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	04/29/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 48879 Based on observations, Review of Resident Council Meetings, facility documentation, and interviews, the facility failed to follow up on resident concerns in Resident Council Meetings timely. The findings include: On 4/24/24 at 10:00 AM during the Resident Council meeting, Resident's # 1, 7, 13 and 17 reported that their bedrooms were cold and drafty. The residents indicated that they had complained about room temperatures often to the Administration and had also brought the concern up in Resident Council Meetings with no resolution. Review of the Resident Council Meeting Minutes from 1/31/24 identified Resident #1 had complained about a draft coming through his/her bedroom window. There were handwritten notes on the meeting minutes stating maintenance was notified and was addressing the issue. Further review of the Resident Council Meeting Minutes from 2/29/24 identified Resident #1 and Resident #7 complained about drafts coming through their bedroom windows. There were handwritten notes on the meeting minutes stating that maintenance was notified and was addressing the issue. Interview with the Recreation Director on 4/24/24 at 12:53 PM identified when there are any resident concerns or issues brought up at Resident Council Meetings, she will then communicate them with the specific departments, indicating that there was no facility process for the concerns voiced in the Resident Council Meetings. She also identified these concerns are not carried over or brought up at the next month's meeting to discuss the resolution, as the meetings last for an extended period, so she will try and go back and follow-up with the residents who had concerns individually, but her follow-ups are not documented. Additionally, she was unaware if these concerns were formally written on concern forms. The Recreational Director also indicated that some of the concerns voiced by the residents have been discussed more than once with no resolution as verbalized by the residents. Interview with the Director of Maintenance on 4/24/24 at 2:58 PM identified the Recreational Director had notified him of the residents who had complained of drafty windows. He sampled room temperatures and placed thermometers in random bedrooms and the bedrooms residents that had complained, but the temperatures had not fallen below 73 degrees Fahrenheit. He indicated that the windows in the facility are drafty and need replacing. The facility was going to caulk the windows as a temporary fix. He reported his maintenance staff resigned and was supposed to do the caulking before he left a few months ago, but it was never completed or followed up on. Additionally, the Maintenance Director failed to produce documentation on the sampled room temperatures. (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: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 4/24/24 at 3:15 PM identified that when there are concerns presented in Resident Council Meetings, there should be concern forms generated regarding the concerns. She reported that after the monthly Resident Council Meeting minutes are completed, she will review them with her team, they will write up concern forms, and then she will sign off on the meeting minutes. The Administrator reported the concern forms are given to the specific department that can address the concern to be completed, and that she would expect the concern to be addressed or resolved as soon as possible or before the next meeting. She reported she would expect the concern and the solution to be communicated to the residents as soon as there is a plan in place and at the next Resident Council Meeting as follow up. Review of the Concern Form Log failed to identify any concern forms for Resident #1 or Resident #7 regarding bedroom window drafts or room temperatures. A second interview with Administrator on 4/25/24 at 11:10 AM identified she was unable to locate any additional concern forms not already in the Concern Form Log binder. Although requested, a facility policy on Resident Council concerns was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record, review of facility policy and interviews for 1 of 1 resident (Resident # 39), the facility failed to ensure the resident's Advanced Directive was reviewed with the responsible party timely. The finding include: Resident #39's diagnosis included cerebral infarction and Alzheimer's disease. A physician's order dated 10/10 2023 directed to provide Full code status for Advanced Directives. A progress note dated 10/11/2023 at 5:11 AM indicated in part Resident #27 had a Conservator of Person (COP) and the code status was to be determined (TBD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #27 had some difficulty in daily decision making in new situations only. On 4/22/2024 at 1:20 PM an interview and record review with Registered Nurse (RN #1) indicated not finding the advanced directives sheet for Resident #39. However, RN # 1 did indicate seeing the resident's Advanced Directives in the past and s/he would investigate the matter right away. An interview and clinical record review with SW #1 on 4/23/24 at 8:05 AM indicated the COP had not been responsive to communications and due spiritual beliefs maybe having difficulty deciding. However, SW #1 could not provide any documentation of communications with the COP since 10/11/2023 and indicates s/he should have documented the attempts to reach out to the conservator. An interview and record review with LPN #2 (unit manager) on 4/23/24 at 8:50 AM indicated the resident's COP was spiritual and on admission had crossed out the Advanced Directives form but LPN #2 could not provide the crossed-out form or any communications with the COP since admission. LPN #2 further indicated the documentation and communication to the COP regarding Advanced Directives would be completed by the social worker. The facility policy dated 4/18/2024 labeled Admission Procedure Advanced Directives indicated in part if a resident does not have an advanced directive on admission and is incapacitated, the advanced directive form will be given to family and or the responsible party noted on the admission check list and then given to the social worker for completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48879 Based on a review of the facility grievance file, observations, facility documentation, facility policy and interviews, the facility failed to inform residents of how to file a grievance and failed to ensure the required information related to contact information for filing a grievance with government officials were posted in the facility. The facility also failed to maintain the results of all grievances for at least 3 years. The findings included: a. On 4/24/24 at 10:00 AM during the Resident Council Meeting, Residents # # 1, # 7 13, 17 and 34 reported they were not aware of how to file a grievance within the facility. Additionally, the residents were unable to locate information within the facility to direct them on who to contact to file a grievance. b. After the Resident Council Meeting on 4/24/24 at 11:17 AM, observations were made of the main entrance area and on all units of the facility identified no contact information of government official and any language on how to file a grievance posted/displayed for residents and visitors at the time of the observation. c. Review of the facility's Concern Form Log identified 6 concerns (grievances) in the binder dating from 4/24/23 through 4/15/24. Interview with Social Worker #1 on 4/24/24 at 12:23 PM identified s/he was not aware of a policy for concerns (grievances) and stated there was no formal process s/he knew of at the time of the conversation. SW #1 identified the Social Workers job is to normally oversee facility grievances at past facilities s/he had been employed. However, this facility ran differently, and the Administrator was the point person for concerns. S/he also indicated s/he is employed part time and that if someone approached him/her with a concern, s/he would speak with them and fill out a Concern Form, then give it to the Administrator. SW #1 also indicated s/he keeps the logbook of the concerns in her/his office and if the Administrator wanted him/her to follow up on the resolution, s/he would, but would only do so if requested by the Administrator. SW #1 further indicated s/he does not always find out the outcomes of the concerns and could not provide documentation of past concerns prior to 4/24/23 in his/her possession and directed surveyor to the Administrator for questions regarding past concerns. Additionally, SW #1 was not aware of any postings within the facility directing the residents/resident representatives on how to file a concern, or who is responsible for posting the grievance procedure and staff contact information for filing grievances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 4/24/24 at 3:15 PM identified the Social Worker is responsible for the facility concerns. She indicated the grievance process involves the Social Worker meeting with the resident/resident representative and fill out the Concern Form, then send the form to the specific department the concern involved, then review the form as a team. The Administrator also identified the Social Worker will then follow up with the resident/family, the administrator will sign the completed form, and then the Social Worker will file a copy of the concern. The Administrator was unable to provide past concerns from 12/28/21 through 10/15/22, prior to the facility closure on 10/28/22, reporting the Social Worker should have had copies of any concerns for that time. Additionally, she was not aware if the facility had a posting directing residents/resident representatives on how to file a grievance, including contact information. The Administrator further indicated there was a resident/family information board on the right-hand side after entering the main entrance and stated the Social Worker would be responsible for the postings and answer questions regarding other postings within the building if they existed. Review of the Resident Concern Form policy directed, in part, staff are responsible for bringing a concern to the Social Worker, or designee. The Social Worker or designee then completes the Resident Concern Form, and then distributes the form to the department of concern to investigate and complete. The completed form is given to Social Services, who then passes it on to the Administrator for review. Social Services then notifies the resident/family of the outcome and will then keep a record of the complete investigation and the report given. Although requested, a policy for Residents/Resident Representatives on how to file a grievance was not obtained. A second interview with Social Worker #1 on 4/25/24 at 10:29 AM identified s/he was not aware that it was his/her responsibility to post information regarding how to file concerns including his/her contact information, nor was s/he aware the Social Worker was responsible for the concerns process prior to surveyor inquiry. SW #1 indicated that if s/he had been aware, s/he would have had postings and would have followed the whole concern process through from reporting to conclusion and follow up and maintain copies of the full investigation for at least 3 years. S/he was unaware of any education provided to staff on this process and reported s/he was unsure of who was responsible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record reviews, facility documentation, review of policy and staff interviews for 2 of 6 residents reviewed for abuse (Resident #26 and Resident # 44), the facility failed to ensure the residents were protected after an allegation of suspected verbal abuse to prevent further potential abuse and were free from physical abuse. The findings included: 1. Resident #26 was admitted to the facility on [DATE]. The resident's diagnoses included dementia, seizures, and schizoaffective disorder. A Resident Care Plan (RCP) dated 3/27/23 identified Resident #26 was unable to vocalize due to cognitive impairment. Interventions included for staff to observe the resident for crying, yelling, or grimacing behaviors. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 had short and long-term memory problems and was severely cognitively impaired. Additionally, the MDS identified Resident #26 required extensive assistance from at least two people for bed mobility, transfers, and personal hygiene. A physician's order dated 6/26/23 directed repositioning every two hours. A facility Incident Report from 7/14/23 identified an incident of suspected verbal abuse which identified a staff member was noted yelling at Resident #26. The facility investigation indicated the Recreation Director overheard Nurse Aide (NA#4) yelling at Resident #26 on 7/13/23 at 4:00 PM. The facility investigation included statements from the Recreation Director, NA#4, NA#3, and Licensed Practical Nurse (LPN# 4). The facility conclusion of the investigation identified no verbal abuse and determined there was no mistreatment of the resident. A nursing progress note by the Director of Nursing Services (DNS) at the time (DNS#2) dated 7/14/23 identified that verbal abuse was reported on 7/14/23 and the staff member involved was sent home. Additionally, the progress note indicated the police, the resident's Power of Attorney (POA), and the resident's provider were notified on 7/14/23. Attempts to contact DNS#2 during the survey were unsuccessful. On 7/24/24 at 11:00 AM, an interview with Licensed Practical Nurse (LPN#4) indicated she had asked NA#4 to reposition Resident#26 on 7/13/23 at around 4:00 PM. LPN#4 indicated she heard a loud noise while she was in the hallway, which she indicated was related to NA#4 bumping into Resident#26's wheelchair. LPN#4 denied hearing yelling or any suspected abuse. Additionally, LPN # 4 indicated she witnessed NA#3 and NA#4 reposition Resident#26 without incident. LPN#4 also identified she was not made aware by any staff member any allegation of abuse until 7/14/23, when she was asked to make a statement. Additionally, LPN#4 indicated NA#4 continued to work until the end of the shift at 11:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 12:04 PM, an interview with the Recreation Director identified on the day in question she overheard NA#4 yelling at Resident #26. The Recreation Director indicated that she was in the room across the hallway from Resident #26's room at the time and she was getting ready to go home. The Recreation Director also indicated NA#5 and LPN#4 were in the hallway. The Recreation Director identified she reported the incident the next day, on 7/14/23, to the Administrator around 8:30 AM. The Recreation Director indicated she was under the impression that she needed to report allegations of abuse directly to the Administrator but was informed by the Administrator on 7/14/23 incidents of abuse should be reported right away and if it is on the off shift staff should report the incident to the nursing supervisor. The Recreation Director indicated that she remembered getting yearly in-services regarding abuse prevention, but felt overwhelmed because she had just begun working as a Recreation Director during that time in question. The Recreation Director indicated she does not recall seeing NA#4 on 7/14/23 and thought NA#4 may have been sent home on 7/14/23. On 4/29/24 at 11:55 AM, an interview with the Administrator identified the facility did not have any knowledge about the abuse allegation until 7/14/23 when she was informed by the Recreation Director. The Administrator indicated the facility performs yearly in-service for abuse prevention, and she would have expected the Recreation Director to have reported the alleged abuse the same day on 7/13/23. The Administrator further identified NA#4 did finish her/his shift on 7/13/23 because the facility was not aware of the alleged abuse until the next day (NA#4 worked for 7 additional hours after the alleged abuse occurred). The Administrator further indicated Resident #26 did not have any roommates at the time. Additionally, the Administrator indicated NA#4 did not work on 7/14/23 pending the investigation and that the punch card for 7/14/23 was manually inputted because the facility paid NA#4 for her/his scheduled shift since the investigation concluded there was no instance of verbal abuse. The Administrator indicated that the facility has no other way to ensure staff get paid when a staff member does not punch in or out other than manually inputting the time. The facility failed to ensure that an allegation of potential verbal abuse was reported immediately to administration to ensure the protection of residents and prevent further potential abuse. 2. Resident #44's diagnoses included dementia, unspecified with other behavioral disturbance, anxiety disorder, and hypertension. A physician's order dated 7/7/22 directed psychiatric evaluation and treatment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 as severely cognitively impaired, and the resident required supervision with toileting, oral hygiene, and partial assistance with showering. The Resident Care Plan dated 9/29/22 identified Resident #44 had behavioral symptoms towards other residents. Interventions included: allowing distance in seating other residents around resident, obtaining a psychiatric consult and psychosocial therapy, and to move resident to a quiet, calm environment when resident became physically abusive. 3. Resident #197's diagnosis included vascular dementia, psychotic disturbance, and mood disturbance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE], identified Resident #197 as severely cognitively impaired, and the resident required set up help for toileting, transfers, and one-person physical assistance for personal hygiene. Requests were made to obtain a copy of the Resident Care Plan for Resident #197 on 4/25/24, 4/29/24, and 4/30/24; however, the care plan was not provided. Review of the Adverse Event Report dated 9/29/22 at 8:10 AM identified Resident #199 observed Resident #44 and Resident #197 vocally exchanging verbiage and reaching out at each other swatting each other's hands with open hands. Resident #197 was sitting in the hallway, and s/he immediately stopped NA #1. NA#1 immediately separated both residents and notified the charge nurse. RN Supervisor #2 assessed both residents and reported no injuries. Actions taken included: residents were separated and placed on 1:1 supervision in a calm quiet environment. RN Supervisor # 2 completed a physical assessment. Social Services and psychiatric services were notified as well as the local police department. A nurse's note dated 9/29/22 at 8:30 AM identified Resident #44 had an altercation with his/her roommate, Resident #197. Roommate, Resident #197, was transferred to another room. Resident #44 noted to be calm and at baseline. A Social Services note dated 9/29/22 at 9:48 AM identified the social worker attempted to contact Resident #44's responsible party at 9:45 AM to inform the responsible party the resident was involved in a verbal dispute with his/her roommate that resulted in a minor physical exchange with no injury, but the social worker was unable to contact the responsible party. Previous progress notes reflect that nursing staff were able to contact responsible party about the incident earlier. Social Worker visited resident to discuss incident Resident was at his/her baseline cognitive, emotional, and physical functioning at time of visit. Resident #44 had significant cognitive deficits. Social Worker educated resident to seek staff if upset about anything and to not physically touch another resident. Social Worker will monitor resident's functioning ongoing and provide psychosocial support as needed. Resident # 197 who was involved in the altercation with Resident # 44 was transferred to another room. A nurse's note dated 9/29/22 at 7:11 PM identified Resident #44 was alert/oriented with baseline confusion. Had verbal and minor physical altercation with roommate, Resident #197. This writer alerted by staff. Residents were already distanced from each other, and Resident #197 was escorted from his/her room. No injury observed at this time to either resident. Resident #197 was changed to another room. No further occurrences. Safety maintained. The family was updated, and a report was made to the local police department. A nurses note dated 9/29/22 at 7:19 PM identified Resident (#44) as alert and oriented with baseline confusion. Had verbal and minor physical altercation with his/her roommate. No injury observed, resident was changed to another room. No further occurrences. Safety maintained. The family was updated, and a report was made to local police department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A written statement on 9/29/22 from NA#1 identified Resident #199 alerted her Resident #44 and Resident #197 were fighting. When she walked in the room Resident #197 stated he/she hit me and Resident #44 stated and I'll hit him/her again. Further NA#1's statement said that she did not witness a physical altercation. She took Resident # 197 to eat in the dining room while a coworker alerted the charge nurse. A written statement on 9/29/22 from NA#2 identified the last time she saw Resident #44 he/she was sitting in his/her chair in his/her room. After the incident she put him/her back in his/her room in the chair because Resident #197 was moved to another room. NA #2 further stated that she did not see anything that happened between the 2 residents. A written statement from RN#2 on 9/29/22 identified NA #2 alerted her to the altercation between Resident #44 and Resident #197 which was witnessed by Resident #199. RN #2 assessed Resident #197. RN #2 spoke with Resident #44 and asked him/her to explain what happened. He/she was not able to explain what occurred. His/her statements were not coherent or associated with the question. At that time was only alert to self. Further RN#2 stated that there were no injuries. He/she was observed by NA#2 and found to be calm. The Nursing Director Services, responsible party, and local police department were notified. The 9/29/22 Nurse Aide Care card interventions for Resident #197, were revised to provide a private room, and to reduce environmental noise to create a calm atmosphere. Review of the facility 24-hour Report dated 9/29/23 did not include increased observation/supervisions for Resident #'s 44 and 197 following the altercation. A physician's order dated from 9/1/2 through 9/30/22 identified Resident #197 was out of bed independently, did not require an assistive device. Required assistance of one for dressing, bathing, toileting, and hygiene. In an interview and clinical record review with DNS on 4/24/24 at 10:00 AM identified the clinical record failed to reflect evidence for the following: a psychiatric evaluation was completed, care plan interventions following the 9/29/22 incident, and that Resident #44 was placed on 1:1 supervision until cleared by psychiatry. Interview on 4/24/24 at 11:05 AM with NA #1 identified that she did not recall the incident between Resident #44 and Resident #197. Interview with RN #2 4/24/24 12:13 PM identified she did not recall the details. She also stated Resident #44 and Resident #197 had issues over the television. frequently but never resulted in a physical altercation. Normally we would put them on 1:1 supervision or checks every 15 minutes and get a psychiatric evaluation. She did not recall if that occurred at that time. Interview with NA#2 4/24/24 at 1:48 PM identified that she did not recall the events of the altercation between Resident #44 and Resident #197. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Requests for documentation for Resident #44 and Resident #197, for 1:1 supervision following the altercation and a psychiatric evaluation, were made on 4/25/24 and 4/29/24, and 4/30/24 were not provided. Review of the Abuse Prohibition policy, undated, directed, in part, to provide any necessary interventions to insure the resident's safety and well-being. Review of the every 15 minutes policy, undated, directed, in part, objectives are to facilitate a rapid response by staff, to any change by patient or within environment that creates unsafe conditions. 48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 6 sampled residents (Residents #18 and # 26) who were reviewed for abuse, the facility failed to implement facility policies following an alleged incident of resident-to-resident physical and verbal mistreatment. The findings included: 1. Resident #18's diagnoses included Parkinsonian and unspecified dementia. The admission Minimum Data Set, dated dated dated [DATE] identified Resident #18 as moderately cognitively impaired, required one to two persons assist with activities of daily living and supervision using a wheelchair. The Resident Care Plan dated 4/27/23 identified Resident #18 had impaired decision making related to dementia. Interventions directed to support and to reassure the resident in new situations. A nurses note dated 5/23/23 at 11:53 PM identified Resident #18 was observed hitting another resident (unknown) with a newspaper on the legs lightly near the nurses' station. Resident #18 stated, We are playing a game Resident # 18 was re-directed and educated that this behavior was not acceptable. Resident #18 stated s/he understood, and the supervisor was made aware. Safety was maintained with continued observation. However, review of facility documentation and state agency Reportable Events submission line identified no documented evidence that the alleged incident of resident-to-resident physical mistreatment was reported to the overseeing state agency or documented investigative report. An interview with Licensed Practical Nurse, LPN #4 on 4/29/24 at 9:25 AM identified she was the assigned charge nurse on 5/23/23 during the second shift. LPN #4 identified she observed Resident #18 lightly hit another resident with a newspaper. LPN #4 could not recall who the other resident was and indicated Resident #18 told LPN #4 that s/he and the other resident were just playing around. LPN #4 separated the two residents and notified the nursing supervisor, Registered Nurse, RN #9. An interview with the Director of Nursing Services on 4/29/24 at 12:32 PM identified the incident should have been reported and investigated following the allegation of resident-to-resident mistreatment. An interview with RN #9 on 4/29/24 at 1:15 PM identified she was the assigned nursing supervisor on 5/23/23 during the 3:00 PM to 11:00 PM shift but she was unable to recall the incident. RN #9 identified for any reported allegation of resident-to-resident mistreatment, she would separate the residents, conduct an assessment for injuries, notify the Director of Nursing Services who would have been responsible for notifying the overseeing state agency and initiate and an investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Abuse prohibition policy dated 5/2022 directed for any allegation of abuse, the facility is required to complete an Incident Report and initiate appropriate interventions to ensure resident safety and or protect the resident from additional harm. Immediate actions included removing the resident from the abuser, notifying the supervisor, completing an assessment if physical abuse was suspected, initiating an investigation, and notifying the overseeing state agency immediately, but not later than (2) hours after the allegation is made. The outcome of the investigation is to be submitted within (5) working days. 2. Resident #26 was admitted to the facility on [DATE]. The resident's diagnoses included dementia, seizures, and schizoaffective disorder. A Resident Care Plan (RCP) dated 3/27/23 identified Resident #26 was unable to vocalize due to cognitive impairment. Interventions included for staff to observe the resident for crying, yelling, or grimacing behaviors. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 had short and long-term memory problems and was severely cognitively impaired. Additionally, the MDS identified Resident #26 required extensive assistance from at least two people for bed mobility, transfers, and personal hygiene. A physician's order dated 6/26/23 directed repositioning every two hours. A facility Incident Report from 7/14/23 identified an incident of suspected verbal abuse where a staff member was yelling at Resident #26. The facility investigation indicated the Recreation Director overheard Nurse Aide (NA#4) yelling at Resident #26 on 7/13/23 at 4:00 PM. The facility investigation included statements from the Recreation Director, NA#4, NA#3, and Licensed Practical Nurse (LPN# 4). The facility conclusion of the investigation identified no verbal abuse and determined there was no mistreatment of the resident. A nursing progress note by the Director of Nursing Services (DNS) at the time (DNS#2) dated 7/14/23 identified that verbal abuse was reported on 7/14/23 and the staff member involved was sent home. Additionally, the progress note indicated the police, the resident's Power of Attorney (POA), and the resident's provider were notified on 7/14/23. Attempts to contact DNS#2 during the survey were unsuccessful. On 7/24/24 at 11:00 AM, an interview with Licensed Practical Nurse (LPN#4) indicated she had asked NA#4 to reposition Resident#26 on 7/13/23 at around 4:00 PM. LPN#4 indicated she heard a loud noise while she was in the hallway, which she indicated was related to NA#4 bumping into Resident#26's wheelchair. LPN#4 denied hearing yelling or any suspected abuse. Additionally, LPN # 4 indicated she witnessed NA#3 and NA#4 reposition Resident#26 without incident. LPN#4 also identified that she was not made aware by any staff member regarding any allegation of abuse until 7/14/23, when she was asked to make a statement. Additionally, LPN#4 indicated NA#4 continued to work until the end of the shift at 11:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 12:04 PM, an interview with the Recreation Director identified on the day in question she overheard NA#4 yelling at Resident #26. The Recreation Director indicated that she was in the room across the hallway from Resident #26's room at the time and she was getting ready to go home. The Recreation Director also indicated NA#5 and LPN#4 were in the hallway. The Recreation Director identified she reported the incident the next day, on 7/14/23, to the Administrator around 8:30 AM. The Recreation Director indicated she was under the impression that she needed to report allegations of abuse directly to the Administrator but was informed by the Administrator on 7/14/23 incidents of abuse should be reported right away and if it is on the off shift that they should be reported to the nursing supervisor. The Recreation Director indicated that she remembered getting yearly in-services regarding abuse prevention, but she felt overwhelmed because she had just begun working as a Recreation Director during that time. The Recreation Director indicated she does not recall seeing NA#4 on 7/14/23 and thought NA#4 may have been sent home on 7/14/23. On 4/25/24 at 10:03 AM, an interview with NA#4 identified she was asked to reposition Resident #26 by LPN#4. NA#4 indicated that she caused a loud noise when she tripped over Resident #26's wheelchair. NA#4 denied yelling at Resident #26 and indicated NA#3 helped her reposition Resident #26. NA#4 indicated she did not finish her shift on 7/13/23 until 11:00 PM because she was doing a double shift that day. NA#4 did not recall working on 7/14/23 and believed she was sent home that day. On 4/25/24 at 10:27 AM, an interview with NA#3 indicated she helped NA#4 reposition Resident #26 on 7/13/23. NA#3 denied hearing any yelling. NA#3 indicated she heard a loud noise when she was in the hallway near Resident#26's room and that NA#4 had informed her (NA# 3) s/he had tripped over Resident#26's wheelchair. NA#3 indicated NA#4 may have come in to work but was sent home. A review of punch cards for NA#4 identified NA#4 worked from 7:00 AM to 11:00 PM on 7/13/23. Additionally, the punch card indicated NA#4 worked on 7/14/23 7:00 AM to 3:00 PM. On 4/29/24 at 11:55 AM, an interview with the Administrator identified the facility did not have any knowledge about the abuse allegation until 7/14/23 when she was informed by the Recreation Director. The Administrator indicated the facility performs yearly in-service for abuse prevention, and she would have expected the Recreation Director to have reported the alleged abuse the same day on 7/13/23. The Administrator further identified NA#4 did finish her/his shift on 7/13/23 because the facility was not aware of the alleged abuse until the next day (NA#4 worked for 7 additional hours after the alleged abuse occurred). The Administrator further indicated Resident #26 did not have any roommates at the time. Additionally, the Administrator indicated NA#4 did not work on 7/14/23 pending the investigation and indicated the punch card for 7/14/23 was manually inputted because the facility paid NA#4 for her/his scheduled shift since the investigation concluded there was no instance of verbal abuse. The Administrator indicated the facility has no other way to ensure staff get paid when a staff member does not punch in or out other than manually inputting the time. The facility policy for abuse in part notes immediate action required when there is suspected abuse, staff is to remove the abuser from the resident and notify the nursing supervisor. The supervisor or designee will then alert the Administrator or DNS and staff will be direct to place the employee on administrative leave pending completion of the investigation. 48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 3 of 6 sampled residents (Residents #18, # 40 and # 44) reviewed for abuse, the facility failed to report an allegation of staff to resident physical mistreatment and or initiate an investigation timely. The findings included: 1. Resident #18's diagnoses that included Parkinsonian and unspecified dementia. The Admission Minimum Data Set, MDS assessment dated [DATE] identified Resident #18 as moderately cognitively impaired, required one to two persons assistance with activities of daily living and supervision using a wheelchair. The Resident Care Plan, RCP dated 3/24/23 identified Resident #18 had impaired decision making related to dementia. Interventions directed to support and to reassure the resident in new situations. A facility Reportable Event dated 4/11/23 at 6:51 PM identified Resident #18 reported to a staff member, Registered Nurse #4 on 4/11/23 at 2:00 PM s/he felt mistreated by a staff member, Licensed Practical Nurse, (LPN #5), when LPN #5 was administering his/her medication on 4/10/23 around 11:00 PM. The physician, responsible party and police were notified, and LPN #5 was removed from the schedule pending outcome of the investigation. The facility failed to report the allegation of mistreatment to the overseeing state agency within required time frames. An interview with the Administrator on 4/22/24 at 1:44 PM identified, once known, the allegation should have been reported immediately to the overseeing state agency and that nursing staff were authorized to initiate notifications when allegations occur outside of routine business hours. A review of the Abuse Prohibition policy dated 5/2022 directed any allegation of abuse, should be reported to the overseeing state agency immediately, but not later than (2) hours after the allegation is made. 2. Resident #40's diagnosis included dementia, mood disturbance dysphagia and anemia. The care plan dated 3/8/2024 indicated Resident #40 was at risk for skin breakdown. Interventions included avoiding shearing, keeping linens clean dry and wrinkle free, to monitor for skin breakdown and use moisture barrier to the perineal area, to turn and reposition in bed and complete weekly wound assessments. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified cognitive skills for daily decision making was moderately impaired, decision making is poor requiring supervision and or cues and noted substantial assistance to roll left and right and the resident was dependent for transfer to and from bed/chair. The MDS further indicated Resident #40 was at risk for but had no pressure ulcers or skin injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/2024 at 1:05 PM wound care of the left heel was observed with LPN #3 completed the treatment with LPN #4 assisting. Treatment was completed per the physicians' orders with no concerns. It was noted that a wedge cushion was in place in bed to allow the heels to hang over the edge of the wedge. The surveyor observed a discolored area on the top lateral aspect of the resident's left foot. LPN #3 indicated if the discoloration was new or had been there but would find out. On 4/25/2024 an interview with the charge nurse LPN #4 indicated s/he did not hear anything regarding Resident #40's bruise/discoloration on the top of left foot while getting report. Interview with LPN #2 the unit manager indicated not knowing about the bruise discoloration on the top of Resident # 40's left foot. LPN # 4 also indicated an incident report should have been completed and s/he would speak to the DNS. A Physician Assistant (PA#1) progress note progress note dated 4/25/24 at 9:02 AM indicated staff requested Resident #40 be seen for discoloration to the dorsum of the left foot, Resident # 40 was noted with no pain or known trauma and has known vascular disease. The resident was diagnosed with purpura. Interview and record review with the DNS on 4/25/2024 at 12:25 PM indicated s/he was not aware of the area on the foot until this am and could not provide evidence of an Incident Report and indicated s/he did ask the PA who was in the building this am to examine Resident #40. who indicated the area is from Peripheral Vascular Disease. The DNS further indicated he/she would have expected LPN #3 to have consulted the supervisor on 4/24/2024 to have the area assessed and indicated an investigation of bruise form should have been completed. The facility Abuse Prohibition policy dated 4/18/2024 labeled Abuse/Potential Abuse: indicated in part an allegation of abuse, neglect exploitation or mistreatment including injuries of unknown source are reported to the state agency immediately but no later than 2 hours after the allegation had been made. The policy further indicated upon identification an Incident Report, supervisor follow up and a comprehensive internal facility investigation will be performed with subsequent timely notification to the appropriate agencies. 3. Resident #44's diagnoses included dementia, unspecified with other behavioral disturbance, anxiety disorder, and hypertension. A physician's order dated 7/7/22 directed psychiatric evaluation and treatment. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #44 as severely cognitively impaired, and required supervision with toileting, oral hygiene, and partial assistance with showering. The Resident Care Plan dated 9/29/22 identified Resident #44 had behavioral symptoms towards other residents. Interventions included allowing distance in seating other residents around resident, obtaining a psychiatric consult and psychosocial therapy, and to move resident to a quiet, calm environment when resident became physically abusive. Review of the Adverse Event Report identified the allegation of abuse occurred on 9/29/22 however, it was reported to the state agency on 10/11/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 4/23/24 at 10:00 AM with the DNS, identified s/he was aware of the untimely filing/ reporting and stated it was due to her/him not having access to the state system as s/he was a recent hire. Review of the Abuse Prohibition Policy, undated, directed, in part, The Administrator, Director of Nursing or their designee assumes responsibility for the immediate verbal notification of the incident to the following: The Department of Public Health for all alleged violations involving abuse, are reported immediately, but not later than 2 hours after the allegation is made. 46046 48792

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 3 of 6 sampled residents (Resident #18 and Resident # 40) reviewed for abuse, the facility failed to ensure the protection of resident(s) following an allegation of resident-to-resident physical mistreatment. The findings included: 1. Resident #18 had diagnoses that included Parkinsonian and unspecified dementia. The Admission Minimum Data Set, MDS assessment dated [DATE] identified Resident #18 as moderately cognitively impaired, required one to two persons assist with activities of daily living and supervision using a wheelchair. The Resident Care Plan, RCP dated 3/24/23 identified Resident #18 had impaired decision making related to dementia. Interventions directed to support and to reassure the resident in new situations. A nurse's note for Resident #18 on 5/13/24 at 9:13 AM identified s/he had a restful night until 5:30 AM when the resident across the hall, Resident #98, turned the television on loud. Resident #18 was heard yelling and complaining about the television volume and alerted NA #4 to check on them. Resident #18 was observed (in Resident #98's room) sitting in a wheelchair and was pushing a table towards Resident #98 who was in a standing position. Resident #98 pushed the table back towards Resident #18 but did not hit h/her. The push from both parties was not abrupt or hard. The two residents were separated with Resident #18 being placed at the nurse's station for supervision. The physician and responsible party were notified, and psychiatry was updated to re-evaluate. A Psychiatric Evaluation note dated 5/19/23 (six days following the event) identified Resident #18 was evaluated for reports of irritability, not sleeping and hallucinating with no reference to the resident-to-resident altercation. Medications were adjusted that included an increase in psychotropic medication and the initiation of Melatonin to treat insomnia. Resident #18 was determined not to be a threat to h/herself or others. However, the clinical record review identified there was no documented enhanced supervision implemented for Resident #18 following the alleged resident to resident altercation with Resident # 98 until Resident #18 was evaluated by psychiatry on 5/19/23. 2. Resident #98 had diagnoses that included chronic obstructive pulmonary disease (COPD) dementia and anxiety. The admission MDS assessment dated [DATE] identified Resident #98 as severely cognitively impaired and required supervision with ambulation. The RCP dated 5/6/23 identified Resident #98 had cognitive loss and dementia. Interventions included anticipating needs and explaining what you intend to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note for Resident #98 dated 5/13/23 at 9:48 AM identified Resident #98 turned on h/her television on loud at 5:30 AM. An argument was heard, and NA #4 was alerted to check on the residents. NA #4 observed Resident #98 standing in h/her room having a conflict with another resident (Resident # 18) who was sitting in a wheelchair. Resident #18 was observed to push the bedside table towards Resident 98's abdomen with Resident #98 pushing back without getting hit. According to NA #4, neither push was abrupt nor hard. Resident #18 was removed from the room. Resident #98 denied injury. The physician and responsible party were notified with no new orders. A Facility Reportable Event dated 5/14/23 at 6:47 AM identified on 5/13/23 at 5:30 AM NA #4 reported hearing Resident #18 yelling to Resident #98 to turn down the volume of her/his television. He/she witnessed Resident #18 sitting in h/her wheelchair holding the end of a bed table. NA #4 observed Resident #18 push the bed table towards Resident #98 striking her/him on the abdomen. Resident #98 was observed standing and holding the end of bed table. An interview and clinical record review with Registered Nurse, RN #5 on 4/24/24 at 9:11 AM identified she was the assigned nursing supervisor who worked during the 11:00 PM to 7:00 AM shift on 5/12/23 overnight to 5/13/23. RN #5 identified NA #4 reported Resident #18 and Resident #98 had an altercation over the loud volume of Resident #98's television. NA #4 had separated the two residents after the incident. RN #5 believed Resident #18 was closely monitored after the incident but could not recall if physician's orders were obtained or if enhanced supervision every 15 minutes had been initiated after the incident and s/he would have normally documented if enhanced supervision was initiated. An interview with the Director of Nursing Services on 4/24/24 at 9:45 AM identified all residents should be separated following a resident-to-resident altercation and placed on one-to-one supervision until evaluated by psychiatry. A review of the Abuse prohibition policy dated 5/2022 directed for any allegation of abuse, the facility is required to complete an Incident Report and initiate appropriate interventions to ensure resident safety and or protect the resident from additional harm. Immediate actions included removing the resident from the abuser, notifying the supervisor, completing an assessment if physical abuse was suspected, initiating an investigation, and notifying the overseeing state agency immediately, but not later than (2) hours after the allegation is made. Although attempted, an interview with the (former) psychiatric provider during the survey the attempt was unsuccessful. 3. Resident #40's diagnoses included dementia, mood disturbance dysphagia and anemia. The care plan dated 3/8/2024 indicated Resident #40 was at risk for skin breakdown. Interventions included: avoiding shearing, keeping linens clean dry and wrinkle free, monitoring skin breakdown and use moisture barrier to the perineal area, turn and reposition in bed and to complete weekly wound assessments. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated cognitive skills for daily decision making was moderately impaired, decision-making poor requiring supervision and or cues and noted substantial assistance to roll left and right and the resident was dependent for transfer to and from bed/chair. The MDS further indicated Resident # 40 was at risk for but had no pressure ulcers or skin injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/2024 at 1:05 PM wound care of the left heel was observed with LPN #3 completed the treatment with LPN #4 assisting. Treatment was completed per the physicians' orders with no concerns. It was noted that a wedge cushion was in place in bed to allow the heels to hang over the edge of the wedge. The surveyor observed a discolored area on the top lateral aspect of the resident's left foot. LPN #3 indicated if the discoloration was new or had been there but would find out. A Physician assistant (PA#1) progress note progress note dated 4/25/24 at 9:02 AM indicated a request to see Resident #40 for discoloration to the dorsum of the left foot, Resident # 40 was noted without pain or known trauma, and has known PVD. A diagnosis was made for purpura. On 4/25/2024 an interview with the charge nurse LPN #4 indicated s/he did not hear anything regarding Resident #40's bruise/discoloration on the top of left foot while getting report. Interview with LPN #2 the unit manager indicated not knowing about the bruise discoloration on the top of Resident # 40's left foot. LPN # 4 also indicated an incident report should have been completed and s/he would speak to the DNS. Interview and record review with The DNS on 4/25/2024 at 12:25 PM indicated s/he was unaware of the area on Resident # 40's foot until this am s/he could not provide an Incident Report but did ask the Physician's Assistant (PA) who was in the building this am to examine Resident #40. The PA indicated the area is from Peripheral Vascular Disease. The DNS further indicated he/she would have expected LPN #3 to have consulted the supervisor on 4/24/2024 to have the area assessed and indicated an investigation of bruise form should have been completed. The facility Abuse Prohibition policy dated 4/18/2024 labeled Abuse/Potential Abuse: indicated in part an allegation of abuse, neglect exploitation or mistreatment including injuries of unknown source are reported to the state agency immediately but no later than 2 hours after the allegation had been made. The policy further indicated upon identification an Incident Report, supervisor follow up and a comprehensive internal facility investigation will be performed with subsequent timely notification to the appropriate agencies. 46046

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, review of facility documentation and interviews for 1 of 2 residents (Resident #44) reviewed for hospitalization , the facility failed provide notification of transfer/discharge to the Regional Ombudsman's Office timely. The findings include: Resident #44's diagnoses included acute respiratory failure with hypoxia, hypertension, and heart disease. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 as severely cognitively impaired, required substantial assistance for bed mobility and personal hygiene, and was dependent on staff for transfers. Review of the clinical record identified Resident #44 was transferred to and admitted to an acute care facility on [DATE] and returned to the facility on [DATE]. Resident #44 was also transferred to and admitted to an acute care facility again on [DATE]. The resident expired in the hospital on [DATE]. However, review of the clinical record failed to identify documentation and the Regional Ombudsman's Office was notified of the transfers to the hospital on [DATE] or [DATE]. Interview with Social Worker #1 on [DATE] at 11:25 AM identified he does not contact the Regional Ombudsman Office about facility transfers to the hospital and indicated the responsibility of the reporting was the business office. SW#1 further indicated the Business Office Manager was not in the facility. Interview with the DNS on [DATE] at 1:16 PM identified that s/he was not aware of where the Regional Ombudsman Office notifications for Resident # 44 were located, but s/he would reach out to the Business Office Manager for clarification. Although requested, a facility policy for notification of the Regional Ombudsman Office when a resident is admitted to the hospital was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, review of policy and interviews for 1 of 2 residents (Resident #44) reviewed for hospitalization , the facility failed to provide evidence that the resident and or responsibly party was made aware of the facility bed hold notice upon hospitalization . The findings include: Resident #44's diagnoses included acute respiratory failure with hypoxia, hypertension, and heart disease. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 as severely cognitively impaired, required substantial assistance for bed mobility and personal hygiene, and was dependent on staff for transfers. Review of the clinical record identified Resident #44 was transferred to and admitted to an acute care facility on [DATE] and returned to the facility on [DATE]. Resident #44 was also transferred to and admitted to an acute care facility on [DATE]. The resident expired in the hospital on [DATE]. Review of the clinical record failed to identify evidence the resident/responsible party was notified of the bed hold policy on [DATE] or [DATE]. Interview with Social Worker #1 on [DATE] at 11:25 AM identified he does not contact the family about the bed hold policy and indicated notification responsibility was the business office. SW # 1 further indicated the Business Office Manager was not in the facility. Interview with the DNS on [DATE] at 1:16 PM identified s/he was not aware of the bed hold process but s/he would contact the Business Office Manager for clarification. Although requested, a Bed Hold policy was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, and interview for 2 of 3 residents (Resident #1 and Resident #35) reviewed for Resident Assessments, the facility failed to complete and transmit the annual Minimum Data Set (MDS) assessments timely. The findings include: 1. Resident #1's diagnoses included diabetes mellitus, hypertension, and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact and required supervision for bed mobility, transfers, and ambulation. Additionally, the MDS signature page identified that section Z was not signed. Review of the facility's electronic health record identified the annual MDS dated [DATE] was in progress and had not yet been signed or transmitted. 2. Resident #35's diagnoses included dementia without behavioral disturbances, hypertension, and dysphagia. The annual MDS dated [DATE] identified Resident #35 was severely cognitively impaired and required supervision for bed mobility and was dependent for transfers. Additionally, the MDS signature page identified that section Z was not signed. Interview and clinical record review with LPN #1 (MDS Coordinator) on 4/25/24 at 10:49 AM identified her assessments require an RN co-signer, as she is an LPN. She indicated that when the MDS is complete, she sends the assessment to the DNS to have her/him signed off and once it is signed, she is then responsible for transmitting the completed assessment. She also reported that there had been software errors, where the system uncheck all of the sections and she have to re-do the assessment and indicated she did not notify anyone of the issues she had been having and the issue has since been resolved. She identified that the annual MDS's for Resident #1 and Resident #35 should have been signed and transmitted within 14 days of the 3/11/24 Assessment Reference Date (ARD), by 3/25/24, per the Resident Assessment Instrument (RAI). Subsequent to surveyor inquiry, LPN #1 indicated she would get the MDS's for Resident's #1 and #35 to signed and transmitted the late assessments. Review of the Resident Assessment Instrument (RAI) Manual identified the MDS completion date must be no later than the Assessment Reference Date (ARD) plus 14 calendar days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 4 of 6 sampled residents (Residents # 5, # 26, # 27 and # 34) who were reviewed for pressure ulcers, the facility failed to ensure a comprehensive care plan was developed to address the residents at risk for skin break down, prevention of pressure ulcer development and incontinence. The findings included: 1. Resident #5 was admitted on [DATE] with a diagnosis of cervical spine fracture, Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had short-term and long-term memory problems and was severely cognitively impaired. The MDS also identified Resident #5 required substantial to maximum assistance with rolling left and right and moving from a lying position to sitting on the side of the bed. Resident #5 required partial to moderate assistance for walking 10 to 50 feet. Additionally, the quarterly assessment noted incontinent of bowel and bladder. The MDS further identified the resident did not have any unhealed pressure injuries and was at risk of developing injuries. A nursing progress note dated 1/29/24 indicated Resident #5 was transferred to a hospital secondary to agitation. A hospital discharge summary dated 2/9/24 indicated that the resident was discharged on [DATE] from the hospital. A nursing progress note dated 2/9/24 identified Resident #5 returned from the hospital with a linear open area to the superior coccyx measuring 0.7 CM by 0.1 CM. The nursing note further identified Triad cream was applied to the area. A Braden scale for prediction of pressure sore risk dated 2/9/24 indicated Resident #5 had a score of 16 where 15-18 indicated a risk for pressure ulcer development. A physician's order dated 2/27/24 directed assistance of one person for bed mobility as well as for transferring from bed to wheelchair. A Braden scale for prediction of pressure sore risk dated 3/1/24 indicated Resident #5 had a score of 13, where 13-14 indicated a moderate risk for pressure ulcer development. A care card dated 3/15/24 indicated Resident #5 was able to stand and pivot with the assistance of one staff member from the bed to a cushioned wheelchair. The care card also identified the resident was incontinent of bowel and bladder. Interventions included walking up to 50 feet with the assistance of two people. However, no interventions addressing the resident's risk for pressure injury were noted. A review of the electronic medical record for 2/10/24 to 4/10/24 failed to identify a care plan addressing Resident #5's high risk for pressure injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound physician's evaluation dated 4/11/24 identified a new Stage 2 pressure ulcer to the coccyx measuring 0.6 cm L, 0.5 cm W, and 0.1 cm D with no exudate and intact peri-wound area. Treatment recommendations included cleansing with saline and the application of barrier cream. A care plan dated 4/12/24 identified Resident #5 had actual skin breakdown to the coccyx; interventions included frequent incontinent care and frequent repositioning on rounds. The skin care plan was initiated and implemented 42 days after the last Braden score which identified the resident as a moderate risk for pressure injury, and 5 months and 5 days after the admission Braden score identified the resident as being a high risk for pressure injury. A care card dated 4/12/24 noted interventions to walk the resident up to 50 feet with the assistance of two people and the implementation of a 24-hour turn and reposition schedule using a repositioning cushion. Included in the care card was a clock diagram illustrating the 24-hour turn and repositioning schedule. On 4/23/24 at 12:18 PM, an interview with the nurse manager (LPN#2) identified residents at risk for pressure ulcers would have turning and positioning in place as an intervention. LPN#2 was unsure if interventions were in place for Resident #5 prior to the identification of the stage 2 pressure ulcer. LPN#2 On 4/23/24 at 1:40 PM, an interview and record review with the MDS Coordinator (LPN#1) indicated she would have expected Resident #5 to have had a care plan addressing his/her risk for pressure injury based on the resident condition and a Braden scale taken on 3/1/24. Additionally, LPN#1 identified that the Interdisciplinary Team is responsible for care planning. A record review with LPN#1 failed to identify a care plan for Resident #5's risk for pressure injury and that a care plan for skin breakdown was developed after the resident had developed a stage 2 pressure injury on the coccyx. 2. Resident #26's diagnoses included diabetes mellitus type II and vascular dementia. An admission nurse's note dated 3/22/23 identified Resident had a stage (3) pressure ulcer to the coccyx, stage (2) pressure ulcer to the right heel and stage (2) pressure ulcer to the right medial malleolus (bony prominence of the ankle) present on admission. A low air loss mattress was placed on the bed and Resident #26 was referred to the specialty wound consultant. The physician's orders dated 3/24/24 directed to cleanse and apply Calcium Alginate daily, offload heels, reposition every two hours, and conduct a weekly body audit on shower days. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was severely cognitively impaired, required total assist of two for bed mobility, transfers, toileting, was at risk for the development of a pressure ulcer and had at least two unhealed pressure ulcers. The Resident Care Plan, RCP dated 3/31/23 identified Resident #26 had a stage (3) pressure ulcer to the right coccyx and a problem with activity of daily living (ADL). Interventions directed to utilize a full back Hoyer pad and provide two assists for transfers and noted no interventions to manage the resident's pressure ulcer. The Braden Scale dated 4/4/23 identified a score of 11 indicating Resident #26 was at high risk for the development of skin breakdown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note dated 2/2/24 identified Resident #26's old stage (4) pressure ulcer had reopened measuring 2cm x 1.2 cm x 0.5cm. The RCP failed to identify Resident #26 was at risk for the development of pressure injuries or any interventions for known pressure injuries. An interview with the Assistant Director of Nursing (ADNS) on 4/24/24 at 12:01 PM identified she was not responsible for the development of a care plan for a resident at risk or with known pressure injuries and any staff could initiate a care plan. An interview with LPN #1 on 04/24/24 at 12:18 PM identified she was responsible for completing the MDS assessments and assisted with care planning along with the Interdisciplinary Team. An interview and clinical record review with DNS on 4/24/24 at 12:22PM identified he was responsible for ensuring wound recommendations were followed and the development of a care plan for a resident at risk or with a known pressure injury. The DNS identified upon admission; a Braden Risk Assessment is performed to identify if a resident was at risk for skin breakdown. From there a care plan should be developed and include interventions such as cleanliness, repositioning, and weekly skin audits on shower days. Although, the DNS identified he conducted rounds to ensure the interventions were being carried out he was unable to identify that a comprehensive care plan in place with interventions for being at risk for and for known pressure injuries for Resident #26 prior to 9/12/23 with the addition of an air mattress. Resident #26 had since been placed on a routine turn schedule as of 3/11/24. The DNS identified all skin care related to a person at risk for pressure injuries should be included in the care plan. An interview with the Medical Director on 4/25/24 at 11:38 AM identified he would expect the care plan to reflect a resident at risk for or with known pressure injuries. An interview with the MD #2 on 4/25/24 at 1:31 PM identified she provided specialty wound services to the facility on a weekly basis. MD #2 identified she was currently treating Resident #26 for a pressure ulcer to the coccyx and communicated mostly with LPN #1 about wound related matters. MD #2 identified she would expect any recommendations she made to be followed including repositioning. 3 Resident #27's diagnosis included dementia and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #40 was rarely or never understood decisions for regarding tasks for daily living were poor and the resident required cues and supervision. The MDS further indicated care planning would proceed for urinary incontinence. A Braden Skin assessment was completed on 3/9/2024 indicating Resident #27 was at high risk for developing a pressure ulcer. The care plan dated 4/14/2024 indicated Resident #27 had a stage 2 pressure ulcer on the left buttock with intervention including 24-hour repositioning and turning schedule and to reposition every two hours in bed, use wedge cushion to keep off back use triad paste to the left buttocks as needed pending occupational therapy evaluation and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DNS and LPN #1 the MDS nurse on 4/29/2024 at 11:25 AM identified although the annual MDS assessment triggered to proceed with care planning for incontinence no care plan was initiated. 4. Resident #34 's diagnoses included diabetes mellitus Type 2, Peripheral Vascular Disease, and altered mental status. Braden Scale for Prediction of Pressure Sore Risk dated 10/29/2023 identified Resident #34 had a score of 11 which indicated a high risk for developing pressure ulcers. The admission Minimum Data Set assessment dated [DATE] identified Resident #34 as moderately cognitively impaired and required maximum assistance for toileting, personal hygiene, and moderate assistance for dressing. The Resident Care Plan dated 10/31/23 identified Resident #34 required assistance with ADLs due to weakness and physical limitations. Interventions included encouraging the resident to participate in care, to provide assistance with personal care, and to be evaluated by physical, occupational, and speech therapy. A physician's order dated 11/2/23 directed to complete a body audit every week on shower day. A physician progress note (MD #2) dated 11/9/23 identified that Resident #34 had moisture associated skin damage and directed, in part, to follow the facility pressure ulcer prevention protocol. A nurse's note dated 11/30/23 at 5:06 PM identified that Resident #34 had moisture associated skin damage on his/her coccyx as per wound MD. In an interview and clinical record review on 4/25/24 at 12:00 with LPN #1 (MDS Coordinator) identified the clinical record failed to include documentation to prevent pressure ulcers, and that a quarterly Braden Scale assessment was not completed. Further LPN #1 identified Resident #34 at risk for skin breakdown should have been care planned for risk of skin breakdown. In an interview and clinical record review with the DNS and Administrator on 4/29/24 at 10:36 AM, it was identified that resident #34 was at risk for skin breakdown at admission and interventions for the prevention of skin breakdown should have been documented on the Resident Care Plan. A review of the facility policy for Care Planning (no date) directed a comprehensive care plan shall be developed based on identified needs, strengths and preferences and developed no later than (7) days after the completion of the MDS. The care plan is developed by the Interdisciplinary Team in collaboration with the resident/family and physician. The care plan will include the statement of the problem, measurable goals, interventions to achieve the goals and the discipline responsible for carrying out the goals. The care plan will be reviewed quarterly or as needed to reflect changes in the resident status. 46046 48792 (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	04/29/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37721

Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 6 residents (Resident # 15 and Resident # 40) at risk for pressure ulcer development, the facility failed to revise the residents plan of care timely. The findings included:

1. Resident #15's diagnosis included diabetes mellitus, heart failure, back pain, and anxiety.

The care plan dated 2/12/24 at risk for skin break down related to activity intolerance due to pain Interventions included: to encourage position change frequently and on rounds, to observe skin/boney prominences, to provide a cushion to the bedside chair when out of bed and to off load heels and to encourage good nutritional intake.

The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 had moderate cognitive impairment and identified the resident was a risk. The assessment noted no pressure ulcers.

A Braden Scale assessment was completed on 3/8/24 which noted Resident # 15 was at high risk for skin break down.

An Admission Nursing Assessment completed on readmission on 4/5/2024 indicated Resident #15 was readmitted with a stage 2 pressure ulcer on the coccyx. Interventions for the plan of care directed a 24-hour positioning plan and blanket rolls under the ankles.

Although the Nurse Aide Care Card dated 4/5/2024 noted a 24-hour position turn schedule with a roll under ankles, incontinence. The care plan failed to reflect the frequency of turning per the Pressure Ulcer Prevention Plan for toileting/incontinent care every 2 hours and turning and repositioning (per the turn schedule) every two hours.

A Braden skin risk assessment completed on 4/20/24 at 4:30 PM indicated Resident #15 was at risk for pressure ulcer with a score of 16.

The care plan dated 4/24/2024 indicated Resident #15 has impaired skin integrity and uses an air mattress with interventions including to provide an air mattress to the bed to promote comfort. The care plan continued to fail to reflect the frequency for turning and repositioning and incontinent care every 2 hours per facility practice/ policy.

A 24-hour positioning schedule Clock Diagram was provided with the date of 4/25/2024.

(20 days later)

An interview and record review with LPN #1 the MDS nurse identified all team members are responsible for updating care plans.

2. Resident #40's diagnosis included dementia, mood disturbance dysphagia and anemia.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 3/8/2024 indicated Resident #40 was at risk for skin breakdown. Intervention included: to avoid shearing, keep linens clean dry and wrinkle free, to monitor for skin breakdown and use moisture barrier to the perineal area, turn and reposition in bed and complete weekly wound assessments. A Braden assessment completed on 3/9/2024 indicated Resident #40 was at high risk for skin breakdown. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired, required substantial assistance to roll left and right and noted dependent for transfer to and from bed/chair. The MDS further indicated risk for pressure ulcer but noted no pressure ulcers or skin injuries. A progress note dated 4/21/2024 at 5:17 PM indicated the charge nurse went to assess Resident # 40 and noted an open area on the left heel. The note further indicated the pressure ulcer was a stage 2 with measurements of 3 CM x 3.5 CM in size (no depth documented), and moisture associated skin damage was noted on the buttocks. The care plan dated 4/21/2024 indicated a pressure ulcer on the left heel. Interventions directed to follow the treatment orders and to offload heels at all times. On 4/24/2024 at 1:05 PM observations of wound treatment by LPN # 4 in the presence of LPN # 3 identified a wedge cushion in place in bed that allowed the resident's heels to hang over the edge of the wedge. Interview and record review with the charge nurse LPN #3 on 4/24/2024 indicated the care card 3/15/2024 reviewed on 4/24/24 did not indicate how or when to reposition Resident # 40 while in bed and failed to reflect turning and repositioning had consistently occurred. Interview and record review with The DNS on 4/29/2024 at 11:20 AM indicated the care card dated 3/15/2024 7 days after completion of the Braden assessment (high risk) did not include turning and repositioning. The DNS further indicated the Pressure Ulcer Prevention Plan for a resident at high risk indicated a resident at high risk should have a heels up pad, Spenco boots and Q 1 hour turning. The facility Pressure Ulcer Prevention Plan dated 4/18/2024 indicated those residents with a score of 15-18 were at mild risk and interventions would include moisturizing skin, Q 2 hour turns and repositioning, toileting per resident's request and incontinent care Q 2 hours. 46046

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, review of facility policy and staff interviews for 5 of 10 residents (Residents #1,# 15, #18, # 23 #26 and #34) reviewed for unnecessary medications and 5 of 5 residents (Resident # #3, #10, #12, #18, #23 and #33) observed during medication pass, the facility failed to ensure a reason or the rationale for the use of the routine and when needed medications were noted in the physician's orders to meet professional standards. The findings included: 1. Resident #1's diagnoses included diabetes mellitus, chronic venous hypertension, and cerebrovascular disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had mild cognitive impairment, received insulin and an antidepressant medication. The physician's medication orders from 3/1/2024 through 4/25/2024 did not indicate the reason for use for all medications ordered during the above time. 2. Resident #3's diagnoses included vascular dementia, diabetes mellitus, cancer, hypertension, and paroxysmal atrial fibrillation. The annual MDS assessment dated [DATE] indicated a mild cognitive deficit and noted the resident received antidepressant, diuretic, and opioid medications. The physician's orders from 3/1/2024 through 4/25/2024 failed to identify the reason for use for all medications ordered during the above time. 3. Resident #10's diagnoses included Atrial Fibrillation, heart failure, diverticulosis, and diabetes mellitus. The quarterly MDS assessment dated [DATE] indicated Resident #10 was cognitively intact and received anticoagulant medication. The physician's orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time. 4. Resident #12 diagnoses included Parkinsonism, Bradycardia, Hypothyroidism, hyperlipidemia, and atrial fibrillation. The quarterly MDS assessment dated ,d+[DATE]/ 2024 indicated Resident #12 was cognitively intact and received an antibiotic, diuretic, opioid and hypoglycemic medications. The physician's orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time. 5. Resident #15's diagnoses included diabetes mellitus, hypoosmolality and hyponatremia, anxiety disorder, hypertension, and heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission MDS assessment dated [DATE] indicated Resident #15 had moderate cognitive impairment and received an antibiotic, antianxiety, anticoagulant, and diuretic medications. a. The physician's orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time. b. A physician's order dated 4/21/2024 directed to provide Seroquel 25 (Antipsychotic) MG tablet orally 3 times daily as needed x 14 days (with no indication for the use of the medication). An interview and record review with LPN #2 on 4/23/24 at 11:00 AM indicated the order for Seroquel 3 times a day as needed physician's orders did not indicate to the nurse what was reason for the medication. LPN # 2 further indicated s/he would call the psychiatric Advanced Practice Registered Nurse (APRN) to clarify the order. 6. Resident #18's diagnoses included parkinsonism, dementia, diabetes mellitus, and atherosclerotic heart disease. The quarterly MDS assessment dated [DATE] indicated Resident #18 was rarely or never understood, moderately impaired for daily decision making and received antipsychotic antidepressant and hypoglycemic medications. The physician's orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time. 7. Resident #23's diagnoses included Bacteremia, Systemic Inflammatory Response Syndrome, diabetes mellitus, hypertension, and atrial fibrillation. The quarterly MDS assessment dated [DATE] indicated Resident 323 was cognitively intact, received insulin injections, antidepressant, anticoagulant, diuretic, and hypoglycemic medications. The physician's orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time. 8. Resident #26's diagnoses included type 2 diabetes mellitus, vascular dementia, schizoaffective disorder, renal agenesis, and insomnia. The annual MDS assessment dated [DATE] indicated Resident #26 was cognitively severely impaired for daily decision making and noted the resident received insulin injections, antipsychotic, and anticoagulant medications. The physician's orders from 3/1/2024 through 4/25/2024 did failed to identify the reason for use for all medications ordered the above time. 9. Resident #33's diagnoses included hypertension, atherosclerotic heart disease, hypothyroidism, depression, and heart failure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS assessment dated [DATE] indicated Resident #33 rarely or never understood and noted modified independence (some difficulty in new situations only) while making decisions regarding tasks of daily living. The physician's medication orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during the above time and the utilization of antidepressant medication. 10. Resident #34's diagnoses included syncope, hypothyroidism, urinary retention, and atherosclerotic heart disease. The quarterly MDS assessment dated [DATE] indicated Resident #34 had moderate cognitive impairment, received antidepressant and antibiotic medications. The physician's medications orders from 3/1/2024 through 4/25/2024 failed to indicate the reason for use for all medications ordered during that time. Interview and record review with the DNS on 4/24/2024 at 10:50 AM identified there was no reason why the resident's use for medications were not noted in the physician's orders. The DNS further s/he has spoken to psychiatric services to be sure they are adding reasons for use for medication in the physician's orders when they write medication orders. An interview with the Medical Director on 4/25/24 at 11:35 AM indicated s/he did not know residents needed reasons for use of all medications and indicated s/he would discuss with the DNS. Although a policy for writing medications orders was requested one was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, review of policy and staff interviews for 4 of 6 residents reviewed for pressure ulcers (Residents #5 # 26 # 34 and # 40), the facility failed to initiate interventions to prevent the development of a pressure ulcer for a resident at risk for developing pressure injuries and who later developed a pressure ulcer and the facility failed to ensure a healed pressure did not reopen. The findings included: 1. Resident #5's diagnoses included cervical spine fracture, Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had short-term and long-term memory problems and had severe impairment of cognitive skills for daily decision making. The MDS also identified Resident #5 required substantial to maximum assistance with rolling left and right and moving from a lying position to sitting on the side of the bed. The resident was frequently incontinent of bowel and bladder. The MDS further identified the resident did not have any unhealed pressure injuries and indicated the resident was at risk for developing injuries. A hospital discharge summary dated 2/9/24 indicated Resident # 5 was discharged and noted no pressures ulcer at time of discharge. A nursing progress note dated 2/9/24 at 1:57 PM identified Resident #5 returned from the hospital at 10:56 AM and was noted with a linear stage 2 coccyx area measuring 0.7 Centimeter (CM) by 0.1 CM. The nursing note further identified that Triad cream was applied. The physician was notified of the stage 2 open area and an order was obtained for Triad paste every shift for 14 days (2/9/24 through 2/23/24). A Braden Scale for prediction of pressure sore risk dated 2/9/24 indicated Resident #5 had a score of 16 where 15-18 indicated a risk for pressure ulcer development. A Braden scale for prediction of pressure sore risk dated 3/1/24 indicated Resident #5 had a score of 13, where 13-14 indicated a moderate risk for pressure ulcer development. A review of the nurse's notes dated 2/14/24, 2/28/24 and 3/6/24 indicated body audits were performed during the resident's shower day, and no new skin issues were identified. A care card dated 3/15/24 indicated Resident #5 was able to stand and pivot with the assistance of one staff member from the bed to a cushioned wheelchair. The care card also identified the resident was incontinent of bowel and bladder. Interventions included walking up to 50 feet with the assistance of two people. However, the care card updated 3/15/24 did not direct staff to turn and reposition the resident until 4/12/24 update. A review of the nurse's notes dated 2/24/24 through 3/27/24 identified no open areas. A review of the Treatment Administration Record (TAR) identified the weekly body audit for skin was completed every week from 2/9/24 through 4/10/24. The weekly body audits did not identify any pressure injury or any skin impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, review of the clinical record from 2/23/24 through 4/10/24 failed to identify any open area until 4/11/24. A wound physician's evaluation dated 4/11/24 identified a new Stage 2 pressure ulcer to the coccyx measuring 0.6 CM L, 0.5 CM W, and 0.1 CM with no exudate and intact peri-wound area. The Treatment Administration Record recommendations included cleansing with saline and the application of barrier cream. A care plan dated 4/12/24 identified Resident #5 had actual skin breakdown to the coccyx; interventions included: frequent incontinent care and frequent repositioning on rounds. The facility implemented on 4/12/24 a 24-hour turn and reposition schedule using a repositioning cushion. However, a review of the clinical record from 2/9/24 through 4/10/24 (2 months) failed to reflect evidence of turning and repositioning of Resident # 5 per facility practice. On 4/23/24 at 12:18 PM, an interview with the nurse manager (LPN#2) indicated for residents identified at risk for pressure ulcers, turning and positioning are put in place. LPN#2 was unsure if interventions were in place for Resident #5 prior to the identification of the stage 2 pressure ulcer. Several attempts to contact the wound physician during the survey were unsuccessful. On 4/29/24 at 11:17 AM, an interview and record review with the DNS in the presence of the Administrator identified turning and position are not formally documented by staff, but the expectation is staff follow what is on the resident's care card. The DNS was not able to provide evidence Resident # 5 was turned and repositioned by staff every 1-2 hours from 2/9/24 through 4/10/24 while in the wheelchair and in bed prior to the resident developing a new stage 2 pressure ulcer on 4/11/24. 2 Resident #34's diagnoses included diabetes mellitus Type 2, Peripheral Vascular Disease (PVD), osteoarthritis and altered mental status. The quarterly MDS assessment dated [DATE] identified the resident was moderately cognitively impaired, incontinent of bowel and bladder. The assessment also noted the resident had no unhealed pressure ulcer. The Resident Care Plan dated 4/16/24 identified Resident #34 had pressure ulcer/injury. Interventions included assessing skin breakdown risk using the Braden scale quarterly and as needed, avoiding shearing resident's skin during positioning, transferring, and turning, and to use pillows for pressure reduction when resident is in the bed. The Resident Care Card updated on 4/16/24 included cloth rolls under heels while in bed, alternating air mattress at resident's weight. A physician's order dated 4/18/24 directed to cleanse stage 3 pressure ulcer left heel with normal saline, covered with Calcium Alginate then apply abdominal pad and wrap with roll gauze daily and when needed. The left heel measured 2.5 CM by 2.0 CM by 0.1 CM with 1-24 percent epithelial and 25-49 percent granulation. The wound was also noted draining moderate amount of serosanguineous drainage with moist maceration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's progress note dated 4/25/24 identified a consultation was requested for reported left heel wound. Additionally noted left heel was first evaluated 4/18/24 and identified as stage 3 pressure ulcer with pain erythema. The left heel measured 1.5 CM by 1.0 CM by 0.1 CM with 1-24 percent epithelial and 25-49 percent granulation. The wound was also noted draining moderate amount of serosanguineous drainage and moist maceration. Assessment plan directed Facility Protocol offload heels per facility protocol/ off load pressure / reposition every two hours. However, the clinical record failed to reflect off loading and turning and repositioning of the resident from 3/1/24 through 4/17/24 until the physician's order on 4/18/24 which directed Facility Protocol offload heels per facility protocol/ off load pressure / reposition every two hours after the resident developed a stage 2 pressure ulcer on the heel. In an interview and clinical record review on 4/25/24 at 12:00 PM with Licensed Practical Nurse LPN #1 (MDS Coordinator) identified the resident was at risk for skin breakdown and the Braden Scale for April 2024 was not completed because the physician's order was discontinued in error. Interview with Wound MD #2, on 4/25/24 at 1:30 PM identified her expectations for residents at risk for skin breakdown would include turning and repositioning, frequent assessment for areas that are prone to pressure areas and heel checks. She also would expect staff to follow any recommendations in her notes. Additional attempts to call MD #2 on 4/25/24 and 4/29/24 were unsuccessful. In an interview and clinical record review with the DNS and Administrator on 4/29/24 at 10:36 AM identified Resident #34 was at risk for skin breakdown at admission and interventions for prevention of skin breakdown should have been documented on the Resident Care Plan and the Resident Care Card but were not included in either document for Resident # 34. An interview with RN# 1 on 5/2/24 at 10:39 A.M. identified she was not sure if skin breakdown prevention measures were in place in Resident # 34's plan of care. Review of the Prevention and Management of Pressure Ulcers policy, undated, directed, in part, residents receive the care and services they need according to established practice guidelines, so that residents who enter the facility without a pressure injury do not develop one unless the individual's clinical condition demonstrates that they were unavoidable. Further the policy states the resident is assessed for pressure injury risk factors on admission then weekly x 3 weeks, quarterly, annually and with any significant change in condition. Review of the Pressure Ulcer Prevention Plan, undated, directed, in part, a score of 10-12 is high risk and interventions to include Heels-up pad, Spenco boots in bed, and every 1 hour turning and repositioning. Although Requests for the facility policy and documentation on 4/29/24 and 4/30/24 to support implementation of pressure ulcer prevention including turning and repositioning, and offloading pressure on heels, were not provided. 3. Resident #26's diagnoses included diabetes mellitus type II and vascular dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission nurse's note dated 3/22/23 identified Resident #26 had a stage (3) pressure ulcer to the coccyx, stage (2) pressure ulcer to the right heel and stage (2) pressure ulcer to the right medial malleolus (bony prominence of the ankle) present on admission. A low air loss mattress was placed on the bed and Resident #26 was referred to the specialty wound consultant. The physician's orders dated 3/24/23 directed to cleanse and apply Calcium Alginate daily, offload heels, reposition every two hours, and conduct a weekly body audit- on shower days. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was severely cognitively impaired, required total assist of two for bed mobility, transfers, toileting, was at risk for the development of a pressure ulcer and had at least two unhealed pressure ulcers. The Resident Care plan dated 3/31/23 identified Resident #26 had a stage (3) pressure ulcer to the coccyx and a problem with activity of daily living (ADL). Interventions directed to utilize a full back Hoyer pad and provide two assists for transfers with no documented interventions to manage the pressure ulcer. The Braden Scale dated 4/4/23 identified a score of 11 indicating Resident #26 was at high risk for the development of skin breakdown. A review of Wound Tracking dated 3/23/23 through 11/9/23 identified on 4/20/23 the left heel pressure ulcer had healed, on 4/27/23 the right ankle pressure ulcer had healed, and the coccyx wound was stable. A Wound Consultation note dated 11/16/23 identified the stage 4 pressure ulcer had resolved with recommendations that included following the facility Pressure Ulcer protocol, continue pressure redistribution mattress, and reposition every two hours. A review of the physician's orders dated 1/5/24 directed the discontinuation of repositioning every two hours with no evidence of documented repositioning for Resident #26. A nurse's note dated 2/2/24 identified Resident #26's old stage (4) pressure ulcer had reopened measuring 2CM x 1.2 CM x 05 CM. A review of the Braden Risk assessments identified (1) documented Braden Risk assessment dated [DATE] with no subsequent Braden Risk assessment until 2/18/24. A review of the weekly skin audits identified that although signed off as completed weekly, there was no documented result of the assessment(s) on (4) of (10) occasions between 11/16/23 and 2/2/24 prior to the re-opening of the coccyx pressure ulcer. An interview with the Assistant Director of Nursing Services (ADNS) on 4/24/24 at 12:01 PM identified that although she was not the designated wound nurse, she assisted with monitoring the facility wounds for any decline in wounds and making sure orders were in place. The ADNS identified the weekly wound consults were provided to the facility by the wound specialist and reviewed by herself, Director of Nursing, DNS and Unit Manager, Licensed Practical Nurse, LPN #2 to ensure recommendations were followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER: Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and clinical record review with the DNS on 4/24/24 at 12:22PM identified he was responsible for ensuring wound recommendations were followed. The DNS identified that there was no documented turning and repositioning schedule for Resident #26 prior to the re-opening of the coccyx pressure ulcer and there should have been. The DNS further identified there was no consistent documentation of weekly skin assessments in the clinical record. The DNS identified that although Braden Skin assessments should be completed on admission, quarterly and with a change of condition, the assessment was not completed according to policy. The DNS further indicated Resident #26 did not have a Braden Risk assessment completed at the time the coccyx wound re-opened on 2/2/24. Resident #26 had since been placed on a routine turn schedule as of 3/11/24. An interview with the MD #2 on 4/25/24 at 1:31 PM identified she provided specialty wound services to the facility on a weekly basis. MD #2 identified she was currently treating Resident #26 for a pressure ulcer to the coccyx and communicated mostly with LPN #1 about wound related matters. Resident #26 was admitted to the facility with the pressure ulcer but had since healed before re-opening on 2/2/24. MD #2 identified that although she was unable to determine with certainty if the return of the pressure injury was avoidable, Resident #26 was at risk for re-opening of the pressure ulcer due to a history of a pressure ulcer and co-morbidities. MD #2 identified she would expect any recommendations she made to be followed including repositioning. 4. Resident #40's diagnosis included dementia, mood disturbance dysphagia and anemia. The care plan dated 3/8/2024 indicated Resident #40 was at risk for skin breakdown with intervention including, avoid shearing, keep linens clean dry and wrinkle free, monitor for skin breakdown and use moisture barrier to the perineal area, turn and reposition in bed and complete weekly wound assessments. A Braden assessment completed on 3/9/2024 indicated Resident #40 was at high risk for skin breakdown. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired, required substantial assistance to roll left and right and noted dependent for transfer to and from bed/chair. The MDS further indicated at risk for but had no pressure ulcers or skin injuries. A progress note dated 4/21/2024 at 5:17 PM indicated charge nurse went to assess the resident and noted an open area on the left heel. The note further indicated the pressure ulcer was a stage 2 with measurements of 3 CM x 3.5 CM in size (no depth documented), and moisture associated skin damage was noted on the buttocks. The physician, family and wound care consultant were notified, and treatment obtained. The care plan dated 4/21/2024 indicated a pressure ulcer on the left heel. Interventions to follow the treatment orders and to offload heels at all times. On 4/24/2024 at 1:05 PM observations of wound treatment by LPN # 4 in the presence of LPN # 3 identified treatment as prescribed. Further observations identified wedge cushion in place in bed that allowed the heels to hang over the edge of the wedge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with the charge nurse LPN #3 on 4/24/2024 indicated the care card 3/15/2024 reviewed on 4/24/24 did not indicate how or when to reposition Resident # 40 while in bed and failed to reflect turning and repositioning had consistently occurred. Interview and record review with The DNS on 4/29/2024 at 11:20 AM indicated the care card dated 3/15/2024 7 days after completion of the Braden assessment (high risk) did not include turning and repositioning. The DNS further indicated the Pressure Ulcer Prevention Plan for a resident at high risk indicated a resident at high risk should have a heels up pad, Spenco boots and Q1 hour turning. The DNS further indicated Spenco boots were contraindicated with the air mattress but was unable to provide the documentation to support the contraindication. A review of the Pressure Ulcer Prevention Plan (no date) directed interventions (based on skin breakdown) were to be initiated upon admission and a copy of the Braden Scale provided to the ADNS. No breakdown or stage I included to moisturize skin, repositioning, incontinent care every two hours and toileting per resident request. Stage II/ excoriations, soft heels/clear blisters would include an air mattress, elevated heels, and mild risk interventions. Stage II, Stage III/deep tissue injury would include heels up pad, Spenco (offload) boots in bed and repositioning every hour. Stage 4/necrotic areas/deep tissue injury include an alternating air mattress, and back to bed schedule. 46046 48792 48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review on clinical record reviews, facility documentation, facility policy and interviews for 3 of 4 Residents (Residents # 22, # 27 and #34) reviewed for nutrition, the facility failed to follow their policy for weight loss. The findings included: 1. Resident #22's diagnoses included protein-calorie malnutrition, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease. The admission Minimum Data Set assessment dated [DATE] identified Resident #22 was cognitively intact and required setup assistance with eating, limited assistance with transfers, and extensive assistance for bed mobility. Review of the clinical record identified Resident #22 weighed 116.2 pounds on 7/3/23, 145.4 pounds on 8/3/23, and 111.4 pounds on 8/16/23 and 8/17/23. A physician's order dated 7/6/23 directed to weigh Resident #22 monthly, compare weight to the previous month, reweigh as needed, and update physician with any significant change. Review of the hospital discharge summary dated 8/9/23 identified Resident #22 was admitted to the hospital on 8/5/23 with diagnoses of blood loss anemia, E Coli urinary tract infection, hypoglycemia (low blood sugar) secondary to reduced appetite and difficulty swallowing, and hypokalemia (low potassium levels), and was discharged back to the nursing facility on 8/9/24. Additionally, the hospital documented a weight of 71 kg (156.528 pounds) on 8/9/23. The nurse's notes dated 8/5/23 through 8/16/23 failed to identify any weights or resident refusal of weights. Review of the Administration Treatment Record and Medication Administration Record of Resident #22 for 8/2024 failed to document any additional weights not documented in the weights section, nor were there any documented weight refusals. The Resident Care Plan dated 8/15/23 identified Resident #22 was on a mechanically altered diet (puree) due to dysphagia, had difficulty swallowing at times, and had a history of significant weight loss with continued gradual weight loss. Interventions included to honor food preferences within mechanical restriction, monitor for signs and symptoms of difficulty chewing and swallowing, offer supplements as ordered, administer Marinol and Remeron medications as ordered to aid in appetite, monitor laboratory work to determine effect of the therapeutic diet, weigh resident per physician's orders and alert physician, dietician, and responsible party with significant weight changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with LPN #2 (Unit Manager) on 4/29/24 at 10:22 AM identified the clinical record failed to provide evidence of the resident's weight after readmission on 8/9/23, until 8/16/23, 1 week later. She indicated that a weight should have been obtained the day of readmission and then daily for 3 days, and then per the physician's orders. She also identified the charge nurse has the overall responsibility of making sure the NA's obtained the weight and the weight is documented timely in the clinical record. She further indicated she was unable to locate a any weight refusal and could not explain why a weight was not obtained until a week after readmission. 2. Resident #27's diagnoses included dementia and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident # 27 was rarely or never understood decisions for regarding tasks for daily living were poor and required cues and supervision. The MDS further indicated there was a weight loss of 5% or more in the last month or 10% in the last 6 months. The assessment also noted the resident received a therapeutic diet and had no oral or dental concerns. The care plan dated 3/30/2024 indicated Resident #40 had risk for impaired swallowing related to dementia Interventions: included in part to monitor and record weight and to notify the physician and dietitian and responsible party of significant weight changes, to assist resident to eat as needed, to provide supplements as ordered, offer substitutes and to report and document when resident leaves 25% or more food uneaten. A review of the weights documented on 3/5/2024 at 4:59 PM indicated a weight of 143.8 pounds and on 4/4/24 the weight recorded was 130.2 pounds (13.6-pound weight loss in 30 days). A nursing progress note dated 4/4/2024 indicated a significant weight loss and the dietitian, the physician, and Power of Attorney (POA) were notified in addition to the supervisor. The Registered Dietitian entered a progress note dated 4/18/2024 at 2:23 PM acknowledging the weight loss, spoke to family and physician. The resident refuses to eat at times and indicated the advanced directives indicated No Tube Feeding. A physician's order dated 5/4/2023 indicated to obtain weights monthly on the first shower day 3-11 PM shift on Fridays and to compare to previous month and reweigh as needed. An interview with the DNS on 4/29/2024 at 11:35 AM indicated Resident # 27 should have been re-weighed after the first weight was found to have a significant weight loss. 2. Resident #22's diagnoses included protein-calorie malnutrition, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease. The admission Minimum Data Set assessment dated [DATE] identified Resident #22 was cognitively intact and required setup assistance with eating, limited assistance with transfers, and extensive assistance for bed mobility. Review of the clinical record identified that Resident #22 weighed 116.2 pounds on 7/3/23, 145.4 pounds on 8/3/23, and 111.4 pounds on 8/16/23 and 8/17/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 7/6/23 directed to weigh Resident #22 monthly, compare weight to the previous month, reweigh as needed, and update physician with any significant change. Review of the Saint [NAME] Hospital discharge summary dated 8/9/23 identified that Resident #22 was admitted to the hospital on 8/5/23 with diagnoses of blood loss anemia, E Coli urinary tract infection, hypoglycemia (low blood sugar) secondary to reduced appetite and difficulty swallowing, and hypokalemia (low potassium levels), and was discharged back to the nursing facility on 8/9/24. Additionally, the hospital documented a weight of 71 kg (156.528 pounds) on 8/9/23. Review of nurse's notes dated 8/5/23 through 8/16/23 failed to identify any weights or resident refusal of weights. Review of the administration record of Resident #22 for 8/2024 failed to document any additional weights not documented in the weights section, nor were there any documented weight refusals. The Resident Care Plan dated 8/15/23 identified Resident #22 was on a mechanically altered diet (puree) due to dysphagia, had difficulty swallowing at times, and had a history of significant weight loss with continued gradual weight loss. Interventions included to honor food preferences within mechanical restriction, monitor for signs and symptoms of difficulty chewing and swallowing, offer supplements as ordered, administer Marinol and Remeron medications as ordered to aid in appetite, monitor lab work to determine effect of the therapeutic diet, weigh resident per physician's orders and alert physician, dietician, and responsible party with significant weight changes. Interview and clinical record review with LPN #2 (Unit Manager) on 4/29/24 at 10:22 AM identified that the clinical record failed to document a weight after readmission on 8/9/23, until 8/16/23, 1 week later. She indicated that a weight should have been obtained the day of readmission and then daily for 3 days, and then per the physician's orders. She identified the charge nurse has the overall responsibility to make sure the NA's obtained the weight and that the weight is documented timely in the clinical record. She was unable to locate a documented weight refusal and was unsure why a weight was not obtained until a week after readmission. Review of the Weight Monitoring policy dated 11/9/2015 directed, in part, that all residents will be weighed upon admission and readmission and then weekly unless otherwise noted in the physician's orders. A discrepancy of 5-pound weight loss or gain from the previous documented weight will be verified by a second weight within 48 hours. 3 Resident #34 's diagnoses included diabetes mellitus Type 2, dysphasia, and altered mental status. The admission Minimum Data Set assessment dated [DATE] identified Resident #34 was moderately cognitively impaired and required maximum assistance for toileting, personal hygiene, and moderate assistance for dressing. The Resident Care Plan dated 11/1/23 identified mechanically altered diet related to dysphagia and noted the resident was at risk for significant weight loss due to less than 75% intake at times. Interventions included to honor location of meals, to ensure dentures were in place, soft and bite sized food pieces, monitor and record weight, and to honor food preferences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 11/1/23 directed to provide a regular diet with a mechanical soft consistency. Although requested on 4/29/24, 4/30/24, and 5/1/24, copies of dietary/nutrition notes, weights since admission, and nursing notes were not provided by the facility. In an interview and clinical record review with the Administrator and DNS on 4/29/24 at 10:19 AM indicated the resident weight on 12/4/23 was 196.2 pounds and on 1/9/24 was 186.1 pounds which resulting in a 10.1 pound weight loss. The DNS identified the resident should have been re-weighed within 48 hours to verify the significant weight loss. DNS was unsure why the re-weight did not occur. The facility policy dated 4/18/2024 and labeled Weight Monitoring indicated in part if a discrepancy of a 5-pound weight loss or gain from the previous documented weight will be verified by a second weight within 48 hours. 48792 48879

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48880 Based on staff interviews and review of Payroll Based Journal (PBJ) submissions for Quarter 4 of 2023, Quarter 3 of 2023, Quarter 2 of 2023, and Quarter 1 of 2023, the facility failed to to ensure the required number of Registered Nurse hours . The findings include: The PBJ submissions for Quarter 4 of 2023 (July 1 through September 30), Quarter 3 of 2023 (April 1 through June 30), Quarter 2 of 2023 (January 1 through March 31), and Quarter 1 of 2023 (October 1 through December 31, 2022) identified identified that the facility had no RN hours reported. On 4/29/24 at 12:21 PM, an interview with the Administrator indicated the facility was not operational from 10/24/22 through 3/15/23, which corresponds with quarters 1 and 2 of 2023. Additionally, the Administrator identified the facility had adopted a new payroll system as of January 2023 and has been working with the software vendor who oversees the system to identify why payroll data has not been submitted automatically. The Administrator further identified that prior to January 2023, PBJ data was entered manually. Although, the facility provided staff schedules from 3/12/23 through 9/30/23 which identified RN nursing supervisors were scheduled to work day, evening, and night shifts, the facility was unable to provide documentation from Centers for Medicare and Medicaid Services (CMS) to indicated the facility had met the required number of RN hours for Quarters 1 of 2023 to Quarters 4 of 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 5 sampled residents (Resident #26) who were reviewed for unnecessary medications, the facility failed to review or discontinue the use of a PRN (as needed) psychotropic medication. The findings include: Resident #26's diagnoses included diabetes mellitus type II and vascular dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was severely cognitively impaired, required total assist of two for bed mobility, transfers, toileting and received psychotropic medication. The Resident Care Plan dated 11/7/23 identified Resident #26 had a diagnosis of depression and was prescribed psychotropic medication. Interventions directed to provide psychiatric consultation as needed and monitor for side effects of medications. The physician's orders dated 2/5/24 directed Trazadone 25MG every (6) hours when needed for 14 days for agitation and restlessness with no date of discontinuation. The psychiatric progress notes dated 3/18/24 and 4/15/24 did not include a documented review of the when needed use of Trazadone, its continued use, or discontinuation of the medication. An interview and clinical record review with the Director of Nursing Services on 4/29/24 at 12:30 PM identified the medication should have been reviewed for its continued use or discontinuation. Although requested, a policy for the PRN use of psychotropic medication was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46046 Based on observations, review of facility documentation and interviews the facility failed to ensure a staff member applied hair/beard net while in the kitchen, consistently logged dishwasher temps daily, document what was done when dishwasher temperatures were not within range, and consistently document food temperatures for all meals daily per facility practice. The findings included: 1. Observation on 4/21/24 at 9:00 AM Dietary Aide #1 identified (DA#1) washing hands at the sink wearing a baseball style hat with hair noted below the cap lower edges and was also noted with a mustache and short beard without the use of a beard and hair net. Dietary aide #1 at the time of the observation indicated not having a beard and applied a hairnet and a face mask to cover exposed hair. Dietary Aide #1 further indicated his/her shift started at 6:00AM. 2. Observation and review of the kitchen dishwasher temperature log on 4/22/2024 at 11:05 AM with the dietary manager indicated on the following dates first shift 4/10 115 for wash and 125 rinse and 4/19/2024 the wash was noted at 110 and rinse 120 were below normal temperatures (120-140 rinse and wash temperatures). Additionally, further review of the dishwashing temperature identified on the second shift on 4/2, 4/4, 4/11, 4/13, and 4/17/2024,no temperatures were logged. The Dietary Manager indicated not knowing why the temperature on the second shift were not logged and further indicted the below temperatures logged may have been due to the the dietary aide not taking the water temperature at the correct time in the process. On 4/22/2024 after service of the mid-day meal at 1:00 PM observation and interview with the Director of Dietary identified s/he could not explain why they were missing. 3. The food temperature by the [NAME] were missing entries on 3/27, 4/1, 4/5, 4/11, 4/17, 4/19/2024 for ground meat, dessert, soup gravy and alternate entree and Director of dietary clarified the log dated Sunday was 4/21/2024. On 4/22/2024 after service of the mid-day meal at 1:00 PM observation and interview with the Director of Dietary identified s/he could not explain why food temperatures were missing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024

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 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** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for the 1 of 1 sampled resident (Resident #45) reviewed for death, the facility failed to ensure the resident's death certificate was in the clinical record. The findings include: Resident #45's diagnoses included dementia without behavioral disturbances, hypertension, and hypothyroidism. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 was moderately cognitively impaired and required supervision for eating, substantial assistance for bed mobility, was dependent for transfers. The Medication Administration Record for Resident #45 dated [DATE] through [DATE] identified Resident #45 had a code status of Do Not Resuscitate, Do Not Intubate, palliative care. The Resident Care Plan dated [DATE] identified Resident #45 was comfort measures only. Interventions included having staff ensure the resident was comfortable during bathing, repositioning, dressing, and during linen changes. Pain controlled as ordered. A nurse's note dated [DATE] at 7:05 AM identified Resident #45 had deceased at 5:00 AM and the APRN, family, and funeral home had been notified. Review of the clinical record failed to identify a signed death certificate from [DATE] for Resident #45. Interview and clinical record review with LPN # 2 (Unit Manager) on [DATE] at 12:31 PM identified the death certificate was not located in the closed record. She indicated the physician signs the death certificates online and that completed death certificates are located on the Connecticut Vital Record website. She further identified she was not aware of the facility printing out any death certificates since the process went electronic about a year ago. Interview with the DNS on [DATE] at 1:16 PM identified death certificates have not been printed out and included in the closed record of any residents that have passed away in the facility since the process went to electronic signing a year ago He reported the process require the RN supervisor to initiate the death certificate in the CT Vital Record website, which will then generate a certificate number. The RN then notifies the physician, and the physician will then go onto the website and sign the certificate electronically. The DNS further indicated s/he was unsure if the facility should be printed out to form to include in the medical record and stated s/he would call CT Vital Record to inquire about how to print the death certificate. Subsequent to surveyor inquiry, a death certificate was provided for Resident #45, reporting the time of death was [DATE] at 5:10 AM and signed by the physician on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Bickford Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Death Policy dated ,d+[DATE] directed, in part, that all records must be completed and forwarded to Medical Records for disposition. Keep all copies and forms in a neat and organized fashion in the front of the chart.

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	04/29/2024

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48880 Based on staff interviews and review of Payroll Based Journal (PBJ) submissions for Quarter 4 of 2023, Quarter 3 of 2023, Quarter 2 of 2023, and Quarter 1 of 2023, the facility failed to ensure that PBJ data was complete and accurate. The findings include: The PBJ submissions for Quarter 4 of 2023 (July 1 through September 30), Quarter 3 of 2023 (April 1 through June 30), Quarter 2 of 2023 (January 1 through March 31), and Quarter 1 of 2023 (October 1 through December 31, 2022) identified the facility failed to have licensed nursing coverage 24 hours/day, noted excessively low weekend staffing, and had no RN hours. On 4/29/24 at 12:21 PM, an interview with the Administrator indicated the PBJ data was not accurate. The Administrator indicated she had to call Centers for Medicare and Medicaid Services (CMS) to understand the issue that was occurring when she found out the facility had triggered PBJ staffing. The Administrator indicated the facility was not operational from 10/24/22 through 3/15/23, which corresponds with quarters 1 and 2 of 2023. Additionally, the Administrator identified the facility had adopted a new payroll system as of January 2023 and has been working with the software vendor who oversees the system to identify why payroll data has not been submitted automatically. The Administrator further identified that prior to January 2023, PBJ data was entered manually.