STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075379	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Center for Health & Rehabilitation	27 Hospital Hill Road Sharon, CT 06069

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** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #2) reviewed for quality of care, the facility failed to honor a resident's advance directives following a change in condition. The findings include: Resident #2's diagnoses included dementia with psychotic disturbances, atrial fibrillation, and malignant neoplasm of prostate. Record review identified Person #1 was Resident #2's court appointed Conservator (COP) for health care decisions. Physician orders dated [DATE] directed Resident #1's code status was a full code. Resident #1 to receive CPR (cardiopulmonary resuscitation). The Resident Care Plan (RCP) dated [DATE] identified Resident #2 had an established advance directive and wished to receive CPR (cardiopulmonary resuscitation). Interventions directed to review advance directives with resident and/or healthcare decision maker quarterly, and support the resident's decision for CPR. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had significantly impaired cognition. A social services note, written by SW #2, dated [DATE] at 1:07 PM identified SW #2 spoke to Person #1/COP to review Resident #2's advance directives and review the care plan (a 72-hour meet and greet admission form). The note indicated Person #1/COP directed Resident #2's advance directives/code status would be DNR/DNI (do not resuscitate/do not intubate). Review of the Advanced Directives Declaration Code Status form dated [DATE] identified Resident #2 was deemed as a DNR/DNI, with verbal consent from Person #1, dated [DATE]. The physician's signature area had an unidentifiable signature, with the date of [DATE], and a time noted of 5:55 PM. Review of the facility and clinical documentation failed to reflect the change was made in the clinical record to reflect Resident #2's updated code status as DNR/DNI in accordance with the POA direction on [DATE]. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note, written by SW #2, dated [DATE] (7 days after the COP directed DNR) at 1:10 PM identified a team meeting was held to discuss Resident #2 care plans. Resident #2 was unable to participate due to cognitive status, and a voicemail was left for Person #1. Advanced directives were reviewed during the meeting and the note indicated Resident #2 was currently a full code/CPR. The incident report dated [DATE] at 5:15 PM identified Resident #2 was found lying on the floor unresponsive at 5:15 PM unresponsive to all verbal and tactile stimuli. No pulse, respirations or blood pressure were detected. Resident #2 remained on the floor and emergency medical services (EMS) were called at 5:16 PM by the charge nurse. A code was called, an AED (automated external defibrillator) brought to the scene, and CPR was initiated at 5:20 PM. The AED was placed at 5:21 PM, EMS arrived at 5:30 PM and took over for CPR. When the nurse began to print paperwork for EMS, he/she found a signed DNR/DNI paperwork (located in a different section of the chart). The RN returned to room and notified EMS of DNR/DNI status. EMS contacted the physician who pronounced Resident #2 to be deceased at 5:59 PM. Interview with RN #1 on [DATE] at 1:05 PM identified he was the RN Supervisor on [DATE] during the 7AM to 3 PM shift (when SW #2 obtained the change in code status from Person #1). RN #1 identified he was not notified by SW #2 regarding the change in advance directives for Resident #2. If he was notified, he would have obtained physician orders and updated the clinical record. Although attempted, interview with RN #2 was unable to be obtained. Interview with SW #2 on [DATE] at 1:20 PM identified she spoke with Person #1 on [DATE], and Person #1 directed to change Resident #2's code status from a full code to DNR/DNI. SW #2 was unable to confirm who she updated on the nursing team of the new advance directives, but indicated it was whichever staff member was on the unit at that time. SW #2 identified she did not report the change to any other staff member, aside from the unidentified person on the unit. SW #2 identified when a resident changes their advance directive, the staff are expected to update the documentation and notify the nursing staff to ensure an order gets placed. SW #2 was unable to explain why her note on [DATE] (7 days after the change) did not reflect Resident #2's accurate code status. SW #2 stated it was most likely an error on her part. Interview with Administrator #2/Regional Director of Operations on [DATE] at 2:00 PM identified that although facility ownership changed after this incident event (during [DATE]), interview failed to identify why the record was not updated to reflect the accurate code status. A facility policy regarding entering code status orders in the clinical records was not provided for surveyor review. Interview and facility documentation review with the Administrator on [DATE] at 10:53 AM identified although staff education was initiated on [DATE] regarding code status documentation in the clinical record, and audits were initiated with a QAPI meeting on [DATE], review failed to identify the education included SW #2. The Administrator stated SW #2 should have received education. Based on review of facility documentation, past non-compliance was unable to be identified due to SW #2 was not included in the education.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1) reviewed for quality of care, the facility failed to monitor the resident's behaviors for a resident receiving antipsychotic medications. The findings include: Resident #1's diagnoses included dementia with behavioral disturbances, major depressive disorder, post-traumatic stress disorder, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 as alert and oriented, and received antipsychotic medications on a routine basis in the prior seven (7) days. The Resident Care Plan (RCP) dated 1/9/2024 identified Resident #1 had the potential to be verbally abusive due to dementia. Interventions directed to monitor behaviors. Physician orders dated 1/23/2024 directed to administer Quetiapine Fumarate (anti-psychotic) 50 milligrams (mg) at 9:00 AM and 100 mg at 8:00 PM, for dementia with behavioral disturbances. Review of the Pharmacy Drug Regimen Review - Physician Referral dated 1/25/2024 identified Resident #1 was on Quetiapine (Seroquel - antipsychotic) for behaviors associated with dementia and recommended a workup to assess resident behaviors. Review of the Pharmacy Drug Regimen Review - Nursing Referral dated 4/12/2024 identified to provide target behaviors monitoring for the psychotropic medications that Resident #1 is taking. Please make sure the target behavior is specific. Review of clinical and facility documentation failed to reflect Resident #1 had target behaviors monitored during the timeframe of 1/23 through 7/18/2024. Physician order dated 7/19/2024 directed to monitor behaviors of labile mood, sad, crying, tearful, paranoid, accusatory, verbally aggressive, and suicidal/homicidal ideations. Interview with Pharmacist #1 on 8/20/2024 at 1:30 PM identified the facility were given notifications (from the pharmacist) in January and April 2024 directing to add target behaviors due to Resident #1 receiving Seroquel and psychotropic medications. Interview with APRN #1 on 08/20/2024 at 9:30 AM identified it was her expectation that the nursing staff monitor target behaviors for Resident #1 and was unaware the facility was not monitoring behaviors prior to 7/19/2024. APRN #1 indicated target behaviors should be monitored every shift and reported to herself if there is any significant change or increased frequency. Review of the Clinical Services Psychotropic Medications Policy dated 5/2023 identified when psychoactive medications are prescribed, a specific condition or targeted behavior that warrants the use of the psychoactive medications shall be documented in the clinical record: a. The healthcare provider progress notes. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The healthcare provider order sheet. c. Behavior monitoring flowsheet.