| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075323 | A. Building<br>B. Wing | 04/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cambridge Health and Rehabilitation Center | 2428 Easton Tnpk<br>Fairfield, CT 06825 |

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) |
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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for one of two sampled residents (Resident #2) who were reviewed for an allegation of neglect, the facility failed to ensure Resident #2 was checked and provided incontinent care from 12:30 AM until 5:30 AM. The findings include:<br><br>Resident #2's diagnoses included subdural hemorrhage, aphonia (loss of the voice), dysphonia (difficulty speaking), and seizures.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily living, required extensive assistance with toileting and personal hygiene, and was incontinent of bowel and bladder.<br><br>The Resident Care Plan dated 1/31/24 identified bladder incontinence secondary to impairment of mobility and benign prostate hypertrophy.<br><br>Interventions directed to clean the peri-area, check every two (2) to four (4) hours and change as required, to wash, rinse, and dry the perineum, change clothing as needed, monitor for signs and symptoms of urinary tract infection, and offer toileting in the morning, after meals and at bedtime.<br><br>The Facility Reported Incident form dated 4/9/24 identified Resident #2 had not been provided incontinent care from 12:30 AM until 5:30 AM, five (5) hours. The report identified that due to a staff change in assignments, the staff member assigned to Resident #2 forgot Resident #2 was assigned to her.<br><br>Interview with the 11PM-7AM nurse aide, Nurse Aide (NA) #1, on 4/26/24 at 12:41 PM identified on 4/9/24 Resident #2 received incontinent care at 12:30 AM by another nurse aide assigned to the unit, NA #2. NA #1 identified she was assigned to the care for Resident #2 throughout the shift. NA #2 identified at approximately 3:00 AM she went on her break and thought NA #2 had provided care to Resident #2 again and upon return from break she resumed care to residents on the other part of her assignment. NA #1 identified she did not provide incontinent care to Resident #2.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1 on 4/26/24 at 1:09 PM identified she was aware Resident #2 had received incontinent care from NA #2 at 12:30 AM. LPN #1 identified she reminded NA #1 throughout the shift that Resident #2 needed frequent checks as Resident #2 had frequent falls. LPN #1 identified at approximately 5:30 AM Resident #2 was found on the floor in the bathroom with a saturated brief.<br><br>Interview with the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #3, on 4/29/24 at 9:25 AM identified on 4/9/24 she was notified that NA #1 was not providing care to the residents and at approximately 5:30 AM Resident #2 was found on the floor in the bathroom with a saturated brief. RN #3 identified she asked NA #1 when the last time Resident #2 had been changed and NA #1 reported Resident #2 had been changed at 12:30 AM by NA #2. RN #3 identified NA #1 admitted she had not checked on Resident #2 until the time Resident #2 was found on the floor at 5:30 AM, five (5) hours later. RN #3 identified facility policy is for incontinent care to be provided to residents every two (2) hours.<br><br>Interview with the Director of Nursing (DON) on 4/29/24 at 11:51 AM identified the facility policy directs for incontinent care to be provided every two (2) to four (4) hours and it was the responsibility of the charge nurses to ensure the nurse aides are providing this care. The DON identified on 4/9/24 it was reported that Resident #2 had not received incontinent care from 12:30 Am until 5:30 AM, five (5) hours and when NA #1 was questioned she reported she had attempted to go to give care to Resident #2 at 2:30 AM, but got called in a different direction, then went on her break and never provided care to Resident #2 upon return from break.<br><br>The facility policy titled Activities of Daily Living (ADL), directed in part, ADLs are the essential tasks that each person needs to perform, on a regular basis, to sustain basic survival and well-being. The policy directed staff are to provide assistance to complete ADL activities per the person-centered evaluation and care plan including toileting and toilet hygiene and personal hygiene and grooming. The Policy included the CNA (certified Nurse's Aide) Standard of Care/Information Sheet, which directed to toilet/offer to toilet every two (2) to four (4) hours (offer bedpan, urinal, commode, or toilet as appropriate). |

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| F 0694<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223<br><br>Based on clinical record reviews, facility documentation review, facility policy review, and interviews for one of three sampled residents (Resident #3) who had poor nutritional intake and required intravenous therapy, the facility failed ensure the resident's intake and output was monitored when receiving the intravenous fluids. The findings include:<br><br>Resident #3 was admitted with diagnoses that included congestive heart failure, atrial fibrillation, thrombocytopenia, chronic obstructive pulmonary disease and myelodysplastic syndrome (a group of syndromes that disrupts the production of red blood cells).<br><br>The annual Minimum Data Set assessment dated [DATE] identified Resident #3 was alert and oriented.<br><br>The Resident Care Plan dated 11/16/23 identified Resident #3 had anemia with myelodysplastic syndrome and a potential for fluid deficit due to poor fluid intake.<br><br>Interventions directed medication as per physician order, monitor hemoglobin and hematocrit, ensure access to fluids, monitor vital signs as ordered, signs and symptoms of dehydration, and record, notify physician as appropriate.<br><br>A physician's order dated 12/3/23 directed Normal Saline (NS) 0.9 percent (%) 75 milliliters (ml) per hour intravenously every shift for poor appetite/lethargy for one (1) day.<br><br>The nursing note dated 12/4/23 at 4:30 PM identified Resident #3's left hand peripheral intravenous (IV) line flushed freely, and IV hydration was completed at 9:30 AM.<br><br>A review of the December 2023 Medication Administration Record (MAR) identified Resident #3 received Normal Saline (NS) 0.9 percent (%) 75 ml per hour intravenously every shift for poor appetite/lethargy for one (1) day starting on 12/3/23 and ending on 12/4/23.<br><br>A physician's order dated 12/16/23 directed Dextrose 5 percent (D5W)/ NS .45 % at 50 ml per hour intravenously every shift for poor appetite times one (1) bag for one (1) day.<br><br>The nursing progress note dated 12/17/23 at 4:28 PM identified Resident #3 had an intravenous line (IV) to left forearm infusing IV hydration as ordered.<br><br>Review of the December 2023 MAR identified Resident #3 received Dextrose 5 percent (D5W)/ NS .45 % at 50 ml per hour intravenously every shift for poor appetite times one (1) bag for one (1) day from 12/17/23 to 12/18/23.<br><br>Although requested, the facility was unable to provide documentation of intake and output monitoring for Resident #3 while receiving the IV fluids.<br><br>Interview with the Director of Nursing (DON) on 4/20/24 at 1:30 PM identified that she would expect the nursing staff to complete intake and output monitoring while a resident is receiving intravenous fluids.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Although requested, the facility was unable to provide a policy for intake and output or nursing care of a resident while receiving IV fluids. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for one of two sampled residents (Resident #1) who were reviewed for significant medication errors, the facility failed to ensure the medications were reconciled when Resident #1 was readmitted to the facility from the hospital. The findings include:<br><br>Resident #1's diagnoses included pleural effusion, diabetes, congestive heart failure, atherosclerotic heart disease and paroxysmal atrial fibrillation.<br><br>The admission assessment dated [DATE] identified Resident #1 was alert and oriented.<br><br>The Resident Care Plan dated 3/23/24 identified an alteration in cardiac status. Interventions directed to administer medications as ordered, lab work as ordered, diet as ordered, vital signs and weights as ordered, cardiac follow up as indicated, and to monitor, document, and report any signs or symptoms of coronary artery disease.<br><br>The nurse's note dated 3/28/24 at 7:30 PM identified Resident #1 complained of nausea and vomiting along with an increased and irregular heart rate. The note identified the provider was notified and an order was received to send Resident #1 to the Emergency Department (ED).<br><br>The hospital inter-agency referral report dated 3/31/24 identified Resident #1 had a new medication to treat atrial fibrillation, irregular heartbeat, and heart failure, Digoxin 0.125 milligrams (mg) give once daily and change to Diltiazem CD 240 mg capsule to be given nightly.<br><br>The nurse's note dated 4/4/24 at 10:05 AM identified at approximately 9:35 AM Resident #1 became unresponsive and quickly began to respond. The note identified Resident #1's heart rate was 136, the Advanced Practice Registered Nurse (APRN) was notified, and an order was received to send Resident #1 to the ED.<br><br>The nurse's note dated 4/4/24 at 8:56 PM identified Resident #1 returned from the hospital, diagnoses included atrial fibrillation with rapid ventricular response, and a new order directed to administer Digoxin 125 micrograms (mcg), Toprol 200 mg daily, and Diltiazem 240 mg daily.<br><br>A physician's order dated 4/5/24 directed to give Digoxin 125 mcg once a day and Diltiazem CD 240 mg capsule once a day.<br><br>Review of the physician orders and the March and April 2024 Medication Administration Records (MAR) failed to reflect documentation the Digoxin 0.125 milligrams (mg) give once daily and Diltiazem CD 240 mg capsule to be given nightly were reconciled with the physician/APRN and if so, were transcribed onto the MAR. The April MAR identified four (4) doses of the Digoxin and Diltiazem CD were omitted.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with the 7PM-7AM weekend Nursing Supervisor, Registered Nurse (RN) #1, on 4/26/24 at 11:39 AM identified the facility policy on readmission was to confirm the medications, review them with the provider and then put them in the electronic medical record (eMAR). RN #1 identified it was the responsibility of the nurse performing the admission to ensure the medication reconciliation was done. RN #1 identified she was assigned to the admission for Resident #1 and thought the 7AM-7PM Nursing Supervisor, RN #2, had completed the medication reconciliation. RN #1 identified Digoxin and Diltiazem CD were omitted from the orders.<br><br>Interview with the 7AM-7PM weekend Nursing Supervisor, RN #2, on 4/29/24 at 9:44 AM identified the policy for medication reconciliation when a resident was readmitted , the admitting confirmed the medications with the provider. RN #2 identified Resident #1 arrived for readmission to the facility on [DATE] at approximately 5:30 PM. RN #2 stated she reactivated Resident #1 into the electronic medical record but was unable to reconcile the medications during her shift. RN #2 identified she gave report to RN #1 and explained she reactivated Resident #1 in the electronic medical record but was unable to reconcile the medications during her shift. RN #2 identified she stayed after her shift ended and prior to leaving the facility she noticed RN #1 had not addressed the medication reconciliation. RN #2 stated she informed RN #1 she would reactivate any medications that were unchanged from prior to hospitalization , but RN #1 would have to address any new medications.<br><br>Interview with the Director of Nursing (DON) on 4/29/24 at 11:41 AM identified the facility policy for medication reconciliation when a resident was readmitted was to obtain the discharge information, transcribe the medications and either give it to the provider who is in the building or do a telehealth visit with the provider after hours using the iPad using a medication reconciliation sheet. The DON identified it was the admitting nurse who was responsible for this during the week, and the supervisor after hours and on weekends. The DON identified it was her expectation that if an admission returns to the facility during the nurse's shift, that nurse would get the orders in and validated. The DON stated RN #1 did not reconcile the medications and Resident #1 missed receiving two (2) cardiac medications (Digoxin and Diltiazem CD) for a few days.<br><br>The facility policy titled Medication Reconciliation, last revised April 2023, directed, in part, the medication reconciliation process is to be completed at admission, re-admission, and discharge by nursing staff. The policy further directed, the purpose is to identify clarifications and discrepancies that need to be resolved with the resident's primary care physician/practitioner to ensure the resident's safety and prevent negative outcomes as it relates to medication management.<br><br>The facility policy titled Admission, Discharge policy, last revised October 2023, directed, in part, a medication reconciliation will be completed in the electronic health record, by the licensed nurse, and orders are reviewed, and discrepancies resolved with the attending healthcare provider when validating admission/re-admission orders. |