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	03/18/2025

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 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** 29050 Based on review of the clinical record, facility policy, and interviews for 1 of 3 residents (Resident #32) reviewed for palliative care, the facility failed to administer medications as prescribed by the physician. The findings include: Resident #32's diagnoses included Alzheimer's disease, dementia, anxiety, chronic kidney disease, and adult failure to thrive. A significant change in status MDS assessment dated [DATE] identified Resident #32 had severely impaired cognitive skills for daily decision making and was dependent on staff with all activities. The care plan dated [DATE] identified Resident #32 was admitted to hospice on [DATE]. Interventions directed to administer pain medications according to the physician order. The hospice narrative note dated [DATE] identified Resident #32 had a significant decline, was not eating and had difficulty swallowing. On assessment, the resident was minimally responsive, breathing was labored, and moaned in pain when moved. Recommendations included discontinue all scheduled medications, start Morphine (opiate for pain relief) and Lorazepam (Ativan for anxiety) around the clock, and add Atropine (antimuscarinic, anticholinergic) as needed. RN #4's nurse note dated [DATE] at 11:40 AM further identified that hospice discontinued all scheduled oral medications and requested Morphine for pain, Lorazepam for anxiety and Atropine for increased secretions. a. A physician's order dated [DATE] at 11:10 AM directed Lorazepam Intensol Oral Concentrate 0.5 milligrams (mg) administer sublingually every 6 hours for anxiety and every 3 hours as needed for anxiety, agitation and shortness of breath. Review of electronic Medication Administration Record (e-MAR) dated February 2025 identified on [DATE], two separate times at 12:00 PM and at 6:00 PM Lorazepam Intensol Oral Concentrate 0.5 mg was administered sublingually to Resident #32 by LPN #3 and LPN #4. Review of facility documentation identified on [DATE] both nurses did not administer the Lorazepam but initialed the e-MAR that medication was administered and failed to go back to strike off their initials. In addition, they failed to document why the medication was not administered, notify the supervisor, and ensure that the medication was requested from the pharmacy. (continued on next page)

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

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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	RN #5's nurses note dated [DATE] at 2:16 AM identified the resident had an order for liquid Lorazepam that was not yet received from the pharmacy. APRN was called and gave an order to substitute with Ativan 0.5 mg tablet from emergency box for both doses during this shift (11:00 PM - 7:00 AM shift). A physician's order dated [DATE] at 1:57 PM directed an increase in Lorazepam Intensol Oral Concentrate 0. 5 mg sublingually to every 4 hours for anxiety and every 2 hours as needed for anxiety, agitation and shortness of breath. Review of hospice narrative note dated [DATE] identified Resident #32 with signs and symptoms of anxiety. The resident was on scheduled Lorazepam increased that day, and it was suggested during facility care plan meeting that administration of Morphine Sulfate Oral Solution and Lorazepam should be two hours apart, with orders directed to alternate every 4 hours around the clock. The nurse's note dated [DATE] at 3:50 AM identified Lorazepam Intensol Oral Concentrate 2 mg/ml sublingually ordered to be administered every 4 hours for anxiety was awaiting delivery from pharmacy. Review of the clinical record and facility documentation identified the facility failed to order and/or send a prescription for controlled medications to the pharmacy. The pharmacy was unable to deliver Lorazepam Intensol Oral Concentrate prescribed for Resident #32 without the prescription and the medication was not available at the facility. b. A physician's order dated [DATE] at 11:38 AM directed Atropine Sulfate Ophthalmic Solution 0.01% administer 2 drops sublingually every 6 hours as needed for increased secretions. Review of hospice Visit Documentation Log dated [DATE] identified Resident #32 with increased secretions. The hospice narrative note dated [DATE] identified Resident #32 had mild secretions and respiratory rate 14 short and shallow. Hospice nurse requested PRN (as needed) for secretions, with positive effect. Review of e-MAR dated February 2025 identified Hyoscyamine Sulfate (anticholinergic) oral tablet disintegrating 0.125 mg sublingually every 4 hours PRN for secretions was administered on [DATE] at 1:41 PM with effect, then Hyoscyamine Sulfate was discontinued on [DATE] at 2:30 PM. A physician's order dated [DATE] at 6:00 PM directed Atropine Sulfate Ophthalmic Solution 0.01% give 2 drops sublingually every 6 hours for increased secretions, (order changed from as needed to scheduled time). Review of February 2025 e-MAR identified that the newly ordered Atropine Sulfate (as needed and then scheduled dose) for increase secretions was not identified as administered. The nurse's note dated [DATE] at 1:11 AM identified Atropine Sulfate Ophthalmic Solution 0.01% sublingually ordered to be administered every 6 hours for increased secretions was awaiting delivery from pharmacy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #5's nurses note dated [DATE] at 3:29 AM identified liquid Lorazepam and Atropine drops still not yet delivered from pharmacy. The resident was resting in bed, no anxiety noted, some secretions noted. Call placed to on-call APRN to request substitute liquid Lorazepam with tablet and Atropine with Scopolamine patch from E-box. APRN stated that her company cannot provide orders for hospice residents, including formulation substitutes. Review of facility documentation identified that the pharmacy faxed, called multiple times, and emailed the facility to clarify and resend Atropine order with no answer from the facility. The pharmacy identified that the Atropine order should have been written for Atropine 1% concentration and not 0.01%. The order was never clarified by the facility and Atropine was not delivered to the resident. c. Review of hospice Outcome/Recommendations dated [DATE] recommended to discontinue all by mouth scheduled medications. Review of February 2025 e-MAR identified Resident #32 was receiving Acetamin (Tylenol, to treat mild to moderate pain) tablet 500 mg, two tablet orally, two times a day for pain. Further review identified that Acetamin order was not discontinued. However, all other scheduled medications designated for oral administration were discontinued on [DATE] prior to 11:00 AM. Nurse's note dated [DATE] at 1:52 PM identified Resident #32 was not alert during the shift, poor by mouth intake, unable to take medications without difficulty, nursing supervisor aware, seen by hospice nurse this shift, increased secretions noted. See new orders, family aware. Further review of e-MAR identified Acetamin 500 mg 2 tablets were documented by LPN #4 as administered orally on [DATE] at 9:00 PM. The care plan meeting progress note dated [DATE] at 1:28 PM identified the resident was transitioning to end of life status, requiring total assistance with care. All by mouth medications have been discontinued as the resident was unable to tolerate swallowing. The plan of care was to maintain comfort. A physician's order dated [DATE] at 2:30 PM directed to discontinue Acetaminophen Rectal Suppository 650 mg ordered to be inserted rectally every 6 hours as needed for mild pain or fever. The nurse's notes dated [DATE] at 8:39 PM identified Acetamin 2 tablets ordered to be administered orally were held because the resident was unable to swallow. The hospice narrative note dated [DATE] identified able to hear loud secretions coming from the resident and facial grimacing. LPN #5 came in and attempted to give the resident Tylenol in applesauce. Requested that the nurse confirm the resident's medications because they were supposed to be discontinued yesterday, and the resident has not been awake or alert enough to swallow. The nurse could not arouse the resident enough to administer anything and went to confirm the orders. Review of the resident's clinical record identified Acetamin tablet 500 mg, two tablet ordered to be administered orally, two times a day for pain was not discontinued during the resident's stay at the facility. Review of RN Pronouncement of Death identified Resident #32 was deceased on [DATE] at 9:30 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and clinical record review with RN #8 Case Manager Hospice on [DATE] at 11:02 AM identified she was not aware that Resident #32 was not receiving ordered Lorazepam and Atropine. The resident had increased secretions and was too weak to cough or swallow. The resident was receiving Morphine for comfort and all other medications were discontinued because she/he was unable to swallow. The resident needed additional medications to help eliminate symptoms like anxiety, agitation, secretions, difficulty breathing and pain, and medications that work great together were ordered to ensure comfort and dignity during the dying process. Interview and facility documentation review with RN #3 on [DATE] at 1:50 PM identified the 24-hour Report designated to provide an oncoming nurse with an accurate overview of each resident's condition and reviewed in morning meetings identified that Resident #32 had Lorazepam and Atropine ordered on [DATE] and the medications were not delivered from the pharmacy. Further interview identified that on [DATE] hospice requested to discontinue all medications that were ordered to be administered by mouth because the resident had swallowing problems and was lethargic. Although APRN agreed with hospice recommendations, the request was incorrectly transcribed and Acetamin to be administered by mouth order was never discontinued. RN #3 further stated that on [DATE] Tylenol suppository ordered to be administered rectally and was recommended by hospice for mild pain and/or fever was discontinued in error and the resident continued to have Tylenol by mouth order. RN #3 identified that if the resident was uncomfortable, in addition to scheduled Morphine Sulfate every 4 hours dose, staff could have administered additional dose that was ordered every 2 hours as needed and/or consult with APRN. In addition, review of the clinical record failed to identify that the APRN/physician and hospice nurse were notified that the resident was not receiving Lorazepam and Atropine as ordered and failed to identify that the pharmacy was called with prescription for Lorazepam and to clarify Atropine concentration order. RN #3 further identified that nurses should administer medications as ordered, document correctly and if the medications were not available, they should have assessed the resident, then notified the physician/APRN and the hospice nurse to obtain further instructions from them. Observation and interview with ADNS on [DATE] at 12:20 PM identified medication emergency box in the supervisor office with unopen 2 ml bottle of Atropine Sulfate 1% ophthalmic solution. The ADNS further identified RN #5 checked the medication emergency box, but she was not aware of pharmacy request for order clarification, and she was looking for Atropine 0.01% as ordered. The ADNS further identified that both LPN #3 and LPN #4 that signed on MAR that they administered Lorazepam on [DATE], should have strike off their signature on MAR as Lorazepam was not delivered from the pharmacy and was not available to be administered to Resident #32. The nursing supervisor should have been notified immediately to assess the resident and to notify APRN, hospice and pharmacy to ensure that Lorazepam and Atropine were administered as ordered. An interview with APRN #1 on [DATE] at 12:50 PM identified nursing staff did not notify her that Resident #32 had no Lorazepam and no Atropine medications available for administration as ordered. If notified APRN #1 would assess the resident and electronically send a prescription for Lorazepam to the pharmacy and resend an Atropine order identifying 1% concentration as requested by the pharmacy. The APRN #1 further identified medications should be administered as ordered to improve comfort during end-of-life care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Medication Administration is directed in part to verify medication order on MAR. Check against physician order. Compare the medication label to the resident's MAR. Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. Assess the residents' condition. Give the resident his/her medication and an appropriate vehicle or liquid as needed and Document medication administration.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29050 Based on review of the clinical record, facility documentation, and interviews for 1 of 3 residents (Resident #32) reviewed for palliative care, the facility failed to ensure that clinical record documentation was accurate by documenting medications that were not actually given. The findings include: Resident #32's diagnoses included Alzheimer's disease, dementia, anxiety, chronic kidney disease and adult failure to thrive. A significant change in status MDS assessment dated [DATE] identified Resident #32 had severely impaired cognitive skills for daily decision making and was dependent on staff with all activities. The care plan dated 2/16/25 identified Resident #32 was admitted to hospice on 1/28/25. Interventions directed to administer pain medications according to the physician order. Further review of the care plan identified the resident had episodes of anxiety and history of anxiety. Interventions included anti-anxiety per order and monitor for effectiveness. The hospice narrative note dated 2/25/25 identified Resident #32 had a significant decline, was not eating and had difficulty with swallowing. The resident was unable to swallow that morning, gurgling with food, and unable to take any medications. On assessment, the resident was minimally responsive, breathing was labored, and the resident moaned in pain when moved. Recommendations included discontinue all scheduled medications, start Morphine (opiate for pain relief) and Lorazepam (Ativan for anxiety) around the clock, and add Atropine (antimuscarinic, anticholinergic) as needed. APRN #1 agreed with medication changes. The family was informed that the resident was started on comfort medications that were focused on comfort care. The RN #4's nurse note dated 2/25/24 at 11:40 AM further identified that hospice discontinued all scheduled oral medications and requested Morphine for pain, Lorazepam for anxiety and Atropine for increased secretions. a. A physician's order dated 2/25/25 at 11:10 AM directed Lorazepam Intensol Oral Concentrate 0.5 milligrams (mg) administer sublingually every 6 hours for anxiety and every 3 hours as needed for anxiety, agitation and shortness of breath. Review of electronic Medication Administration Record (e-MAR) dated February 2025 identified on 2/25/25, two separate times at 12:00 PM and at 6:00 PM Lorazepam Intensol Oral Concentrate 0.5 mg was administered sublingually to Resident #32 by LPN #3 and LPN #4. Review of facility documentation identified on 2/25/25 both nurses actually did not administer the Lorazepam but initialed the e-MAR that medication was administered and failed to go back to strike off their initials. In addition, they failed to document why the medication was not administered, notify the supervisor, and ensure that the medication was requested from the pharmacy. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN #5's nurses note dated 2/26/25 at 2:16 AM identified the resident had an order for liquid Lorazepam that was not yet received from the pharmacy. APRN was called and gave an order to substitute with Ativan 0. 5 mg tablet from emergency box for both doses during this shift (11:00 PM - 7:00 AM shift). A physician's order dated 2/26/25 at 1:57 PM directed an increase in Lorazepam Intensol Oral Concentrate 0. 5 mg sublingually to every 4 hours for anxiety and every 2 hours as needed for anxiety, agitation and shortness of breath. Review of hospice narrative note dated 2/26/25 identified Resident #32 with signs and symptoms of anxiety. The resident was on scheduled Lorazepam increased that day, and it was suggested during facility care plan meeting that administration of Morphine Sulfate Oral Solution and Lorazepam should be two hours apart, with orders directed to alternate every 4 hours around the clock. Interview and clinical record review with LPN #3 on 3/4/25 at 12:59 PM identified on 3/25/25 at 12:00 PM, she signed the e-MAR then went to get Morphine Sulfate and Lorazepam as ordered. When she realized that Lorazepam was not available, she told the oncoming nurse to ask the supervisor for Lorazepam. Interview with LPN #4 on 3/5/25 at 3:05 PM identified although Lorazepam Intensol oral concentrate was not available for administration on 2/25/25 at 6:00 PM, she signed that she administered the medication to the resident. LPN #4 further identified that she was learning on how to navigate the documentation system, and she signed the e-MAR first, when she realized that Lorazepam was not available, she did not know on how to strike off her signature. LPN #4 wrote a note on a sticky pad and without writing a note on an APRN Referral Form in the APRN binder, she put a prescription request someplace in that binder for the APRN to sign and fax to the pharmacy. LPN #4 was unable to explain why she failed to ask another nurse that was working that evening, notify the nursing supervisor, call the on call APRN and/or hospice and/or pharmacy to ask for instructions. Interview with ADNS on 3/5/25 at 12:20 PM identified that both LPN #3 and LPN #4 that signed on MAR that they administered Lorazepam on 2/25/25, should have strike off their signature on MAR as Lorazepam was not delivered from the pharmacy and was not available to be administered to Resident #32. The nursing supervisor should have been notified immediately to assess the resident and to notify APRN, hospice and pharmacy to ensure that Lorazepam and Atropine were administered as ordered. administration, what to do if medication was not available, documentation, reporting and hospice end of life care. Although requested, a facility policy was not provided.