STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075351	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abbott Terrace Health Center	44 Abbott Terrace Waterbury, CT 06702

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 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** 16837 29050 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #140) reviewed for abuse, the facility failed to report an allegation of physical abuse within the required time in accordance with facility policy. The findings include: Resident #140's diagnoses included dysphagia, neuropathy, glaucoma, arthritis, left leg, knee and low back pain. The admission MDS assessment dated [DATE] identified Resident # 140 had intact cognition, had no behavioral symptoms, required supervision or touching assistance to roll left and right and partial/moderate assistance with personal hygiene. The care plan dated 8/12/24 identified a self-care deficit. Interventions directed staff to explain what they were going to do, encourage the resident to do as much for herself/himself as able and to offer to assist the resident with tasks as required. The psychotherapy's progress note dated 9/6/24 identified Resident #140 oriented to person, place, time and situation. The resident was pleasant and cooperative with logical thought process and appropriate thought content. The resident's mood was identified as depressed and anxious. The resident had good short-term and long-term memory, attention, insight and judgement. The APRN #1's progress note dated 9/12/24 identified Resident #140 was alert, oriented, cooperative and calm. Further review identified the resident without depression, anxiety, mood swings, sleep disturbances, with no changes in memory and no changes in concentration. The In-House Care report (written communication between nurses and APRNs) dated 9/16/24 identified Resident #140's chief complaint as UTI monitoring/cough. The 24-Hour Supervisor Report sheet dated 9/16/24 identified Resident #140 said that someone working at 6 AM, two weeks ago Friday, hit her/him in her/his back. Staff identified that the resident told the physical therapist that the owner's daughter hit her/him. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Reportable Event Form dated 9/17/24 identified that the resident reported that someone smacked her/him on her/his back two weeks ago on Friday at 6 AM. The nurse's note dated 9/17/24 identified Resident #140 was alert and forgetful. The resident reported that someone struck her/him on her/his back two weeks ago. The nurse's note further identified that a body audit was done showing the skin was intact with no redness or swelling, and the resident denied pain. Further review identified the resident stated she/he had a history of lower back pain that was relieved with pain medication. Person #1 and APRN #1 were notified. The APRN #1's progress note dated 9/17/24 identified Resident #140 was evaluated for some confusion over the weekend that was reported by staff. The resident also had some urinary complaints at this time and a Urine test was ordered. APRN #1 discussed with the resident any events over the weekend, and she/he denied any incidents. The resident had no complaints of pain or injury. Further review identified the resident was alert, cooperative and calm, the confusion over the weekend appeared resolved. The physiatry APRN's progress note dated 9/17/24 identified Resident #140 was alert and oriented times three (person, place and time), with a good mood and appropriate affect. Further review identified the resident's pain was controlled. An interview with PT #1 on 9/18/24 at 2:53 PM identified on 9/15/24 around 2:00 PM Resident #140 stated the owner's daughter rolled me and smacked my back, she hit me on my back and now my back hurts. The resident sounded upset, and PT #1 report the allegation of abuse to LPN #1 immediately. Review of the resident's clinical record and facility documentation failed to provide documentation of the alleged abuse that was reported on 9/15/24. An interview with OT #1 on 9/18/24 at 3:16 PM identified that on 9/16/24 around 11:00 AM during an evaluation, Resident #140 was somehow confused, refused to stand up and complained of little pain in her/his back. When asked if something was wrong, the resident stated that the owner's daughter rolled her/him on the side and hit her/him on her/his back. The resident showed the hit to OT #1 with her/his opened hand in the air. OT #1 assessed the resident's skin, and there was no redness. The resident was unable to describe the person and stated she hit me the other day, I think it was the owner's daughter. Although OT #1 was aware of the resident's allegations of abuse from PT#1's report on 9/15/24, OT #1 reported the allegation to nursing staff, but they stated that it was already reported on 9/15/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN #1 on 9/19/24 at 12:33 PM identified on 9/15/24, PT #1 reported that the resident stated that the owner's daughter hit her/him on her/his back, and the resident was refusing to participate in therapy session. When LPN #1 went to speak to the resident about the allegation, the resident denied being hit and denied pain at that time. The resident identified that she/he was nauseas, and the nurse administrated Zofran as ordered. LPN #1 further identified that although she received in-service on 9/9/24 directing immediate reporting and to ensure that all incidents including physical, verbal, sexual and misappropriation of funds were to be reported to supervisor immediately, she did not report the allegation of physical abuse because the resident denied the allegation during their conversation. LPN #1 was unable to recall the time she spoke to the resident and what time she administered Zofran for nausea, but stated it was during the 7AM to 3PM shift on 9/15/24 and about the same time she asked for UTI monitoring by writing in the In-House Care report for APRN to review. Review of the Medication Administration Record (MAR) identified Zofran 4 mg was administered on 9/15/24 at 6:05 PM and did not include a record of Zofran 4 mg administration during 7AM to 3PM shift. Further interview with LPN #1 identified that although she administered Zofran during 7AM to 3PM shift on 9/15/24, she did not realize that she did not document it but possibly administered a second dose later that day. In addition, she made an error while writing the date in the In-House Care report and therefore the date was inaccurate. Further review of the In-House Care report identified a written note for APRN to review was dated 9/16/24 and not 9/15/24. An interview with RN #1 on 9/19/24 at 2:45 PM identified that on 9/16/24 Person #1 was visiting Resident #140 when the resident stated that somebody hit her/him at 6AM two weeks ago Friday. The resident stated that she/he already told PT #1 and the nurse. RN #1 further identified that the staff member informed her that the nursing staff was already notified and the APRN ordered a urine test. RN #1 stated she only wrote the information in the 24-Hour Supervisor Report sheet dated 9/16/24 because she thought that the facility was aware and already acted. Interview and clinical record review with ADNS on 9/19/24 at 3:20 PM identified the facility administrator and DNS should be notified immediately or as soon as possible of all allegations of abuse. The DNS or designee should then notify the state agency immediately but no later than 2 hours after the allegation was made. The ADNS further identified she was not notified of the alleged abuse until 9/17/24 during morning meeting (two (2) days after the allegation of physical abuse was reported by the resident). ADNS indicated that had she known about the incident she would have reported the incident to the Administrator, DNS and state agency. The ADNS identified based on the investigation, LPN #1 received a Written Counseling dated 9/19/24 for failing to follow protocol for reporting all allegations of abuse and received in-service directing to document changes in the resident's condition in the medical record, in shift report and to inform RN supervisor. Review of the clinical records and facility documentation failed to reflect documentation showing the incident was communicated, investigated, and followed through to ensure interventions were put in place to protect and support Resident #140 immediately after the alleged abuse was reported by the resident to facility staff. Review of facility Abuse, Neglect and Exploitation Policy dated 2/2023 directed reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious body injury.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on clinical record review, review of facility documentation, observations, and interview with facility staff for one sampled resident (Resident #73) who was reviewed for medication administration, the facility failed to ensure the resident consumed her medication in the presence of a staff member. The findings include: Resident #73 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, epilepsy, and hyperlipidemia. Review of the MDS assessment dated [DATE] identified the resident had no cognitive impairment or behavior issues. Review of a corresponding care plan and updated on 9/12/24 identified the resident demonstrates noncompliance with the plan of care and often refuses medications. Interventions included document refusals, allow to verbalize non-compliance, and approach in a nonjudgemental manner. Physician orders directed in part, Januvia 100 milligrams (mg) daily at 6:00 A.M.(medication for diabetes, ordered 5/26/23), Depakote Extended Release 500 mg daily at 6:00A.M. (medication for seizures, ordered 7/31/24), Aspirin 81 mg daily at 6:00 A.M. (ordered 5/9/23), AREDS 1 tablet twice a day at 6:00 A.M and 6:00 P.M. (nutritional supplement, ordered 2/27/24), and Protonix 40 mg daily at 6:00 A.M. (medication for gastroesophageal reflux disease, ordered 1/2/24). Observations and interview with Resident #73 on 9/12/24 at 11:00 A.M. identified 5 medication tablets were in a medication cup and left at the bedside. Resident #73 indicated they were left at the bedside for her to consume, however, she did not want to take them. Review of facility reportable event documentation dated 9/12/24 identified that medications were found at the resident's bedside. The review identified the medications as Januvia 100 milligrams., Depakote Extended Release, Aspirin 81 mg, AREDS and Protonix. Further review identified that LPN # 3 left the resident's medication at the bedside and coaching and counseling was provided. Interview with the Assistant Director of Nurses on 9/24/24 at 2:30 P.M. identnfied that during the investigation, LPN # 3 left the medications at the bedside and intended to return but forgot. She further stated that LPN #3 received counseling and education regarding the incident. Review of the Policy and Procedure: Medication Administration-ORAL, procedure point 17, stay with the resident/patient until he/she has swallowed the medication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16837 Based on review of the clinical record, review of facility documentation, interviews with facility staff and observation for one sampled resident (Resident #120) who had a history of multiple falls and was demonstrating unsafe behaviors and movements while seated in a wheel chair, the facility failed to provide a seating system that had been assessed for the resident. The findings include: Resident #123 was admitted to the facility with diagnoses that included fracture of the upper end of the left humerus, vascular dementia, anxiety disorder, Wernicke's encephalopathy and repeated falls. An annual MDS assessment dated [DATE] identified the resident had disorganized thinking, an altered level of consciousness, rarely understood, and severely impaired decision making. The assessment further identified the resident is at risk for physical illness or injury that interferes with the plan of care and puts others at risk. The Resident Care Plan's (RCP) dated 8/2/24, 8/6/24, 8/9/24, 8/12/24, 8/13/24, 8/24/24, 8/28/24, 9/1/24, and 9/4/24, identified a problem with trauma/falls with interventions that included appropriate referrals as needed. Review of the progress notes from 8/1/24 through 9/6/24 identified multiple falls with transfers to the hospital on 8/1/24, 8/9/24, 8/13/24, 8/27/24 and 9/6/24. Further review of the progress notes dated 9/6/24 indicated the resident sustained a fracture to the left humerus post fall. Review of an Occupational Therapy evaluation dated 9/9/24 identified poor sitting balance with constant restlessness forcing self into extension with a pitching trunk. The evaluation further identified clinical impressions that included the resident was lethargic and restless when aroused and was consistently pitching his/her trunk forward and back causing the standard arm chair to tip off the front legs which required the therapist to provide support to avoid the chair from tipping over. The evaluation indicated the resident was provided an adapted tilt in space wheel chair with a head rest, lateral support due to poor trunk control during periods of lethargy, a ROHO cushion and arm rest cushion supports and bilateral fixed leg rests with medial guides. A physician order dated 9/13/24 directed an adaptive wheel chair with head rest, lateral supports, anti-tippers, cushion arm rest, bilateral fixed leg rests with medial guides and a ROHO cushion. Observations on 9/13/24 from 5:10 A.M. through 5:20 A.M. identified Resident #123 seated in an adaptive wheel chair, positioned in the corner of the corridor with the bilateral legs rests not positioned correctly and/or secured in place. Resident #123 was observed to be aggressively pitching his/her trunk side to side and up and down causing the wheel chair to tip backwards. When tipped backwards the wheel chair connected to the corner of the wall which prevented the chair from tipping over completely. At 5:20 A.M. the resident swung their legs over the arms of the chair which prompted the LPN #2 who was in the process of medication administration to quickly respond and direct the resident not to get up. At the same time NA #1 was also responding to Resident #123's behaviors/restlessness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with NA#1 on 9/13/24 at 5:25 A.M. she stated that Resident #123 returned from the emergency department at the change of shift, was very restless and it was not safe to keep him/her in bed. She stated that although the wheel chair that she used was not the residents, she needed to keep an eye on him/her because of the unsafe behaviors and the only way that could be accomplished was keeping the resident in a wheelchair in the corridor. She further indicated that she was not aware if a wheel chair had been given to the resident for his/her use. Interview with LPN #2 on 9/13/24 at 5:30 A.M. indicated that she asked NA #1 to sit with the resident, however, NA #1 indicated she was not done with her assignment and needed to provide care to other residents. After surveyor inquiry, LPN #2 notified Nurse Supervisor #1 of the challenging behaviors. During an interview with Nurse Supervisor #1 on 9/13/24 at 5:40 A.M., she stated she would sit with the resident for supervision related to the behaviors. During an interview with the Assistant Director of Nurses on 9/24/24 at 2:30 P.M. she stated that although the resident was assessed on 9/9/24 and recommendations were made for an adaptive wheel chair with specific modifications, it was not provided until after surveyor observations on 9/13/24. She further stated that staff have been trained with regards to resident positioning in the wheel chair on 9/13/24.