuretics per provider order, and to obtain daily weights and report a weight gain greater than 2 pounds (lbs.) in a day to the provider. A Provider order dated 12/13/2024 directed to obtain a daily weight. A Provider order dated 12/17/2024 directed to administer bumetanide 1mg by mouth one time of day related to CHF and to administer bumetanide 1 mg by mouth one time a day PRN if Resident #8's weight increased 2 lbs. in one day or 5 lbs. in one week and to notify the provider. A Nursing progress note by RN #4 on 12/17/2024 at 5:43 PM identified Resident #8 was seen by MD #1 and Resident #8's scheduled bumetanide (diuretic) order was decreased to 1 milligram (mg) daily, and a PRN dose of bumetanide was ordered for administration if Resident #8's weight increased 2lbs. in 1 day or 5 lbs. in 1 week. A Nursing progress note by RN #2 on 1/6/2025 at 3:06 PM identified she notified MD #1 of a 3 lb. weight gain in 1 day for Resident #8. A Nursing progress note by RN #2 on 1/6/2025 at 3:08 PM identified she received instructions from MD #1 to utilize the PRN bumetanide order for Resident #8. Review of the Weights and Vitals Summary report identified weights of 130.8 lbs. on 12/14/2024, 132.6 lbs. on 12/17/2024, 136.0 lbs. on 12/18/2024 (a weight gain of 3.4 lbs. in 1 day), 137.0 lbs. on 12/20/2024 (a weight gain of 6.2 lbs. in 6 days from 12/14/2024), 137.8 lbs. on 12/22/2024, 140.4 lbs. on 12/23/2024 (a weight gain of 2.6 lbs. in 1 day), 141.7 lbs. on 1/5/2025, and 144.4 lbs. on 1/6/2025 (a weight gain of 3.3 lbs. in 1 day). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 1/8/2025 at 12:50 PM identified she was unaware Resident #8 had a PRN diuretic order. RN #3 identified there was no instruction in the daily weight order to direct her to Resident #8's diuretic order for an extra dose of bumetanide 1mg as needed for weight increased 2 lbs. in one day or 5 lbs. in one week and to notify the provider. Subsequent to surveyor inquiry, there was a new Provider order dated 1/8/2025 for daily weights which contained instructions that directed to administer an extra dose of bumetanide 1 mg if Resident #8's weight increased 2 lbs. in one day or 5 lbs. in one week, and to notify the provider. Interview with RN #2 on 1/9/2025 at 3:00 PM identified she did not notify MD #1 of a 6.2 lb. weight gain in 6 days on 12/20/2024 nor did she administer the PRN bumetanide because she did not know the accuracy of the weight entries and she was unaware Resident #8 had a PRN diuretic order for bumetanide 1 mg for an increased weight of 2 lbs. in one day or 5 lbs. in one week. RN #2 further identified she was unaware of Resident #8's PRN bumetanide order until 1/6/2025 after reporting a 3 lb. weight gain in 1 day for Resident #8 to MD #1. Review of the Progress Notes report dated 1/10/2025 identified there was no documentation of an extra dose of bumetanide 1mg administered PRN on 12/18/2024, 12/20/2024, or 12/23/2024. Interview with RN #4 on 1/10/2025 at 11:00 AM identified Resident #8 had both a scheduled dose of bumetanide 1mg and a PRN order for bumetanide 1 mg. RN #4 stated the PRN bumetanide order was ordered for administration for weight increased 2 lbs. in one day or 5 lbs. in one week. RN #4 could not identify why weight gain parameters or instructions to administer a PRN dose of bumetanide were not included in the daily weight order or how nurses would know to look in the PRN orders without these instructions. RN #4 identified that the daily weight order for Resident #8 had been revised to include weight parameters with instructions for utilization of Resident #8's PRN bumetanide. Review of the Congestive Heart Failure policy identified weights will be obtained daily and a weight that has increased 3 lbs. in one day or 5 lbs. in one week will be reported to the provider. The policy failed to include direction for utilization of medications per provider orders for management of weight gain. 2. Resident #36 was admitted to the facility in October of 2024 with diagnoses that included hypertension, chronic kidney disease, diabetes and dermatophytosis (a common fungal infection of skin, hair or nails). The admission Minimum Data Set (MDS) assessment dated [DATE] identified the Resident #36 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required maximum assistance for toileting, bed mobility and transfers, moderate assistance for personal hygiene and was dependent for bathing. The MDS further identified that Resident #36 was always incontinent of urine and bowel, was at risk of developing pressure ulcers/injuries and had moisture associated skin damage (MASD) at the time of admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident Care Plan dated 10/21/24 identified Resident #36 was at risk for alteration in skin integrity. Interventions included applying medicated cream to fungal rash as needed, assessing heels for redness, offloading heels with blue bolster while in bed, cleansing and drying skin folds thoroughly related to chronic rash due to moisture, encouraging/assisting with periodic repositioning to avert pressure injuries, using pressure reducing mattress, completing skin audit on admission and weekly, monitoring skin during care and reporting any changes or concerns and monitoring feet closely for changes in skin integrity. Review of Physician's orders dated 11/1/24 identified an order for weekly skin assessments. Further review of physician's orders identified an order to complete a skin check every shift over bony prominences for redness, blanching and integrity and to document and notify the physician of changes. Review of the Treatment Administration Record dated 11/1/24 identified a physician order to complete skin check over bony prominences for redness, blanching and integrity and to document and notify the physician of changes. Further review identified that nurses were documenting the order as administered on all three shifts. Review of progress notes dated 10/17/24 through 1/9/24 failed to identify documentation of weekly skin assessments/condition or refusals. Review of the clinical record from 10/17/24 through 1/9/25 identified skin assessments dated 10/18/24, 10/25/24, 11/1/24, 11/8/24, 11/20/24, 12/5/24 and 12/16/24. The record failed to identify skin assessments from 12/16/24 through 1/9/25. Interview and record review with RN #5 on 1/9/25 at 1:30 PM identified that skin checks/assessments are completed weekly by a licensed nurse on shower days. RN #5 was not able to identify documentation of weekly skin assessments after 12/16/24 in the electronic medical record (EMR) or paper chart. RN #5 identified that skin assessments should have been completed on 12/23/24, 12/30/24 and 1/6/25 and results documented in Resident #36's clinical record. RN #5 was unable to explain why weekly skin assessments were not completed for 3 consecutive weeks. Interview with the DNS on 1/9/25 at 3:00 PM, identified that skin assessments should be completed weekly by a licensed nurse on shower days and documented in the EMR. The DNS was unable to explain why Resident #36's weekly skin assessments were not completed for 3 consecutive weeks but indicated that the facility recently transitioned to a new charting system and staff were still learning the new system. The DNS indicated that after 1 assessment was missed, the missed assessment would stop subsequent assessments from automatically triggering when due. Subsequent to surveyor inquiry, a skin assessment was completed and documented in the clinical record on 1/9/25. No alteration in skin integrity was identified. Review of facility policy titled, Protocols for Prevention of Pressure Ulcers, Identified, in part, routine skin inspection is done daily when care is being provided by the nurse aid. Any changes in skin integrity are reported to the nurse for assessment such as reddened or open areas, edema and spongy or blistered areas. Skin assessment and documentation is done on admission by the nurse and then weekly (usually on bath day) by the nurse aide with the nurse assessing any changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51183

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 3 residents (Resident #36) reviewed for weight changes, the facility failed to obtain weights per facility policy. The findings include: Resident #36 was admitted to the facility in October of 2024 with diagnoses that included hypertension, hypo-osmolarity and hyponatremia (fluid and electrolyte imbalance), chronic kidney disease, and diabetes. Review of the hospital Discharge Summary document dated 10/17/24 identified that Resident #36 was discharged on [DATE] and a weight of 199.0 pounds (Lbs) was obtained on 10/17/24. A Dietary/Nutrition Profile note dated 10/20/24 at 9:44 AM by the Dietician identified that Resident #36 was at risk for altered nutrition due to abnormal labs, diabetes with Hemoglobin A1C (average blood sugars in blood during the past 2 to 3 months) of 7.0 (normal range: below 5.7%) and hyponatremia (low blood sodium level) which improved upon being discharged from the hospital. The note identified a reweight request which was not reflected in the clinical record. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required maximum assistance for toileting, bed mobility and transfers and moderate assistance for personal hygiene. A Resident Care Plan dated 10/21/24 identified Resident #36 was at risk for nutritional deficit. Interventions included administering a carbohydrate consistent diet, dietary counseling as needed, monitoring blood sugar as ordered, monitoring for digestive complaints as needed, monitoring labs as needed, monitoring weights per physician order, seeing resident for meal preferences, and skin checks as ordered. Review of the Weights and Vitals Summary identified the following weights: 10/18/24: 181.2 pounds (Lbs.), 10/30/24: 181.2 Lbs., 11/14/24: 181.2 Lbs., 12/2/24: 226.2 Lbs., 12/3/24, 227.9 Lbs., and 12/16/24, 226.4 Lbs. Resident #36's weights for 10/30/24 (181.2 Lbs.) and 11/14/24 (181.2Lbs.) were struck out on 12/9/24 by RN #6 as incorrect documentation. Interview and clinical record review with RN #6 on 1/9/25 at 1:35 PM, identified that she documented weights on 10/30/24 and 11/14/24 in the Electronic Medical Record (EMR). RN #6 indicated that on 12/9/24 she struck out the 10/30/24 and 11/14/24 weights because she thought the weights were incorrect based on a significant weight gain reflected on 12/3/24. RN #6 was unable to explain why Resident #36 was not weighed weekly for 4 weeks post admission to the facility or why Resident #36 was not reweighed on 10/18/24 due to the discrepancy between hospital discharge weight and the facility admission weight. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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	Interview and clinical record review with the DNS on 1/9/25 at 3:20 PM, identified Resident #36 should have been weighed on admission and then weekly for 4 weeks according to the facility weight policy. The DNS identified that NA ' s are responsible for obtaining weights under the direction of the unit manager. The DNS identified licensed nurses are responsible for ensuring weights are documented in the EMR and for updating the provider, family and dietician of weight changes. The DNS was unable to explain why a reweight was not obtained subsequent to the facility admission weight reflecting a significant weight loss of 17.8 Lbs (8.94%) between 10/17/24 (199 Lbs.) and 10/18/24 (181.2 Lbs.) or why a reweight was not obtained on 10/20/24 as directed by the dietician. The DNS was unable to explain why Resident #36 ' s weights were obtained and documented on 10/30/24 as 181.2 Lbs. and on 11/14/24 as 181.2 Lbs. then struck out 1 month later (on 12/9/24) by RN #6 with a documented reason of: inaccurate documentation. The DNS was unbale to provide documentation that interventions were initiated for Resident #36 due to a significant weight increase of 27.2 Lbs. (13.67%) between 10/17/24 (199.0Lbs) and 12/2/24 (226.2 Lbs.). Subsequent to surveyor inquiry, the EMR was updated to reflect the following late entry weights: 10/28/24: 215.2 Lbs. and 11/25/24: 189.3 Lbs. Interview with the Unit Nurse Manager (RN #4) on 1/10/25 at 11:30 AM, identified that all weights should have been documented in the EMR after Resident #36 was weighed and further indicated that if weights were not documented, it means they were not done. Review of facility policy titled, Policy and Procedure for Weights/Re-weights, identified in part, that, each Health Center resident will be weighed upon admission and then once weekly for four weeks, then monthly on bath days unless specified by the physician. When a significant weight loss or gain occurs (5 Lbs.), the following measure will be implemented. a). Resident will be reweighed to ensure accuracy. If weight loss is confirmed, Dietician will be notified. b) Consultant dietician will reassess during the next visit. c) Physician and family will be notified by nursing staff as appropriate. d). Documentation in nurses notes that weight loss has taken place, and the physician, Dietician and family have been notified. Weights are recorded in the EMR. Supervisor/designee will review weights weekly and report concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the clinical record, facility policy and interviews for the only sampled resident (Resident #8) reviewed for urinary tract infections (UTI), the facility failed to timely start treatment for a resident with a confirmed infection. The findings include: Resident #8 was admitted to the facility in December of 2024 and had diagnoses that included cellulitis of left lower limb, dementia, and congestive heart failure. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 10) and was dependent for eating, toileting hygiene, and transfers. The Resident Care Plan (RCP) dated 1/2/2025 identified Resident #8 was at risk for infection related to chronic illness, and a history of bacteremia and cellulitis. Interventions included encouragement and assistance with good hand hygiene, and social distancing as indicated. The RCP further identified Resident #8 had a self-care deficit and required assistance with activities of daily living. Interventions included staff assistance with toileting. A provider order dated 12/31/2024 directed to obtain a clean catch urine specimen for laboratory testing for urinalysis (UA) with culture and sensitivity (C&S) related to Resident #8 ' s complaint of dysuria. A Nursing progress note by RN #4 dated 12/31/2024 at 5:11 PM identified Resident #8 had complaints of dysuria which was reported to MD #1, and a new order to obtain a (UA)/(C&S) was obtained. A Nursing progress note by RN #7 dated 12/31/2024 at 10:39 PM identified that a clean catch urine specimen had been obtained for UA/C&S and the laboratory was called for pickup. A provider order dated 1/3/2025 directed to administer cephalexin 500mg by mouth 2 times a day for 7 days related to cellulitis of the left lower limb. A Nursing progress note by RN #7 dated 1/3/2025 at 11:17 PM identified an order had been obtained from MD #1 for cephalexin 500 milligrams (mg) by mouth 2 times a day for 7 days related to cellulitis of the left lower limb and Resident #8's family had been updated. A Laboratory report dated 1/6/2025 at 11:37 AM identified Resident #8 had a positive UA which triggered a culture be performed and the C&S results identified Resident #8 had growth of 2 different bacteria and further provided a list of antibiotic medications which would be effective treatments. The list contained the antibiotic ciprofloxacin which both bacteria were sensitive to. A provider order dated 1/6/2025 directed to administer ciprofloxacin 500 mg by mouth 2 times a day for 7 days for UTI. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing progress note by RN #4 dated 1/6/2025 at 2:26 PM identified MD #1 reviewed the C&S results, Resident #8 was positive for a UTI, a new order for ciprofloxacin 500 mg by mouth 2 times a day for 7 days was obtained, and Resident #8's family member was notified. A Nursing progress note by RN #7 on 1/6/2025 at 8:29 PM identified that ciprofloxacin 500mg was not available for administration in the Omnicell (automated medication dispensing system used to ensure the availability of certain medications) or medication cart. The progress note failed to identify that the provider had been notified. A Nursing progress note by RN #7 on 1/6/2025 at 11:05 PM identified Resident #8 was to start on ciprofloxacin, but the facility was waiting for the ciprofloxacin delivery from the pharmacy and ciprofloxacin was unavailable in the Omnicell. The progress note failed to identify that the provider had been notified. Review of the Administration Record report dated 1/10/2025 for the Medication Administration Record from 1/1/2025 through 1/31/2025 identified documentation that Resident #8 ' s first dose of ciprofloxacin 500 mg was administered on 1/7/2025 at 8:00 AM (this administration was more than 17 hours after documentation of order receipt of ciprofloxacin from MD #1). Interview with the DNS on 1/10/2025 at 11:30 AM identified antibiotics stocked in the facility Omnicell are automatically ordered by the computer when items are removed by the nurses and the pharmacy is efficient at filling those orders. The current facility stock for ciprofloxacin was verified and revealed 2 ciprofloxacin 250 mg capsules with an expiration date of 8/2025 and 4 ciprofloxacin 250mg capsules with an expiration date of 12/2025. The Omnicell did not contain ciprofloxacin in a dosage form of 500mg. The DNS stated she was confident the ciprofloxacin 250mg capsules were available for administration on 1/6/2025, that RN #7 would only have needed to remove 2 capsules, and could not identify why RN #7 had documented the medication was unavailable in the Omnicell. The DNS identified that after completion of the shift on 1/6/2025 RN #7 had resigned without notice. Interview with MD #1 on 1/10/2025 at 12:08 PM identified that she had not been notified that Resident #8 had not started antibiotic treatment for his/her UTI until 8:00 AM on 1/7/2024 because the medication was unavailable for administration. Interview with RN #7 on 1/10/2025 at 2:50 PM identified she did not administer ciprofloxacin 500 mg to Resident #8 on 1/6/2025 at 8:00 PM because it was not in the Omnicell. RN #7 identified she did not know ciprofloxacin 250mg was available in the Omnicell. Review of the Policy on Physician's Orders identified if a medication is not available the provider will be notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Essex Meadows Health Center	30 Bokum Rd Essex, CT 06426

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the clinical record, facility policy and interviews for 1 of 5 residents (Resident #38) reviewed for unnecessary and psychotropic medications, the facility failed to enter a 14 day stop date for an as needed antipsychotic medication. The findings include: Resident #38 was admitted to the facility in November of 2024 and had diagnoses that included personal history of malignant neoplasm, severe sepsis with septic shock, and generalized anxiety disorder. A Provider order dated 11/29/2024 directed to administer prochlorperazine maleate (antiemetic-vomit prevention) 5 milligrams (mg) by mouth every 6 hours as needed for nausea/vomiting. The Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #38 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), had no issues found during a drug regimen review, required setup or clean-up assistance with oral hygiene, partial/moderate assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 12/4/2024 identified Resident #38 received psychotropics related to nausea and the prescribed medication was classified as an antipsychotic. Interventions included to administer psychotropic medications as ordered and monitor for efficacy and side effects. The RCP further identified Resident #38 required medication management related to chemotherapy. Interventions included administration of medications per provider orders and pharmacy review of medications. A Pharmacy Consultation Report dated 12/29/2024 from the Consultant Pharmacist failed to identify a recommendation for a 14 day stop date for the antipsychotic medication prochlorperazine maleate. Review of the Administration Record Report dated 1/10/2025 identified Resident #38 was administered prochlorperazine maleate 5 mg by mouth on 12/16/2024 at 12:08 PM, 12/19/2024 at 1:24 PM, 12/19/2024 at 9:31 PM, 12/23/2024 at 8:36 AM, 1/1/2025 at 4:07 PM, 1/7/2025 at 12:15 PM, and 1/9/2025 at 7:50 AM. This was a total of 7 administrations of prochlorperazine maleate 5 mg as needed beyond 14 days from the provider order date of 11/29/2024. Interview with the Consultant Pharmacist on 1/10/2025 at 10:22 AM identified prochlorperazine maleate is classified as an antipsychotic and when ordered on an as needed basis, requires a 14 day stop date. The Consultant Pharmacist stated she missed this medication order during her medication review for Resident #38, and that she would make a recommendation to the facility to add a stop date to the order for prochlorperazine maleate or change the order to a different antiemetic medication. Review of the Psychoactive Drug Management policy directed, in part, monthly pharmacy consultant reviews would be conducted to ensure appropriate diagnosis, indication, dose, monitoring for effectiveness, monitoring for side effects and adverse consequences, and potential for gradual dose reductions.