STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075375	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bride Brook Rehabilitation & Nursing Center	23 Liberty Way Niantic, CT 06357

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #5) who required assistance for nail care, the facility failed to ensure the resident's nails were clean and trimmed. The findings include: Resident #5's diagnoses included rheumatoid arthritis, lupus, and repeated falls. The quarterly MDS assessment dated [DATE] identified Resident #5 was cognitively intact, had no behaviors, required touching assistance for personal hygiene, was a partial to moderate assistance for toileting, bathing, lower body dressing, and was independent for eating, and oral hygiene. The assessment further identified the resident was able to ambulate using a walker and was dependent when using a wheelchair. The care plan dated 2/12/25 identified Resident #5 had a self-care deficit related to generalized weakness and impaired mobility, which required assistance with personal hygiene, bathing, nail care and transfers. It also indicated the resident was visually impaired, wore glasses and had interventions that included assistance with personal hygiene and nail care. Resident #5's Care Card (utilized by nurses' aides to guide care) identified his/her shower day was on Wednesday's and Saturdays on the 7-3 shift. Review of the weekly skin checks-body audits completed for February 2025; March 2025 & April 2025 did not identify any concerns with Resident #5's nails. Observation on 4/15/25 at 10:30 AM identified Resident #5's right- and left-hand ring fingers and pinky fingernails were 0.6 inches long with debris noted underneath the nails. The occupational therapy progress note dated 4/18/25 identified Resident #5's Self-Care Score was an 8 out of 12. (score 0-12, 12 is the highest functioning). Interview on 4/22/25 at 12:59 PM with Resident #5 identified he/she had not refused nail care and was unable to recall the last time his/her fingernails were cleaned, cut and filed and noted that it would be nice if they were a little shorter. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/22/25 at 1:03 PM of Resident #5's fingernails, identified three fingers on the right hand were contracted (turned inward toward the palm of the hand), as well as the fingers on the left hand. The right-hand pointer fingernail and second fingernail on the right hand had black/brown color debris under them. Also observed the pointer finger on the left hand had debris under it. The nails were 0.6-0.7 inches long. Interview on 4/22/25 at 1:04 PM with the recreation staff on the second floor (recreation office), indicated they provide nail care for residents. They can clean the nails and paint them. Recreation staff were not allowed to cut any resident's fingernails. If or when they need to be cut, they update the nursing staff, the staff person further identified there was also an individual who could be hired to provide professional manicures if any of the residents are interested. The facility staff would coordinate with the manicurist, resident or family, for payment from the resident's account. None of the recreational staff could recall if or when they had provided nail care to Resident #5. Interview on 4/22/25 at 1:06 PM with the unit nurse (RN #4) indicated she was unsure if there was a policy regarding nail care. She further identified that if a resident's nails appeared to need grooming, they would then be cleaned and filed. RN #4 identified that nail care would also be provided upon request. Upon learning that Resident #5's nails were long with debris, RN #4 identified the nails would be cleaned and cut that day. Interview on 4/23/25 at 10:55 AM with the DNS, Administrator and RN #3 (Regional Clinical Manager) identified Resident #5 refused nail care on 4/20/25. Residents are scheduled for biweekly showers, unless they prefer weekly showers. The nail care task is attached to one of the weekly showers, there by triggering the staff to complete nail care on one of the shower days. When a resident refuses a shower or nail care, the staff should update the floor nurse, the nurse would then speak to the resident regarding the refusal. The DNS further identified that residents are reapproached when they refuse nail care. The Administrator identified that residents have the right to refuse care or nail care and showers. Following the interviews with the DNS, and Administrator, Subsequent to the interview with the DNS and the Administrator, a request for documentation of Resident #5's refusals of nail care and completed nail care. A nail care flow sheet was provided by the facility that identified the refusal of nail care on 4/20/25. It also indicated the resident received nail care on 3/20/25, 4/1/25, 4/6/25 and 4/13/25. Observation on 4/23/25 at 11:11 AM identified Resident #5 in the bathroom with a recreational staff member washing his/her hands, after which Resident #5's nails appeared clean and trimmed. Interview on 4/23/25 at 11:12 AM with Resident #5, identified he/she was happy with his/her shorter and cleaned nails. He/she further identified the staff were welcome to provide him/her with nail care any time. Review of the activities of daily living policy dated 2024 directed, that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy, and interviews for one sample resident (Resident #61) reviewed for skin condition, the facility failed to ensure treatment to a wound was provided timely and for one of five sampled residents (Resident #83) reviewed for unnecessary medication the facility failed to ensure that physician's orders were implemented and completed as prescribed by the physician. The findings include: 1. Resident #61 was readmitted to the facility on [DATE] with diagnoses that included foot drop, arterial disease, muscle wasting and atrophy. The admission nurse's note dated 1/3/25 at 9:16 PM identified Resident #61 was alert and oriented, had a left second toe amputation and the left third toe had a scabbed area that measured 0.5 centimeters (cm) in length by 0.5 cm in width. The 5-day MDS assessment dated [DATE] identified Resident #61 had intact cognition and required extensive assistance with toileting, personal hygiene, bed mobility, and transfers. The care plan dated 1//11/25 identified Resident #61 had actual skin impairment related to arterial disease to the left first toe, third toe, and second toe amputation. Care plan interventions directed to administer treatment per physician's order, and podiatry consult as needed. Review of the January 2025 monthly Treatment Administration Record (TAR) identified the first recorded treatment to the left third toe was on 1/11/25, Which was 8 days after it was first identified on 1/3/25. Review of physician's orders from 1/3/25 to 1/10/25 failed to identify an active physician's treatment order to the left third toe. The physician's orders dated 1/11/25 directed to administer Xeroform to the wound base and cover with dry clean dressing to the left and third toe daily. Review of the weekly wound evaluation by RN #2 (wound nurse) dated 1/24/25 identified Resident #61 had an arterial open wound to the left medial third toe on 1/3/25. The wound measurement recorded as 0.5 cm in length by 0.5 cm in width by 0.3 cm in depth with a small amount of serosanguineous drainage. The wound bed was identified with 50 percent slough (dead tissue) and 50 percent granulation (healthy tissue). The wound assessment also identified a treatment of Xeroform to the left third toe daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 (wound nurse) on 4/22/25 at 12:45 PM identified that she was responsible for administering the daily treatment and monitoring the healing of the wound. She also identified that any open wound would have an active physician's treatment order, and it would also be documented in the TAR when the treatment was administered on the day of the onset of the wound. She identified Resident #61 had a chronic arterial wound to the left third toe related to the arterial disease. She identified that Resident #61 third toe was noted open on 1/3/25 and she obtained a Xeroform treatment to the left third toe. She further identified that first recorded treatment administered to Resident #61 left third toe was on 1/11/25 and she identified that she forgot to transcribe the treatment in the physician's order. Interview with the DNS on 4/23/24 a 10:00 AM identified RN #2 is responsible for ensuring treatment is included in the physician's order when there was a noted open wound. Review of physician's order with the DNS for Resident #61 open wound to the left third toe that was first identified on 1/6/25 and she could not find a treatment was administered in the physician's order. She further identified that Resident #61 should have a physician's treatment order when it was noted on 1/3/25. The Wound Treatment Management facility policy identified that the facility would provide an evidence-based treatment in accordance with the current standards of practice and physician orders. The facility policy also identified that the license nurse would notify the physician to obtain a treatment, and treatment would be documented on the TAR and/or in electronic medical records. 2. Resident #83's diagnoses included generalized anxiety disorder, delusional disorder, depressive disorder, and dementia. The 5-day MDS assessment dated [DATE] identified Resident #83 had moderate cognitive impairment, required extensive assist with transfers, dressing and personal hygiene, and utilized anti-psychotic (used for managing mental health disorders) medication. The care plan dated 11/15/24 identified Resident #83 used psychotropic medication to help manage his/her delusional disorder. The care plan interventions directed to administer medication as per physician's orders, monitor and record targeted behavior, monitor for adverse reaction of psychotropic medication, and psychiatry follow-up as needed. Review of physician's order dated 12/3/24 directed to administer Zyprexa 15 mg (anti-psychotic medication) by mouth at bedtime related to delusional disorder. Review of physician's order dated 12/9/24 directed to obtain orthostatic blood pressure (check resident blood pressure while lying, sitting, and standing) for resident on a new dose or dose change of anti-psychotic medication once weekly in 4 weeks. Review of the Treatment Administration Record (TAR) for December 2024 identified Resident #83 orthostatic blood pressure was signed off by the nurse as completed on 12/10/24, 12/17/24, 12/24/24, and 12/31/24; however, a review of Resident #83's clinical record failed to identify the orthostatic blood pressures were taken as ordered by the physician on 12/10/24, 12/17/24, 12/24/24, and 12/31/24 (missed 4 out 4 opportunities). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 (7-3 charge nurse) on 4/22/25 at 10:15 AM identified that the charge nurse was responsible for obtaining and assessing the orthostatic blood pressure. She identified that the orthostatic blood pressure should include the blood pressure while a resident was lying, sitting and standing with 5 minutes apart each time. She also identified that the orthostatic blood pressure would be recorded in the vital sign section and indicated the resident position when the blood pressure was taken. She identified Resident #83 had a physician's order for orthostatic blood pressures because of the dosage change of the Zyprexa medication. She also identified that she worked on 12/17/24 and signed off that the orthostatic blood pressure was completed but she could not identify why the orthostatic blood pressure was not recorded properly in the vital sign record. She further identified Resident #83 was capable of standing with assistance and his/her orthostatic blood pressure should include while lying, sitting, and standing. Interview with the DNS on 4/22/25 at 10:40 AM identified that orthostatic blood pressure would be obtained by a nurse to ensure that resident was free from the adverse reaction related to the use of psychotropic medication. She identified that blood pressure would be taken while a resident was lying, sitting and standing to complete the physician's order for orthostatic blood pressure unless a resident was unable to stand up. She identified Resident #83 was capable of standing with assistance so the orthostatic blood pressure should have been taken while lying, sitting, and standing. Review of the Consulting Physician/Practitioner Orders identified that the facility would meet all current standards of nursing practice in accepting, transcribing and executing doctor's orders to ensure compliance with current standards of nursing practice a ensure the resident's needs are met.