STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheriden Woods Health Care Center	321 Stonecrest Drive Bristol, CT 06010

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021 Based on clinical record reviews, review of facility documentation and policies, and interviews for two (2) sampled residents (Resident #1 and #2) who were reviewed for the misappropriation of personal property, the facility failed to ensure the residents' controlled medications and the controlled disposition sheets were not removed from the facility. The findings include: 1. Resident #1's diagnoses included Alzheimer's disease and malignant neoplasm of the colon. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, received scheduled pain medication, experienced shortness of breath, and was on hospice services. The Resident Care Plan dated 6/11/24 identified Resident #1 had the potential for pain. Interventions directed to administer pain medications as ordered and assess the characteristics of the pain, location, and severity. A physician's order dated 7/12/24 directed to administer Morphine Sulfate (concentrate) oral solution twenty (20) milligrams per milliliter give 0.25 milliliters sublingually every three (3) hours as needed for pain or shortness of breath. The Advanced Practice Registered Nurse (APRN) progress note dated 8/9/24 identified she was asked by the facility for a renewal prescription for the Morphine Sulfate, a new script for a thirty (30) day supply was written and was sent to the pharmacy. The Facility Reported Incident form dated 8/12/24 identified an unopened thirty (30) milliliter bottle of Morphine was reported missing from the facility on 8/10/24 at 10:30 AM. The report indicated the Department of Consumer Protection, the Drug Enforcement Division was notified. The investigation identified that an unopened thirty (30) milliliter bottle of Morphine was discovered missing on 8/9/24 from the controlled medication box located in the medication cart when Resident #1 was noted to have increased shortness of breath and required a dose of the Morphine for comfort. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility incident report with the Director of Nursing (DON) on 1/15/25 at 1:05 PM indicated she was the Regional Nursing Director at the time of the incident and was first informed of the missing Morphine by the previous Administrator on 8/10/24 at 10:45 AM. The DON identified the previous DON was made aware of the missing bottle of Morphine on 8/9/24 by the Assistant Director of Nursing (ADON) but did not report it. The DON indicated an investigation was initiated on 8/10/24 that included a search of the facility, an audit of all medication carts, controlled medication boxes, and the controlled medication disposition sheets. The DON identified during the investigation, controlled medications were also noted to be missing from the Emergency Box (Morphine, Oxycodone) and the drug destruction box. The DON explained the outcome of the investigation identified the previous DON had removed the controlled medications and was terminated. The DON indicated facility policy prohibited misappropriation of resident property. 2. Resident #2's diagnoses included epilepsy and dementia. The nursing admission assessment dated [DATE] identified Resident #2 was alert and oriented to person, place, and time. A physician's order dated 8/20/24 directed to give Lacosamide 150 milligrams (mg) by mouth two (2) times daily related to epilepsy. The Resident Care Plan dated 8/21/24 identified Resident #2 had a history of seizure disorder. Interventions directed to administer medications as ordered. Review of the August 2024 Medication Administration Record (MAR) identified Lacosamide was administered at 9:00 AM from 8/21/24 through 8/23/24 and at 6:00 PM from 8/20/24 through 8/22/24. Upon further review, the Medication Administration Record dated 8/23/24 identified the Lacosamide was on order. Review of the Controlled Substance Disposition Record for the house stock identified one (1) tablet of Lacosamide was taken from stock on 8/24/24 and 8/25/24 for the 9:00 AM doses and one (1) tablet of Lacosamide was taken on 8/24/24 and 8/25/24 for the 6:00 PM doses. The Advanced Practice Registered Nurse (APRN) progress note dated 8/26/24 identified she was asked by the facility for a renewal prescription for the Lacosamide 150mg for Resident #2, a new script for a thirty (30) day supply was written and sent to the pharmacy. The Facility Reported Incident form dated 8/26/24 identified the Lacosamide was missing from the narcotics box in the medication cart. The report identified the error was found when nursing was counting narcotics on 8/26/24 at 8:00 AM. The report indicated that the Department of Consumer Protection, the Drug Enforcement Division, was notified. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility incident report with the DON on 1/15/25 at 12:45 PM identified Resident #2 was a transfer from a sister facility for a few days and fifty-eight (58) tablets of Lacosamide were sent by the transferring facility and thirty (30) tablets were delivered by the pharmacy on admission. The investigation determined a total of eighty-eight (88) tablets of Lacosamide were noted to be missing, along with the accompanying Controlled Substance Disposition Record (white sheets). The DON indicated although the outcome of the investigation substantiated the Lacosamide was missing, the investigation did not determine the individual who was responsible for removing the Lacosamide. Review of the facility Abuse Policy dated 2/2023 defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent and directed that misappropriation of resident property was prohibited.