STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075332	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valerie Manor	1360 Torringford St Torrington, CT 06790

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 42117 Based on review of the facility documentation and interviews for Resident Council funds, the facility failed to ensure resident council funds were utilized appropriately. The findings include: 1. Resident council meeting interview with Resident #8, #38, #44, #53, and #108 on 4/22/24 at 10:00 AM indicated Resident Council pays for bingo prizes, gift cards for the volunteers in addition to entertainment and art classes. Resident #44 identified his/her understanding was in order to have music, entertainment, art/painting classes that the Resident Council had to pay for it and the facility does not provide the entertainment. Resident #8, #38, #44, #53, and #108 all indicated they were obligated to vote yes in Resident Council to the music, entertainment, and art classes in order to have these activities at the facility. A review of the Resident Council minutes for the period of January 2023 to April 2024 identified evidence of the voting for the use of the Resident Council Funds. Interview with Administrator on 4/23/24 at 2:27 PM indicated that Resident Council funds can be used for whatever the residents want like donating to charities or host special events or a party, or a juke box for the residents. The Administrator indicated that the Resident Council would have to agree and vote on what that money is used for. The Administrator indicated the facility pays for a monthly budget to the recreation department for art supplies, other supplies needed, and entertainment including music. A review of the Resident Council bank statements dated 2/1/23 - 2/29/24 identified the resident council funds were paying for music entertainment 1 to 2 times a month for $100-$200 each time. A review of the Resident Council bank statements dated 9/1/23 to 3/31/24 identified resident council paid for the art/painting class at $100 per hour for 5 times (once a month) and additionally paid $50 for art supplies. A review of the Resident Council bank statements dated 6/1/23 to 4/30/24 identified miscellaneous art supplies, gift cards for volunteers, and supplies items including candy for the gift shop. The amount totaling more than $568. (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Director of Recreation (TRD) on 4/23/24 at 2:45 PM indicated the facility provides $700 a month for entertainment but the residents want more music and the residents agreed to pay for the entertainment out of the resident council funds every month. The TRD indicated that the art supplies were paid for by the facility and some from the Resident Council funds because her budget was too small for all the supplies needed. The TRD indicated she did not discuss the possibility of increasing the recreation budget with the Administrator. 2. A review of the Resident Council Bank statements dated 1/1/21 to 1/2/24 identified the resident council funds paid for the annual licensure fee of $55 to the local health district for the beauty salon on 3/21/21, 1/1/22, 12/28/22, and 1/2/24. Interview with local Health Department on 4/23/24 at 1:19 PM indicated the expense of $55 a year was for one beauty salon chair to be licensed at the facility and is renewed annually. Person #1 indicated the fee was paid every year, and the last payment was 1/5/24 for $55 with check #1084 (from the Resident Council funds). Interview with Administrator on 4/23/24 at 2:40 PM indicated that the license for the facility beauty salon chair should be paid for by the facility not the Resident Council. The Administrator indicated that she was not aware that the residents were paying for the art class instructor monthly, weekly music entertainment, and for the beauty salon chair license as has not reviewed the resident council funds and how they are dispersed. Although requested, a facility policy for resident council funds was not provided.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42117 Based on review of the clinical record, review of facility documentation, and interviews for 1 sampled resident (Resident #63) reviewed for insulin administration, the facility failed to notify the APRN/MD and responsible party of a blood glucose reading exceeding the ordered parameters; and for 1 of 2 residents (Resident #114) reviewed for medications, the facility failed to ensure the physician was notified of refusal of medication. The findings include: 1. Resident #63 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, end stage renal disease, and dependence on renal dialysis. The quarterly MDS assessment dated [DATE] identified Resident #63 had intact cognition, was independent with eating, had taken a hypoglycemic medication during the last 7 days, and required dialysis while a resident at the facility. The care plan dated 1/17/24 identified Resident #63 has diabetes; therefore, blood sugars may fluctuate. Interventions included administering insulin/medications as ordered, providing lab work/diagnostic tests as indicated, and updating the physician as indicated. A physician's order dated 3/17/24 directed to check blood sugar, two times daily every Monday and Thursday; notify physician if results are less than 70 or greater than 300. The weights and vitals summary dated 3/1/24 through 4/22/24 identified blood sugars greater than 300 on the following days: 3/10/24 at 6:57 AM blood sugar reading of 378 mg/dl 3/18/24 at 5:39 AM blood sugar reading of 311 mg/dl 4/01/24 at 5:07 PM blood sugar reading of 337 mg/dl 4/11/24 at 4:50 PM blood sugar reading of 487 mg/dl A review of the nursing progress notes dated 3/10/24 through 4/22/24 failed to identify the physician/APRN was notified of the blood sugars greater than 300 mg/dl on 3/10, 3/18, 4/1, and 4/11/24. Interview with the night nursing supervisor (RN #4) on 4/22/24 at 6:50 AM identified that if the charge nurse obtains a blood sugar reading that is outside of the ordered parameters, she is expected to report it to the RN supervisor and the RN supervisor would then notify the physician/APRN. RN #4 further identified that either the charge nurse or the RN supervisor would document in the progress note that the blood sugar was reported to the physician/APRN and any new orders, if applicable. Interview with MD #1 on 4/22/24 at 11:35 AM identified that if a blood sugar parameter is part of the order, the physician/APRN should be notified if the reading falls outside of the parameter so a new treatment order can be written, if necessary. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 4/22/24 at 8:37 AM failed to identify that the physician/APRN was notified of the blood sugars greater than 300 mg/dl on 3/10, 3/18, 4/1, and 4/11/24. The DNS indicated that he would expect the charge nurse to notify the physician/APRN for a blood sugar reading exceeding parameters, as the provider may want to put in new orders. The DNS further indicated that he would complete an in-service educating charge nurses on reporting values that exceed ordered parameters to the physician/APRN. The facility's Significant Change policy directs professional staff to communicate with the physician, resident/patient, and family regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management. The policy further directs that the physician, resident/patient, and/or responsible party will be notified by the nurse in the event of a change in condition, order changes given by the physician would be carried out, and the notification shall be documented in the clinical record. 2. Resident #114 was admitted to the facility on [DATE] with a diagnosis of diabetes, severe protein calorie malnutrition, mild cognitive impairment, and pain. A physician's order dated 4/5/24 directed to administer Lidocaine Viscous HCL mouth/throat suspension 2% give 5 ml by mouth before meals for mouth pain. The Medicare 5-day MDS assessment dated [DATE] identified Resident #114 had intact cognition and has pain frequently. The April 2024 care plan dated identified potential for pain. Interventions included administering pain medications as ordered and assessing resident for pain. Observation of RN #2 medication administration on 4/21/24 at 9:42 AM Resident #114 refused the Lidocaine Viscous and stated he/she does not like how it tastes and everything after it tastes horrible. RN #2 indicated that she would have to notify the physician because the physician had ordered the Lidocaine Viscous. Resident #114 indicated to RN #2 to call the physician and tell the physician that he/she was not going to take this medication anymore because it tastes horrible and makes everything else taste horrible. RN #2 indicated she would discard the Lidocaine Viscous and notify the physician. Interview with MD #1 on 4/22/24 at 11:53AM indicated that on 4/21/24 and 4/22/24 that no one had notified him Resident #114 had refused the Lidocaine Viscous. MD #1 indicated if Resident #114 had refused any medication he would want and expect to be notified about it. MD #1 indicated if the APRN or physician were notified he would expect it in a progress note. Interview with the DNS on 4/22/24 at 3:35PM indicated if a resident refused any medication that the nurse would update the APRN or physician and the resident's representative and document it in the progress notes in the medical record. Interview and clinical record review with the DNS on 4/22/24 at 4:00 PM indicated that there was not a progress note identifying that the APRN/MD was notified of the medication refusal on 4/21/24 including the reason for refusal. Although requested, a facility policy for refusal of medications was not provided.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42117 Based on review of the facility documentation, employee files, and interviews for 6 out of 6 (NA #2, NA #6, LPN #5, LPN #6, RN #2, and RN #6) personnel files reviewed, the facility failed to ensure the required references and background checks were completed prior to hire. The findings include: Interview and review of personnel files with the Director of Human Resources (HR) on 04/23/24 at 12:11 PM indicated that she was responsible to make sure all employee files were completed at hire. HR indicated that she was responsible to do the background checks and get the 2 professional references. HR indicated that she is responsible to make sure the employee files were complete prior to the employee starting. HR once employment is offered to someone then the potential employee will come back to the facility and fill out the background form and she enters ABCMS and then ABCMS will tell if already had fingerprints or need fingerprints. HR indicated that if a potential new employee need fingerprints ABCMS will tell her immediately if they need fingerprints. HR will call the new employee to inform the new employee they need to go to state police and get fingerprinted. HR indicates that ABCMS will notify her when the fingerprints were taken and another email regarding the when the eligibility is available, then she will sign into ABCMS to see the results. HR indicated she was aware that she should print the eligibility form and place it in every employee file. Review of employee files with HR identified: 1. NA #2 date of hire was 5/30/22. HR indicated NA #2 employee file lacked a new complete background check/eligibility form and 2 professional references prior to hire/transfer and allowing NA #2 to work at the facility. 2. NA #6 date of hire was 5/1/06. HR indicated NA #6 employee file lacked the complete background check/eligibility form and allowing NA #6 to work at the facility. 3. LPN # 5 date of hire 11/17/20. HR indicated LPN #5's employee file lacked a complete background check/eligibility form and 2 reference checks prior to hire and allowing LPN #5 to work at the facility. 4. LPN #6 date of hire 3/8/22. HR indicated LPN #6's file lacked background check/eligibility form and the 2 professional references needed prior to allowing LPN #5 to work in the facility. 5. RN #2 date of hire 5/31/22. HR indicated RN #2 file lacked the background check/eligibility form and lacked the 2 professional reference checks prior to allowing RN #2 to work at the facility. 6. RN #6 date of hire 7/5/22. HR indicated RN #6 file lacked the background check/eligibility form prior to allowing RN #6 to work at the facility. The Administrator on 4/23/24 at 1:10 PM indicated she was now aware that the references and background checks were not being completed prior to hire. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Abuse Prohibition Policy identified screening of personnel for a history of abuse. Screening of all personnel is part of the hiring processes a criminal background check will be required. In addition, a minimum of 2 reference checks. This information will be documented and kept in a separate file in Human Resources. The Human Resources New Hire Checklist identified that pre-offer paperwork for all employee files will have completed and signed 2 references and the ABCMS completed and signed fingerprinting information form. Pre-hire If employee was a transfer from another facility must call the previous facility for a reference. Additionally, must print the ABCMS eligibility form from the Application tab.

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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** 47457 Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #63) reviewed for dialysis, the facility failed to complete vital sign monitoring in accordance with the physician's order and for 1 of 1 resident (Resident #94), reviewed for abuse, the facility failed to ensure neurological monitoring was conducted in accordance with the facility policy. The findings include: 1. Resident #63 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD), and congestive heart failure (CHF). The quarterly MDS assessment dated [DATE] identified Resident #63 had intact cognition and received dialysis while a resident at the facility, during the last 14 days. The care plan dated 1/17/24 identified that Resident #63 had respiratory disease related to CHF, COPD, chronic respiratory failure, obstructive sleep apnea and pneumonia. Interventions included monitoring lung sounds, oxygen saturation, vital signs, and intake and output as ordered. The care plan further identified that Resident #63 required hemodialysis secondary to end stage renal disease. Interventions included going to dialysis treatments on Tuesdays, Thursdays, and Saturdays. A physician's order dated 2/14/24 directed for vital signs and intake and output (I&Os) to be completed every shift. The weights and vital signs summary dated 3/1/24 through 4/22/24 failed to identify vital signs were taken for 91 out of 135 shifts. The nurse's note dated 3/1/24 through 4/21/24 failed to identify documentation Resident #63 refused vital sign monitoring. Interview with LPN #2 on 4/22/24 at 12:05 PM identified that she works the 7AM-3PM shift, and that she monitors Resident #63's vital signs every shift. LPN #2 further identified that she would need to review the policy for vital sign monitoring on a dialysis resident, but she was taught that dialysis residents get vital signs every day, on every shift. Interview and clinical record review with the DNS on 4/22/24 at 8:37 AM failed to identify that Resident #63's vital signs were being monitored every shift, per the physician's order. The DNS indicated that if vital signs are ordered every shift, then he would expect vital signs to be taken every shift. The DNS identified that there is inconsistency in Resident #63's vital sign monitoring, and aside from the times that he/she is out of the facility for dialysis, he would expect the charge nurse to monitor vital signs, per the physician's order. Review of the facility's Vital Sign policy directs that resident's vital signs (temperature, pulse, respirations and blood pressure) will be monitored and abnormal signs are reported to the physician and family/responsible party. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #94 was admitted to the facility in January 2022 with diagnoses including Alzheimer's disease, dementia with behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder. The annual MDS assessment dated [DATE] identified Resident #94 with severely impaired cognition, no physical or verbal behavioral symptoms directed towards others, and exhibited wandering behaviors. The physician's order dated 1/1/24 directed Resident #94 was independent with transfers and ambulation with rolling walker. Review of the reportable event dated 1/15/24 at 9:00 AM identified Resident #94 was observed being struck on the back of the head by Resident #331. NA #7 immediately separated both residents. The APRN and resident representative were notified and an investigation was initiated. A statement from NA #7 dated 1/15/24 identified she was picking up dishes in the common area when Resident #331 tried to grab Resident #94's breakfast plate. Resident #94 moved the plate away and Resident #331 struck Resident #94 on the head. NA #7 indicated she separated them. The nurse's note dated 1/15/24 at 12:26 PM identified Resident #94 was sitting at the table in the common area finishing breakfast when Resident #331 tried to take Resident #94's plate. When Resident #94 said no, Resident #331 struck Resident #94 on the back of the head. Resident #94 had no recall of the incident. RN assessment was performed with no noted skin impairment, no redness, no headache, and no dizziness. Pupils were equal and reactive, hand grasps equal and strong. Resident #94 was seen by psychiatric physician and APRN with no new orders at that time. Resident representative was notified. Review of Resident #94 clinical record failed to reflect documentation that neurological monitoring was completed every fifteen (15) minutes for one (1) hour, every thirty (30) minutes for one (1) hour, every hour (1) for four (4) hours, every four (4) hours for sixteen (16) hours, every eight (8) hours for forty-eight (48) hours. The licensed staff only completed 1 out of the 20 required neurological monitoring. The APRN note dated 1/15/24 at 1:15 PM identified Resident #94 was seen today as he/she was involved in an altercation with another resident in which the other resident struck Resident #94 in the back of the head. Resident #94 had no apparent injury and denies any complaints at this time. No pain present to head on palpation, denies pain and discomfort. Interview and clinical record review with the DNS on 4/23/24 at 10:23 AM failed to provide documentation that neurological monitoring was completed. The DNS indicated he was not aware of the issue. The DNS indicated staff did not complete the neurological monitoring. The DNS indicated the expectation was the neurological monitoring would be completed after the resident was struck on the back of the head and placed in the resident's clinical record. The DNS indicated the licensed staff will be in-serviced. Although attempted, an interview with RN #7 was not obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility neurological signs policy identified any resident who sustains a head injury or when a head injury is questioned or suspected will have neurological signs monitored as follows: Every fifteen (15) minutes for one (1) hour Every thirty (30) minutes for one (1) hour, Every hour (1) for four (4) hours Every four (4) hours for sixteen (16) hours Every eight (8) hours for forty eight (48) hours The findings of each evaluation is compared, analyzed and documented in the medical record. The physician is promptly notified of any abnormal findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #36) reviewed for pressure ulcers, the facility failed to ensure the air mattress was utilized per manufacturer recommendations. The findings include: Resident #36 was admitted to the facility with diagnoses including: dementia, severe malnutrition, stage 4 pressure injury of left hip, stage 4 pressure injury of sacral region, unstageable pressure injury of right hip, stage 3 pressure injury of left buttock, and a suspected deep tissue injury of left heel. Review of the Weights Summary dated 2/27/24- 3/11/24 identified: Weight 2/27/24 was 95 lbs. Weight 3/4/24 was 91 lbs. Weight 3/9/24 was 88 lbs. Weight 3/10/24 was 81 lbs. Weight 3/11/24 was 81 bs. A physician's order dated 3/10/24 directed to apply a specialty air mattress at check setting cycle 10/105 and check function every shift. The care plan dated 3/11/24 identified Resident #36 as a risk for skin breakdown. Interventions included a low air loss mattress with setting cycle at 10/105. Check inflation and setting every shift. The Medicare 5-Day MDS assessment dated [DATE] identified Resident #36 had moderately impaired cognition and was totally dependent for toileting, dressing, and personal hygiene. Resident #36 was at risk for developing pressure injuries and identified the presence of one stage 3 pressure injury, two stage 4 pressure injuries, and one unstageable pressure injury. Review of the Weights Summary dated 3/16/24- 4/8/24 identified: Weight 3/18/24 was 86 lbs. Weight 4/1/24 was 86 lbs. Weight 4/8/24 was 89 lbs. Observations on 4/21/24 at 8:51 AM identified Resident #36 was lying on his/her left side on the air mattress in bed. The air mattress pump was set at 10/65 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Regional Nurse (RN #1), on 4/21/24 at 9:00 AM indicated Resident #36's pump was set at 10/65 lbs. RN #1 indicated that the setting of 105 is supposed to be the resident's weight, therefore the settings and physicians order were incorrect. RN #1 indicated if a resident experiences a weight change, the air mattress setting must be changed. Interview with the DNS on 4/21/24 at 2:10 PM indicated that the air mattress was set based on the physician orders. Nursing was responsible for monitoring functioning and pressure settings every shift. The DNS indicated the wound nurse was responsible for ensuring Resident #36's air mattress was set according to Resident #36's weight. Review of the facility Alternating Pressure Air Mattress Policy identified the rationale for use is to maintain adequate circulation, relieve pain due to pressure and aid in healing and/or prevention of pressure ulcers. Policy indicated the procedure was to verify the physicians order and settings according to manufacturer guidelines.

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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** 46040 Based on observations, clinical record review, review of facility documentation, facility and interviews for 1 of 8 residents reviewed for nutrition (Resident #60), the facility failed to ensure weight monitoring was completed and reviewed per physician's order and facility policy for a resident with a history of weight loss. The findings include: Resident # 60 was admitted to the facility on [DATE] with diagnoses which included mild protein calorie malnutrition, weakness, and dementia. The physician's orders dated 2/13/24 directed to obtain Resident #60's weight on admission and then weekly for 4 consecutive weeks every Monday on day shift. The orders also directed Resident #60 required a regular diet. Review of the clinical record identified Resident #60 had an admission weight of 112 lbs. on 2/13/24. The care plan dated 2/16/24 identified Resident #60 had a history of malnutrition related to significant weight loss and dementia. Interventions included weights per physician's order, monitor oral intake, regular diet, and suggest 8 ounces of Ensure plus (a nutritional supplement) 3 times a day. The admission MDS assessment dated [DATE] identified Resident # 60 had moderately impaired cognition, required and set up only for meals. The MDS assessment also identified Resident #60 had a history of weight loss. Review of the clinical record identified that Resident #60 had a documented weight of 112 lbs. on 2/26/24, 13 days following admission. Review of the clinical record failed to identify any other weight monitoring was completed or documented from 2/13-2/26/24. Review of the clinical record identified Resident #60 had a documented weight of 102 lbs., a 10 lb or 9.1% loss, on 3/4/24. A Dietician note dated 3/5/24 at 1:35 PM identified Resident #60's weight was 102 lbs. and had a 10 lb loss in the last week. The note further identified that Resident #60's oral intake varied between 26-100%. Interventions included continuing Ensure plus 3 times daily, add magic cup (a nutritional supplement) with lunch and dinner for increased calories, and to monitor weights weekly. Review of the clinical record identified Resident #60 had a documented weight of 102 lbs. on 3/11/24. A Dietician note dated 3/13/24 at 1:35 PM identified Resident #60's admission weight was 112 lbs. on 2/13, with weight of 112 lbs. on 2/26/24, 102 lbs. on 3/4/24 and re-weight of 102 lbs. on 3/11/24 confirming weight loss. The note further identified that Resident #60's meal intake was between 50-100% and had a weight loss. Interventions included increasing supplements to four times daily and weekly weights in place. (continued on next page)

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	075332	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valerie Manor	1360 Torringford St Torrington, CT 06790

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified the following weights documented for Resident #60: 3/28/2024 108.0 lbs., 3/28/2024 108.12 lbs., and 4/2/2024 112.0 Lbs. A Dietician note dated 4/3/24 identified Resident #60 had a weight loss previously and weekly weights were in place. The note further identified that Resident #60 had a current weight of 112 lbs. which was back to baseline from admission. The note identified that weight gain was beneficial and that all interventions should continue, including supplements and weekly weights. A weekly weight list dated 4/8/24 identified that Resident #60 was supposed to have weekly weights done on every Monday on the 3:00 PM-11:00 PM shift. Review of the clinical record identified documentation on 4/9/24 by LPN #4 for recorded weight of 108.8 lbs., 3.2 lb or 2.85% weight loss from the previous weight of 112 lbs. obtained a week prior, with a strike out correction to remove the documentation. Further review of the clinical record failed to identify any additional weights were documented for Resident #60. Interview with Resident #60 on 4/21/24 at 10:25 AM identified that he/she had a weight loss following admission to the facility due to burnt food. Resident #60 identified sometime at the beginning of March 2024, he/she received multiple meals that were delivered burnt. Resident #60 identified My appetite isn't good to start with. Burnt food completely shut it down. I didn't want to eat at all. Resident #60 reported that while he/she still gets meals that are overcooked, it had not been as frequently. Interview with LPN #4 on 4/22/24 at 11:45 AM identified Resident #60 was supposed to have weekly weights. LPN #4 identified she initially obtained and recorded the weight of 108.8 lbs. on 4/9/24 and noted that the weight was a loss from the previous weight on 4/2/24. LPN #4 identified that during report to the oncoming shift (3-11 PM) she had requested the nurse obtain a re weight to confirm if the weight LPN #4 obtained was accurate. LPN #4 identified that she could not remember who the nurse was she reported or made the re weight request to, and she did not follow up to see if the re weight was done. LPN #4 also identified she struck the weight out of the clinical record as she was awaiting the results of the re weight, however the weight of 108.8 lbs. was the weight she obtained and was accurate. LPN #4 identified she should not have struck out the 4/9/24 weight and should have followed up to ensure that the re weight was done due to Resident #60's history of weight loss. Observation of meal test trays provided to the survey team on 4/22/24 at 12:00 PM by the Dietary Director identified test trays that included 2 plates of cheese ravioli with tomato sauce, one of the main meals being served for lunch. The plates included an opaque cover over the meals that prevented observation of the meals prior to removal. The 2 test trays that included ravioli were observed to have at least 50% of the meal blackened and hardened. Observations on 4/22/24 at 12:30 PM of the meal service to the Skyview unit, where Resident #60 resided, identified the tray of cheese ravioli provided as one of the main meals for residents was charred and blackened areas of ravioli on all 4 sides of the inner portion of the tray. A tomato based sauce, used to top the ravioli underneath, was also observed to be dry, cracked, and discolored. Subsequent to surveyor inquiry, review of the clinical record identified Resident #60 had a documented weight of 112 lbs. on 4/22/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of documentation and interview with the Dietician on 4/23/24 at 12:00 PM identified that Resident #60 should have continued to have weekly weights and identified that per her tracking, the last recorded weight for Resident #60 was 112 lbs. on 4/2/24. The Dietician identified that if the weights were not obtained, she would communicate the missing weights for all the residents who needed them via a communication tab in the electronic medical record to the DNS. The Dietician also identified it was the responsibility of the nursing staff to ensure that the weights were obtained as ordered. The Dietician further identified that she had not spoken to or been notified that Resident #60 had not been eating meals during the time of the weight loss from 2/26-3/4/24 due to burnt meals. The Dietician identified that regarding burnt meals being provided to residents, I have never heard of that or ever seen that happen. Review of communication documentation provided by the Dietician identified that on 4/16/24 and 4/17/24 the Dietician notified the DNS that Resident #60 had missing weekly weights that were needed. Interview with the DNS on 4/23/24 at 12:30 PM identified that it was the policy of the facility to obtain weights on admission, weekly for 4 weeks, and then at least monthly for all residents, unless the resident had an order for more frequent weight monitoring. The DNS identified that he had received communication from the Dietician regarding the need for weekly weights for residents, and that Resident #60 was included on the list. The DNS identified it was the responsibility of the nurse assigned to the resident to ensure that the weights were obtained and that the nurse was to document the weight in the clinical record. The DNS identified he was not aware that Resident #60 had a period when he/she did not eat meals provided by the facility due to the meals being burnt. The DNS identified that burnt meals being delivered to residents were unacceptable, and that going forward the facility would work on this. The DNS identified that he would reeducate the nursing staff on the importance of obtaining weekly weights as ordered. The facility policy on nutrition directed that all residents/patients would be assessed to identify those residents at risk for weight loss. The policy directed that assessment would include obtaining the resident's weight within 24 hours of admission, weekly for 4 weeks, and then monthly unless clinically indicated. The policy further directed residents with an MD order should be weighed weekly, and weights should be documented in the resident's medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility policy, and interviews for 4 of 6 residents (Resident #7, #16, #20 and #81) reviewed for respiratory care, the facility failed to ensure oxygen tubing was changed and dated, in accordance with the facility policy. The findings include: 1. Resident #7 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). A physician's order dated 12/26/23 directed to change Resident #7's oxygen tubing every Sunday on 11:00PM- 7:00 AM shift. The annual MDS assessment dated [DATE] identified Resident #7 had intact cognition and was dependent on supplemental oxygen. The care plan dated 1/23/24 identified Resident #7 had the potential for cardiopulmonary complications related to diagnoses of chronic respiratory failure, COPD, emphysema, anemia, atrial fibrillation, hypertension, pleural effusion, and pneumonia. Interventions included administering oxygen via nasal cannula at 2 liters/minute continuous every shift, as ordered. Observation and interview with LPN #1 on 4/21/24 at 8:44 AM identified Resident #7's oxygen tubing was dated 3/31/24. LPN #1 indicated that she would have to refer to the facility's policy to identify the frequency that oxygen tubing gets changed; she further identified that it is the responsibility of the 11:00PM-7:00AM shift to complete that task. Interview with the day nurse supervisor (RN #3) on 4/21/24 at 8:47 AM identified the facility policy directs oxygen tubing to be changed weekly. RN #3 further identified that it is the responsibility of the 11:00PM-7:00AM nurse to change the oxygen tubing, every Sunday night, and it is the expectation that the tubing is labeled and dated to reflect the date and time the tubing was changed. The facility Nasal Cannula Oxygen Administration policy directs the cannula be replaced periodically and more frequently when the patient has an upper respiratory infection. 2. Resident # 16 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and hypertension. The admission MDS dated [DATE] identified Resident # 16 had intact cognition, and required oxygen therapy The care plan dated 2/14/24 identified Resident #16 had a diagnosis of COPD. Interventions included to administer oxygen as ordered. The physician's order dated 4/3/24 directed to administer oxygen at 2 liters by nasal cannula and titrate as tolerated to maintain an oxygen saturation of greater than 90% every shift. The orders also directed to change the oxygen tubing every Sunday on the 11:00 PM-7:00 AM shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with Resident #16 on 4/21/24 at 9:45 AM identified he/she required continuous oxygen therapy due to COPD. Resident #16 was observed to have nasal cannula tubing applied and oxygen delivered at 2.5 liters with a label at the end of the tubing. The label identified Resident #16's name, a date/time of 4/8/24 (Monday) 11-7 and illegible initials. Resident #16 identified he/she was unable to remember when the oxygen tubing was last changed. Review of the treatment administration record for April 2024 identified Resident #16's oxygen tubing was documented to have been changed on 4/7/24, 4/14/24, and 4/21/24. Interview with DNS on 4/21/24 at 2:18 PM indicated that the oxygen tubing must be changed every week on Sundays on the 11:00 PM - 7:00 AM shift. The DNS indicated the oxygen tubing must be labeled when changed with the nurse's initials and the date. The DNS also identified that the label on the tubing would identify the date and time the tubing was last changed. The facility policy on oxygen tubing directed that the nasal cannula and oxygen tubing should be changed weekly or when visibly soiled or damaged. 3. Resident #20 was admitted to the facility with diagnoses that included dementia, pneumonia, and heart failure. The quarterly MDS dated [DATE] identified Resident #20 had moderately impaired cognition and required maximum assistance for toileting, dressing and personal hygiene. A physician's order dated 4/4/24 directed to change oxygen tubing every Sunday on 11:00 PM -7:00 AM, provide oxygen via nasal cannula at 2 Liters per minute as needed, and check pulse ox every shift, and titrate oxygen to maintain pulse ox greater than 92%. The care plan dated 4/8/24 identified Resident #20 had cardiopulmonary complications. Interventions included administering oxygen as needed and administering medication per physician order. Observations on 4/21/24 at 7:30 AM Resident #20 was lying in bed with nasal cannula in his/her nose attached to a concentrator between the 2 beds. Observation and interview with RN #2 on 4/21/24 at 8:30 AM noted oxygen nasal cannula and tubing was laying on the floor with the concentrator on/running between the 2 beds. RN #2 indicated she did not know which resident the oxygen tubing belonged to. NA #1 indicated that Resident #20 wears oxygen every night and it was on him/her earlier. RN #2 indicated that the oxygen tubing that Resident #20 was wearing had a date written 4/8 with the initials [NAME]. RN #2 indicated that the oxygen tubing was to be changed weekly and labeled with the nurse's initials and the date it was changed. Observation of RN #2 picking up the oxygen tubing and folding it up and placed it on top of the concentrator she did not discard the tubing or place it in a bag. Interview with RN #2 on 4/21/24 at 9:00 AM indicated that when oxygen tubing was not in use it was to be placed in a bag for cleanliness. RN #2 indicated that after she had left the room, she realized she should have just thrown the oxygen tubing away. RN #2 indicated that she will discard the oxygen tubing on top of the concentrator and get new oxygen tubing and label and date it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with DNS on 4/21/24 at 2:18 PM indicated that the oxygen tubing must be changed every week on Sundays on the 11:00 PM to 7:00 AM shift. The DNS indicated the oxygen tubing must be labeled when changed with the nurse's initials and the date. The DNS indicated that if the oxygen tubing was on the floor, it must be discarded and when the tubing is not being used it must be bagged. 4. Resident # 81 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), asthma and dementia. The quarterly MDS dated [DATE] identified Resident #81 had moderately impaired cognition, uses a wheelchair for mobility, and had an anxiety disorder. The care plan dated 4/3/24 identified a concern with cardiopulmonary complications with interventions that included to administer medications as ordered, administer oxygen as ordered at 3/L (liters per minute) via nasal cannula continuously for diagnosis of COPD/SOB (shortness of breath) as ordered. A physician's order dated 3/14/24 directed to administer oxygen 0-3 L (liters per minute) via nasal cannula continuously for diagnosis of COPD/SOB. May titrate to maintain oxygen saturation above 90%. Observations on 4/21/23 at 9:20 AM identified the tubing associated with both the nasal cannula and the nebulizer unit were dated 4/8/24. Interview with LPN #3 identified the oxygen tubing should have been changed on the 11 PM-7AM shift on Sunday and did not know why it was overlooked. LPN #3 secured new tubing for the resident. Review of the facility Oxygen Administration Nasal Cannula Policy identified oxygen was to deliver low flow oxygen per physician's order. Replace and date cannula and tubing weekly or when visibly soiled or damaged. The nasal cannula will be stored in a plastic bag and maintained off the floor.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 42117 Based on review of the facility documentation, facility employee handbook, and interviews for 5 of 5 nursing assistant (NA #2, NA #3, NA #4, NA #5, and NA #6) for staffing , the facility failed to ensure the introductory period and the last annual performance reviews were conducted. The findings include: Interview with Director of Human Resources (HR) on 4/23/24 at 12:11 PM indicated it was her responsibility to make sure all employee files were complete. HR indicated that all new employees or transfer employees prior to June 2023 would have a performance evaluation at 6 months and annually. HR indicated after June 2023 all new employees will have a performance evaluation at the end of 3 months and annually from date of hire. HR indicated she keeps track of when evaluations are due to be completed and the department heads keeps track of when the 3 month and annual evaluations are due to be completed. HR indicated the department head must give her the completed evaluations to put in the employees file as soon as they are completed and are they are kept in the HR office. Review of employee files: 1. NA #2 date of hire was 5/30/22. HR indicated that NA #2 employee file lacked a completed evaluation for the 6 month and the annual due 5/30/23. 2. NA #3 date of hire was 7/28/05. HR indicated the last annual performance evaluation completed was 12/7/19. HR indicated that NA #3 employee file lacked a completed annual evaluation for 2020, 2021, 2022, and 2023. 3. NA #4 date of hire was 7/19/11. HR that NA #4 employee file lacked any completed annual evaluation since date of hire. 4. NA #5 date of hire was 2/23/99. HR indicated the last annual performance evaluation completed was 1/8/21. HR indicated that NA #5 employee file lacked a completed annual evaluation for 2022 and 2023. 5. NA #6 date of hire was 5/1/06. HR indicated the last annual performance evaluation completed was 12/19/19. HR indicated that NA #6 employee file lacked a completed annual evaluation for 2020, 2021, 2022, and 2023. HR indicated that she was aware that they are behind with the evaluations but there is a new DNS in the facility. HR indicated after surveyor inquiry of employee files, she and the Administrator had spoken today, and they have decided they will start doing the annual performance evaluations for all employees in the month of May 2024 and then those employees will be due annually moving forward every May. Interview with the Administrator on 4/23/24 at 12:59 PM indicated she was now aware that the performance evaluations were not being done and she will start a QAPI for the evaluations to be completed. The Administrator indicated that she had spoken with HR after surveyor inquiry about the employee files not being complete. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the employee handbook dated 6/1/23 identified that the first 90 days of employment is the introductory period. During and at the end of the introductory period your performance will be reviewed. The facility maintains complete records on all staff members. The purpose of a performance review is to assure the employee that his/her efforts are being recognized by the facility and to assure the facility the employee is properly placed in his/her current position. It is the facility's intent to review the performance of every staff member with him/her at the end of the introductory period and at least once a year thereafter.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record, facility policy, and interviews for 1 of 6 residents (Resident #7) reviewed for accidents, the facility failed to ensure medications were stored appropriately. The findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. A physician's order dated 12/26/23 directed to administer 325mg of Acetaminophen, 2 tablets by mouth every 6 hours, as needed, for pain. The annual MDS assessment dated [DATE] identified Resident #7 had intact cognition, was independent with eating and ambulation, and received or was offered an as needed (PRN) pain medication within the last 5 days. The care plan dated 1/23/24 identified Resident #7 had pain or the potential for pain related to generalized weakness status post low hemoglobin and a right arm deep vein thrombosis (DVT). Interventions included administering pain medications as ordered and assessing characteristics of pain, including location and severity on a scale of 0-10. The medication administration record dated 4/14/24 at 9:04 PM identified Resident #7 was last given 325mg of Acetaminophen, 2 tablets, for a pain rating of 8/10. Observation and interview on 4/21/24 at 8:40 AM identified a medication cup containing 2 white tablets on Resident #7's bedside table. Resident #7 indicated the tablets on the bedside table were Tylenol, which was brought to him, at night, about a week ago. Observation and interview with LPN #1 on 4/21/24 at 8:44 AM identified while she was not the nurse who dispensed the medication that was left at the bedside, all 5 rights of medication administration should be honored when passing medications. LPN #1 further identified that the nurse is expected to remain at the bedside until the resident has taken the medication and then document the medication administration or a reason for refusal. Interview with the day nurse supervisor (RN #3) on 4/21/24 at 8:47 AM identified that medications are not to be left at the bedside and that it is the expectation of the facility that the nurse administering the medications remains at the bedside until the mediation is taken. RN #3 further identified that she will begin an investigation to identify the root cause of why the medications were left at the bedside and education will be provided to the nursing staff. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/22/24 at 8:37 AM identified that medications are not to be left at the bedside. The DNS further identified that his expectation is that the nurse administering the medication explains to the resident which medication is being administered and that the nurse remains at the bedside until the medication is taken. The DNS further identified that in-servicing for the licensed nurses will be completed regarding medications not being left at the bedside. The facility's Oral Medication Administration policy directs the licensed nurse to stay with the resident/patient until he/she has swallowed the medication. The facility's Self-Administration of Medications policy directs that residents are afforded the right to self-administer their own medications upon request and after the determination the practice is safe. If the resident elects to self-administer his/her own medications, an evaluation of their cognitive, physical, and visual ability to perform this task is conducted to ensure accurate and safe medication management. If the evaluation indicates the resident can safely perform required functions, self-administration of medications is allowed. If unable to safely perform this task, the licensed staff, or trained medications aides/technicians, as allowed by state law, will administer medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46040 Based on observations, review of facility documentation, and interviews for 1 of 6 nursing units, the facility failed to ensure residents were provided palatable and presentable meals. The findings include: Observation of meal test trays provided to the survey team on 4/22/24 at 12:00 PM by the Dietary Director identified test trays that included 2 plates of cheese ravioli with tomato sauce, one of the main meals being served for lunch. The plates included an opaque cover over the meals that prevented observation of the meals prior to removal The 2 test trays that included ravioli were observed to have at least 50% of the meal blackened and hardened. Continuous observation on 4/22/24 beginning at 12:30 PM of the meal service to the Skyview unit, where Resident #60 resided, identified that the steam table included a large sheet metal tray of cheese ravioli with a tomato based sauce. The tray of cheese ravioli was observed to have charred and blackened areas of ravioli on all 4 sides of the inner portion of the tray. A tomato based sauce, used to top the ravioli underneath, was also observed to be dry, cracked, and discolored. A total of 22 meals that included the ravioli observed on the steam table was observed to be delivered to residents on the unit, including a total of 6 residents observed in the unit's dining room and 16 residents throughout the Skyview unit. At the conclusion of the continuous observation at 1:10 PM, a total of 22 meals that included ravioli from the steam table tray were portioned, with 11 of those returned and exchanged for alternatives. Observation and interview with the Dietary Director on 4/22/24 at 1:15 PM identified that based on observation of the ravioli tray from the steam table used on the Skyview unit, that the ravioli had been prepared by being baked in the oven with tomato sauce and parmesan cheese and it appeared that the tray had been left in the oven too long, causing it to burn. The Dietary Director further identified that the ravioli should not have been delivered to the residents and he would speak to the dietary staff about the issue. The Dietary Director also identified that he had not looked at the test trays prior to providing them to the survey team, and had not observed the ravioli that was prepared for residents of the facility and placed on the steam table lines prior to delivery to the residents. The Dietary Director further identified he had not been made aware of any complaints by residents. Subsequent to surveyor inquiry, the facility provided in-service documentation related to re-educating dietary staff on food quality and appearance beginning 4/22/24. Topics included ensuring food was not burnt or dry, ensuring food quality was at its best at all times, ensuring food was cooked to proper temperatures, and that staff should never serve burnt or darkened food. The facility policy on nutrition directed that residents of the facility would receive nourishing, attractive meals to meet the individual and special needs of the residents, while providing a positive dining experience to enhance the resident's quality of life and respect his/her rights. The policy further directed this would be monitored by administrative staff to ensure positive outcomes. The facility policy on test trays directed that meals served to residents would be monitored 3 times weekly for proper temperatures, appearance, food quality, and timeliness of tray delivery, and the findings would be reviewed by the Dietary Director or designee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075332	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valerie Manor	1360 Torringford St Torrington, CT 06790

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on residents' rights directed that all residents of the facility had the right to receive quality care and services with reasonable accommodation to their individual needs and preferences. Although requested, the facility failed to provide any documentation related to test tray monitoring for review.