STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075334	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Healthcare Center	180 Regan Road Vernon, CT 06066

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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 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** 51182 Based on review of the clinical record, facility policy, and staff interviews for 1 of 3 residents (Resident #96) reviewed for weight loss, the facility failed to notify the dietician in order to make recommendations when a significant weight loss occurred. The findings include: Resident #96's diagnoses include cerebral infarction, dysphagia, and cholecystitis. The Resident Care Plan dated 3/8/24 through 7/2924 identified Resident #96 was on a mechanically altered diet secondary to dysphagia. Interventions included to provide a regular ground diet with thin liquids, encouraging fluids, intake and output as needed, nutritional assessments as needed, supplements as ordered, and weights as ordered. Resident #96's admission Nutritional Evaluation from the dietician and dated 3/11/24 at 11:53 AM identified Resident #96 weighed 141.2 pounds (lbs.). The Nutritional Evaluation further identified the dietician was provided with Resident #96's food preferences and did not identify any dietary concerns, or cultural accommodation needs for meal offerings. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #96 had severe cognitive impairment, required substantial assistance with chair/bed to chair transfers, and required set-up assistance with eating. A record review of Resident #96's weights identified the following weight entries: On 3/11/24 a weight of 141. 2 lbs., on 4/16/24 a weight of 132.0 lbs. (a 10.2 lb./6.25% loss in one month). On 5/11/24 Resident #96 weighed 130.8 lbs., and on 6/11/24 weighed 128.8 lbs., a 12.2 lb. loss over 3 months (8.78%). Physician's order dated 5/20/24 directed to administer House Supplement 120 milliliter (ml) twice daily (34 days after a 10.2 lb/6.25% weight loss). A Dietician's progress note dated 7/29/24 identified a weight loss of 13.5 lbs. from a pre-hospital weight (on 7/13/24) and recommended a Glucose Control supplement of 120 milliliters three times a day. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician progress notes dated 7/31/24 identified Advanced Practice Registered Nurse (APRN) #1 evaluated Resident #96's weight loss and referred him/her to the Dietician for supplements. An interview with Registered Nurse (RN) #5 on 10/10/24 at 11:24 AM identified that nursing was responsible for the monitoring of weights and weight trends for residents. When a concern with a resident's weight was identified, nursing was responsible to notify both the dietician and the provider, but RN #5 was unable to identify that the dietician had been notified prior to 7/29/24. An interview with Advanced Practice Registered Nurse (APRN) #1 on 10/10/24 at 11:38 AM identified that she was made aware of Resident #96's weight loss all along and no medical consultation was required for the weight loss. An interview with the Dietician on 10/11/24 at 9:50 AM identified that she did not receive any notification of Resident #96's weight loss in March 2024 through June 2024. The first time she was notified of Resident #96's weight loss was on 7/29/24. Review of the Weight Assessment and Intervention Policy identified that any verified weight change of 5 lbs. or greater should be reported to both the dietician and the practitioner.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #3) reviewed for abuse, the facility failed to report injuries of unknown source to the state agency (SA) timely. The findings include: Resident #3's diagnoses included vascular dementia, osteoarthritis and a fracture of the left hand. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 was significantly cognitively impaired and required substantial/maximal assistance with transfers and toileting, and supervision or touching assistance with bed mobility. The Resident Care Plan dated 5/13/24 identified a risk for skin injuries (bruising/bleeding/skin tears) and a potential for falls. Interventions included to inspect skin daily during care, encourage to call for assistance, and orient to surroundings. An APRN progress note dated 7/4/24 at 1:01 PM identified Resident #3 had an area of bruising (spontaneous ecchymosis) on the lateral side of his/her left orbital (eye) area with no concern for fracture or pain. A nurse's progress note dated 7/8/24 at 2:39 PM identified Resident #3 had a slight bluish/purple hue to his/her pinky and ring finger extending up to the top of the back of his/her hand. An APRN progress note dated 7/11/24 at 9:41 AM, for a date of service on 7/10/24, identified Resident #3's left hand had no obvious bruising or deformity with mild swelling to the left side which appeared non-tender with movement. The APRN progress note further indicated the bruise to Resident #3's left periorbital (eye) area was non-tender. An APRN progress note dated 7/11/24 at 9:56 AM identified Resident #3 had bruising of the left hand and bruising of the left eye. The APRN progress note further indicated that Resident #3 stated that he/she fell from a chair and could not recall the day. Additionally, the APRN progress note identified that after discussion with Resident #3's responsible party, an x-ray of the left hand was ordered. A radiology (x-ray) result report for Resident #3 dated 7/11/24 at 12:00 PM identified an acute hairline non-displaced fracture of the 4th metacarpal of the left hand with diffuse osteopenia and soft tissue swelling indicated. An APRN progress note on 7/11/24 at 2:15 PM identified that Resident #3's left hand x-ray had revealed an acute non-displaced fracture of the 4th metacarpal (bones that connect the finger to the wrist), and the family requested to have Resident #3 evaluated further at the hospital Emergency Department. A nurses note dated 7/11/24 at 4:23 PM identified that the DNS was notified of Resident #3's acute left hand fracture of the 4th metacarpal bone and that Resident #3 had self-reported a fall. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Reportable Event form signed as filed on 7/12/24, identified Resident #3 had new bruising and swelling noted to the left hand on 7/10/24 with x-rays taken on 7/11/24. The x-ray report dated 7/11/24 indicated a fracture of the left hand, 4th metacarpal. The DNS and APRN were notified, an investigation was initiated, and the family was present. Family requested transfer of Resident #3 to the hospital Emergency Department for further evaluation. A nurses note dated 7/12/24 at 8:11 AM identified that Resident #3 had returned from the hospital Emergency Department with a diagnosis of closed fracture of the left metacarpal bone and a left orbital contusion. Interview and record review on 10/11/24 at 10:00 AM with PT #1 indicated that she was familiar with Resident #3 as she was asked to evaluate Resident #3 post incident on 7/12/24. A review of PT #1's treatment encounter note identified Resident #3 was unable to perform fall recovery tasks and that he/she would be unable to perform floor to standing position on his/her own without physical assist. PT #1 further indicated that Resident #3 would not be able to get up on his/her own if he/she fell as he/she required moderate to maximum assistance for wheelchair to bed transfers. Although Resident #3 reported that he/she had fallen, the resident would have been unable to rise independently from a fall. Interview and record review with APRN #1 on 10/11/24 at 10:14 AM identified that she had evaluated Resident #3 on 7/10/24 and although he/she had a bruise to his/her left eye, she did not see an injury to his/her left hand. APRN #1 indicated that when she evaluated Resident #3 on 7/11/24 she did see a bruise to his/her left hand and ordered an x-ray which showed a fracture. APRN #1 further identified that due to Resident #3's advanced dementia and inability to get up on his/her own, she did not believe Resident #3's report of falling or that a fall had caused his/her injuries. Additionally, APRN #1 indicated that although she was notified and saw Resident #3 in person on both dates, she was unsure if the facility further investigated how the injury had occurred or if the facility had notified the SA timely. Interview with the facility's Medical Director, MD #1, on 10/11/24 at 12:38 PM indicated she was unable to identify a possible cause of Resident #3's injuries and that although the injuries were reported to her, she did not evaluate Resident #3 and did not know the mechanism of injury. Interview and record review with the DNS on 10/11/24 at 1:15 PM indicated that Resident #3 had sustained a left eye bruise and a left hand fracture in July 2024. The DNS identified that without a witnessed fall incident, investigation information indicating the resident fell and was assisted to rise, and with the residents advanced dementia, the facility was unable to determine the cause of the injuries. The DNS indicated that Resident #3's left eye bruise and left hand fracture were considered injuries of unknown source, and the fractured hand should have been correctly classified as a possible allegation of mistreatment (injury of unknown origin) and subsequently sent to the SA, per the facility Abuse/Neglect/Exploitation policy. The DNS was unable to identify a reason Resident #3's injuries of unknown origin were not reported timely, but she was not in the DNS role at that time. Review of the facility policy, Abuse/Neglect/Exploitation, dated 4/29/24, directed that possible indicators of abuse include physical injury of a resident of unknown source. The Abuse/Neglect/Exploitation policy further directed that all alleged violations would be reported to the SA immediately if the event resulted in serious bodily injury, and that the results of the facility's investigation would be reported to the SA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Unexplained Injuries, dated 5/10/23, directed that an injury shall be classified as an injury of unknown source when the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and the injury is suspicious. The policy further directed that reporting and investigation procedures for injuries of unknown source would be implemented in accordance with the facility's abuse policies and procedures.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #96) reviewed for weight loss, and for 1 of 6 sampled residents (Resident #706) reviewed for unnecessary medications, the facility failed to revise the Resident Care Plan (RCP) when a change occured. The findings include: 1. Resident #96's diagnoses included cerebral infarction, dysphagia, and right sided hemiplegia and hemiparesis. An initial Nutritional Evaluation dated 3/11/24 at 11:53 AM and written by the dietician identified that on 3/11/24, Resident #96 weighed 141.2 pounds (lbs.). The Nutritional Evaluation further identified the dietician was provided with Resident #96's food preferences and did not identify any dietary concerns or cultural accommodations for meal offerings. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #96 had severe cognitive impairment, required substantial assistance with chair/bed to chair transfers, and required set-up assistance with eating. The Resident Care Plan (RCP) dated 3/8/24 through 7/29/24 identified Resident #96 was on a mechanically altered diet secondary to dysphagia. Interventions included a regular ground diet with thin liquids, encouraging fluids, intake and output as needed, nutritional assessments as needed, supplements as ordered, and weights as ordered. The RCP further identified that Resident #96 had Halal cuisine and food, and communication barriers. A record review of Resident #96's weights identified the following weight entries: An admission weight on 3/11/24 was 141.2 lbs., on 4/16/24 a weight of 132.0 lbs. was recorded for a 10.2 lb. loss (6.25% in one month). On 5/11/24 Resident #96 weighed 130.8 lbs., and on 6/11/24 weighed 128.8 lbs., a 12.2 lb. loss over 3 months (8.78%). On 9/17/24 Resident #96 weighed 115.2 lbs. (18.4% loss over 6 months), and on 10/2/24 weighed 112.2 lbs. for a total loss of 29 lbs. The RCP dated 3/8/24 through 9/11/24 failed to identify that the care plan was reviewed and revised following Resident #96's significant weight loss. An interview with the dietician on 10/11/24 at 9:50 AM identified she was notified on 7/29/2024 of Resident #96's weight loss. She was unaware of a pattern of weight loss for Resident #96 before 7/29/24. Review of the Weight Assessment and Intervention Policy identified that care planning for weight loss shall address the cause of the weight loss, goals and benchmarks for improvement, and time frames and parameters for monitoring and reassessment. 2. Resident #706's diagnoses included atrial fibrillation, hypertension, and congestive heart failure. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission nursing assessment dated [DATE] identified Resident #706 was cognitively intact, required staff assistance with toileting, was dependent with transfers, and was non-ambulatory. A physician's order dated 9/25/24 directed to administer warfarin 3 milligrams (mg) by mouth at bedtime every Monday, Wednesday, and Friday for atrial fibrillation. Review of the Resident Care Plan (RCP) dated 9/25/24 through 10/10/24 failed to identify Resident #706 was on an anticoagulant. A warfarin worksheet entry dated 9/26/24 identified that 1 dose of warfarin was held and not administered on 9/26/24 and then a Prothrombin Time and International Normalized Ratio (PT/INR) blood test (which monitored how well the blood thinning medication was working to prevent blood clots) was completed on 9/27/24. In an interview and clinical record review with the MDS (Minimum Data Set) Coordinator Licensed Practical Nurse (LPN) #3 on 10/10/24 at 10:30 AM, the clinical record failed to include an anticoagulation focus, goal, and intervention in the RCP. LPN #3 identified that there had been an anticoagulation focus on admission on 9/25/24 for Resident #706, but that she had resolved this focus on 9/26/24 when she didn't see an active order for an anticoagulant in Resident #706's electronic medical record. LPN #3 identified that due to Resident #706 being on warfarin, it should have been included in the RCP, and if there had been a hold order in the electronic medical record, she would not have resolved (discontinued) the anticoagulation focus. Subsequent to surveyor inquiry, an anticoagulation care plan was added with a potential for bleeding and interventions to administer the anticoagulant medication per the physician's order and observe for bruising or bleeding were added to Resident #706's RCP. Review of the High Risk Medications-Anticoagulants policy directed, in part, that the resident's plan of care shall alert staff to monitor for adverse consequences and risks associated with anticoagulants included bleeding such as bleeding gums, nosebleed, unusual bruising, and blood in urine or stool. 51183

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50167 Based on observations, review of the clinical record, and interviews for the only sampled resident (Resident # 46) reviewed for Hospice, the facility failed to follow a physician's order for the application of arm protectors, for 1 of 3 residents (Resident #96) reviewed for nutrition, the facility failed to obtain and document the resident's weekly weights per physician orders for a resident with a significant weight loss. The findings include: 1. Resident #46's diagnoses included dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #46 was severely cognitively impaired and totally dependent for bed mobility, upper and lower body dressing, and transfers. A Physician's order dated 9/9/24 directed to apply bilateral arm protectors to be worn at all times, may be removed for care and reapplied every shift. The Resident's Care Plan in effect from 10/1/24 to 10/11/24 identified a potential for skin impairment. Interventions included apply bilateral arm protectors to be worn at all times, may be removed for care and reapplied, observe for changes in skin integrity, and update the provider. Review of the undated nurse aid care card directed that bilateral arm protectors were to be worn at all times. Observations on 10/10/24 at 12:15 PM and 2:33 PM, and again on 10/11/24 at 10:04 AM identified Resident #46 sitting up in the wheelchair next to the bed in his/her room without the benefit of arm protectors. Resident #46 was noted to be wearing a short sleeve garment during both observations and both upper arms were exposed to his/her hands. An interview with NA #4 on 10/11/24 at 10:04 AM identified that although a review of the NA care card directed to apply bilateral arm protectors, NA #4 indicated bilateral arm protectors were not present on the care card. NA #4 stated that in the last year, sometimes bilateral arm protectors were placed on Resident #46 and sometimes not. Further, NA #4 searched Resident #46's room, drawers, and closet but was unable to locate any arm protectors which could be placed on Resident #46. Review of Resident #46's Treatment Administration Record (TAR) identified that although bilateral arm protectors were signed off as applied on 10/10/24 during the 7:00 AM to 3:00 PM shift, observations on that day failed to identify the arm protectors had been placed on Resident #46. An interview with the DNS on 10/11/24 at 10:50 AM indicated that bilateral arm protectors were noted on Resident #46's RCP and NA care card but were identified as skin protection versus what the physician's order indicated, bilateral arm protectors, and that the skin protection devices should have been applied. Although requested, the facility indicated there was no policy for the use of arm protectors. (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 #96's diagnoses include cerebral infarction, cholecystitis, and dysphagia. The Resident Care Plan (RCP) dated 3/8/24 through 9/11/24 identified Resident #96 was on a mechanically altered diet secondary to dysphagia. Interventions included a regular ground diet with thin liquids, encourage fluids, intake and output as needed, nutritional assessments as needed, supplements as ordered, and weights as ordered. The Quarterly Minimum Data Set assessment dated [DATE] identified Resident #96 had moderate cognitive impairment, required substantial assistance with chair/bed to chair transfers, and required set-up assistance with eating. An Advanced Practice Registered Nurse order dated 8/7/24 directed weekly weights be taken for Resident #96 every Wednesday at shower-time by 7:00 AM to 3:00 PM staff. Review of Resident #96's electronic medical record (EMR) and Treatment Administration Record (TAR) identified missing documentation of weekly weights or documented resident refusal for the dates of 8/21/24, 8/28/24, 9/4/24, 9/11/24, and 9/25/24 (missing 5 of 9 opportunities). The Nurse Aide (NA) Care Card identified that Resident #96's weights should be monitored. The NA Care Card did not indicate when to weigh, how often to weigh, or who was responsible for weighing Resident #96. An interview with Licensed Practical Nurse (LPN) #5 on 10/10/24 at 10:44 AM identified the only place she documents a resident's weight was in the EMR. NAs do not document the weights of residents but do weigh the residents. NAs write the resident's weight on a piece of paper, which is handed to the LPN, for review and documentation within the EMR and TAR. LPN #5 was not able to identify the reason weights were not documented for the dates 8/21/24, 8/28/24, 9/4/24, 9/11/24, and 9/25/24 despite the TAR indicating a check mark as completed. An interview with Registered Nurse (RN) #4 on 10/10/24 at 11:01 AM identified that weights taken on residents should only be entered into the resident's chart. If a weight was not charted in the weights section of the EMR, it might also be referenced in a RN progress note. RN #4 was not able to locate any weights documented in a progress note for the dates 8/21/24, 8/28/24, 9/4/24, 9/11/24, and 9/25/24. RN #4 indicated RN #5 was responsible for ensuring LPNs and RNs documented weights in the resident chart. An interview with RN #5 on 10/10/24 at 11:12 AM identified that there was a pattern of weights being marked as taken by a check mark, with no weight being documented. RN #5 stated there was a step in the order entry process that was omitted which included triggering a mandatory weight value documentation at the time of documenting a weight was completed. Subsequent to surveyor inquiry, a change was made to the order that initiates a hard stop and requires a weight be documented when charting a weight was taken. Review of the Weight Assessment and Intervention Policy identified that weights are to be recorded in each resident's electronic medical record and in the unit's weight record chart. 50249 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51182 51756

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50167 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents reviewed for positioning and mobility, the facility failed to provide range of motion (ROM) to a dependent resident. The findings include: Resident #357's diagnoses included fracture of the right humerus (broken bone of the upper arm), and congestive heart failure. The Admission Nursing Evaluation dated 10/3/24 identified Resident #357 was cognitively intact, mobility was very limited and was unable to make significant changes independently, and his/her ability to walk was severely limited and required moderate assistance. The Resident Care Plan dated 10/4/24 identified Occupational Therapy for alteration in self-care and activities of daily living (ADLs) deficit related to decreased strength. Interventions included Occupational Therapy 5 times a week, non-weight bearing (NWB) of the right upper arm, leave the sling on at all times, may remove 3 times daily for active range of motion (AROM) of the right elbow, wrist, and fingers only. A physician's order dated 10/4/24 directed non-weight bearing of the right upper extremity (arm), sling on at all times, may remove 3 times daily to perform AROM of right elbow, wrist, and fingers only. Observation and interview with Resident #357 on 10/7/24 at 12:48 PM, identified that his/her sling was not being removed 3 times daily to perform AROM of right elbow, wrist, and fingers per what he/she was instructed to do in the hospital. The Hospital Discharge Summary instructions dated 10/2/24 directed the right upper extremity (arm) should remain in a sling at all times, however, should be removed approximately 3 times per day to perform range of motion at the elbow, wrist, and fingers to prevent stiffness. In an interview and clinical record review on 10/9/24 at 11:53 AM with Licensed Practical Nurse (LPN) #2 facility documentation failed to identify that Resident #357's sling was to be removed 3 times a day to perform AROM to the elbow, wrist, and fingers per the hospital Discharge Summary. Additionally, a review of the Treatment Administration Record (TAR) failed to direct the nursing staff to remove the sling and provide AROM 3 times daily. An interview and clinical record review with PT (Physical Therapist) #1 on 10/9/24 at 12:06 PM identified the AROM order for Resident #357 was entered into the computer system on 10/4/24 and should have been followed by staff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Nurses on 10/9/24 at 12:39 PM identified the order for Resident #357's sling removal for staff to provide AROM 3 times daily, but the information had been entered into the computer system inaccurately. Further, the DNS indicated although there was a physician order, the nursing staff had not been prompted to provide Resident #357 with AROM and would not have known to provide range of motion per the hospital Discharge Summary due to the way the order was entered. Subsequent to surveyor's inquiry on 10/9/24 a therapy order; NWB, Therapy to perform AROM of right elbow, wrist, fingers, as tolerated by Resident #357. Although requested, a facility policy for Physical Therapy was not provided.

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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** 50179 Based on clinical record review, observations, review of facility policy and staff interviews for 2 of 3 residents, (Resident #96 and #406), reviewed for nutrition and hydration, for Resident #96 the facility failed to implement interventions for a resident who continued to experience significant weight loss, and for Resident #406, the facility failed to consistently document intake and output for a resident on intravenous hydration. The findings include: 1. Resident #96's diagnoses include cerebral infarction, cholecystitis, and dysphagia. The Resident Care Plan (RCP) dated 3/8/24 through 9/11/24 identified Resident #96 was on a mechanically altered diet secondary to dysphagia. Interventions included a regular ground diet with thin liquids, encouraging fluids, intake and output as needed, nutritional assessments as needed, supplements as ordered, and weights as ordered. A Nutritional Evaluation dated 3/11/24 at 11:53 AM written by the dietician identified Resident #96's weighed 141.2 pounds (lbs.) and identified the dietician was provided with Resident #96's food preferences, did not identify the dietician had any dietary concerns, and did not make any recommendations for cultural accommodations for meal offerings. The admission Minimum Data Set assessment dated [DATE] identified Resident #96 had severe cognitive impairment, required set-up assistance with eating and required substantial assistance with chair/bed to chair transfers. A record review of Resident #96's weights identified the following weight entries: An admission weight on 3/11/24 was 141.2 lbs., on 4/16/24 a weight of 132.0 lbs. was recorded for a 10.2 lb. loss (6.25% in one month). On 5/11/24, Resident #96 weighed 130.8 lbs., and on 6/11/24 weighed 128.8 lbs., a 12.2 lb. loss over 3 months (8.78%). On 9/17/24 Resident #96 weighed 115.2 lbs. (a 26 lb/18.4% loss over 6 months), and on 10/2/24 weighed 112.2 lbs. for a total loss of 29 lbs in 205 days. A progress note by Advanced Practice Registered Nurse (APRN) #1 dated 3/8/24 identified Resident #96's albumin level, (a measure of the amount of protein in an individual's blood plasma that can be an indicator of malnutrition) was 3.8 (Normal albumin levels range from 3.5 to 5.5). A progress note by APRN #1 dated 4/2/24 identified Resident #96's albumin level, was 3.1 (Normal albumin levels range from 3.5 to 5.5). APRN #1 did not indicate within the progress note that Resident #96's albumin had decreased since the last albumin level of 3.8 obtained on 3/8/2024. A dietician progress note dated 4/15/24 identified that Resident #96 had an approximate 50%-75% meal intake, albumin levels were within normal limits per 4/2/24 labs (despite an albumin level being in the below normal range), and meal preferences were provided as requested. No diet changes were recommended. The dietician's note failed to acknowledge or address Resident #96's significant weight loss and failed to acknowledge Resident #96's albumin level per 4/2/24 labs was below normal limits. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note by APRN #1 dated 5/7/24 identified that she was aware of Resident #96's 11 lb. weight loss since admission and she stated the reports she had received from nursing was the resident ate well. APRN #1's progress note failed to address Resident #96's significant weight loss at that time and no interventions for the resident's continued weight loss were added to his/her plan of care. The Medication Administration Record (MAR) for July 2024 indicated a House Supplement of 120 milliliters (ml) to be administered twice a day was added to Resident #96's plan of care on 5/20/24 (35 days after the 10.2 lb./6.25% one month weight loss was documented on 4/16/24) and was discontinued on 7/20/24 when Resident #96 was hospitalized for cholecystitis. A progress note by APRN #1 dated 7/22/24 identified Resident #96's albumin level was 3.0 (Normal albumin levels range from 3.5 to 5.5). APRN #1 did not indicate within the progress note that Resident #96's had further decreased since the last albumin level of 3.1 obtained on 4/2/24. A dietician progress note dated 7/22/24 identified that Resident #96 had an approximate 50%-75% meal intake, had not lost any weight during his/her recent hospitalization for cholecystitis, and the resident was maintaining his/her weight without gain. No diet changes were recommended. The dietician's note failed to address the severe weight loss for Resident #96's since admission, (a 12.2 lb/8.8%. loss over 3 months from 3/11/24 through 6/11/24). The Medication Administration Record (MAR) from 7/30/24 through August 2024 identified a House Supplement Glucose Control Boost of 120 ml to be administered 3 times a day was added to the Resident #96's plan of care on 7/30/24. An interview with the dietician on 10/11/24 at 12:47 PM identified she was unable to determine if adding the Glucose Control Boost supplement in April would have prevented or slowed down the weight loss for Resident #96. Review of the Weight Assessment and Intervention Policy identified that any verified weight change 5 lbs. or greater should be reported to both the dietician and the practitioner. The dietician will review the unit weight record by the 15th of the month to follow weight trends over time. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort. Care plans for weight loss should include identified causes of the weight loss, goals and benchmarks for improvement, and timeframes and parameters for monitoring and reassessment. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a) 1 month - 5% weight loss is significant; greater than 5% is severe b) 3 months - 7.5% of weight loss is significant; greater than 7.5% is severe c) 6 months - 10% weight loss is significant; greater than 10% is severe 2. Resident #406 's diagnoses included dementia, malnutrition, and small bowel obstruction. A Nutritional Evaluation dated 9/16/24 identified a total fluid need of 1392 milliliters (ml) in 24 hours. A good appetite was noted on admission with poor intake noted the past few days with some meals refused. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #406 was severely cognitively impaired with long- and short-term memory loss and required total assistance with all activities of daily living. A physician's order dated 9/20/24 at 8:30 AM directed intravenous hydration (IV) of dextrose 5 percent (%), 1/2 normal saline at 60 milliliters (ml) per hour for 2 liters. A nurse's note dated 9/21/24 at 4:42 PM identified Resident #406's IV was patent (functioning), Foley urinary catheter output was 840 (cubic centimeters) cc, and the resident had poor oral intake. A nurse's note dated 9/22/24 at 10:57 PM identified resident #406 had independently pulled out his/her IV at 3:30 PM, the supervisor was notified, and the IV nurse was to reinsert the IV to continue therapy. Additionally, the Resident #406 had taken 25% or less of his/her meal, and that the IV nurse had reinserted the IV access at 8:00 PM. A physician's order dated 9/23/24 at 3:30 PM directed IV hydration of dextrose 5%, 1/2 normal saline at 75 ml per hour for 3 liters for hypernatremia (high sodium level) and anemia (low red blood cell count). Review of the intake and output worksheets for 9/23/24 failed to identify any IV intake for the 7:00 AM to 3:00 PM shift, 3:00 PM to 11:00 PM shift, or the 11:00 PM to 7:00 AM shift. Additionally, the document failed to identify if Resident #406 had any output for the 7:00 AM to 3:00 PM shift and failed to identify 24-hour totals. A nurse's note dated 9/24/24 at 4:06 PM identified that Resident #406 independently pulled out the IV. The nurse practitioner (APRN) was notified and instructed to have the IV replaced. Review of intake and output documents for 9/24/24 on the 7:00 AM to 3:00 PM shift failed to identify IV intake, on the 11:00 PM to 7:00 AM shift the documentation failed to identify IV or per orum (oral PO) intake and 24-hour totals were not calculated. Review of intake and output documents for 9/25/24 failed to identify IV intake or output on the 7:00 AM to 3:00 PM shift. Although Resident #406 should have received 600 ml of IV fluid on the 11:00 PM to 7:00 AM shift, the documentation indicated 250 ml of IV fluid was received and documentation failed to identify a 24-hr total. A physician's order dated 9/26/24 directed intravenous hydration of dextrose 5% 1/2 normal saline at 75 ml per hour for 1 liter. An APRN progress note dated 9/26/24 identified blood work indicating hypernatremia: Sodium 148, (normal 135-145), slowly trending down. Resident #406 has completed intravenous fluids. Oral intake is fair. Intravenous fluid dextrose 5% 1/2 normal saline at 75 milliliters per hour for 7 days, 3 liters, discontinue when complete. Review of the intake and output documents for 9/26/24 for the 7:00 AM to 3:00 PM failed to identify IV intake or any output. Additionally, the documents failed to identify any intake or output for the 3:00 PM to11:00 PM shift and failed to identify a 24-hour total. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 9/27/24 at 6:23 AM identified IV Dextrose 5% 1/2 normal saline infusing at 75 milliliters per hour. Review of intake and output documents on 9/27/24 failed to identify any intake, for the 11:00PM to 7:00 AM shift, the 7:00 AM to 3:00 PM shift, failed to identify any output, and the 3:00 PM to 11:00 PM failed to identify any intake or output; no 24-hour totals were calculated. On 9/28/24 the documents failed to identify intake for 11:00 PM to 7:00 AM, 7:00 AM to 3:00 PM, or 3:00 PM to 11:00 PM shifts. Additionally, output was identified only for the 11:00 PM to 7:00 PM shift, was 100 ml, and 24-hour totals were not calculated. On 9/29/24 documents failed to identify intake for the 11:00 PM to 7:00 AM and 3:00 PM to 11:00 PM shifts and failed to identify a 24-hour total. A physician's order dated 9/30/24 at 1:00PM directed intravenous hydration dextrose 5% 1/2 normal saline at 75 ml per hour for 2 liters. An APRN note dated 9/30/24 in part, identified poor oral intake, hyperosmolality and hypernatremia: sodium 147 mEq /Liter (normal 135-145) intravenous fluid dextrose 5% 1/2 normal saline at 75 ml per hour for 2 bags. Mucous membranes dry, malnourished, thin, alert and confused. A nurse's note dated 9/30/24 at 12:53 PM identified that Resident #406 did not have an active IV site on assessment. A nurse's note dated 9/30/24 at 10:22 PM identified the APRN ordered IV therapy and IV nurse to place an IV at 4:30 PM. IV fluids were started at 5:00 PM. On 9/30/24 the intake and output documents failed to identify intake for 11:00 PM to 7:00 AM shift, failed to identify output on 7:00AM to 3:00 PM shift, and failed to identify intake or output on 3:00 PM to11:00 PM, with no 24-hour totals. A nurse's note dated 10/1/24 at 10:40 PM identified a second IV bag was hung and infusing. Resident #406 did not eat their dinner meal. On 10/1/24 the intake and output documents failed to identify IV intake or output for 7:00 AM to 3:00 PM shift, failed to identify IV intake or output for 3:00 PM to 11:00 PM shift, and failed to identify a 24-hour total. A nurses note dated 10/2/24 at 2:38 AM identified Resident #406 independently pulled out the IV at 1:30 AM. Approximately 400 ml of IV fluid was remaining and the APRN was notified and instructed to hold reinsertion and resumption of fluids until seen by the house ARPN in the morning. On 10/2/24 the intake and output documents failed to identify output on 7:00 AM to 3:00 PM, and 3:00 PM to11:00 PM shifts. Additionally, the documents failed to identify a 24-hour total. A Physician's order dated 10/3/24 at 4:00PM directed intravenous hydration dextrose 5% 1/2 Normal saline at 60ml per hour for 2 liters for hypernatremia. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ARPN note dated 10/4/24 for follow up for dehydration: most recent blood work shows sodium of 148 (normal 135-145). In the past Resident #406 has been given several liters of fluids, and the sodium level has stayed in the high 140's. Nursing staff report resident #406's appetite is poor, and Resident #406 gets agitated with care. The Resident Care Plan dated 10/4/24 identified nutrition and hydration. Interventions included to encourage fluids, intake and output as needed, nutritional assessment, and weight as ordered. A nurses note dated 10/5/24 identified Resident #406's IV infiltrated into the forearm and elbow. The IV was removed and a call was placed to the IV nurse for reinsertion because 1.25 liters of IV fluid was remaining. A nurse's note dated 10/5/24 at 11:21 PM identified that the IV was infusing. An APRN note date 10/6/24 identified intravenous fluid dextrose 5% 1/2 normal saline at 60 ml per hour for hypernatremia for 3 days to infuse 2 liters. A nurses noted dated 10/6/24 at 4:16 AM identified that Resident #406 pulled out the IV saline lock with 100ml left in bag, the APRN was notified and instructed to encourage oral fluids. A physician's order dated 10/7/24 at 1:20 PM directed to reinsert the IV, dextrose 5% 1/2 normal saline at 75 ml per hour for 3 liters for hypernatremia and leukocytosis. A nurse's note dated 10/8/24 identified dextrose 5% 1/2 normal saline infusing at 75 ml per hr. A nurse's note dated 10/9/24 identified fluids were not able to be run due to IV not being patent. The provider assessed Resident #406 and ordered STAT (immediate) labs. On 10/9/24 at 10:28 PM, IV hydration was noted, 3rd bag hung at 8:00 PM. A physician's order dated 10/9/24 directed to hold IV fluids until IV line reinserted. Observation on 10/9/24 at 11:15 AM Resident #406 noted to be restless in bed, uncovering self, without an IV running. NA #2 repositioned Resident #406 in bed for comfort. Observation on 10/10/24 at 9:25 AM, Resident #406 was lying in bed, with IV infusing in the left arm, somewhat restless but more awake. Interview with LPN #1 on 10/9/24 at 12:30 PM identified that although Resident #406 had been receiving IV fluids from 10/3/24 through 10/9/24 according to the nurse progress notes, intake and output records could not be located. LPN #1 indicated that Resident #406 should have intake and output documents since s/he was on an IV hydration. Additionally, LPN #1 stated she had not started an intake and output document for Resident #406 as yet, but she would start one for today. Interview with MDS/Case Manager LPN #3 on 10/9/24 at 3:00 PM identified that she could not locate any additional intake and output documents from 10/3/24 through 10/9/24 and could not locate 24-hour totals in the progress notes for any of the days Resident #406 had an IV from 9/20/24 until present. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with DNS on 10/10/24 at 10:21 AM identified that the facility policy was to ensure IV fluid amounts were documented on the intake and output form. Review of Resident #406's intake and output record with DNS identified numerous missing and blank intakes as noted. The DNS identified that both oral and IV intake as well as output should be recorded as well as 24-hour totals. The charge nurse was responsible to calculate the total for the shift they worked and the 11:00 PM to 7:00 AM nurse was responsible to calculate the 24 totals. The DNS was unable to explain the omissions. Review of the intake and output (I&O) recording policy directed, in part, intake and output of fluids is documented when indicated by attending physician order or by nursing per resident diagnosis and or treatment. I&O recording may be instituted per an attending physician order or by a licensed nurse for any resident with the following: intravenous therapy for hydration, and urinary catheter. Nursing staff will be responsible for completing the I&O records at the end of each shift. Information obtained from the I&O will be totaled daily and reviewed to ensure resident's intake and output are sufficient to meet the resident's needs. 51182

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **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 2 residents (Resident #85) reviewed for hospitalization , the facility failed to ensure that a resident who was hospitalized for digoxin toxicity did not receive the same high risk medication (digoxin) on readmission from the hospital which resulted in a significant medication error. The findings include: Resident #85 's diagnoses included atrial fibrillation, congestive heart failure, and thrombophilia. The admission nursing assessment dated [DATE] identified Resident #85 was cognitively intact, required staff assistance with toileting, required total/maximum assistance of two staff members for transfers, and was non-ambulatory. Review of the Resident Care Plan (RCP) in effect 9/30/24 through 10/11/24 identified Resident #85 was at risk for cardiac distress. Interventions included to administer medications as ordered and monitor for adverse effects. The RCP failed to identify that Resident #85 had been hospitalized with digoxin toxicity. A hospital discharge interagency referral form (W10) dated 9/30/24 identified Resident #85 had been admitted to the hospital after being sent out from the facility due to severe bradycardia related to digoxin toxicity and was discharged back to the facility on [DATE]. The discharge instructions included to stop taking digoxin 250 micrograms (mcg) daily. A physician's order dated 9/30/24 directed to administer digoxin 250 mcg by mouth in the morning for atrial fibrillation. Review of the October medication administration record (MAR) for Resident #85 identified that digoxin 250 mcg had been administered on 10/1/24 at 9:00 AM. A physician's order dated 10/1/24 directed to discontinue the digoxin 250 mcg order. A nurse practitioner note (NP) dated 10/1/24 at 4:00 PM identified that Resident #85 was seen after being readmitted from the hospital. Resident #85 was in the hospital for bradycardia related to digoxin toxicity for which he/she received 7 doses of Digibind (an antidote to treat a life-threatening overdose of digoxin). The note further identified that digoxin was to be avoided. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Registered Nurse (RN) #3 on 10/10/24 at 11:45 AM identified that she had entered the admission medication orders for Resident #85 into the electronic medical record (EMR) on 9/30/24. RN #3 stated that she had completed a drug regimen review (DRR) with the covering on-call Nurse Practitioner (NP). She entered the orders under the attending medical doctor's name due to the covering NP's name not being available in the Electronic [NAME] Record (EMR) system. Further RN #3 indicated that she would have documented the completion of the DRR in her nursing progress note to show the NP, not the attending physician, had completed the DRR with her. RN#3 stated she could not recall entering the order for digoxin and that she would not have entered an order for a medication that was not listed on the W10 from the hospital but could not recall the specific circumstances. RN#3 stated she was not aware Resident #85 was treated for digoxin toxicity, and that if she had known she would not have entered the order for digoxin into Resident #85's EMR. Review of the progress notes written on 9/30/24 for Resident #85 failed to identify a note authored by RN #3. Interview with the Assistant Director of Nursing Services (ADNS) on 10/10/24 at 2:00 PM identified that on 10/2/24 she had co-signed Resident #85's nursing admission assessment from 9/30/24 after verifying that the orders in the EMR matched the W10 however, she had not done the DRR. The ADNS stated that the DRR would have been done at the time of re-admission by the RN entering the medication orders. The ADNS further identified that re-admission orders are not double checked on the 11-7 shift. The policy was that re-admission orders were reviewed in morning report the following day, and the order summary report, which was used for the DRR, was printed and signed by two nurses and the MD or APRN to verify accuracy. The ADNS further identified that the order for digoxin 250 mcg for Resident #85 was seen on review in morning report and subsequently it was discontinued. Review of the order summary report used for the DRR for Resident #85 identified a signature from APRN #1 on 10/1/24, and only one nurse's signature, RN #3, on 9/30/24. Interview with Pharmacist #1 on 10/11/24 at 9:50 AM identified that digoxin being given after digoxin toxicity was a major medication error and demonstrated a deficiency in the transition of care. Pharmacist #1 stated that the facility's first priority on re-admission would have been to determine what had changed for Resident #85. Pharmacist #1 further identified that digoxin being ordered and given following Resident #85's hospitalization for digoxin toxicity was highly negligent, as digoxin was one of the worst medications for Resident #85 to have received if he/she wasn't supposed to be administered digoxin. Further digoxin would slow down an individual's heart rate and could result in cardiac insufficiency. Interview with Licensed Practical Nurse (LPN) #2 on 10/11/24 at 10:20 AM identified that she could not specifically recall administering medications to Resident #85 on 10/1/24 following his/her re-admission the previous evening. LPN #2 stated that if the EMR directed digoxin be given and the documentation showed she had administered the medication, then she did. LPN #2 stated that if a medication had not been available for Resident #85, she would have gone to retrieve it from the pyxis machine (emergency medication storage) and if it had not been available in the pyxis machine she would have called the pharmacy to have it sent to the facility. LPN #2 stated she would have then documented within the EMR the appropriate code for the medication not being available and written a progress note documenting steps she had performed to obtain the medication. Review of the Medications policy directed, in part, all medications administered to the resident should be ordered by the physician, and medications should be dispensed using the correct protocol for the mobile medications cart. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility policy for Drug Regimen Review was not provided.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on interviews, observations and facility policy for the only sampled resident (Resident #96) reviewed for cultural food preferences, the facility failed to ensure the dietician identified and provided Halal cuisine. The findings include: Resident #96 was admitted to the facility in March 2024 with diagnoses that included cerebral infarction, dysphagia, and right sided hemiplegia and hemiparesis. A Resident Care Plan (RCP) dated 3/8/24 identified Resident #96 followed Halal cuisine and food with interventions that included for Resident #96's family to come in for support, and the family wanted to provide translation as well. Additional interventions included to observe for any changes in baseline cognition, mood or behavior and offer and allow family to visit often. An initial Nutritional Evaluation dated 3/11/24 at 11:53 AM and written by the dietician identified that on 3/11/24, Resident #96 weighed 141.2 pounds (lbs.). The Nutritional Evaluation further identified the dietician was provided with Resident #96's food preferences and did not identify any dietary concerns or cultural accommodations for meal offerings (despite the RCP dated 3/8/24 indicating Resident #96 followed a Halal cuisine diet). The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #96 had severe cognitive impairment, required substantial assistance with chair/bed to chair transfers, and required set-up assistance with eating. A physician order dated 4/15/24 directed a ground texture, thin consistency diet with no concentrated sweets (but failed to identify Resident #96 followed a Halal cuisine). On 10/8/24 at 12:37 PM, observation of Resident #96's meal identified he/she was served pumpkin dump cake, mashed potatoes, and cut mixed vegetables (green beans, carrots and cauliflower). On 10/9/24 at 12:33 PM, observation of Resident #96's meal tray identified the meal ticket noted ground consistency, vegetarian diet, dislikes ham, pork, sausage, bacon, chicken, veal and turkey, fish was ok. Further observation of the meal identified Resident #96 was served a crustless egg salad sandwich, 2 pieces of toast, buttered noodles and a Styrofoam container of a white substance. On 10/11/24 at 9:43 AM, interview with the Director of Dietary identified she was aware that Resident #96 was being provided a vegetarian diet (although Resident #96 was not a vegetarian) but was unaware Resident #96 followed a Halal cuisine diet prior to admission. Additionally, the Director of Dietary indicated had she been aware of Resident #96's Halal diet, she would have been able to accommodate the cultural diet request because she was familiar with a supplier who could provide Halal foods. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075334	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vernon Rehabilitation and Healthcare Center	180 Regan Road Vernon, CT 06066

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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 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	On 10/22/24 at 9:50 AM, interview with the dietician identified being unaware of Resident #96's cultural requirements of a Halal diet (despite the RCP dated 3/8/24 indicating Resident #96 followed a Halal cuisine diet). Additionally, she identified being able to accommodate a Halal diet into Resident #96's nutritional diet plan, and was aware Resident #96's family brought in food for the resident in the evening. Interview with Social Worker (SW) #2 on 10/11/24 at 12:23 PM identified she spoke regularly with the family, was aware Resident #96 was Muslim, followed a Halal diet, and that Resident #96's family brought in Halal food every evening for dinner because Resident #96 ate nothing provided by the facility for lunch and dinner. Facility policy regarding Cultural Competent Care identified each resident will be assessed upon admission to determine if they are culturally diverse and once identified, food preparation/choices will be added to the Resident Care Plan. Additionally, resident specific approaches will be developed and included in the RCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of the clinical record, facility documentation and interviews for the only sampled resident, (Resident #46), reviewed for hospice, the facility failed to collaborate and communicate the provision of hospice services with the contracted hospice provider. The findings include: Resident #46's diagnoses included major depressive disorder, dementia without behavioral disturbances, psychotic disturbance, mood disturbance, and anxiety. A W-10 (transfer document) signed by Resident #46's physician on 3/22/23 directed Resident #46 to be admitted to the facility on comfort care and to notify hospice with any changes in condition or needs. The Nursing Admission Evaluation dated 3/23/23. Identified Resident #46 was totally dependent for personal hygiene, mobility, transfers, and toilet use. Further, Resident #46's discharge goal was to remain in the facility with hospice care coordination. The nursing admission note dated 3/23/23 at 7:42 PM identified that when Resident #46 arrived, he/she was unable to communicate due to cognitive impairment, required total care, and the contracted hospice nurse had evaluated Resident #46 and had not recommended any new orders. The APRN admission note dated 3/24/23 at 1:01 PM identified Resident # 46 was receiving hospice services. Review of Resident #46's Resident Care Plan (RCP) dated 3/23/23 through 9/16/24 identified the resident was receiving contracted hospice services. The RCP failed to include a contracted hospice provider plan of care for Resident #46. Review of Resident #46's clinical record identified an initial Hospice Election, State of Connecticut form dated 6/28/22 (9 months prior to Resident #46's admission to the facility), which was signed by the Power of Attorney (POA). Additional hospice information present in the clinical from prior to the resident's admission included an Interdisciplinary Plan of Care and revision/Physician Orders from 6/30/2022 and 9/30/2022. The only post admission documentation located in Resident #46's clinical record was 1 hospice provider comprehensive nursing assessment dated [DATE] and 6 contracted hospice provider social work notes. The clinical record post facility admission failed to contain a hospice election form signed after admission in March 2023, the initial hospice physician's certification, an every 6 month physician recertification renewal for continued hospice services, coordination of which hospice provider staff would be providing care, documentation of facility visits/notes (other than social work notes) by the hospice providers, schedules, or a hospice Resident Care Plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with Social Worker (SW) #2 on 10/9/24 at 2:00 PM identified she assumed she was responsible to coordinate hospice services for Resident #46 and that the process for facility staff to communicate with hospice was done so verbally. SW #2 indicated she believed hospice staff wrote any recommendations related to Resident #46's care in the physician orders. SW #2 was unable to explain how nursing knew when hospice staff were scheduled to visit with Resident #46. SW #2 stated she ran the Resident Care Plan conferences, but the hospice team had never attended, asked about attending the Resident Care Plan meeting, and, except for an initial meeting with a hospice nurse on Resident #46's admission (19 months prior), she has never met with any hospice provider team members to coordinate Resident #46's care. SW #2 indicated that all hospice documentation for Resident #46 should be in the resident's clinical record or in a hospice binder. Review of the clinical record and inspection of the nursing station failed to identify any hospice information with the exception of a hospice sign-in visit log, the nursing assessment dated [DATE], and the 6 social work notes since Resident #46's admission in March of 2023. Interview and review of the clinical record with the DNS on 10/10/24 at 3:28 PM failed to reflect hospice documentation in Resident 46's clinical record or a hospice binder. The DNS identified that based on documentation in Resident #46's clinical record, she was unaware of which hospice provider disciplines (staff) participated in Resident #46's care or how often visits occurred. Although hospice provider staff verbally communicated the plan of care with facility nursing and/or the APRN, the policy was that communication would be documented in the paper chart. The DNS indicated that SW #2 coordinated hospice provider care and she would have to speak to her regarding the location of documentation for Resident #46's. The DNS indicated that hospice nurses come in to see Resident #46 and according to what they determine, information should be communicated in writing and placed in the paper chart. The DNS stated she was not aware that the last hospice care plan update was on 3/23/23. The DNS stated nurses follow the facility change of condition policy when hospice needs to be notified of changes for Resident #46. The DNS reviewed the clinical record of Resident # 46 and did not locate an updated plan of care, nursing visit forms, signed hospice election form, the physician initial certification or recertifications, or any scheduled visits. The DNS was unable to explain how facility staff on other shifts would be able to review hospice information. The DNS stated the ADNS, and nursing supervisor were responsible for implementation of issues identified in Resident #46's record. The DNS indicated that the lack of information regarding hospice was due to lack of coordination with hospice. Although attempted a phone interview with hospice nurse on 10/10/24 at 2:35pm, an interview was not obtained. Subsequent to surveyor inquiry, the facility obtained updated plans of care, completed nursing weekly visit forms, a hospice election form, a physician's certification and recertifications for Resident #46's clinical record. Although requested, the facility identified that there was no policy for Hospice.