STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075343	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerome Home	975 Corbin Avenue New Britain, CT 06052

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 51102 Based on interviews, review of the clinical record, and facility policy for 1 of 2 residents (Resident #343) reviewed for transmission-based precautions, the facility failed to notify the social worker, physician, and psychiatrist after a suicidal ideation statement was made, per the facility policy. The findings included: Resident #343 was admitted to the facility on [DATE] with diagnoses that included homicidal ideation, sepsis, chronic combined systolic and diastolic heart failure, and muscle weakness. A facility consult form for psychiatry services dated 1/24/25 and signed by Resident #343 identified the reason for the referral was due to a comment made in the ICU (at the hospital and prior to facility admission) regarding homicidal ideation, knives, glass, cans were withheld in the hospital. (Psychiatry at the Long Term Care facility was not updated regarding Resident #343's psychosocial behavior in the hospital). A physician's order dated 1/24/25 directed for consultations as needed, to include, but not limited to dental, podiatry, audiology, ophthalmology, behavioral health, and wound care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #343 was cognitively intact, was fully dependent on staff for upper and lower dressing and required substantial/maximal assistance to roll from a sitting to lying position in bed. Additionally, the MDS identified that in the 2 weeks prior to admission, Resident #343 felt down, depressed or hopeless for several days (frequency identified as 2-6 days). A nursing note dated 1/31/25 at 11:04 PM and written by Licensed Practical Nurse (LPN) #2 identified writer walked down to check on resident and observed him/her on the floor next to his/her bed lying on his/her belly with a pillow, when asked what were you trying to do just before you fell , resident stated he/she was trying to jump out the window. The nursing note failed to identify further assessments by the charge nurse (Registered Nurse), or documentation that the nursing supervisor, social services, physician, or psychiatrist were notified. A nursing note dated 2/3/25 at 8:18 AM identified a request for Resident #343 to be seen by psychiatry was put in the psychiatric book secondary to Resident #343 stating he/she was trying to jump out the window (3 days after the statement was made, and 10 days after admission). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Jerome Home		STREET ADDRESS, CITY, STATE, ZIP CODE 975 Corbin Avenue New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with Registered Nurse (RN) #4 on 2/4/25 at 3:17 PM identified she was the nursing supervisor on 1/31/25 but was not notified Resident #343 stated he/she wanted to jump out the window. Additionally, the facility policy for residents with suicidal statements was to have 15-minute checks or be put on 1:1 observation. An interview with LPN #2 on 2/4/25 at 3:26 PM identified the facility policy on suicidal statements was to complete 15-minute checks on the resident, have them be seen by psychiatry, and maintain close observation. LPN #2 identified she did not notify anyone (supervisor, social worker, physician/APRN) of Resident #343's statement that he/she wanted to jump out the window because she did not interpret the statement as suicidal since the resident had been saying he/she wanted to go home. An interview with Social Worker #1 on 2/4/25 at 3:52 PM identified that it was part of the facility policy to notify the social worker when suicidal statements were made so that the resident could be further assessed and behavioral health involved if needed. Social Worker #1 identified that she was not notified about Resident #343's statements, but due to the time of the incident (Friday after hours) she would have expected nursing to institute protocol by calling the on call psychiatric services and/or starting 1:1 observation. The Resident Care Plan dated 2/4/25 (developed subsequent to surveyor inquiry) identified Resident #343 made a vague provocative comment that he/she was trying to go out the window, he/she had recently been more angry, discouraged, refused to attend short term therapy and declined medications. Interventions included psychiatric evaluation as ordered and report changes in behavior to the doctor. An interview with APRN #1 on 2/5/25 at 10:07 AM identified that she was not notified of Resident #343's statement regarding jumping out the window, and she would expect to be notified of suicidal statements. If she had been notified, she would have gotten clarity from Resident #343 about the statement by asking additional questions, then, if necessary, instituted 1:1 or sent him/her out to the emergency room . Review of the Suicide Precaution Policy dated 11/12 directed in part that suicide precaution will be initiated when a resident has put his/her safety in question. Subsequently notifying the nursing supervisor and /or social worker, notifying the physician or psychiatrist, placing the resident on 1:1 by staff until otherwise directed by the physician or psychiatrist.

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51867 Based on observations and staff interviews for 2 of 6 common areas, the facility failed to maintain a clean environment for two large vents on the North and East units. The findings include: During a tour of the East wing on 2/3/25 at 10:30 AM, and 2/5/25 at 12:00 PM, a large vent measuring approximately 2.5 feet by 5.0 feet tall located in the open common area, was observed to have significant amount of debris, dark in color, within the slats of the vent. During a tour of the North unit on 2/4/25 at 10:30 AM, a large vent, approximately 2.5 feet by 5.0 feet on the wall in the open common area was observed to have a significant amount of dark colored debris visible throughout the slats and inside of the vent. Interview with the Director of Facilities on 2/5/25 at 1:15 PM, identified vent cleaning was the responsibility of the housekeeping staff, that the vents were supposed to be vacuumed weekly, and required cleaning. Subsequent to survey inquiry, the Director of Facilities identified that the housekeeping staff reported directly to him, the vents had been cleaned, and that going forward he would ensure that the housekeeping staff were vacuuming the debris from the large vents.

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observation, review of the clinical record, facility policy, and interviews for 1 of 3 residents, (Resident #35), reviewed for abuse, the facility failed to ensure a resident exposed to a communicable illness was free to exit their room when wearing appropriate Personal Protective Equipment (PPE). The findings include: Resident #35's diagnoses included ischemic cardiomyopathy, adjustment disorder, dementia, and stage 3 chronic kidney disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #35 was severely cognitively impaired, required supervision from a sit to stand position, required moderate assistance in walking 150 feet, and had no history of wandering. The Resident Care Plan (RCP) identified Resident #35 required assistance with activities of daily living. Interventions included providing staff assistance for ambulation using a wheeled walker on first and second shifts. A nurse progress note dated 1/30/25 identified Resident #35's roommate had tested positive for Respiratory Syncytial Virus (RSV), Resident #35 had no fever, cough, cold symptoms, or congestion, and was on contact and droplet precautions. A nurse progress note dated 1/31/25 identified Resident #35 to be free from fever, cough, cold symptoms, or congestion, and was on contact and droplet precautions. Nurse progress notes dated 2/1/25, 2/2/25, and 2/3/25 identified Resident #35 was not experiencing any signs or symptoms associated with RSV (congestion, cough, fever, and runny nose). Review of physician order's dated 12/3/24 through 2/3/25 failed to identify Resident #35 had been tested for RSV or had an order for placement on droplet or contact precautions and/or isolation An observation on 2/3/25 at 3:27 PM identified a sign indicating contact and droplet precautions outside of Resident #35's room. Resident #35 was not visible from the doorway, he/she was observed seated behind a privacy curtain, and lacked any engaging activities such as television, radio, or personal activity, and sat silently. A nurse progress note dated 2/5/25 identified Resident #35 had no RSV symptoms, was on contact and droplet precautions, and he/she slept in long naps throughout the shift. An observation on 2/5/25 at 12:21 PM identified Resident #35 was seated behind a closed privacy curtain, not visible from the doorway of the room, eating alone, silently, without any type of any engaging activities such as television, radio, or personal activity. Resident #35's roommate's television was playing. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with Nurse Aide, (NA), #3 on 2/5/25 at 12:53 PM identified the facility practice was to keep both the resident who tested positive for an illness, and their roommate on droplet and contact precautions even when only 1 resident had become ill. Further, Resident #35 was encouraged not to leave his/her room and that if Resident #35 wanted to leave the room, access was denied through a physical barricade at the door. NA #3 demonstrated how the physical barrier was implemented by standing in the doorway and extending her arms open across the doorway leading from the room to the hallway. NA #3 indicated that when Resident #35 left the bathroom, s/he turned right, and attempted to exit the room and that was when she would physically block Resident #35's exit and redirect him/her to return and sit in a chair within the room, behind the curtain. An interview with Licensed Practical Nurse, (LPN), #1 on 2/5/25 at 1:14 PM indicated Resident #35 had not been allowed to leave his/her room since his/her roommate became ill and staff were keeping the resident in his/her room intentionally as s/he was considered a high risk for RSV development. An interview with the Recreation Coordinator on 2/6/25 at 10:05 AM indicated that she was informed by nursing that all roommates of RSV positive residents were to stay in their rooms and not attend activities. An interview with the Director of Recreation and the Recreation Coordinator on 2/6/25 at 10:26 AM identified that Resident #35 had not been as active and napping more than usual during the daytime shift recently. The Director of Recreation further indicated that Resident #35 was usually very active with recreation activities. If the resident was currently allowed out of the room s/he would have been able to participate socially in activity programs for stimulation. The increased napping had not been reported to nursing or social services. An interview with the Director of Nursing Services (DNS) on 2/6/25 at 1:39 PM identified that all roommates of any resident who had tested positive for RSV was confined to their room. The DNS identified the risk of spreading RSV between roommates was addressed by utilizing the barrier curtain, keeping it closed, between residents in the shared room. The DNS indicated that it was unsafe for the roommate of an RSV positive resident to leave the room due to exposure of being in the same room without a mask, however, no roommate of an RSV positive resident had ever tested positive for RSV after cohorting. Although Resident #35 had never have been tested for RSV, he/she was kept in his/her room as this was the least restrictive way to prevent exposure of other residents. The DNS indicated that it was safe for staff to enter and exit Resident #35's room while wearing a mask, but that Resident #35 had never been trialed for mask use or for compliance to be out of his/her room with a mask in place. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with RN #4, (Infection Control Nurse), on 2/10/25 at 9:57 AM identified that prior to Resident #35's roommate testing positive for RSV on 1/30/25, he/she was allowed and observed to leave the room wearing a mask without any issues. RN #4 indicated the facility followed the Centers for Disease Control (CDC) Directory of Infectious Diseases to determine isolation or precautions for residents. She indicated that the outbreak control guidance was used as the basis for keeping the roommates of positive residents confined to their room for the duration of the positive resident's isolation period. RN #4 was unable to identify where in the guidance the Directory of Infectious Diseases applied to roommates of RSV positive residents. RN #4 was unaware of the CDC guideline for RSV which stated when cohorting permitted, patients must have the same infection/condition with no concurrent infections. RN #4 indicated that there was guidance to restrict access for symptomatic residents to their room, however, failed to identify that residents without symptoms were required to remain in their rooms due to residing with a positive resident per the Directory of Infectious Diseases. An interview with the DNS on 2/10/25 at 11:52 AM identified she believed restricting Resident #35 from leaving his/her room could not qualify as involuntary seclusion as he/she had a roommate and if he/she felt secluded the resident would have told someone (the resident was assessed to be severely cognitively impaired per the MDS). The DNS failed to identify within the facility policy how the definition of involuntary seclusion applied to restricting residents from leaving their room. Review of the facility's Transmissions-Based Precautions policy identified residents who are known or to be suspected to be infected with an infectious agent that required additional controls to prevent transmission would have an order for isolation placed. That isolation would be the least restrictive possible for the residents under the circumstances. Review of the facility's Abuse policy identified, in part, all residents have the right to be free of abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse was defined as any unreasonable infliction of confinement resulting in physical harm, pain, or mental anguish. Abuse included deprivation by an individual including a caretaker, of care, goods, or services that are necessary to attain or maintain physical mental, and psychosocial well-being.

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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 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, review of facility documentation, review of facility policy, and interviews for 1 of 3 residents, (Resident #10), reviewed for abuse, the facility failed to ensure that an injury of unknown source was reported to the state agency. The findings include: Resident #10's diagnoses included dementia, psychosis, restlessness, and agitation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was severely cognitively impaired, dependent with transfers and toileting, required extensive assistance of 2 staff for bed mobility, was non-ambulatory, and had no functional limitations in range of motion. The Resident Care Plan dated 11/13/24 identified Resident #10 had discoloration to the left forehead and a memory deficit with impaired judgement. Interventions included the nurse to observe transfers for 7 days and to observe skin discoloration every shift. Further interventions included providing a calm and consistent environment using a calm and gentle approach. A nurse's note dated 1/21/25 at 5:15 AM identified Resident #10 was found with a bruise on the forehead that measured 5.0 centimeters (cm) by 3.5 cm which was red with a purplish color. There were no witnesses to the incident, but it was suspected that the cross bar of the mechanical lift used on the prior shift was the source of the bruising. The resident was noted to be combative at times when transferred in and out of bed and subsequent family notification and a report would be completed by the charge nurse. A Reportable Event Report dated 1/21/25 identified Resident #10 had a red discoloration to the left forehead measuring 5.0 cm by 3.5 cm. A review of the report identified that although the incident was unwitnessed and the resident was unable to indicate how the injury occurred, the injury had a state classification (E) indicating it was not an incident which required reporting to the state agency. Additionally, the area indicating that the incident was reported to the state agency was blank. A nurse's note dated 1/21/25 at 7:42 AM identified Resident #10 was reported to have redness to the left side of the forehead with swelling observed. Resident #10 was unable to communicate what occurred to cause the area, neurological checks were initiated, and the responsible party was notified. An Advanced Practice Registered Nurse (APRN) progress note dated 1/21/25 at 2:50 PM identified Resident #10 was being evaluated after being noted to have an area of discoloration to the forehead and staff had suspected the resident may have bumped his/her head on the horizontal bar of the mechanical lift during a transfer on the prior shift (1/20/25 3:00 PM to 11:00 PM shift). The APRN note indicated Resident #10 had an area of erythema and evolving ecchymosis with slight swelling to the left forehead measuring approximately 3.5 cm by 5 cm. The APRN note further identified that Resident #10 had advanced dementia and was unable to indicate how the bruise to his/her left forehead had occurred. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the Director of Nursing Services (DNS) on 2/5/25 at 11:20 AM identified that Resident #10's injury on 1/21/25 was of an unknown source and an injury of unknown source should have been reported to the state agency. Review of Resident #10's progress notes for 1/21/25 failed to identify that there were witnesses to the incident which had resulted in Resident #10's injury to the forehead. The DNS indicated she needed to locate additional documents related to the 1/21/25 incident. Interview and review of the clinical record with the Administrator on 2/5/25 at 11:28 AM identified that Resident #10's injury on 1/21/25 was of unknown source and an injury of unknown source should have been reported to the state agency. Review of Resident #10's progress notes for 1/21/25 failed to identify that there was a witness to the incident which had resulted in Resident #10's injury to the forehead. The Administrator indicated that she or the DNS would have been responsible to report Resident #10's injury of unknown source to the state agency. Interview and review of NA #1's statement with NA #1 on 2/5/25 at 3:06 identified she had transferred Resident #10 back to bed with the mechanical lift on 1/20/25 on the 3:00 PM to 11:00 PM shift. NA #1 indicated that although Resident #10 was restless and grabbed the bar of the mechanical lift with his/her hand during the transfer, she did not witness Resident #10 hit his/her head on any part of the mechanical lift nor did she witness anything strike the resident's head. NA #1 identified that she did not observe any redness or signs of injury to Resident #10's face after the transfer was completed and if she had she would have reported the injury to the charge nurse. NA #1 indicated 2 staff had transferred the resident. Re-interview, review of the clinical record, and review of witness' statements with the DNS on 2/6/25 at 9:05 AM identified that accidents and incidents are usually discussed in morning huddles and she could not explain why she was under the impression the origin of the bruise was witnessed, yet there were no statements or other documentation to validate that the bruise was from a known source. The DNS further identified she or the administrator should have reported Resident #10's 1/21/25 injury of unknown source to the state agency. Review of the facility Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property policy, revised 8/2022, directed, in part that an injury of unknown source was one that was not observed by any person, or the source of the injury could not be explained by the resident. The policy further directed that all allegations of abuse, including injuries of unknown source, would be reported to the state agency, in accordance with regulations, immediately but no less than 2 hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on review of the clinical record, review of facility documentation, review of facility policy, and interviews for 1 of 3 residents, (Resident #10), reviewed for abuse the facility failed to ensure a complete investigation and summary were completed for a resident with an injury of unknown source. The findings include: Resident #10's diagnoses included dementia, psychosis, restlessness, and agitation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was severely cognitively impaired, was dependent with transfers and toileting, required extensive assistance of 2 staff for bed mobility, was non-ambulatory, and had no functional limitations in range of motion. The Resident Care Plan dated 11/13/24 identified Resident #10 had discoloration to the left forehead and a memory deficit with impaired judgement. Interventions included the nurse to observe transfers for 7 days and to observe skin discoloration every shift. Further interventions included providing a calm and consistent environment using a calm and gentle approach. A nurse's note dated 1/21/25 at 5:15 AM identified Resident #10 was found with a bruise on the forehead that measured 5.0 centimeters (cm) by 3.5 cm which was red with a purplish color. There were no witnesses to the incident, but it was suspected that the cross bar of the mechanical lift on the prior shirt was the source of the bruising. The resident was noted to be combative at times when transferred in and out of bed and subsequent family notification and a report would be completed by the charge nurse. A Reportable Event Report dated 1/21/25 identified Resident #10 had a red discoloration to the left forehead measuring 5.0 cm by 3.5 cm. A review of the report identified that the incident was unwitnessed and lacked an indication as to how the injury occurred. A nurse's note dated 1/21/25 at 7:42 AM identified Resident #10 was reported to have redness to the left side of the forehead with swelling observed. Resident #10 was unable to communicate what occurred to cause the area. An Advanced Practice Registered Nurse (APRN) progress note dated 1/21/25 at 2:50 PM identified Resident #10 was being evaluated after being noted to have an area of discoloration to the forehead and staff had suspected the resident may have bumped his/her head on the horizontal bar of the mechanical lift during a transfer on the prior shift (1/20/25 3:00 PM to 11:00 PM shift). The APRN note further identified that Resident #10 had advanced dementia and was unable to indicate how the bruise to his/her left forehead had occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of NA #1's statement with NA #1 on 2/5/25 at 3:06 identified she had transferred Resident #10 back to bed with the mechanical lift on 1/20/25 on the 3:00 PM to 11:00 PM shift. NA #1 indicated that although Resident #10 was restless and grabbed the bar of the mechanical lift with his/her hand during the transfer, she did not witness Resident #10 hit his/her head on any part of the mechanical lift nor did she witness anything strike the resident's head. NA #1 identified that she did not observe any redness or signs of injury to Resident #10's face after the transfer was completed and if she had, she would have reported the injury to the charge nurse. NA #1 indicated that 2 staff had transferred the resident. Interview, review of the clinical record, and review of witness' statements with the DNS on 2/6/25 at 9:05 AM identified although she had obtained statements from staff for Resident #10's 1/21/25 incident, the investigation was incomplete and lacked documentation indicating the cause of the injury. The DNS indicated that she did not have a statement from the second NA who assisted NA #1. Additionally, the DNS stated that she had not written a summary because she thought the cause of the bruise was known (witnessed). The DNS indicated that accidents and incidents are usually discussed in morning huddles and she could not explain why she was under the impression the origin of the bruise was witnessed, yet there were no statements or other documentation to validate that the bruise was from a known source. Review of the facility Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property policy, revised 8/2022, directed, in part that an injury of unknown source was one that was not observed by any person, or the source of the injury could not be explained by the resident. The policy further directed that a thorough investigation should be conducted for any injury of unknown source and the results of the investigation must be documented in a report and completed within 72 hours.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews, review of the clinical records and facility policy for 1 of 2 residents (Resident #343) reviewed for transmission-based precautions, the facility failed to ensure the baseline care plan included statements/behaviors of homicidal ideation that were made prior to admission. The findings included: Resident #343 was admitted to the facility on [DATE] with diagnoses that included homicidal ideation, sepsis, chronic combined systolic and diastolic heart failure, and muscle weakness. A hospitalist progress note from the hospital (prior to Resident #343's facility admission) dated 1/20/25 at 3:36 PM identified Resident #343 was very emotional but no longer suicidal-per psychiatry held off on Lexapro (a medication indicated for depression). A facility consult form for psychiatry services dated 1/24/25 and signed by Resident #343 identified the reason for the referral was due to a comment made in the ICU (at the hospital and prior to facility admission) regarding homicidal ideation, knives, glass, cans were withheld in the hospital. (Psychiatry at the Long Term Care facility was not updated regarding Resident #343's psychosocial behavior in the hospital). The Resident Care Plan Dated 1/27/25 (3 days after admission) failed to identify any psychosocial concerns or behaviors. A nursing note dated 1/31/25 at 11:04 PM and written by Licensed Practical Nurse (LPN) #2 identified writer walked down to check on resident and observed him/her on the floor next to his/her bed lying on his/her belly with a pillow, when asked what were you trying to do just before you fell , resident stated he/she was trying to jump out the window. A Resident Care Plan dated 2/4/25 (developed subsequent to surveyor inquiry) identified Resident #343 made a vague provocative comment that he/she was trying to go out the window, he/she had recently been more angry, discouraged, refused to attend short term therapy and declined medications. Interventions included psychiatric evaluation as ordered and report changes in behavior to the doctor. An interview with Registered Nurse (RN) #3 on 2/6/25 at 9:43 AM identified that it was facility policy to have a resident centered baseline care plan developed within 24 hours of admission for all residents, and the expectation was that residents with a signed psychiatry consent or identified psychosocial or behavioral issues would have a resident care plan in place. Additionally, RN #3 identified that Resident #343 should have had a baseline care plan reflecting his/her psychosocial status but did not because Resident #343 did not have any behaviors during his/her previous admission at the facility. Review of the Baseline Care Plan Policy dated November 2017 identified in part that the facility will develop a baseline care plan within 48 hours of a resident's admission and include at minimum healthcare information necessary to properly care for a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Jerome Home		STREET ADDRESS, CITY, STATE, ZIP CODE 975 Corbin Avenue New Britain, CT 06052	

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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** 50249 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #53) reviewed for accidents, the facility failed to ensure floor mats were in place per the physician's order. The findings include: Resident #53's diagnoses included dementia, hypotension, and unspecified abnormalities of gait and mobility. Review of the clinical record identified a Fall Risk Assessment Tool dated 1/20/24 indicated Resident #53 was a high risk for falls. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 was severely cognitively impaired, required extensive assistance of 2 staff for transfers and bed mobility, and was dependent with toileting. The Resident Care Plan dated 2/1/25 identified falls. Interventions included fall prevention with placement of floor mats to the left and right side of the bed. A physician's order dated 2/1/25 directed to place floor mats to the left and right side of the bed every shift. Review of the Nurse Aide Card (individualized resident assignment) identified Resident #53 was bed fast and refused to get out of bed. The nurse aide care card indicated to place floor mats to the left and right side of the bed every shift. Observations on 2/3/25 at 11:40 AM and 2/5/25 at 10:40 AM identified Resident #53 was in bed without the benefit of a floor mat to the window side of the bed. A fall mat was observed folded-up and leaning against the wall; the tray table was placed away from the bed and next to the window. Interview and observation with Nurse Aide (NA) #1 on 2/5/25 at 2:05 PM identified Resident #53 was in bed with 1 floor mat in place to the door side of the bed but the resident was without the benefit of a floor mat on the window side of bed. NA #1 identified that Resident #53's tray table was placed against the window, and she should have made sure the second floor mat was in place after Resident #53 had finished lunch. NA #1 further indicated that she needed to reference Resident #53's Nurse Aide Care Card on the computer as it was not posted in the resident's room. Interview and observation with Licensed Practical Nurse (LPN) #1 on 2/6/25 at 8:58 AM identified Resident #53 had a history of falls and being found on the floor. LPN #1 indicated Resident #53 was in bed without the benefit of a fall mat on the window side of the bed. LPN #1 identified that she or the NA should have made sure the second mat was in place after the resident had finished breakfast. Interview with the Director of Nursing Services (DNS) on 2/6/25 at 2:05 PM identified that Resident #53 should have had floor mats in place to both sides of the bed. The DNS identified that both nurses and NAs were responsible for the placement of the floor mats but could not explain the reason staff failed to put the floor mats in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075343	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jerome Home	975 Corbin Avenue New Britain, CT 06052

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Fall Prevention Program, dated 10/7/19, directed each resident would be assessed for the risk of falling and receive care and services in accordance with the level of risk to minimize the likelihood of falls. The policy further directed the nurse would indicate the resident's fall risk and initiate interventions on the care plan and implement environmental interventions as measured by the fall risk assessment tool.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews, review of the clinical records and facility policy for 1 of 2 residents (Resident #343) reviewed for transmission-based precautions, the facility failed to provide appropriate treatment and services for a resident who displayed psychosocial behaviors. The findings included: Resident #343 was admitted to the facility on [DATE] with diagnoses that included homicidal ideation, sepsis, chronic combined systolic and diastolic heart failure, and muscle weakness. A hospitalist progress note from the hospital (prior to Resident #343's facility admission) dated 1/20/25 at 3:36 PM identified Resident #343 was very emotional but no longer suicidal-per psychiatry, held off due to being on Lexapro (a medication indicated for depression). A hospitalist progress note from the hospital (prior to Resident #343's facility admission) dated 1/22/25 at 7:28 AM identified psychiatry was consulted due to suicidal statements made by Resident #343. After further interview, it was determined Resident #343 was just joking around and had no intention of hurting himself/herself. A facility consult form for psychiatry services dated 1/24/25 and signed by Resident #343 identified the reason for the referral was due to a comment made in the ICU (at the hospital and prior to facility admission) regarding homicidal ideation, knives, glass, cans were withheld in the hospital. (Psychiatry at the Long Term Care facility was not updated regarding Resident #343's psychosocial behavior in the hospital). A physician's order dated 1/24/25 directed for consultations as needed, to include, but not limited to dental, podiatry, audiology, ophthalmology, behavioral health, and wound care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #343 was cognitively intact, was fully dependent on staff for upper and lower dressing and required substantial/maximal assistance to roll from sitting to lying position in bed. Additionally, the MDS identified that in the 2 weeks prior to admission, Resident #343 felt down, depressed or hopeless for several days (frequency identified as 2-6 days). A nursing note dated 1/31/25 at 11:04 PM and written by Licensed Practical Nurse (LPN) #2 identified writer walked down to check on resident and observed him/her on the floor next to his/her bed lying on his/her belly with a pillow, when asked what were you trying to do just before you fell , resident stated he/she was trying to jump out the window. The nursing note failed to identify further assessments by the charge nurse (Registered Nurse), or documentation that the nursing supervisor, social services, physician or psychiatrist were notified. A nursing note dated 2/3/25 at 8:18 AM identified a request for Resident #343 to be seen by psychiatry was put in the psychiatric book secondary to Resident #343 stating he/she was trying to jump out the window (3 days after the statement was made, and 10 days after admission). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Jerome Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 975 Corbin Avenue New Britain, CT 06052	

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with Registered Nurse (RN) #4 on 2/4/25 at 3:17 PM identified she was the nursing supervisor on 1/31/25 when Resident #343 made the statement of trying to jump out the window and was not notified of Resident #343's statement regarding jumping out the window. Additionally, it was facility policy for residents with suicidal statements to have 15-minute checks or be put on 1:1 observation. An interview with LPN #2 on 2/4/25 at 3:26 PM identified the facility policy on suicidal statements was to complete 15-minute checks on the resident, have them be seen by psychiatry and maintain close observation. LPN #2 identified she did not notify anyone (supervisor, social worker, physician/APRN) of Resident #343's statement about trying to jump out the window because she did not interpret the statement as suicidal since the resident had been saying that he/she wants to go home. An interview with Social Worker #1 on 2/4/25 at 3:52 PM identified that psychiatry consents were signed by all newly admitted residents, but that psychiatry services needed to be notified of the need to be seen. Further, due to Resident #343's referral reason (homicidal ideation while at the hospital), psychiatric services should have been provided closer to the admitted d and he/she should have been seen the week of 1/27/25. The Resident Care Plan dated 2/4/25 (developed subsequent to surveyor inquiry) identified Resident #343 made a vague provocative comment that he/she was trying to go out the window, he/she had recently been more angry, discouraged, refused to attend short term therapy and declined medications. Interventions included psychiatric evaluation as ordered and report changes in behavior to the doctor. An interview with APRN #1 on 2/5/25 at 10:07 AM identified that she was not notified about Resident #343's statement regarding jumping out the window, and she would expect to be notified of suicidal statements. If she had been notified, she would have gotten clarity from Resident #343 about the statement by asking additional questions, then, if necessary, instituted 1:1 or sent him/her out to the emergency room . An interview with the DNS on 2/10/25 at 9:15 AM identified psychiatric consents were signed by all new admissions in case services were needed and that psychiatric services were in the facility Monday through Friday. Although she could not identify how soon after being admitted residents should be seen by psychiatry services, in Resident #343's case due to the note on the consent, the admitting nurse should have called psychiatric services for evaluation. Additionally for statements made by Resident #343 on 1/31/25, the DNS identified that LPN #2 should have followed the facility policy which included contacting and notifying psychiatry services of the statement. Review of the Suicide Precaution Policy dated 11/12 directed in part that suicide precautions will be initiated when a resident has put his/her safety in question. The procedure included the charge nurse to assess the immediate situation by observing the resident's behavior, engaging the resident in conversation to determine their feelings and thoughts regarding the threat and attempt to determine if the resident has a plan to harm self. Subsequently notifying the Nursing Supervisor and /or Social Worker, notifying the physician or psychiatrist, placing the resident on 1:1 by staff until otherwise directed by the physician or psychiatrist. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Behavioral Health Services Policy dated 10/1/22 directed in part that the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person centered care. This process includes in part, obtaining history from medical records, MDS and care area assessments, ongoing monitoring of mood and behavior and care plan development and implementation.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of the clinical record, facility policy and interviews for 1 of 5 residents (Resident #53) reviewed for unnecessary medications, the pharmacist failed to identify irregularities for a resident receiving an antipsychotic (psychotic disorder) medication. The findings include: Resident #53's diagnoses included dementia, adjustment disorder with depressed mood and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 was severely cognitively impaired and required partial to moderate assistance with bed mobility and was dependent with toileting and transfers. The MDS indicated Resident #53 was receiving an antipsychotic medication. The Resident Care Plan (RCP) dated 12/5/23 identified antipsychotic medication use. Interventions included observing changes in mood and behavior, complete and thorough documentation in the nursing notes, and report behavioral changes to the Medical Doctor (MD). The physician's orders in effect from 12/5/23 through 8/15/24 directed staff to administer Risperidone (an antipsychotic medication). Review of the Medication Administration Record (MAR) identified that behavior monitoring had occurred for Resident #53 from 12/5/23 through 2/14/24, but no further behavioral monitoring had been completed on the MAR through 8/15/24. On 8/15/24 the physician discontinued all of Resident #53's Risperidone dosing. Physician's orders dated 9/4/24 identified that Resident #53's Risperidone was re-started and continued through 2/6/25. Review of the MAR failed to identify any behavioral monitoring from 9/4/24 through 2/6/25. Psychiatric progress notes written by APRN #2 dated 7/18/24 and 12/22/24 identified that although she was in to assess Resident #53 for ongoing psychiatric monitoring and medication management, the last AIMS assessment had been completed on 12/16/23 (14 months prior). Interview and review of the clinical record with the DNS on 2/6/25 at 2:08 PM failed to identify an AIMS assessment which had been completed for Resident #53 since 12/16/23 (14 months prior). The DNS indicated that according to facility policy AIMS assessments should be completed every 6 months. The DNS was unable to identify why the AIMS assessments had not been conducted per the facility policy, but the facility had contracted with a new psychiatric provider as of 1/1/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview and review of the clinical record with the consulting pharmacist on 2/10/25 at 4:30 PM identified that AIMS assessments should be conducted every 6 months for a resident receiving an antipsychotic medication. The consulting pharmacist indicated that although she conducted medication regimen reviews (MRR's) on a monthly basis, review of the 7/18/24 and 12/22/24 psychiatric progress notes for Resident #53 identified the last AIMS assessment completion date was 12/16/23. Continued Review of the clinical record for Resident #53 failed to indicate behavior monitoring had been completed since 2/14/24. The consultant pharmacist was unable to explain the lack of behavioral monitoring, but since Resident #53 continued receiving an antipsychotic after 2/14/24, the facility should have continued to complete behavior monitoring while the Risperidone was being administered. The consulting pharmacist indicated that although she completed MRR's for Resident #53 on 12/28/24 and 1/24/25, she had made no recommendations to conduct an AIMS assessment and/or to complete behavior monitoring on either consultation report. The consulting pharmacist stated that the recommendations should have been made. Although requested, copies of Resident #53's MRR's for 12/2023 through 2/10/25 were not provided by the facility. The facility provided 4 consultation reports dated December 2023, January 2024, February 2024, and October 2024, that failed to recommend the completion of an AIMS or to begin behavior monitoring. Review of the facility policy, Medication Regimen Review, dated 12/1/07, directed that the facility and consultant pharmacist will follow guidance outlined in the CMS State Operations Manual Appendix PP and current practice guidelines, for the appropriate provision of pharmaceutical care. The policy further directed that the facility should maintain readily available copies of the consultant pharmacists reports on file in the facility, and as part of the resident's permanent health record. 50249

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51102 Based on a tour of the Dietary Department, interviews and facility documentation, the facility failed to ensure foods were at appropriate temperatures for palatability. The findings included: Interview with Resident #83 on 2/3/25 at 11:17 AM identified that food was sometimes cold. Interview with Resident #28 on 2/3/25 at 11:45 AM identified that hot food was often served cold. Interview with Resident #33 on 2/3/25 at 2:51 PM identified that hot food comes cold by the time he/she receives the meal. Interview with Resident #22 on 2/3/25 at 3:12 PM identified that the food was not tasting good. An interview with the Food Services Director on 2/5/25 at 12:27 PM identified the process to ensure foods were hot included the cook taking temperatures in the kitchen and recording them in the temperature log, plates kept in a plate warmer prior to plating, and metal meal covers to keep the food temperature hot. A review of the temperature log for the week of 2/3/25 identified temperatures were taken daily for breakfast, lunch and dinner and met the food code standard. On 2/5/25 at 12:27 PM, a test/temperature tray was conducted with the Food Services Director. The following was identified: A lunch meal was plated in the main dining room at 12:34 PM, the truck arrived on East Wing at 12:36 PM. At 12:37 PM, 2 Nurses' Aides were observed to begin passing out the meal trays to residents and the last tray was delivered at 12:42 PM. A temperature tray was conducted (from an entree that was plated on a white ceramic dish that was taken from a plate warmer), covered with a stainless steel cover (similar to what resident's were served on) and temperatures were conducted with the Food Services Director at that time (12:42 PM) and identified the following: a. The meatballs' internal temperature was 121.3 degrees Fahrenheit from the surveyor's thermometer and 119 degrees Fahrenheit from the Food Services Director's thermometer. The Food Service Director identified that the internal temperature should be 135 degrees Fahrenheit. b. The spaghetti internal temperature was 119.7 degrees Fahrenheit from the surveyor's thermometer and 115 degrees Fahrenheit from the Food Services Director's thermometer. The Food Services Director identified that the internal temperature should be 135 degrees Fahrenheit. c. The green beans internal temperature was 120.6 degrees Fahrenheit from the surveyor's thermometer and 119 degrees Fahrenheit from the Food Services Director's thermometer. The Food Services Director identified that the internal temperature should be 135 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the Food Services Director on 2/5/25 at 12:46 PM identified the temperatures for the lunch tray were low because it takes a while for the food to travel from the plating area to the unit. A review of the Record of Food Temperatures Policy dated 6/1/19 directed in part that hot foods will be held at 135 degrees Fahrenheit or greater.