STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075359	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresh River Healthcare	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for change in condition, the facility failed to ensure a resident was transferred to a higher level of care in a timely manner. The findings include: Resident #1 was admitted to the facility with diagnoses that included displaced fracture of the base of the neck of the left femur and atrial fibrillation. Resident #1's responsible party was Person #1. Resident #1 was a full code. A physician's order dated 12/9/25 directed apixaban (Eliquis) five (5) mg every twelve (12) hours for atrial fibrillation. A Physician's history and physical dated 12/10/24 identified Resident #1 was admitted to the hospital after a fall sustaining a left femoral neck fracture and was started on Eliquis for atrial fibrillation. The admission MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of thirteen (13) indicative of intact cognition, was frequently incontinent of bowel and bladder and required one staff assistance for bed mobility and two staff assistance for transfers. The care plan dated 12/17/24 identified Resident #1 had Activities of Daily Living (ADL) care performance and mobility deficit with interventions that included to assist with ADL's as needed. Review of the resident's pulse rate from admission on [DATE] through 1/16/25 identified pulse rates ranging from 74 to 82 Beats Per Minute (BPM) with a regular rhythm (normal rate). Review of Resident #1's vitals dated 1/7/25 identified at 9:16 PM Resident #1's pulse was 156 BPM irregular, new onset (normal pulse 60 - 100 BPM). A nurse's note written by LPN #1 dated 1/7/25 at 9:24 PM identified Resident #1 was observed being restless, lethargic with increased confusion, attempted to climb out of the bed and had unstable vital signs. The supervisor (RN #2) was made aware of resident's altered mental status. Resident #1's family member insisted Resident #1 be sent out to the emergency department for an evaluation. Resident #1 left the building with the EMT's at exactly 9:15 PM. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital transfer form dated 1/7/25, completed by RN #2, identified Resident #1's vital signs were blood pressure of 159/97, heart rate 156 BPM and respiratory rate of 22 breaths/minute. Resident #1 was transferred out of the facility at 9:17 PM. Review of the pre-hospital report (ambulance documentation) dated 1/7/25 identified dispatch received the call at 8:57 PM for a resident with altered mental status. Person #1, in Resident #1's room, identified Resident #1 also had a high pulse rate. Upon assessment, Resident #1 had an irregular pulse rate and rhythm. Interview with LPN #1 on 3/5/25 at 11:56 AM identified on 1/7/25 around 8:00 and 8:15 PM she was in Resident #1's room and asked Resident #1 a question and Resident #1 did not make sense and had word salad (confused or unintelligible mixture of random words). She identified that was not Resident #1's baseline and took Resident #1's vital signs. She identified she told the supervisor of Resident #1's altered mental status and heart rate of 156 BPM. The nursing supervisor assessed Resident #1. She identified Resident #1's family member (Person #1) insisted Resident #1 go to the hospital right away and told him/her there is a protocol that needs to be followed. She identified that she followed up with the supervisor two to three times regarding sending Resident #1 to the hospital. She identified it was not in her power to send Resident #1 to the hospital immediately but is the supervisors' decision. She identified it was a total of about forty-five minutes until 911 was called. Interview with RN #2 on 3/5/25 at 3:00 PM identified on 1/7/25 (unable to identify the time) LPN #1 requested that she assess Resident #1. She identified she immediately went to assess Resident #1 and Resident #1 was restless, did not answer her, and had a high pulse. She identified she re-checked Resident #1's pulse and it was 122 BPM (however, this was not documented in the clinical record). She identified Resident #1 needed to be sent to the hospital so she then started the papers for a hospital transfer. She identified the paperwork usually takes about thirty minutes. She identified when she realized how long the paperwork was taking, about halfway through the paperwork, she stopped to call the physician (Medical Director). She identified the Medical Director answered right away and told her to send Resident #1 to the emergency department. She identified she then called 911 and finished her paperwork. However, she further identified Resident #1 had a history of atrial fibrillation which could result in a stroke and would send a resident to the hospital immediately if tachycardiac (high pulse). Interview with the Medical Director on 3/5/25 at 2:12 PM identified he could not remember if he was notified of Resident #1's change in condition on 1/7/25. He identified if the symptoms that Resident #1 had were reported to him he would have had staff call 911 right away. He further identified for stroke like symptoms, 911 should be called immediately. He further identified he is a phone call away and expects to be notified. He identified staff, using their judgement, can call 911 first and then notify him after. Interview with the DNS on 3/5/25 at 2:38 PM identified when there is a change in a resident she expects the supervisor the assess the resident right away and then notify the physician. She further identified when a resident is transferred to the hospital, the process is for the supervisor to complete the transfer paperwork. However, the paperwork should not delay the resident from going to the hospital. She identified staff should call 911 then do the paperwork. She identified depending on the emergency personal that respond, the EMT's either wait for the paperwork to be completed until they leave, or they have the staff fax it to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician notification change in condition policy directed that if a resident is evaluated by a charge nurse to have a change in condition, the charge nurse will notify the RN supervisor on duty. The RN supervisor will do a follow up assessment to ensure that the assessment is documented and reported to the physician. All assessment findings and any relevant information should be complied prior to calling the physician to ensure accuracy of information. The nurse will document in the nurses notes regarding assessments, findings, changes, physician notified and resident and/or responsibility party notification.