STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075390	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Brook Center for Health & Rehabilitation	89 Wied Drive Naugatuck, CT 06770

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who's medications were put on hold when the resident was transferred to the Emergency Department, the facility failed notify the Advanced Practice Registered Nurse or physician at the time when the medications were not resumed when the resident returned to the facility, therefore the medications were omitted for eleven (11) days. The findings include: Resident #1's diagnoses included diabetes, cardiac infarction, atrial fibrillation and neuromuscular dysfunction of the bladder, and pain related to immobility. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily life. The Resident Care Plan dated 9/3/24 identified altered cardiac status related to congestive heart failure and heart attack, neurological bladder with indwelling foley and pain related to decreased mobility. The nurse's note dated 9/15/24 at 11:55 AM identified Resident #1 was having hallucination, was pale in color, blood was noted in the urine, Resident #1 had a low blood pressure of 96/52, the Advanced Practice Registered Nurse was notified, and Resident #1 was sent to the hospital. The hospital discharge summary 9/15/2024 identified no changes to prehospital medication orders Keflex (antibiotic) was ordered for a urinary infection, was identified to be the only new medication ordered. The nurse's note dated 9/15/24 at 7:37 PM identified Resident #1 returned from the Emergency Department around 6:40 PM with a new order for Keflex, to encourage oral fluids for hydration, and the medication orders were verified with the Advanced Practice Registered Nurse. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital discharge medication instructions dated 9/15/24 directed to administer Albuterol every six (6) hours as needed, Amiodarone 200 milligrams (mg) daily, Eliquis 5 mg, Vitamin C, Aspirin 81 mg daily, Atorvastatin 30 mg daily, Baclofen 10 mg three (3) times a day, Bisacodyl suppository as needed, Carvedilol 3.125 every twelve (12) hours, Famotidine 20 mg, Insulin (NovoLog) sliding scale, Insulin detemir per glucose results, Lactulose 30 milliliters (ml) as needed, Lorazepam 1 mg, Methenamine 1 gram, Oxybutynin 5 mg three (3) times a day, MiraLAX 17 gram daily, Entresto 24-26 mg every twelve (12) hours, and Pericolace two (2) tablets at bedtime. The nurses note dated 9/27/24 at 1:54 PM identified that on 9/15/24 after being transferred back to the facility from the hospital the second page of the medication orders were not resumed therefore, the medications were omitted for a total of eleven (11) days. The medications omitted included the Baclofen 10 mg three (3) times a day, Lactulose 30 ml as needed, Eliquis 5 mg twice a day, Atorvastatin 80 mg at bedtime, Amiodarone 200 mg daily, and Oxybutynin 5 mg three (3) times a day, the Advanced Practice Registered Nurse was notified, and labs were ordered. A physician's order dated 9/27/24 identified medications that had not been transcribed and were held on hold for eleven (11) days. The medications reordered included: Amiodarone (a heart medicine) 200 mg daily, Apixaban (Eliquis a blood thinner) 5 mg give one (1) tablet every twelve (12) hours, Atorvastatin (for high cholesterol) Calcium 80 mg at bedtime, Baclofen (a muscle relaxant) 10 mg three (3) times a day, Lactulose(for constipation) 20 GM/30ML give 30ML as needed for constipation, Oxybutynin (a bladder relaxant) and Chloride tablet 5 mg give three (3) times a day. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 10/8/24 at 11:00 AM identified she was not on duty when Resident #1 had gone to the Emergency Department on 9/15/24. LPN #1 explained that when she returned to work on 9/24/24 she saw the medications were on hold and she thought they were held for the pending surgery Resident #1 was suppose to have, therefore she did not report this to the Nursing Supervisor. Interview with Advanced Practice Registered Nurse (APRN) #1 on 10/8/24 at 11:20 AM identified when a resident is transferred to an acute care facility the Nursing Supervisor places the medications on hold, if the resident returns in less than twenty-four (24) hours, and there are no changes in medications, the nurse (any nurse) can remove the hold and resume the medications as ordered. APRN #1 stated if the resident returns in less than twenty-four (24) hours and if myself or another APRN are in the building, generally the nurses will give the discharge paperwork to the APRN to review, and we will resume the medications, ideally this should be done within one (1) to two (2) hours of the resident returning. The APRN indicated she was at the facility when it was discovered that some of Resident #1's medications were still on hold, labs were ordered, she discussed the incident with the attending physician and the medications were ordered with no significant injury to the resident. Interview with the Assistant Director of Nursing (ADON) on 10/8/24 at 11:30 AM identified when a resident is transferred to an acute care facility the Nursing Supervisor places the medications on hold, if the resident is transferred back to the facility in less than twenty-four (24) hours, and there are no changes in medications, the nurse (any nurse) can remove the hold and resume the medications as ordered and if there are changes to the medications the APRN or on-call physician would need to verify the changes. The ADON identified the 3-11PM nurse on duty on 9/15/24 was unaware there were two (2) pages of medications, and only resumed some of the medications, each page had to be individually activated or resumed. RN #2 did not question the hold or inform the nursing supervisor. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with 11PM-7AM charge nurse, Registered Nurse (RN) #2, on 10/8/24 at 12:15 PM identified the Supervisor usually resumes the medications when a resident returns to the facility and on 9/16/24 she noticed that some of Resident #1's medications were still on hold. RN #2 indicated Resident #1 had gone to the hospital for hematuria and was scheduled for a surgical procedure, so she thought the medications were held for that reason. RN #2 identified she didn't question the medication hold and did not tell the Nursing Supervisor. Interview with the ADON on 10/8/2024 at 12:30 pm identified the APRN or physician should have been notified as soon the held meds were identified on two (2) occasions, 9/16/24 and 9/24/24, to obtain new orders. The Admission/Re-Admission policy identified: A medication reconciliation will be completed in the electronic health record, by the licensed nurse. Orders are resolved with the attending healthcare provider when validating admission/re-admission orders

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41682 Based on clinical record reviews, facility documentation, facility policy, and interviews for one (1) of three (3) sampled residents (Resident #4) who were reviewed for an allegation of abuse, the facility failed to ensure appropriate supervision, for a resident on one-to-one (1:1) supervision due to aggressive and sexual behaviors, to prevent the resident from having inappropriate physical contact with another resident. The findings include: Resident #3's diagnoses included dementia with behavior disturbances, frontotemporal neurocognitive disorder, myocardial infarction, and antisocial personality disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had short-and long-term memory recall deficits, made poor decisions regarding tasks of daily life, had verbal behavioral symptoms towards others, and was independent for mobility utilizing a wheelchair. The Resident Care Plan dated 7/26/24 identified Resident #3 has mood and behavior patterns including verbal expressions of distress and/or persistent anger toward self or others. Interventions directed to initiate one to one (1:1) supervision when the resident was out of bed, psych follow-ups as needed, medicate as ordered, assess, monitor and document responses, and attempt to identify sources of anxiety and help to resolve where appropriate. Resident #4's diagnoses included dementia with behavioral disturbances, persistent depressive disorder, and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had short-and long-term memory recall deficits, made poor decisions regarding tasks of daily life, and was independent for mobility utilizing a walker or wheelchair. The Resident Care Plan dated 8/18/24 identified Resident #4 had mood and behavior patterns. Interventions directed to use a calm and gentle approach, encourage the resident to cooperate, praise all cooperation, attempt to identify sources of anxiety and help to resolve where appropriate, and encourage participating in activities of interest as a form of diversion to reduce anxiety. The Facility Reported Incident form dated 6/21/24 at 3:30 PM identified Resident #3 was sitting next to another resident in their wheelchairs conversing with each other in the corridor near the social worker's office when staff witnessed Resident #3 tug on the bottom of the resident's shirt, no body contact was made. The report indicated the corrective action plan to prevent reoccurrence was Resident #3 was immediately placed on one to one (1:1) supervision, without a known end date. A physician's order dated 6/22/24 directed to provide one to one (1:1) supervision when Resident #3 was out of bed and going in/out of the building. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident form dated 9/18/24 at 1:40 PM identified Resident #4 had self-propelled his/her wheelchair to the reception area and was sitting in front of the reception desk. Resident #3 was self-propelling toward the reception area in his/her wheelchair, as Resident #3 passed by Resident #4, Resident #3 asked Resident #4 twice what time it was and Resident #3 then unexpectantly, without warning, reached out and touched Resident #4's private chest area over his/her clothing. The report indicated the staff immediately separated the residents and notified the Nursing Supervisor and Assistant Director of Nursing (ADON). The report identified Resident #4 was not in distress and did not recall the event, a body audit was performed on Resident #4 with no findings, and Resident #3 returned to his/her room with continued one to one (1:1) supervision in place. In a written statement by the 7AM-3PM nurse aide, Nurse Aide (NA) #2, on 9/18/24 she identified she was walking behind Resident #3, when Resident #3 stopped and asked Resident #4 what the time was. NA #2 indicated shortly after, Resident #3 placed his/her left hand on Resident #4's private chest area, the receptionist verbalized to Resident #3 that action wasn't appropriate, and Resident #3 continued to go outside after the event. Interview with the Administrative Assistant on 10/8/24 at 10:25 AM identified on 9/18/24, she was at the front office desk, when Resident #3 and Resident #4 crossed paths in the reception area. The Administrative Assistant stated Resident #3 was accompanied by NA #2, and Resident #3 began to ask Resident #4 what the time was, which Resident #4 answered appropriately. Resident #3 continued to respond huh/what? as if he/she couldn't hear Resident #4 and moved closer to Resident #4 and suddenly, Resident #3 grabbed Resident #4's private chest area. Interview with the ADON on 10/8/2024 at 12:15 PM identified Resident #3 was on one to one (1:1) supervision for sexual and physical behaviors. The ADON indicated that on 9/18/24, Resident #3 approached Resident #4 at the reception area, asking what time of the day it was. Resident #3 was not able to hear Resident #4's response and continued to repeat the question, at that time, Resident #3 suddenly inappropriately grabbed Resident #4, and the residents were separated immediately. The ADON identified after the investigation was completed, the facility substantiated the event as an abuse, and Resident #4 was not harmed in the event. The ADON identified the plan of correction included continued one to one monitoring for Resident #3 and every 15-minute checks while in bed and to keep Resident #3 within arm's length away from female residents. Although attempted, interview with NA #2 was unable to be obtained. Review of facility Abuse Procedures and Policy dated 12/2023 identified it is the policy of the facility that each resident has the right to be free from abuse, neglect, and misappropriation of resident property and exploitation. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse includes but is not limited to sexual harassment, sexual coercion, or sexual assault.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for transfer to the Emergency Department, the facility failed to ensure the residents' medication regimen was accurately reconciled after returning from the hospital to prevent the omission of medications for eleven (11) days. The findings include: Resident #1's diagnoses included diabetes, cardiac infarction, atrial fibrillation and neuromuscular dysfunction of the bladder, and pain related to immobility. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 made reasonable and consistent decisions regarding tasks of daily life. The Resident Care Plan dated 9/3/24 identified altered cardiac status related to congestive heart failure and heart attack, neurological bladder with indwelling foley and pain related to decreased mobility. The nurse's note dated 9/15/24 at 11:55 AM identified Resident #1 was having hallucination, was pale in color, blood was noted in the urine, Resident #1 had a low blood pressure of 96/52, the Advanced Practice Registered Nurse was notified, and Resident #1 was sent to the hospital. The hospital discharge summary 9/15/2024 identified no changes to prehospital medication orders Keflex (antibiotic) was ordered for a urinary infection, was identified to be the only new medication ordered. The nurse's note dated 9/15/24 at 7:37 PM identified Resident #1 returned from the Emergency Department around 6:40 PM with a new order for Keflex, to encourage oral fluids for hydration, and the medication orders were verified with the Advanced Practice Registered Nurse. The hospital discharge medication instructions dated 9/15/24 directed to administer Albuterol every six (6) hours as needed, Amiodarone 200 milligrams (mg) daily, Eliquis 5 mg, Vitamin C, Aspirin 81 mg daily, Atorvastatin 30 mg daily, Baclofen 10 mg three (3) times a day, Bisacodyl suppository as needed, Carvedilol 3.125 every twelve (12) hours, Famotidine 20 mg, Insulin (NovoLog) sliding scale, Insulin detemir per glucose results, Lactulose 30 milliliters (ml) as needed, Lorazepam 1 mg, Methenamine 1 gram, Oxybutynin 5 mg three (3) times a day, MiraLAX 17 gram daily, Entresto 24-26 mg every twelve (12) hours, and Pericolace two (2) tablets at bedtime. The nurses note dated 9/27/24 at 1:54 PM identified that on 9/15/24 after being transferred back to the facility from the hospital the second page of the medication orders were not resumed therefore, the medications were omitted for a total of eleven (11) days. The medications omitted included the Baclofen 10 mg three (3) times a day, Lactulose 30 ml as needed, Eliquis 5 mg twice a day, Atorvastatin 80 mg at bedtime, Amiodarone 200 mg daily, and Oxybutynin 5 mg three (3) times a day, the Advanced Practice Registered Nurse was notified, and labs were ordered. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 9/27/24 identified medications that had not been transcribed and were held on hold for eleven (11) days. The medications reordered included: Amiodarone (a heart medicine) 200 mg daily, Apixaban (Eliquis a blood thinner) 5 mg give one (1) tablet every twelve (12) hours, Atorvastatin (for high cholesterol) Calcium 80 mg at bedtime, Baclofen (a muscle relaxant) 10 mg three (3) times a day, Lactulose(for constipation) 20 GM/30ML give 30ML as needed for constipation, Oxybutynin (a bladder relaxant) and Chloride tablet 5 mg give three (3) times a day. Interview with Advanced Practice Registered Nurse (APRN) #1 on 10/8/24 at 11:20 AM identified when a resident is transferred to an acute care facility the Nursing Supervisor places the medications on hold, if the resident returns in less than twenty-four (24) hours, and there are no changes in medications, the nurse (any nurse) can remove the hold and resume the medications as ordered. APRN #1 stated if the resident returns in less than twenty-four (24) hours and if myself or another APRN are in the building, generally the nurses will give the discharge paperwork to the APRN to review, and we will resume the medications, ideally this should be done within one (1) to two (2) hours of the resident returning. The APRN indicated she was at the facility when it was discovered that some of Resident #1's medications were still on hold, labs were ordered, she discussed the incident with the attending physician and the medications were ordered with no significant injury to the resident. Interview with the Assistant Director of Nursing (ADON) on 10/8/24 at 11:30 AM identified when a resident is transferred to an acute care facility the Nursing Supervisor places the medications on hold, if the resident is transferred back to the facility in less than twenty-four (24) hours, and there are no changes in medications, the nurse (any nurse) can remove the hold and resume the medications as ordered and if there are changes to the medications the APRN or on-call physician would need to verify the changes. The ADON identified she noted the nurse on duty 9/15/24 was unaware there were two (2) pages of medications, and only resumed some of the medications, each page had to be individually activated or resumed. Interview with 11PM-7AM charge nurse, Registered Nurse (RN) #2, on 10/8/24 at 12:15 PM identified the Supervisor usually resumes the medications when a resident returns to the facility and on 9/16/24 she noticed that some of Resident #1's medications were still on hold. RN #2 indicated she knew Resident #1 was scheduled for a surgical procedure, so she thought the medications were held for that reason. RN #2 identified she didn't question it and did not tell the Nursing Supervisor. The Admission/Re-Admission policy identified: A medication reconciliation will be completed in the electronic health record, by the licensed nurse. Orders are resolved with the attending healthcare provider when validating admission/re-admission orders