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	10/30/2024

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 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** 41223 Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed ensure the resident was free from neglect and care was provided timely. The findings include: Resident #1 was admitted with diagnoses that included a stroke with hemiplegia/hemiparesis (weakness/loss of movement) affecting the right dominant side. A quarterly MDs assessment dated [DATE] identified Resident #1 BIMs was 99, indicating Resident #1 was severely cognitively impaired and could not complete the interview, and Resident #1 did not speak, rarely understood verbal content and had highly impaired vision. Resident #1 was at risk for pressure ulcers, was incontinent, was dependent for all care, required two (2) staff for bed mobility and transfers. The RCP dated 8/12/2024 identified Resident #1 was incontinent of bowel and bladder. The RCP directed to provide incontinent care every two (2) to three (3) hours and use of incontinent briefs. A facility incident report dated 10/21/2024 identified an event of neglect: on 10/21/2024 at 4:00 PM. The report indicated Resident #1 was aphasic (unable to speak), and required total care for ADLs, and it was observed that Resident #1's bed linen had a yellow dried ring under the resident's buttocks. Incontinent care was not provided for two (2) hours beyond the care planned time frame and NA #1 was suspended pending investigation. A facility event summary dated 10/25/2024 identified there were no known negative effects due to extended hours of before incontinent care was provided (beyond what was care planned). Resident #1's skin was intact without maceration, redness or open areas. Resident #1 was bathed and showered after the event was discovered. The summary indicated NA #1 was new to the facility and new to a long-term care setting, there was no intent, and education was provided for NA #1. RN #1's written statement dated 10/21/2024 identified at approximately 4 PM she observed Resident #1 lying in bed and the drawsheet was stained with a dry yellow ring under his/her buttocks, and the brief was soiled but drying, and was wearing two (2) briefs. Incontinent care was not provided in a timely manner. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER: Beacon Brook Center for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 89 Wied Drive, Naugatuck, CT 06770	

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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	NA #1 written statement dated 10/21/2024 identified care was NA #1 provided personal care at 11 AM and placed one (1) brief under and one (1) brief over Resident #1. The statement further indicated although she repositioned Resident #1 after 11 AM, NA #1 was unsuccessful providing future care (during the shift) due to Resident #1 was resisting and she was struggling to complete her assignment. Statement review identified NA #1 did not provide care between 11 AM and 3 PM. Interview with RN #1 on 10/30/2024 at 11:33 PM identified she was the nursing supervisor on 10/21/2024 when about 4:00 PM, Resident #1's visitor (Person #1) requested her to look at Resident #1. RN #1 stated the draw sheet under Resident #1 had a large yellow ring, there were two (2) briefs both saturated with urine in place and Resident #1's clothing appeared dry without stains. Resident #1's skin had no open areas or visible redness, she immediately notified the DON and asked NA #3 to provide care (5 hours after incontinent care was provided by NA #1). She identified that incontinent residents should be provided incontinence care every two (2) hours. Interview with NA #1 on 10/31/2024 at 10:30 AM identified she was assigned Resident #1 on 10/21/2024 and was the only NA on that wing of the unit. NA #1 stated she had not worked in long-term care previously, had recently ended her orientation and had not worked with the residents on that unit. NA #1 stated she knew Resident #1 required two (2) staff for care, and needed to be repositioned and checked for incontinence every two (2) hours. NA #1 identified that she provided care at 11 AM by herself as she could not find any other available staff to assist her, so she did not get Resident #1 out of bed as per his/her routine. She continued that she attempted to turn and position Resident #1 every two (2) hours but could only turn him/her slightly to the side to tuck a pillow under him/her because she did not have a second staff to assist, and she did not check each time for incontinence. NA #1 stated went over to the other side of the unit to ask for help, but everyone seemed very busy, and she did not notify the nurse (LPN #2). Interview with LPN #2 on 10/30/2024 at 12:30 PM identified she was the charge nurse on 10/21/2024 on the day shift and she was not aware Resident #1 did not receive care timely. LPN #2 stated she was not notified that NA #1 was unable to provide the care timely and there other NAs available that NA #1 could have also asked for help. Interview with the DON on 10/30/2024 at 1:50 PM identified that she expected the staff to provide every two (2) hour incontinence care for dependent residents. NA #1 identified she provided incontinent care for Resident #1 on 10/21/2024 at 11:00 AM but did not provide any additional incontinence care for the remainder of her shift (4 hours from 11 AM to 3 PM) on 10/21/2024. The DON stated NA #1 was off orientation and the workload that day was too much for NA #1, and she fell behind. The DON stated NA #1 should have asked for help, and she was unable to explain why NA #1 did not ask for help or let other staff know that she could not complete her assignment. Further, LPN #1 should have checked in or followed up with NA #1 to ensure care was provided timely. Subsequent to the incident, NA #1 was provided with additional orientation time. The facility policy Abuse dated 12/2023 directed in part, that all residents have the right to be free from abuse and neglect. Neglect is defined as the failure of the facility its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. (continued on next page)

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Beacon Brook Center for Health & Rehabilitation	89 Wied Drive Naugatuck, CT 06770

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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	Facility documentation review identified staff education was initiated on 10/21/2024 and included providing personal care and incontinent care timely and to report refusals of care to the nurse. Random audits were initiated on 10/21/2024 and a QAPI meeting was held on 10/24/2024. Based on review of facility documentation, past non-compliance was identified.

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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** 41223 Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure care was provided in accordance with physician orders and failed to ensure the NA reported when she could not provide care timely, resulting in a delay in care. The findings include: Resident #1 was admitted with diagnoses that included a stroke with hemiplegia/hemiparesis (weakness/loss of movement) affecting the right dominant side. A quarterly MDs assessment dated [DATE] identified Resident #1 BIMs was 99, indicating Resident #1 was severely cognitively impaired and could not complete the interview, and Resident #1 did not speak, rarely understood verbal content and had highly impaired vision. Resident #1 was at risk for pressure ulcers, was incontinent, was dependent for all care, required two (2) staff for bed mobility and transfers. The RCP dated 8/12/2024 identified Resident #1 was incontinent of bowel and bladder. The RCP directed to provide incontinent care every two (2) to three (3) hours and use of incontinent briefs. A physician order dated 10/8/2024 directed activities of daily living (ADL) assist of two for all ADL care. A facility incident report dated 10/21/2024 identified Resident #1 was aphasic (unable to speak), required total care for ADLs, and was observed that Resident #1's bed linen had a yellow dried ring under the resident's buttocks. Incontinent care was not provided for two (2) hours beyond the care planned time frame and NA #1 was suspended pending investigation. RN #1's written statement dated 10/21/2024 identified she observed Resident #1 lying in bed and the drawsheet was stained with a dry yellow ring under his/her buttocks, and the brief was soiled but drying, and was wearing two (2) briefs. Incontinent care was not provided in a timely manner. NA #1 written statement dated 10/21/2024 identified care was NA #1 provided personal care at 11 AM and placed one (1) brief under and one (1) brief over Resident #1. The statement further indicated although she repositioned Resident #1 after 11 AM, NA #1 was unsuccessful providing future care (during the shift) due to Resident #1 was resisting and she was struggling to complete her assignment. Statement review identified NA #1 did not provide care between 11 AM and 3 PM. Interview with RN #1 on 10/30/2024 at 11:33 PM identified she was the nursing supervisor on 10/21/2024 when about 4:00 PM, Resident #1's visitor (Person #1) requested her to look at Resident #1. RN #1 stated the draw sheet under Resident #1 had a large yellow ring, there were two (2) briefs both saturated with urine in place and Resident #1's clothing appeared dry without stains. Resident #1's skin had no open areas or visible redness, she immediately notified the DON and asked NA #3 to provide care (5 hours after incontinent care was provided by NA #1). She identified that incontinent residents should be provided incontinence care every two (2) hours. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 10/31/2024 at 10:30 AM identified she was assigned Resident #1 on 10/21/2024 and was the only NA on that wing of the unit. NA #1 stated she had not worked in long-term care previously, had recently ended her orientation and had not worked with the residents on that unit. NA #1 stated she knew Resident #1 required two (2) staff for care and needed to be repositioned. NA #1 identified that she provided care at 11 AM by herself as she could not find any other available staff to assist her, so she did not get Resident #1 out of bed as per his/her routine. She continued that she attempted to turn and position Resident #1 every two (2) hours but could only turn him/her slightly to the side to tuck a pillow under him/her because she did not have a second staff to assist, and she did not check Resident #1 for incontinence each time she tucked a pillow under the resident. NA #1 stated went over to the other side of the unit to ask for help, but everyone seemed very busy so she did not ask, and she did not notify the nurse (LPN #2). Interview with LPN #2 on 10/30/2024 at 12:30 PM identified she was the charge nurse on 10/21/2024 on the day shift and gave NA #1 her assignment at the beginning of the shift. LPN #2 stated she was not aware Resident #1 did not receive care timely after 11 AM (four hours). LPN #2 stated she was not notified that NA #1 was unable to provide the care timely and there other NAs available that NA #1 could have also asked for help to ensure two (2) staff provided care as ordered. Interview with the DON on 10/30/2024 at 1:50 PM identified that she expected staff to provide care as ordered and per the resident plan of care. The DON stated NA #1 was newly off her orientation and the workload was too much for NA #1. The DON stated NA #1 should have asked for help from a second NA to provide care (as ordered) and NA #1 should have notified the nurse that she was not able to provide the care. The DON indicated she did not know why NA #1 did not ask for help or let other staff know that she could not complete her assignment, and she should have notified someone to ensure care could be provided timely. The facility policy Activity of Daily living (ADLs) dated 6/2023 directed in part, to provide assistance to complete ADL activities per the person-centered evaluation and plan for care. Facility documentation review identified staff education was initiated on 10/21/2024 and included providing personal care and incontinent care timely and to report refusals of care to the nurse. Random audits were initiated on 10/21/2024 and a QAPI meeting was held on 10/24/2024. Although review identified education was provided, review failed to identify education and audits were completed regarding notification when staff are unable to provide care time or get a resident out of bed, and to ensure the required number of staff provide care in accordance with physician orders and the plan of care. Based on documentation review, past non-compliance was not identified.