

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075336	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Southington Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Meriden Ave Southington, CT 06489	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950</p> <p>Based on the interviews, observations, facility policy, and record review for 1 of 1 sampled resident (Resident #27) reviewed for edema, the facility failed to report a weight gain of 3 pounds or more in 24 hours as directed by the physician, and for one (1) of three (3) residents (Resident #626), reviewed for fluid restrictions, the facility failed to ensure the physician was notified when the resident exceeded the daily fluid restriction. The findings include:</p> <p>1) Resident #27's diagnosis included congestive heart failure, dementia, and hypertension.</p> <p>Physician orders dated 10/6/23 through 5/2/24 directed to obtain a weight daily and to notify the physician with a 3 pound (lb) weight gain in 1 day or a 5 lb weight gain in 1 week.</p> <p>The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #27 was moderately cognitively impaired and was dependent with personal hygiene, bathing and toileting. Additionally, the MDS identified Resident #27 required set up assist for oral hygiene and was independent with eating.</p> <p>The Resident Care Plan dated 1/10/24 indicated Resident #27 was at risk for cardiopulmonary compromise related congestive heart failure. Interventions included to monitor daily weights, report a weight gain of 3 lbs in 24 hours or 5 lbs in 1 week to the physician, vital signs daily, and monitor lung sounds every shift.</p> <p>Review of the Vital Reports identified Resident #27's weight on 3/10/24 was 150.4 lbs and on 3/12/24 Resident #27's weight was 158 lbs (a weight gain of 7.6 pounds in 2 days). Additionally Resident #27's weight was 148 lbs on 3/22/24 and on 3/24/24 Resident #27's weight was 157.6 (a weight gain of 9.6 lbs in 2 days). Resident #27's weight on 4/9/24 was 152 lbs and on 4/11/24 was 156.2 lbs (a weight gain of 4.2 pounds in 2 days). Additionally, the clinical record failed to identify the physician/APRN was notified of Resident #27's weight gain on 3/12/24, 3/24/24 and on 4/11/24.</p> <p>On 5/1/24 at 11:15 AM interview with RN #1 identified the Charge Nurse was responsible for making sure that daily weights were completed and for reporting the changes to the physician or APRN. RN #1 indicated being unsure as to the reason the weight gain was not reported to the physician or APRN, and that they should have been notified.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/24 at 11:23 AM interview with APRN #1 identified that if she was notified of the weight gain that the nurse's note would reflect that. APRN #1 reviewed the dates of 3/12/24, 3/24/24, and 4/11/24 and stated that she was not notified of Resident #27's weight gain of 3 pounds or more. She identified the expectation was for her to be notified and that a weight gain of 3 pounds or more could be an indication of heart failure.</p> <p>On 5/2/24 at 11:58 AM interview with RN #4 indicated that she was not working on the unit, and just entered the weight results in the clinical record to assist the other nurse on the unit. RN #4 identified that she did not report the weight gain to the physician or the APRN.</p> <p>On 5/2/24 at 12:03 PM interview with LPN #2 identified that she did not report the weight gain of 9.6 pounds from 3/24/24 to the physician or the APRN because she was unsure of the policy, and the physician order.</p> <p>Subsequent to this surveyor's inquiry daily weights were discontinued.</p> <p>The Weight Tracking Policy identified that residents with a diagnosis of congestive heart failure will be weighed daily or as ordered by the physician. Weights will be given to the nurse on the unit and documented in the electronic health record. If the resident has a weight gain of 3 pounds or more, the nurse will request a reweight to be completed immediately. A nursing note must be written to include the weight change and completion of updates to the physician/APRN and the registered dietician. Residents with a diagnosis of congestive heart failure and weight gain of 3 pounds or more are to notify the physician/APRN and the registered dietician immediately.</p> <p>2) Resident #626 was with diagnoses that included acute diastolic heart failure, and chronic systolic heart failure.</p> <p>The quarterly MDS dated [DATE] identified Resident #626 had severely impaired cognition, was frequently incontinent of bowel, always incontinent of bladder, and was dependent with eating, toileting, personal hygiene, bed mobility, and dressing.</p> <p>A physician's order dated 2/16/2023 directed that Resident #626 had a fluid restriction of 1900 milliliters (ml) in 24 hours.</p> <p>The care plan dated 3/15/2023 identified Resident #626 at risk for alteration in fluid balance due to diagnosis of congestive heart failure with interventions directed that the resident was on a strict fluid restriction and to monitor daily intake and output.</p> <p>Review of Resident #626's oral intake records from 2/16/23 to 2/28/23 identified Resident #626 exceeded the daily fluid restriction of 1900 ml's 8 days out of the 12 days reviewed. Fluid intake on the 8 days ranged from 1955 ml's to 2680 ml's (between 55 and 780 ml's over the fluid restriction).</p> <p>Review of Resident #626's oral intake records from 3/1/23 to 3/31/23 identified Resident #626 exceeded the daily fluid restriction of 1900 ml's 23 days out of 31 days reviewed. Fluid intake on the 23 days ranged from 2090 ml's to 2945 ml's (between 190 and 1045 ml's over the fluid restriction).</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #626's oral intake records from 4/1/23 to 4/26/23 identified Resident #626 exceeded the daily fluid restriction of 1900 ml's 16 out of 26 days. Fluid intake on the 16 days ranged from 2055 ml's to 2679 ml's (between 155 and 779 ml's over the fluid restriction).</p> <p>Interview and clinical record review with the DNS on 5/9/2024 at 9:00 A.M. identified her expectation is that when a resident exceeds the daily fluid restriction the nurse would notify the APRN.</p> <p>Interview with APRN #1 on 5/9/2024 at 9:35 A.M. identified that she was not made aware when Resident # 626 had exceeded the daily fluid intake of 1900 ml's in 24 hours. APRN#1 identified her expectation is the nurse notifies her when a resident exceeds the daily fluid restriction.</p> <p>Review of facility congestive heart failure care pathway policy, in part, directed to monitor changes in intake and output and notify MD on any changes in condition.</p>

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on interviews, review of the clinical record, and facility documentation, for 1 of 3 residents (Resident #40) reviewed for Resident Assessments, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessment was accurately coded for PASRR (Preadmission Screening and Resident Review) Level II.</p> <p>Resident #40 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, major depressive disorder, and anxiety disorder.</p> <p>The PASRR Level I report dated 8/10/18 indicated that a PASRR Level II evaluation must be conducted. The PASRR Level II report dated 8/10/18 indicated that Resident #40's care needs were appropriate to be serviced in a nursing facility setting, although the resident had diagnoses of schizoaffective disorder, bipolar disorder, major depressive disorder, and anxiety disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was mildly cognitively impaired and required moderate assistance for bed mobility and transfers, and supervision with ambulation. Additionally, the MDS identified diagnoses of anxiety, depression, and schizophrenia but failed to identify Resident #40 was coded to reflect a Level II PASRR in Section A 1500.</p> <p>Interview and clinical record review with RN #2 (MDS Coordinator) on 5/1/24 at 12:36 PM failed to identify that Section A 1500 of the annual MDS dated [DATE], 8/17/20, 8/2/21, 7/21/22, and 6/17/23 were coded to reflect Resident #40's Level II PASRR status and therefore was not coded correctly. She reported that Resident #40 should have been coded as being evaluated for a Level II PASRR and having a serious mental illness and that she would correct the 6/17/23 MDS, but that it was too late to go back and correct the 6/24/19, 8/17/20, 8/2/21, 7/21/22 dates. She indicated the omissions were errors, and that MDS staff were responsible for answering questions A 1500 and A 1510 of the MDS.</p> <p>Subsequent to surveyor inquiry on 5/1/24, a correction to section A, questions 1500 and 1510 of the MDS was completed and submitted for the annual MDS dated [DATE], which identified Resident #40 as having a PASRR Level II status and indicating the PASRR conditions.</p> <p>Review of the Resident Assessment Instrument (RAI) Manual identified, in part, that if a PASRR Level II screening determined that the resident had a serious mental illness, question A 1500 should be coded as 1 (yes) and should be continued to question A 1510, Level II PASRR Conditions.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950</p> <p>Based on the interviews, observations, facility policy, and record review for 1 of 1 sampled resident (Resident #27) reviewed for edema, the facility failed to obtain daily weights as per physician orders. The findings include:</p> <p>Resident #27's diagnosis included congestive heart failure, dementia, and hypertension.</p> <p>Physician orders dated 10/6/23 through 5/2/24 directed to obtain a weight daily and to notify the physician with a 3 pound (lb) weight gain in 1 day or a 5 lb weight gain in 1 week.</p> <p>The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #27 was moderately cognitively impaired and was dependent with personal hygiene, bathing and toileting. Additionally, the MDS identified Resident #27 required set up assist for oral hygiene and was independent with eating.</p> <p>The Resident Care Plan dated 1/10/24 indicated Resident #27 was at risk for cardiopulmonary compromise related congestive heart failure. Interventions included to monitor daily weights, report a weight gain of 3 lbs in 24 hours or 5 lbs in 1 week to the physician, vital signs daily, and monitor lung sounds every shift.</p> <p>Review of the Vital Reports weight record and Treatment Administration Record identified the following weights were missing: In November 2023, 8 days of 30, December 2023, 13 days of 31, January 2024, 15 days of 31, February 2024, 10 days of 29, March 2024, 9 days of 31, and in April 2024, 5 days of 30 were missing from the record for daily weights.</p> <p>On 5/1/24 at 11:15 AM an interview with RN #1 identified the Charge Nurse on the unit was responsible for making sure that daily weights were completed and for reporting the changes to the physician or APRN. RN #1 reviewed the weights and confirmed that daily weights had not been completed as ordered and she was unsure the reason weights were not completed.</p> <p>Subsequent to this surveyor's inquiry daily weights were discontinued.</p> <p>The Weight Tracking Policy identified that residents with a diagnosis of congestive heart failure will be weighed daily or as ordered by the physician. Weights will be given to the nurse on the unit and documented in the electronic health record. If the resident has a weight gain of 3 pounds or more, the nurse will request a reweight to be completed immediately. A nursing note must be written to include the weight change and completion of updates to the physician/APRN and the registered dietician. Residents with a diagnosis of congestive heart failure and weight gain of 3 pounds or more are to notify the physician/APRN and the registered dietician immediately.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 50177</p> <p>Based on observations, review of the clinical record, facility policy, and interviews for 1 sampled resident (Resident #27) observed on tour, the facility failed to properly store bed pans and for 6 of 6 residents (Resident #30, Resident #68, Resident #77, Resident #111, Resident #118, and Resident #675) reviewed for Infection Prevention, the facility failed to appropriately implement Enhanced Barrier Precautions (EBP) and The findings include:</p> <p>1. Resident #27's diagnosis included congestive heart failure, dementia, and hypertension.</p> <p>The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #27 was moderately cognitively impaired and was dependent with personal hygiene, bathing, transfers, toileting, required substantial maximal assist with oral hygiene and independent with eating.</p> <p>Observation on 4/29/24 at 3:18 PM identified a bed pan was noted to be uncovered, not labeled, on the floor, beside the toilet of Resident #27's bathroom.</p> <p>A second observation on 4/30/24 at 9:22 AM with RN #1 identified a bed pan was noted to be uncovered, not labeled, on the floor, beside the toilet of Resident #27's bathroom.</p> <p>Interview with RN #1 on 4/30/24 at 9:30 AM identified that bed pans should be in a paper sleeve, labeled, and not placed on the floor but stored in the resident's nightstand. She also stated that Resident #27 uses a bedpan with staff assistance.</p> <p>Review of the facilities policy for cleaning bedpans and urinals identified that bedpans are to be cleansed, dried, covered and placed in the resident's bedside cabinet.</p> <p>2. Resident #30's diagnoses included dementia, benign prostatic hyperplasia (BPH) with foley catheter use, urinary retention, and Methicillin Resistant Staphylococcus Aureus infection (MRSA).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 was severely cognitively impaired and required substantial/maximal assistance with oral hygiene, was dependent with toileting hygiene and personal hygiene, and was independent with walking 10 feet. Additionally, the MDS identified that Resident #30 had an indwelling catheter.</p> <p>The Resident Care Plan (RCP) dated 1/23/24 identified Resident #30 had an indwelling urinary catheter related to obstructive uropathy and BPH. Interventions included documenting urinary output every shift, provide catheter care every shift and as needed, and to report signs/symptoms of a urinary tract infection.</p> <p>A physician's order dated 4/1/24 through 4/30/24 identified Resident #30 had an indwelling foley catheter.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order dated 4/6/24 directed EBP (the physician's order failed to identify that EBP was initiated from 4/1/24 through 4/5/24 during which time Resident #30 had an indwelling foley catheter.)</p> <p>On 4/29/24 at 10:30 AM, tour of the unit failed to identify EBP were initiated as evident by Personal Protective Equipment (PPE) not being available outside Resident #30's room and failed to include signage at or outside of Resident #30's room that indicated Resident #30 was on EBP.</p> <p>3. Resident #68's diagnoses included dementia, non-pressure chronic ulcer of buttock with fat layer exposed, pilonidal cyst without abscess, and nutritional deficiency.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #68 was severely cognitively impaired and required setup or clean-up assistance with eating and oral hygiene, substantial/maximal assistance with showering/bathing and personal hygiene, and supervision or touching assistance with walking. Additionally, the MDS identified that Resident #68 had an open lesion with treatments that included application of nonsurgical dressings and ointments/medications.</p> <p>The RCP dated 3/22/24 identified Resident #68 had fragile skin and was at risk for skin integrity alteration due to occasional incontinence of bladder and potential for friction and shear. Additionally, the RCP identified that Resident #68 had a pilonidal cyst/open lesion to the coccyx. Interventions included treatment to wounds and impaired skin as ordered, to monitor healing, and to complete skin checks with care and as needed.</p> <p>A physician's order dated 4/1/24 through 4/30/24 identified Resident #68 had a wound to the coccyx.</p> <p>A physician's order dated 4/29/24 directed EBP (the physician's order failed to identify that EBP was initiated from 4/1/24 through 4/28/24 during which time Resident #68 had a wound).</p> <p>On 4/29/24 at 10:30 AM, tour of the unit failed to identify EBP were initiated as evident by PPE not being available outside Resident #68's room and failed to include signage at or outside of Resident #68's room that indicated Resident #68 was on EBP.</p> <p>4. Resident #77's diagnoses included Fournier disease of the vagina and vulva, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, sepsis, and nutritional deficiency.</p> <p>The admission MDS assessment dated [DATE] identified Resident #77 was cognitively intact and required partial/moderate assistance with showering/bathing, was dependent with toileting hygiene, and required substantial/maximal assistance with walking 10 feet. Additionally, the MDS identified that Resident #77 had one or more unhealed pressure injuries, including one Stage 4 pressure ulcer and two Stage 1 pressure ulcers, and a surgical wound with treatments that included application of ointments/medications.</p> <p>The RCP dated 4/3/24 identified Resident #77 had a pressure ulcer/injury and a surgical wound status post incision and drainage of Fournier's gangrene. Interventions included checking the wound daily and as needed, observe for redness, drainage, new or increased pain, and poor healing, and surgical follow up as needed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order dated 4/1/24 through 4/30/24 identified that Resident #77 had a perianal wound.</p> <p>A physician's order dated 4/29/24 directed EBP (the physician's order failed to identify that EBP was initiated from 4/1/24 through 4/28/24 during which time Resident #77 had a wound).</p> <p>On 4/29/24 at 10:30 AM, tour of the unit failed to identify EBP were initiated as evident by PPE not being available outside Resident #77's room and failed to include signage at or outside of Resident #77's room that indicated Resident #77 was on EBP.</p> <p>5. Resident #111's diagnoses included Type 2 diabetes mellitus, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, cellulitis of left lower limb, and nutritional deficiency.</p> <p>The admission MDS assessment dated [DATE] identified Resident #111 was moderately cognitively impaired and required substantial/maximal assistance with toileting hygiene, showering/bathing, and personal hygiene, and walking was not attempted due to medical condition or safety concerns. Additionally, the MDS identified Resident #111 had a surgical wound with treatments that included application of ointments/medications.</p> <p>The RCP dated 4/1/24 identified Resident #111 had a surgical wound to the left knee status post debridement of an infected wound. Interventions included checking the incision daily and as needed, observe for redness, drainage, new or increased pain, and poor healing, and surgical follow up as needed.</p> <p>A physician's order dated 4/1/24 through 4/30/24 identified Resident #111 had a left knee wound.</p> <p>A physician's order dated 4/29/24 directed EBP (the physician's order failed to identify that EBP was initiated from 4/1/24 through 4/28/24 during which time Resident #111 had a wound).</p> <p>6. Resident #118's diagnoses included Type 2 diabetes mellitus, BPH with foley catheter use, urinary retention, and neuromuscular dysfunction of bladder.</p> <p>The admission MDS assessment dated [DATE] identified Resident #118 was severely cognitively impaired and required substantial/maximal assistance with toileting hygiene and showering/bathing, setup or clean-up assistance with personal hygiene, and partial/moderate assistance with walking 10 feet. Additionally, the MDS identified Resident #118 had an indwelling catheter.</p> <p>The RCP dated 2/5/24 identified Resident #118 had an indwelling urinary catheter, alteration in elimination, and a foley due to diagnosis of neurogenic bladder. Interventions included to offer and encourage fluids if not contraindicated, maintain tubing to straight drainage keeping drainage bag below level of the bladder, and foley care per protocol.</p> <p>A physician's order dated 4/1/24 through 4/30/24 identified Resident #118 had a foley catheter.</p> <p>A physician's order dated 4/29/24 directed EBP (the physician's order failed to identify that EBP was initiated from 4/1/24 through 4/28/24 during which time Resident #118 had a foley catheter).</p> <p>(continued on next page)</p>		

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