

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Fresh River Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 96 Prospect Hill Rd East Windsor, CT 06088	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation review, facility policy review, and interviews for three (3) of five (5) residents (Resident#6, #7 and #8) reviewed for abuse, the facility failed to ensure the State Agency was notified timely of a resident-to-resident physical interaction. The findings include:</p> <p>1. Resident #7 was admitted with diagnoses that included dementia. A resident care plan (RCP) dated 9/3/2024 identified Resident #7 had a potential to be physically aggressive with staff pushing others away due to poor impulse control and wandered aimlessly, pacing daily with entering other residents' rooms due to confusion. Interventions directed to engage in clam conversation and to distract from wandering by offering pleasant diversions. A quarterly MDS assessment dated [DATE] identified Resident #7 had a BIMS of 2 which indicated severe cognitive impairment and was independent for ambulation.</p> <p>2. Resident #8 was admitted with diagnoses that included dementia, bipolar disorder, schizoaffective disorder and depression. An annual MDS dated [DATE] identified Resident #8 had a BIMS of 5 which indicated severe cognitive impairment and was independent for ambulation. A resident care plan (RCP) dated 12/9/2024 identified Resident #8 had impaired thought processes and anxiety. Interventions directed to allow resident time to answer questions.</p> <p>a) A facility reportable event form dated 12/12/2024 at 10:45 PM identified Resident #8 reported that Resident #7 had entered his/her room, had messed with Resident #8's stuff and Resident #8 punched Resident #7 one time. The residents were separated and assessments performed. Resident #7 was noted with multiple scratches and two (2) knots on his/her face. An ice pack was applied to Resident #7's face and both residents were placed on every 15-minute checks.</p> <p>Additional review of the reportable event form identified the State Agency was notified of the incident on 12/13/2024 at 8:00 AM, nine (9) hours and 15 minutes after the incident occurred.</p> <p>A facility summary dated 12/16/2024 identified Resident #7 was hit by Resident #8, and Resident #7 confirmed Resident #8 hit him/her. Resident #8 reported he/she hit Resident #7 for coming into his/her room and touching his/her pictures. Facility investigation indicated at approximately 10:40 PM NAs had observed Resident #7 on his/her bed and provided incontinent care. the summary indicated although staff did not witness the incident, Resident #7 was noted to have 2 small scratches on the forehead and two pink areas on his/her cheek, and Resident #8 was moved to another unit.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #2/Supervisor on 12/19/2024 at 1:12 PM identified LPN #3 had notified her on 12/12/2024 about 10:45 PM that Resident #8 had come out of his/her room and told staff that he/she had just hit someone who was in his/her room. Resident #7 was walking in the hallway at the time, and Resident #8 identified it was Resident #7 who he/she had just punched. Resident #7 had scratches and a bump on his/her cheek and reported Resident #8 had hit him/her. Both residents were placed on every 15-minute checks and she notified the physician and the responsible parties. RN #2 stated she did not notify the DON of the incident and passed the information in report to the on-coming RN Supervisor at 7 AM. RN #2 further stated she did not realize that when a resident hits another resident that it was considered abuse and did not implement the facility's abuse policy.</p> <p>Interview and review of the 12/12/204 resident to resident investigation documents with the DON on 12/19/2024 at 1:30 PM identified the alleged punch by Resident #8 to Resident #7 should have been considered an allegation of abuse. The DON stated RN #2 should have immediately notified her and the Administrator of the incident, and the State Agency should have been notified. The DON identified she learned of the incident during morning report the day after the incident occurred and she notified the State Agency.</p> <p>3. Resident #6's diagnoses included major depressive disorder, anxiety disorder, history of suicidal behavior and disruptive mood dysregulation disorder (ongoing irritability, anger and frequent, intense temper outbursts).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required setup assistance for showering/bathing self and was independent with toileting, dressing, bed mobility, transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated 7/23/24 identified that Resident #6's concerns will be listened to and explored with interventions that included not challenging Resident #6's beliefs as this may anger him/her. If the resident makes statements about his/her peers or staff that may not be true, attempt to limit his/her exposure to them and listen to what he/she is saying and determine if there's any truth to what was said. If the resident makes statements about staff that may not be true, provide him/her with two (2) care givers. Offer the resident one to one visits by the social worker so that he/she can discuss concerns/issues regarding others.</p> <p>Review of a facility grievance dated 9/26/24 and filled out by Social Worker #1 (Director of Social Services) identified, in part, that Resident #6's concerns included the response of two (2) staff members when he/she asked for the bathroom to be cleaned. The Investigation Details and Summary of Findings sections identified that showers were scrubbed and cleaned, and the shower was to be regouted after the third-floor shower was repaired but failed to mention details on the concern about responses from the staff. The Actions Taken section identified that the resident was provided with wipes in the bathroom, the staff was instructed to randomly check on the bathrooms and the showers were scheduled to be cleaned with soft scrub. The form identified that a resolution to the grievance was reached on 9/27/24, but that Resident #6's acceptance fluctuates between accepting the resolution/outcome and not accepting the resolution/outcome. The form was signed by the Administrator on 9/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the interview statement collected by the facility from Resident #6 on 9/26/24 identified that LPN #1 verbally reprimanded him/her when Resident #6 reported to her that there was stool on the toilet from another resident. The resident also reported that RN #1 stated to him/her that, She doesn't have to worry about feces on her toilet at home because she owns her home and doesn't live in a nursing home. Resident #1 reported to Social Worker #1 that he/she had reported these concerns to the Administrator in the past and had not been updated on the resolution.</p> <p>Interview with Resident #6 on 12/18/24 at 10:18 AM identified that he/she had been having issues with LPN #1, stating she is very moody and if you question her about anything, she becomes snappy and asks why Resident #6 is questioning her. She identified that LPN #1 talks to him/her in a condescending manner and has yelled at him/her in front of other residents when he/she asks LPN #1 questions, stating she has also told Resident #6 not to bother her when he/she is eating dinner at the nursing station. Resident#6 reported that although he/she did not have specific dates he/she did file a grievance with Social Worker #1 on 9/26/24 and that a typed-out statement was attached, providing more detail. The resident reported that LPN #1 has been verbally abusive to him/her more than once and the facility has not responded to the written grievance, and he/she wants it addressed.</p> <p>Interview with Social Worker #1 on 12/18/24 at 10:48 AM identified that Resident #6 had come to her with concerns regarding LPN #1 and another nurse (RN #1) about the way they talked to and reprimanded him/her, along with other bathroom and housekeeping concerns. She identified that she filled out a grievance form and attached the interview she completed with Resident #6, notified and presented both documents immediately to the Administrator and the DNS. Social Worker #1 reported that normally the Administrator responds to the grievance and communicates the outcome to the resident/representative after the investigation is completed. She identified that although it was an allegation of mistreatment, she was unsure what transpired after she initially spoke with the Administrator and DNS, stating she was not asked to follow-up with the resident.</p> <p>Interview with the Administrator on 12/18/24 at 12:55 PM identified that she could not recall specifics of the 9/26/24 grievance regarding Resident #6 but identified that although it's required for all allegations of abuse that the State Agency be notified within two (2) hours, the resident could not provide dates or specifics, so the accusations towards the staff had been determined unsubstantiated and not reported.</p> <p>Interview with the DNS on 12/18/24 at 3:35 PM identified that she had received Resident #6's statement attached to the 9/26/24 grievance. She identified that although there was no investigation dated 9/26/24 for Resident #6, the allegations towards LPN #1 and RN #1 should have been reported then investigated, stating that she should have initiated audits with other residents but was unsure why it hadn't been done.</p> <p>Although attempted, interviews with LPN #1 or RN #1 were not obtained.</p> <p>Review of the Abuse CT policy dated 3/20/24 directed, in part, that allegations of abuse will be reported promptly and thoroughly investigated. Allegations of abuse or neglect are to be reported to the Department of Public Health immediately but not later than two (2) hours after the allegation is made if the allegations involve abuse. An investigation of the witnessed or alleged abusive action or neglect will be initiated within 24 hours of its discovery. It is the responsibility of the facility Administrator or designee to initiate the investigation.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #6) reviewed for allegations of mistreatment, the facility failed to investigate an allegation of verbal abuse. The findings include:</p> <p>Resident #6's diagnoses included major depressive disorder, anxiety disorder, history of suicidal behavior and disruptive mood dysregulation disorder (ongoing irritability, anger and frequent, intense temper outbursts).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required setup assistance for showering/bathing self and was independent with toileting, dressing, bed mobility, transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated 7/23/24 identified that Resident #6's concerns will be listened to and explored. Interventions included not challenging Resident #6's beliefs as this may anger him/her. If the resident makes statements about his/her peers or staff that may not be true, attempt to limit his/her exposure to them and listen to what he/she is saying and determine if there's any truth to what was said. If the resident makes statements about staff that may not be true, provide him/her with two (2) care givers. Offer the resident one to one visits by the social worker so that he/she can discuss concerns/issues regarding others.</p> <p>Review of a facility grievance dated 9/26/24 and filled out by Social Worker #1 (Director of Social Services) identified, in part, that Resident #6's concerns included the response of two (2) staff members when he/she asked for the bathroom to be cleaned. The Investigation Details and Summary of Findings sections identified that showers were scrubbed and cleaned, and the shower was to be regouted after the third-floor shower was repaired but failed to mention details on the responses from the staff. The Actions Taken section identified that the resident was provided with wipes in the bathroom, the staff was instructed to randomly check on the bathrooms and the showers were scheduled to be cleaned with soft scrub. The form identified that a resolution to the grievance was reached on 9/27/24, but that Resident #6's acceptance fluctuates between accepting the resolution/outcome and not accepting the resolution/outcome. The form was signed by the Administrator on 9/27/24.</p> <p>Review of the interview statement collected by the facility from Resident #6 on 9/26/24 identified that LPN #1 verbally reprimanded him/her when Resident #6 reported to her that there was stool on the toilet from another resident. The resident also reported that RN #1 stated to him/her that, She doesn't have to worry about feces on her toilet at home because she owns her home and doesn't live in a nursing home. Resident #1 reported to Social Worker #1 that he/she had reported these concerns to the Administrator in the past and had not been updated on the resolution.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #6 on 12/18/24 at 10:18 AM identified that he/she had been having issues with LPN #1, stating she is very moody and if you question her about anything, she becomes snappy and asks why Resident #6 is questioning her. She identified that LPN #1 talks to him/her in a condescending manner and has yelled at him/her in front of other residents when he/she asks LPN #1 questions, stating she has also told Resident #6 not to bother her when he/she is eating dinner at the nursing station. Resident #6 reported that although he/she did not have specific dates he/she did file a grievance with Social Worker #1 on 9/26/24 and that a typed-out statement was attached, providing more detail. The resident reported that LPN #1 has been verbally abusive to him/her more than once and the facility has not responded to the written grievance, and he/she wants it addressed.</p> <p>Interview with Social Worker #1 on 12/18/24 at 10:48 AM identified that Resident #6 had come to her with concerns regarding LPN #1 and another nurse (RN #1) about the way they talked to and reprimanded him/her, along with other bathroom and housekeeping concerns. She identified that she filled out a grievance form and attached the interview she completed with Resident #6 and submitted them to both the Administrator and the DNS. Social Worker #1 reported that normally the Administrator responds to the grievance and communicates the outcome to the resident/representative after the investigation is completed. She identified that she was unsure what transpired after she turned in the grievance form, stating she was not asked to follow-up with the resident.</p> <p>Interview with the Administrator on 12/18/24 at 12:55 PM identified that she could not recall specifics of the 9/26/24 grievance regarding Resident #6 but identified that the resident could not provide dates or specifics, so the accusations towards the staff had been determined unsubstantiated. She identified that although an investigation should have been initiated and statements should have been obtained if staff was mentioned by name, she was unsure if that had happened, but that it should have been documented on the grievance form and the resident should have been notified of the outcome. She reported that the resident interview should have been attached to the grievance and she was unsure why it wasn't available in the grievance book.</p> <p>Interview with the DNS on 12/18/24 at 3:35 PM identified that she had received Resident #6's statement attached to the 9/26/24 grievance. She identified that although there was no investigation dated 9/26/24 for Resident #6, the allegations towards LPN #1 and RN #1 should have been investigated, stating that she should have completed audits with other residents but was unsure why it hadn't been done.</p> <p>Although attempted, interviews with LPN #1 or RN #1 were not obtained.</p> <p>Review of the Abuse CT policy dated 3/20/24 directed, in part, that allegations of abuse, neglect and mistreatment will be thoroughly investigated. An investigation of the witnessed or alleged abusive action, neglect or mistreatment will be initiated within 24 hours of its discovery. It is the responsibility of the facility Administrator or designee to initiate the investigation.</p> <p>Review of the Resident Grievances policy dated 12/2016 directed, in part, that facility residents have the right to have prompt efforts made by the facility to attempt to resolve grievances.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for skin injuries, failed to ensure that interventions for skin protection were followed in accordance with the plan of care. The findings include:</p> <p>Resident #2's diagnoses included Huntington's disease (an inherited condition where nerve cells in the brain break down over time resulting in progressive movement, cognitive and psychiatric symptoms) and chorea (neurological disorder that causes involuntary, irregular and unpredictable muscle movements).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Staff Assessment for Mental Status completed indicating moderate cognition impairment of both long- and short-term memory problems and required total staff assistance with hygiene, dressing and transfers and maximal assistance with bed mobility. Additionally, it identified that Resident #2 had no skin injuries but was at risk for developing pressure ulcers/injuries.</p> <p>The Resident Care Plan (RCP) dated 11/19/24 identified that Resident #2's skin is fragile, and he/she may get bruises and/or skin tears easily with interventions included to apply moisturizing lotion as indicated, encourage wearing long sleeves, inspecting skin during care and ensuring padded siderails with pillows.</p> <p>Review of the nurse's notes from 11/1-12/18/24 identified various entries for old bruises, bruises noted to legs, and bruises noted to both feet.</p> <p>Observations of Resident #2 with the DNS on 12/18/24 at 9:51 AM, identified the resident sitting in a specialized chair in the hallway wearing a short-sleeved shirt with scattered scabs and scratches to both lower extremities, left greater than right, baseball sized bruising to the right inner ankle and redness noted to the skin around the right eye. There was a pillow on the floor to the left of the resident, a positioning wedge was in place between the upper thighs and a pelvic belt was in place around the resident's waist.</p> <p>Observation on 12/18/24 at 2:44 PM identified Resident #2's bed in the lowest position, a floor mat on the right side of the bed next to the window and a pillow under the sheet on the right side of the bed. There was no padding to either siderail noted.</p> <p>Interview and observation with NA #7 on 12/18/24 at 2:47 PM identified that Resident #2 did not have siderail padding and hadn't for as long as she could remember, stating the resident did need the padding but that they propped pillows up on both sides of the resident's hips instead since the siderail padding was unavailable.</p> <p>Interview with LPN #2 on 12/18/24 at 2:50 PM identified that she was aware that Resident #2 required side-rail padding but reported that she was unsure why it wasn't available.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 12/18/24 at 2:15 PM identified that the resident was care planned for padded side rails and she was unsure why the padded side rails were utilized and she was unsure why the padded side rails were not available.</p> <p>Review of the Care Plan policy dated 11/16/23 directed, in part, that the interdisciplinary team (IDT) develops, in collaboration with the resident, a comprehensive care plan based on the Resident Assessment Instrument, which is compromised of the Minimum Data Set (MDS), Care Area Assessments (CAA's), other applicable clinical information, resident's goals for admission, resident's preferences and resident's preference and potential for discharge. Within seven (7) days of completing the MDS and CAA's, the IDT develops, reviews, and revises the plan of care to insure it is person centered and individualized to meet the needs of the resident. The care plan contains resident's goals, resident's strengths, resident's preferences, identified problems, measurable realistic goals, and the interventions to be utilized to reach the goals.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for skin alterations, the facility failed to document alterations in skin integrity in the clinical record upon identification and failed to monitor and measure the alterations in skin integrity upon identification and weekly until resolved. The findings include:</p> <p>Resident #2's diagnoses included Huntington's disease (an inherited condition where nerve cells in the brain break down over time resulting in progressive movement, cognitive and psychiatric symptoms) and chorea (neurological disorder that causes involuntary, irregular and unpredictable muscle movements).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Staff Assessment for Mental Status completed indicating moderate cognition impairment of both long- and short-term memory problems and required total staff assistance with hygiene, dressing and transfers and maximal assistance with bed mobility. Additionally, it identified that Resident #2 had no wounds.</p> <p>The Resident Care Plan (RCP) dated 11/19/24 identified that Resident #2's skin is fragile, and he/she may get bruises and/or skin tears easily with interventions included to apply moisturizing lotion as indicated, encourage wearing long sleeves, inspecting skin during care and ensuring padded siderails with pillows.</p> <p>Review of the nurses notes and skin checks from 11/1/24 through 11/22/24 identified old bruises, bruises noted to legs, bruises noted to both feet.</p> <p>Observations of Resident #2 on 12/18/24 at 9:51 AM, identified the resident sitting in a recliner like chair in the hallway wearing a short-sleeved shirt with scattered scabs and scratches to both lower extremities, left greater than right, baseball sized bruising to the right inner ankle and redness noted to the skin around the right eye. There was a pillow on the floor to the left of the resident, a positioning wedge was in place between the upper thighs and a pelvic belt was in place around the resident's waist.</p> <p>Interview with the DNS on 12/18/24 at 2:15 PM identified that although skin abnormalities were noted in Resident #2's clinical record and identified as not new on 11/8/24, 11/15/24, 11/19/24 and 11/22/24, no A &amp; I's were initiated, and the areas were not monitored and measured. She was also unable to identify when the resident sustained the scattered scabs and scratches to both lower extremities, left greater than right, and the baseball sized bruised area to the right inner ankle that was observed on 12/18/24 by the surveyor, as they don't correlate with the documentation in the clinical record, and she was unsure why. The DNS reported that for all new alterations in skin integrity, she expects nursing to document the location, appearance and size (measurement) in the clinical record.</p> <p>Although requested, a facility policy for altered skin integrity was not provided.</p>