STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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	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** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers, the facility failed to notify the practioner timely of deterioration to a pressure ulcer. The findings include: Resident #1's diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time), dementia with behavioral disturbances, type 2 diabetes mellitus and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status completed identifying short-term and long-term memory problems indicative of severely impaired cognition and required supervision assistance with bed mobility, maximal assistance with toileting hygiene and transfers and was dependent on staff for personal hygiene. The Resident Care Plan (RCP) dated 12/31/24 identified that Resident #1 had a new stage 2 pressure ulcer (partial thickness skin loss, presenting as a shallow open ulcer with a red or pink wound bed) with innterventions that included turning and repositioning the resident every two hours and as needed, therapy to screen for custom wheelchair positioning, visits with the wound physician as needed and treatment to the coccyx as ordered. a) A wound physician note dated 2/4/25 at 6:04 AM identified that Resident #1 had a stable stage 2 pressure ulcer to the coccyx measuring 2.5 centimeters (cm) in length by 0.3 cm in width by 0.2 cm in depth with a scant amount of serosanguinous drainage (fluid that's discharged from a wound that's a mixture of the watery part of blood and red blood cells), 100 percent (%) granulation tissue (new pink or red tissue that forms in the healing process of wounds) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying hydrogel (provides moisture to the wound, promotes granulation tissue and encourages complete healing) to the wound bed and then securing with a dry, clean dressing daily and as needed. A nurse's note dated 2/8/25 at 4:55 PM identified that Resident #1's coccyx wound had worsened, reporting that there was slight tunneling 0.5 cm depth and was 1.5 cm length by 0.5 cm width and that the resident was to be reassessed by the wound team for further evaluation and treatment update. A nurse's note dated 2/9/25 at 5:00 PM identified that Resident #1's coccyx wound had worsened, reporting that there was slight tunneling 0.5 cm depth and was 1.5 cm length by 0.5 cm width and that the resident was to be reassessed by the wound team for further evaluation and treatment update. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 2/8/25 through 2/10/25 failed to identify that the nursing supervisor nor a provider was notified of the decline of Resident #1's wound. A wound physician note dated 2/11/25 at 6:52 AM identified that Resident #1 had a worsening stage 2 pressure ulcer to the coccyx measuring 3.5 centimeters (cm) in length by 1.6 cm in width by 0.2 cm in depth with a moderate amount of serosanguinous drainage, 75 percent (%) granulation tissue (new pink or red tissue that forms in the healing process of wounds) and 25 % eschar tissue (dead tissue that forms over healthy skin and over time falls off) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying calcium alginate with silver (an antimicrobial dressing that helps absorb moderate to heavy wound drainage that's at a high-risk for infection) to the wound bed and then securing with a dry, clean dressing daily and as needed. Interview with LPN #1 on 3/14/25 at 12:03 PM identified that on 2/8/25 and 2/9/25, she notified the Nursing Supervisor (RN #3) that Resident #1's wound had worsened and that tunneling was present but was unsure if the provider was notified, stating that would have been RN #3's responsibility to notify the provider and that she (LPN #1) didn't follow up with RN #3. She identified that on 2/23/25, the Santyl was unavailable, so she notified the Nursing Supervisor (RN #3) and although she was unsure if RN #3 notified the provider or obtained dressing orders pending the delivery of the Santyl, she reported that she applied calcium alginate per the previous treatment order so that the drainage was contained and documented it in the administration note. She identified that she should follow orders when administering treatments and medications but reported that she thought it was better than not administering a treatment at all. Interview with RN #3 on 3/14/25 at 3:06 PM identified that LPN #1 never notified her on 2/8/25 or 2/9/25 that Resident #1's wound had worsened and that tunneling was present. She identified that if she had, she would have assessed Resident #1's wound and notified the provider if her assessment greatly differed from the last time the resident was seen by MD #1 and she would have written a note documenting everything she had observed and done. Additionally, she identified that LPN #1 never notified her on 2/23/25 that Resident #1's Santyl was unavailable, stating she would have called the pharmacy to inquire about the status of the medication and then contacted the on-call to obtain an alternative treatment pending the delivery of the Santyl. b) A wound physician note dated 2/18/25 at 6:40 AM identified that Resident #1 had a worsening unstageable pressure ulcer to the coccyx measuring 3.2 centimeters (cm) in length by 1.7 cm in width by 0 cm (unable to determine) in depth with a small amount of serous drainage (a clear fluid that drains from wounds and is a sign of healing), 100 percent (%) slough tissue (non-healing tissue that needs to be removed from the wound for healing to take place) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying Santyl (a prescription ointment that removes dead tissue from wounds so that they can start to heal) to the wound bed and then securing with a dry, clean dressing daily and as needed. The note identified that the wound continues to deteriorate and was now unstageable so Santyl will now be started and recommend for the resident to be placed on an air mattress for pressure offloading. A physician's order dated 2/18/25 directed to apply Santyl ointment to the coccyx open area. Cleanse open area with wound cleanser/Normal Saline, pat dry and cover with dry clean dressing daily. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.A nurse's note dated 2/23/25 at 11:51 PM identified that the wound on Resident #1's coccyx appeared infected and reported that the area was cleansed and covered and that it had measured 3.5 cm in length by 4 cm in width. The note identified that the supervisor (RN #4) assessed the wound and placed a call to the pharmacy about the medication order. A nurse's note dated 2/24/25 at 12:12 AM identified that the nurse (LPN #5) had called the writer (RN #4) into the resident's room to assess the coccyx wound and that the wound was noted to be black and contain slough. It reported that the resident's family member was present and was concerned that the wound was infected. The note identified that vital signs were obtained and were within normal limits but that the resident appeared to be in discomfort, so medication was given. It reported that the charge nurse (LPN #5) did a wound dressing change but that it required Santyl, which had been unavailable so she called the pharmacy, and they stated the Santyl would arrive that evening. It identified that she called MD #2 (previous wound doctor) for any recommendations, but that MD #2 did not pick up, so she left a message. It identified that report was given to the next shift to follow-up in the morning. Review of progress notes dated 2/23/25 failed to identify that MD #1 (current wound physician) or an in-house provider (APRN #1 or MD #3) was notified of the wound changes. An Advanced Practice Registered Nurse (APRN) note dated 2/24/25 at 7:30 PM identified that she was requested to see Resident #2 for their wound, but reported that she did not assess the wound, as the treatment was already in place. The note identified that the family was notified and was upset that the dressing was not removed and the area assessed but she reported to them that MD #1 would assess the wound the next morning. A wound physician note dated 2/25/25 at 7:06 AM identified that Resident #1 had a worsening unstageable pressure ulcer to the coccyx measuring 4 centimeters (cm) in length by 1.7 cm in width by 0 cm (unable to determine) in depth with a moderate amount of serosanguinous drainage (fluid that's discharged from a wound that's a mixture of the watery part of blood and red blood cells), 100 percent (%) slough tissue (nonhealing tissue that needs to be removed from the wound for healing to take place) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying Santyl (a prescription ointment that removes dead tissue from wounds so that they can start to heal) to the wound bed and then securing with a dry, clean dressing daily and as needed. The note identified that the wound was again measuring larger but that they were starting to debride with Santyl, recommending for the resident to offload pressure from the area and that he/she would benefit from a back to bed schedule to offload pressure, as well as a low air loss mattress. An APRN note dated 2/25/25 at 7:31 PM identified that she discussed Resident #2's wound with MD #1 who reported that if the Santyl was ineffective in wound debridement then the resident may require surgical debridement and the possibility of a Foley catheter (a tube inserted into the bladder to drain urine) or a temporary ostomy (a surgical procedure that creates an opening in the abdomento allow waste to exit the body) to keep the wound area clean and dry to aid in healing. Interview with MD #1 (wound physician) on 3/14/25 at 11:20 AM identified that if staff had assessed the wound and noticed a decline in the size, appearance, odor, drainage or the surrounding skin, he expected that either himself or a facility provider should have been contacted about the change or requesting an alternative treatment, stating he had not been contacted between his weekly scheduled visits regarding Resident #1. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nurses on 3/14/2025 at 10:37 AM on identified that he could not speak to whether or not the physician was notified of the provider of the change in condition of the wound, however, if they did it should be documented in the clinical record. Although attempted, interviews with RN #4 and LPN #5 were not obtained. Review of the Pressure Ulcer Prevention and Managing Skin Integrity policy (undated) directed, in part, that staff will communicate skin concerns so the entire healthcare team can implement interventions. Physical agents that may improve the overall integrity of the skin such as protective creams, barriers, coverings, pressure reducing devices, etc. The care and intervention for any identified skin breakdown or wound will be aimed at the prevention of any further advancement of the wound, or additional skin breakdown; Implementation of appropriate evidence-based care for the problem identified; Collaboration with the independent and interdisciplinary health care teams regarding the presence of breakdown and the intervention plan; Close monitoring and response to treatment; Provisions for changes in the plan if progress toward expected outcomes are not evident. The presence of skin breakdown/abnormal skin appearance will be documented upon admission and daily. Upon identification of a wound, a full wound assessment, including its location, size and description of the tissue involved will be completed. Interventions and progress towards outcome focused goals need regular documentation according to established procedures. Review of the Prevention of Pressure Ulcers policy (undated) directed, in part, that the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family, and are addressed. Although requested, a facility policy for Physician's Orders was not provided.

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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** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers, the facility failed to ensure that a pressure ulcer was treated in accordance with physician's orders. The findings include: Resident #1's diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time), dementia with behavioral disturbances, type 2 diabetes mellitus and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status completed identifying short-term and long-term memory problems indicative of severely impaired cognition and required supervision assistance with bed mobility, maximal assistance with toileting hygiene and transfers and was dependent on staff for personal hygiene. The Resident Care Plan (RCP) dated 12/31/24 identified that Resident #1 had a new stage 2 pressure ulcer (partial thickness skin loss, presenting as a shallow open ulcer with a red or pink wound bed). Interventions included turning and repositioning the resident every two hours and as needed, therapy to screen for custom wheelchair positioning, visits with the wound physician as needed and treatment to the coccyx as ordered. A wound physician note dated 2/18/25 at 6:40 AM identified that Resident #1 had a worsening unstageable pressure ulcer to the coccyx measuring 3.2 centimeters (cm) in length by 1.7 cm in width by 0 cm (unable to determine) in depth with a small amount of serous drainage (a clear fluid that drains from wounds and is a sign of healing), 100 percent (%) slough tissue (non healing tissue that needs to be removed from the wound for healing to take place) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying Santyl (a prescription ointment that removes dead tissue from wounds so that they can start to heal) to the wound bed and then securing with a dry, clean dressing daily and as needed. The note identified that the wound continues to deteriorate and was now unstageable so Santyl would now be started. A physician's order dated 2/18/25 directed to apply Santyl ointment to the coccyx open area. Cleanse open area with wound cleanser/Normal Saline, pat dry and cover with dry clean dressing daily. Review of the Medication Administration History for February 2025 identified that the above wound treatment was transcribed on 2/18/25 and had been signed off as not administered on 2/23/25. An administration note dated 2/23/25 at 1:57 PM identified that the drug was unavailable and that the wound was cleansed and alginate was applied followed by a dry clean dressing until the medication arrived. Review of nurse's notes dated 2/23/25 failed to identify that the provider was notified that the Santyl was unavailable for Resident #2 on 2/23/25 and that an alternative order was obtained to apply alginate pending the delivery of the Santyl from the pharmacy. Review of physician's orders dated 2/23/25 failed to identify an order directing to apply alginate to the resident's wound pending delivery of the Santyl from the pharmacy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 3/14/25 at 12:03 PM identified that on 2/23/25, the Santyl was unavailable for Resident #1 on 2/23/25, so she notified the Nursing Supervisor (RN #3) and although she never followed up with RN #3 and was unsure if RN #3 notified the provider or obtained dressing orders pending the delivery of the Santyl, she reported that she applied calcium alginate per the previous treatment order so that the drainage was contained and documented it in the administration note. She identified that she should always follow physician's orders when administering treatments and medications but reported that she thought it was better than no treatment to the wound. Interview with RN #3 on 3/14/25 at 3:06 PM identified that LPN #1 never notified her on 2/23/25 that Resident #1's Santyl was unavailable, stating that if she had she (RN #3) would have called the pharmacy to inquire about the status of the medication and then contacted the on-call to obtain an alternative treatment pending the delivery of the Santyl. Interview with RN #2 (Infection Control nurse) on 3/14/25 at 12:14 PM identified that it was not appropriate for LPN #1 to apply calcium alginate to Resident #1's wound on 2/23/25 without first notifying the provider and requesting an alternative treatment pending the delivery of the Santyl. She reported that she was unaware that LPN #1 had documented that she had applied alginate to Resident #1's wound as an alternative and stated she was unsure why she would have done that without direction from the provider. Interview with APRN #1 on 3/14/25 at 1:51 PM identified that if there was a change in Resident #1's wound, including size, tissue appearance, drainage and skin surrounding the wound, or if the Santyl was unavailable, and if MD #1 (wound physician) was unavailable at the time, she would expect to be notified so that she could direct the staff in a treatment plan or offer an alternative treatment or substitute. She identified that it was not appropriate for staff to administer a different treatment from what was ordered without first notifying a provider. Review of the Pressure Ulcer Prevention and Managing Skin Integrity policy (undated) directed, in part, that staff will communicate skin concerns so the entire healthcare team can implement interventions. Physical agents that may improve the overall integrity of the skin such as protective creams, barriers, coverings, pressure reducing devices, etc. The care and intervention for any identified skin breakdown or wound will be aimed at the prevention of any further advancement of the wound, or additional skin breakdown; Implementation of appropriate evidence-based care for the problem identified; Collaboration with the independent and interdisciplinary health care teams regarding the presence of breakdown and the intervention plan; Close monitoring and response to treatment; Provisions for changes in the plan if progress toward expected outcomes are not evident. The presence of skin breakdown/abnormal skin appearance will be documented upon admission and daily. Review of the Administration of Medication Overview policy (undated) directed that medications will be administered by licensed personnel as ordered by the physician for the treatment of disease and maintenance of residents health. Although requested, a facility policy on Physician's Orders was not provided.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for pressure ulcers, the facility failed to report a deterioration in wound status to the physician, ensure wound care was completed in accordance with physicians orders, and ensure an air mattress was provided timely which resulted in a deterioration of a pressure ulcer. The findings include: Please cross reference F 580 and F 658. Resident #1's diagnoses included Parkinson's disease (a movement disorder of the nervous system that worsens over time), dementia with behavioral disturbances, type 2 diabetes mellitus and muscle weakness. A Braden assessment dated [DATE] identified that Resident #1 was a moderate risk for developing pressure ulcers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Staff Assessment for Mental Status completed identifying short-term and long-term memory problems indicative of severely impaired cognition, was always incontinent of bladder, frequently incontinent of bowel, had two (2) stage two (2) pressure ulcers, one (1) which was present on admission and required assistance with bed mobility and Activities of Daily Living, and was at risk for developing additional pressure ulcers. The Resident Care Plan (RCP) dated 12/31/24 identified Resident #1 had a new stage 2 pressure ulcer (partial thickness skin loss, presenting as a shallow open ulcer with a red or pink wound bed) with interventions that included turning and repositioning the resident every two hours and as needed, keeping the bed linens dry, therapy to screen for custom wheelchair positioning, visits with the wound physician as needed and treatment to the coccyx as ordered and to follow the skin care protocols. a) A wound physician note dated 2/4/2025 at 6:04 AM identified that Resident #1 had a stable stage 2 pressure ulcer to the coccyx measuring 2.5 centimeters (cm) in length by 0.3 cm in width by 0.2 cm in depth with a scant amount of serosanguinous drainage (fluid that's discharged from a wound that's a mixture of the watery part of blood and red blood cells)., 100 percent (%) granulation tissue (new pink or red tissue that forms in the healing process of wounds) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying hydrogel (provides moisture to the wound, promotes granulation tissue and encourages complete healing) to the wound bed and then securing with a dry, clean dressing daily and as needed. A nurse's note dated 2/8/2025 at 4:55 PM identified that Resident #1's coccyx wound had worsened, reporting that there was slight tunneling 0.5 cm depth and was 1.5 cm length by 0.5 cm width and that the resident was to be reassessed by the wound team for further evaluation and treatment update. A nurse's note dated 2/9/2025 at 5:00 PM identified that Resident #1's coccyx wound had worsened, reporting that there was slight tunneling 0.5 cm depth and was 1.5 cm length by 0.5 cm width and that the resident was to be reassessed by the wound team for further evaluation and treatment update. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of progress notes dated 2/8, 2/9, 2/10/2025 failed to identify that the nursing supervisor nor a provider was notified of the deterioration of Resident #1's wound. A wound physician note dated 2/11/2025 at 6:52 AM identified that Resident #1 had a worsening stage 2 pressure ulcer to the coccyx measuring 3.5 centimeters (cm) in length by 1.6 cm in width by 0.2 cm in depth with a moderate amount of serosanguinous drainage, 75 percent (%) granulation tissue (new pink or red tissue that forms in the healing process of wounds) and 25 % eschar tissue (dead tissue that forms over healthy skin and over time falls off) with no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying calcium alginate with silver (an antimicrobial dressing that helps absorb moderate to heavy wound drainage that's at a high-risk for infection) to the wound bed and then securing with a dry, clean dressing daily and as needed. Interview with Licensed Practical Nurse (LPN) #1 on 3/14/2025 at 12:03 PM identified that on 2/8/2025 and 2/9/2025, she notified the Nursing Supervisor (Registered Nurse (RN) #3) that Resident #1's wound had worsened and that tunneling was present but was unsure if the provider was notified, stating that would have been RN #3's responsibility to notify the provider. Interview with RN #3 on 3/14/2025 at 3:06 PM identified that LPN #1 did not notify her on 2/8/2025 or 2/9/2025 that Resident #1's wound had worsened and that tunneling was present. She identified that if she had, she would assessed Resident #1's wound and notified the provider if her assessment greatly differed from the last time the resident was seen by Medical Doctor (MD) #1 and she would have written a note documenting everything she had observed and done. b) A wound physician note dated 2/18/2025 at 6:40 AM identified that Resident #1 had a worsening unstageable pressure ulcer to the coccyx measuring 3.2 centimeters (cm) in length by 1.7 cm in width by 0 cm (unable to determine) in depth with a small amount of serous drainage (a clear fluid that drains from wounds and is a sign of healing), 100 percent (%) slough tissue (nonhealing tissue that needs to be removed from the wound for healing to take place) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying Santyl (a prescription ointment that removes dead tissue from wounds so that they can start to heal) to the wound bed and then securing with a dry, clean dressing daily and as needed. The note identified that the wound continues to deteriorate and was now unstageable so Santyl will now be started and recommend for the resident to be placed on an air mattress for pressure offloading. i. A physician's order dated 2/18/2025 directed to apply Santyl ointment to the coccyx open area. Cleanse open area with wound cleanser/Normal Saline, apply Santyl, pat dry and cover with dry clean dressing daily. Review of the Medication Administration History for February 2025 identified that the above wound treatment was transcribed on 2/18/2025 and had been signed off as administered on 2/19, 2/20, 2/21, and 2/22/2025. An administration note dated 2/18/2025 at 12:36 PM identified that the treatment was not administered, as it was completed by the wound team. An administration note by LPN #1 dated 2/23/2025 at 1:57 PM identified that the Santyl was unavailable and that the wound was cleansed and alginate was applied followed by a dry clean dressing until the medication arrived. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #1 on 3/14/2025 at 12:03 PM identified that on 2/23/2025, the Santyl was unavailable, so she notified the Nursing Supervisor (RN #3) and although she was unsure if RN #3 notified the provider or obtained dressing orders pending the delivery of the Santyl, she reported that she applied calcium alginate per the previous treatment order so that the drainage was contained. She identified that she should follow orders when administering treatments and medications but reported that she thought it was better than no treatment. Interview with RN #2 (Infection Control nurse) on 3/14/2025 at 12:14 PM identified that on 2/18/2025 the treatment was not done during the wound care visit as stated in the nurses note, as they don't carry a house stock of Santyl. RN #2 further identified that it was not appropriate for LPN #1 to apply calcium alginate to Resident #1's wound on 2/23/2025 without first notifying the provider and requesting an alternative treatment pending the delivery of the Santyl. ii. A nurse's note dated 2/23/2025 written by LPN #5 at 11:51 PM identified that the wound on Resident #1's coccyx appeared infected the area was cleansed and covered. A nurse's note dated 2/24/2025 at 12:12 AM identified that the nurse (LPN #5) had called the writer (RN #4) into the resident's room to assess the coccyx wound and that the wound was noted to be black and contain slough. It reported that the resident's family member was present and was concerned that the wound was infected. The note identified that vital signs were obtained and were within normal limits but that the resident appeared to be in discomfort, so medication was given. RN #5 called MD #2 (wound doctor) for any recommendations, but that MD #2 did not pick up, so she left a message. It identified that report was given to the next shift to follow-up in the morning. Review of the clinical record failed to identify that the physician was notified on 2/23/2025 when the wound appeared to be infected. An Advanced Practice Registered Nurse (APRN) note dated 2/24/2025 at 7:30 PM identified that she was requested to see Resident #2 for their wound, but reported that she did not assess the wound, as a treatment was already in place. The note identified that the family was notified and was upset that the dressing was not removed and the area assessed but she reported to them that MD #1 would assess the wound the next morning. Although attempted, interviews with RN #4 and LPN #5 were not obtained. iii. The clinical record failed to identify that an order was in place or that the resident was placed on an air mattress as recommended by the wound care doctor on 2/18/15. Interview with RN #2 (Infection Control nurse) on 3/14/2025 at 12:14 PM identified that she must not have read down far enough in MD #1's note and missed the recommendation for the air mattress on 2/18/2025, stating that an order should have been entered to check function and settings every shift and it should have been applied on 2/18/2025, but because the recommendation was missed, it was not, and maintenance was not notified to either apply and house stock air mattress or order an air mattress for Resident #1. Interview with MD #1 (wound physician) on 3/14/2025 at 11:20 AM identified that when he assessed Resident #1's wound on 2/25/2025, the resident did not have an air mattress in place to his/her bed as recommended on 2/18/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview and with RN #1 on 3/14/2025 at 11:36 AM identified that she could not speak for the 2/18/2025 visit with MD #1 as to why the air mattress was not entered as an order, but stated the air mattress was currently in place and set to 180 pounds, normal pressure, and that on 2/25/2025 when the air mattress was recommended again on MD #1's note, she must have forgotten to enter the order for the air mattress, as all air mattresses should be entered as an order for the nurses to ensure function and settings every shift. A wound physician note dated 2/25/2025 at 7:06 AM identified that Resident #1 had a worsening unstageable pressure ulcer to the coccyx measuring 4 centimeters (cm) in length by 1.7 cm in width by 0 cm (unable to determine) in depth with a moderate amount of serosanguinous drainage (fluid that's discharged from a wound that's a mixture of the watery part of blood and red blood cells)., 100 percent (%) slough tissue (nonhealing tissue that needs to be removed from the wound for healing to take place) and no odor was noted. The treatment recommendations included cleansing the wound with wound cleanser, applying Santyl (a prescription ointment that removes dead tissue from wounds so that they can start to heal) to the wound bed and then securing with a dry, clean dressing daily and as needed. The note identified that the wound is again measuring larger but that they are starting to debride with Santyl, recommending for the resident to offload pressure from the area and that he/she would benefit from a back to bed schedule to offload pressure, as well as a low air loss mattress. Interview with APRN #1 on 3/14/2025 at 1:51 PM identified that for Resident #1, she would review and sign off on any treatment recommendations from MD #1 that she thought were appropriate, including the Santyl and air mattress to Resident #1's bed and stated she would expect that they both be entered as physician's orders when recommended. She reported that if there was a change in Resident #1's wound, including size, tissue appearance, drainage and skin surrounding the wound, or if the Santyl was unavailable, and if MD #1 was unavailable at the time, she would expect to be notified so that she could direct the staff in a treatment plan or offer an alternative treatment or substitute. She identified that it not appropriate for staff to administer a different treatment from what is ordered without first notifying a provider. Interview with MD #1 (wound physician) on 3/14/2025 at 11:20 AM identified that the further decline in Resident #1's wound from 2/18/2025 to 2/25/2025 was due to the inconsistent treatment application of the Santyl and the air mattress not being implemented as recommended for offloading the area on 2/18/2025. Interview with the Director of Nurses on 3/14/2025 at 10:37 AM on identified that he could not speak to whether or not the physician was notified of the provider of the change in condition of the wound, however, if they did it should be documented in the clinical record. The DNS further identified that he was unsure what happened with the air mattress and was unsure why the Santyl was unavailable on 2/23/25. Review of the Prevention of Pressure Ulcers policy (undated) directed, in part, that the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family, and are addressed. Review of the Administration of Medication Overview policy (undated) directed that medications will be administered by licensed personnel as ordered by the physician for the treatment of disease and maintenance of resident's health. (continued on next page)

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	075358	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Although requested, facility policies for Air Mattresses and Physician's Orders were not provided.