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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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** 46046 Based on review of the clinical record interviews and facility policy for 1 of 1 resident (Resident #268) reviewed for change in condition , the facility failed to ensure staff notified the physician and the responsible party when the resident experienced a change in condition and for 1 of 3 residents (Resident #418) reviewed for pressure ulcers, the facility failed to notify physician when a treatments were not provided. The findings included: 1. Resident # 268's diagnoses included Cerebral infarction, aphasia following cerebral infarction, dysphagia, and atrial fibrillation. A physician's order dated 12/2/2022 directed Eliquis (Anticoagulant) 5 Milligrams (MG) tablet orally twice daily for a Deep Vein Thrombosis (blood clot) of the left lower extremity for 12 weeks. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #268 was cognitively intact. The care plan dated 12/15/2022 indicated Resident #268 had a diagnosis of Atrial Fibrillation with interventions to provide medications as ordered and look for signs of atrial fibrillation. A nursing progress noted dated 12/26/2022 at 2:06 PM indicated Resident #268 stated his/her speech was a little off that morning no facial droop, hand grasp firm and the resident was able to communicate effectively with no complaints of pain or headache. The nursing supervisor was made aware of the concerns of the resident. A nursing progress note labeled late entry dated 12/26/2022 at 2:39 PM indicated Resident #268 stated s/he did not want to go to the hospital. A nursing progress note labeled Late entry dated 12/26/2022 at 3:02 PM written by the nursing supervisor indicated at approximately 1:00 PM a Nurse's Aide (NA) assigned to Resident #268 reported the resident had indicated s/he was feeling funning in the morning. The resident was assessed and noted with bilateral hand grasps equal, able to smile, raise eyebrows, and stick out tongue without unilateral weakness, no complaints of chest pain or shortness of breath. However, the resident had difficulty finding words and Resident #268 had verbalized not wanting to go to the hospital. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An SBAR Communication Form and progress note dated 12/26/22 at 5:15 PM identified Resident # 268 was observed with a left sided mouth droop, speech slightly affected and Resident #268 indicated feeling something occurring earlier in the morning at 6:00 AM. The SBAR form further indicated the Advanced Practice Registered Nurse (APRN) was notified and the resident transfer to the emergency room . A nursing progress note dated 12/26/2022 at 5:00 PM and 6:00 PM indicated temperature was 97.0 (normal range), pulse 79 (normal range), and respiration 20 with an oxygen saturation of 95% on room air (both normal range). The note further indicated when the writer (charge nurse) entered the room Resident #268 spoke and the left side of the mouth drooped with voice slurred. Resident # 268 was able to understand words and stated s/he did not want to go to the hospital. The progress note further indicated reporting resident condition to the supervisor immediately. The nurse told the resident in presence of a family member s/he should go to the hospital to be evaluated and Resident # 268 agreed to go to the hospital. 911 was called and the resident was transferred to an acute care facility at approximately 5:25 PM. The hospital discharge summary dated 12/27/2024 at 5:41 PM indicated a discharge diagnosis of right frontal lobe acute lacunar infarct and a 5 mm left middle cerebral aneurysm, history of a stroke. A consult with the neurologist indicated not a candidate for thrombolytics given current status of anticoagulation with Eliquis. The discharge summary further indicated the facial droop resolved, able to move all extremities, no focal neurological deficit with a plan was to discharge resident back to the facility in stable condition. On 2/2/2024 a Duplex scan of the left lower extremity indicated extensive clot formation noted elsewhere throughout the deep venous system with impression of extensive Deep Vein Thrombosis (DVT). A telephone interview with Licensed Practical Nurse (LPN#12)on 4/15/2024 at 11:25 AM indicated s/he could not recall any complaints by Resident #268 were made on her/his shift. A telephone interview on 4/15/2024 at 11:26 AM with LPN #11 indicated no concerns were voiced by Resident #268 on the 11-7 AM shift on 12/26/2023. An interview and record review with RN Supervisor RN #4 indicated Resident #268 had indicated s/he was feeling funny at about 1:00PM which was not usual for the resident. RN #4 further indicated per the progress note written regarding the 1:00 PM notification his/her assessment did not reveal a change in condition even though the note indicated the resident not wanting to go to the hospital. An interview and review of the progress notes 12/26/2024 10:10 AM on 4/15 2024 at 2:10 PM with LPN #3 indicated s/he believed Resident #268 had told the Nurse Aide about feeling funning in the afternoon when care was provided care. LPN # 3 indicated s/he spoke with the resident who appeared fine and notified the RN supervisor but cannot recall if the RN supervisor went in at that time to assess Resident # 268. S/he checked on the resident at 2:00 PM and Resident # 268 was his/her normal self and asked the resident if s/he wanted to go to the hospital to be evaluate and the resident said no. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/2024 at 2:45 PM a telephone interview with LPN #7 indicated remembers the shift well worked on the other unit on the same floor 7-3 PM shift and indicated NA#2 from 7-3 PM shift came to him/her and the charge nurse on unit LPN #13, and indicated he/she noted a difference in the resident earlier in the day but the charge nurse said nothing was wrong. LPN #7 indicated s/he visually noticed a facial droop on Resident #268 which was not usual so s/he reported to RN#4 supervisor. RN #4 and the charge nurse LPN #13 discussed assessing the resident. A telephone interview with NA#3 who worked the 7-3 PM shift on 12/26/2024 indicated Resident #268 was fine and made no complaints. The resident seemed usual self and indicated NA #2 was usually assigned to Resident #268. A telephone interview on 4/15/2024 at 2:30 PM with NA #2 indicated noticing Resident #268's speech was off and s/he reported to the charge nurse (LPN #13) and nursing supervisor RN #4 who went in to see the resident and discussed also talking with the other charge nurse LPN #5 as the Charge Nurse (LPN #13) was new employee. NA #2 further indicated checking on Resident #268 frequently as she knew there was something wrong and around 12:00 PM Resident #268 had trouble finding words and slight facial droop and reported having a headache which NA # 2 reported to the supervisor who indicated Resident #268 may just have been tired. NA#2 further indicated s/he had not notiifed the DNS about her/his concern when s/he felt a change was not being addressed but did give a statement at later date. NA # 2 indicated the DNS told her/him to call the DNS in the future if s/he has a concern and thought in-servicing may have been done on the matter. Although attempts were made to contact LPN #13 via telephone on 4/15/2024 at 2:06 PM the attempts were unsuccessful. An interview and record review with RN #4 on 4/16/2024 at 9:54 AM indicated even though Resident #268 had word fining trouble s/he did not notify the physician and did not recall if any other staff member indicated this was change from the resident's usual baseline. RN #4 indicated his/her assessment found Resident #268 more or less at his/her baseline even though there was word finding difficulty. Interview with the DNS on 4/16/2024 at 10:05 AM indicated based on the note written by RN#4 at 15:02 that refers to 1:00 PM note on the day in question s/he would expect a family member and the physician to be contacted. Interview via telephone on 4/16/2024 at 4:23 PM with MD #4 indicated He/she would have expected the supervisor upon noticing word fining difficulty to have notified the APRN or the physician. MD # 4 also indicated it was difficult to say if there was a delay in sending Resident #268 to the hospital (4.5 hours after the word fining difficulty) would have had a better outcome due to Resident #268's overall condition and the resident was not a candidate for anticoagulation/thrombolytics in the hospital. On 4/16/2024 at 12:00 PM an interview and review of a facility document in-service attendance sheet dated 12/22 (the actual day left blank) with Target Group RN/LPN labeled Family Notification with only RN #4 in attendance and the content indicated families as part of the facility's team should be updated with health changes including resident's responsible for themselves if alert and oriented. The DNS further indicated he/she had thought the physician was notified after the 1:00 PM findings but seen now the physician had not be notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Condition: Significant Change indicted in part staff will communicated with the physician, resident and family regarding changes in condition to provide timely communication of resident status changes which is essential to quality care management. 2. Resident #418 was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, traumatic spinal cord dysfunction, and paraplegia (paralysis of the legs and lower body). The quarterly Mininum Data Set (MDS) assessment dated [DATE] identified Resident #418 required extensive assistance from at least two people for bed mobility and transfers. Additionally, the MDS identified Resident #418 had two stage 3 pressure ulcers. a.A care plan dated 6/29/22 identified Resident #418 had two stage 3 pressure ulcers to the right and left buttocks. Interventions included a low air loss mattress, turning and positioning every 2 hours, and providing treatments as ordered. The physician's orders dated 6/17/22 with start date 6/18/22 directed wound vac to right and left buttock bridge to one another , 125MMHG continous change dressing Tuesday, Thursday and Saturday every day shift. The physician's orders dated 6/27/22 with start date 7/27/22 directed wound vac to right and left buttock bridge to one another , 125MMHG continous change dressing Tuesday, Thursday and Saturday every day shift. The physician's orders dated 7/26/22 through 8/31/22 directed right buttocks cleanse with 1/4 Dakins solution followed by silver alginate f/b silicone dressing every day and when needed . Wound observations during survey b.The physician's orders dated 6/17/22 directed skin prep to heels twice a day for 14 days every day and evening shift until 7/1/22. The physician's order 6/17/22 through 7/27/22 directed offload heels every shift as tolerated. A wound physician progress note dated 8/2/22 identified a new wound on the left heel. The wound was described as a deep tissue pressure injury with a maroon or purple discoloration. The wound measured 0.5 CM in length x 0.5 CM in width x 0.0 CM depth and noted no drainage. New recommendations for treatment directed the application of skin prep, application of an abdominal pad dressing, and application of a rolled gauze dressing daily and when needed. A nursing pressure injury evaluation dated 8/3/22 indicated an initial evaluation for a left heel unstageable pressure ulcer with a healthy wound edge and no drainage. The size of the wound was 0.5 CM L x 0.8 CM W x 0 CM D. The nursing evaluation further indicated the physician was notified and treatment orders included daily and as-needed dressing changes with skin prep, an abdominal pad dressing, and a kerlix (rolled gauze) dressing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 8/3/22 identified a left heel pressure injury was evaluated by a wound specialist and a wound treatment order was obtained which directed the application of skin prep and a kerlix dressing daily and keeping the resident's heels offloaded. No further nursing progress notes were identified in the medical record that indicated additional dressing changes were performed after (what date) A wound physician progress note dated 8/9/22 identified a left heel pressure injury was reclassified as a stage 2 pressure ulcer. The wound physician's progress notes further identified the wound as deteriorating. The wound had a moderate amount of sero-sanguineous drainage and measured 0.5 CM L x 0.5 CM W x 0. 1 CM D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, application of alginate with silver, and application of a bordered foam dressing. A nursing pressure injury evaluation dated 8/9/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with a healthy wound edge and a moderate amount of serosanguineous drainage. The size of the wound was 0.5 CM L x 0.5 CM W x 0.1 CM D. No nursing progress note was identified in the medical record indicated a new order for a left heel dressing change was obtained or that a dressing change was performed. (for how long). A wound physician progress note dated 8/16/22 identified a left heel stage 2 pressure ulcer was overall stable with a moderate amount of sero-sanguineous drainage and measured 0.5 CM L x 0.5 CM W x 0.1 CM D. New recommendations for treatment included daily and as needed dressing changes with Dakin's 1/4 strength, application of alginate, application of Medihoney, and application of a bordered foam dressing. A nursing pressure injury evaluation dated 8/16/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with healthy wound edge and no drainage. The size of the wound was 0.5 CM L x 0.5 CM W x 0.1 CM D. No nursing progress note was identified in the medical record which indicated a new order for a left heel dressing change was obtained or that a dressing change was performed (how long) A physician's order dated 8/22/22 directed the application of silver alginate with a silicone dressing to the left heel daily and as needed. The order was noted to have been subsequently discontinued on 8/23/22. (Who discontinued the order and why) A wound physician progress note dated 8/23/22 identified a left heel stage 2 pressure ulcer with increased drainage and maceration that measured 2.0 CM L x 2.0 CM W x 0.1 cm D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, application of Santyl, application of alginate dressing, and application of a bordered foam dressing. Additionally, the wound physician's progress note identified the wound was deteriorating and indicated facility staff were educated on proper dressing changes. A nursing pressure injury evaluation dated 8/23/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with an unhealthy wound edge and with moderate sero-sanguineous drainage. The size of the wound was 2.0 cm L x 2.0 cm W x 0.1 cm D. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 8/28/22 indicated a left heel dressing was changed as ordered . A review of physician orders from 7/15/22 through 8/22/22 identified active orders that directed the offloading of the residents' heels and the use of a low air loss mattress. The review of physician's orders from 7/15/22 through 8/22/22 failed to identify orders for dressing changes to the left heel pressure ulcer (Is this accurate given wound consult and progress notes with treatment . The first identified treatment order for the left heel was dated 8/22/22, 20 days after the left heel pressure ulcer was discovered and recommendations made by the wound specialist. A review of the Treatment Administration Record (TAR) and the Medication Administration Record (MAR) from 8/1/22 through 8/30/22 failed to identify that a daily left heel dressing change was performed by staff from 8/2/22 through 8/23/22. The first documented dressing to the left heel pressure ulcer was on 8/24/22 with Santyl, calcium alginate, and a silicone dressing, 22 days after the left heel pressure ulcer was discovered and initial recommendations made by the wound specialist. A review of nursing progress notes from 8/1/22 through 8/30/22 failed to identify daily left heel dressing change were performed from 8/2/22 to 8/23/22. On 4/16/24 at 2:39 PM, an interview and record review with the wound nurse (RN#1) failed to identify orders or treatment administration records for Resident #418's left heel pressure ulcer prior to 8/22/22. Additionally, RN#1 indicated she rounds with the wound physician and transcribes orders into the computer from the physician's recommendations and progress notes. However, she indicated that she was not the wound nurse at the facility in August of 2022. On 4/17/24 at 11:32 AM, an interview and record review with the DNS failed to identify dressing change orders for the left heel pressure ulcer from 8/2/22 through 8/22/23. The DNS indicated RN#1 had trained Registered Nurse (RN#7) as the wound nurse and RN#7 was the wound nurse during August of 2022. The DNS indicated that she would have expected the process would remain the same, where the wound nurse would round with the wound physician and transcribe orders from the physician's notes and recommendations. Additionally, the DNS was able to provide the names and dates of some staff members who provided care to Resident # 418 between 8/2/22 and 8/22/22. On 4/17/24 at 12:19 PM, an interview with LPN#4 who provided care to Resident #418 on 8/3, 8/4, 8/13, 8/14, 8/17, and 8/18/22 indicated she remembered the resident but did not recall the resident's wounds or treatments involved. LPN#4 indicated she would use the physician's orders in the electronic medical record and the TAR to determine what treatments to perform for a specific resident. On 4/17/24 at 12:21 PM, an interview with LPN#1, who took care of Resident# 418 on 8/1, 8/2, 8/10, 8/11, 8/15, and 8/19/22, identified s/he did not recall the resident. LPN#1 identified the TAR would indicate to her what treatments need to be performed for a specific resident. Additionally, LPN#1 indicated she would usually go to the wound nurse if she had any questions regarding wound care for a resident. On 4/17/24 at 12:39 PM an interview with LPN#9 indicated she did not recall the resident. LPN#9 indicated she performs some dressing changes in the evening shift and she would look at the physician orders and the TAR to determine what treatments to provide. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 1:50 PM, an interview and record review with the wound specialist (MD#3) identified wound specialist progress notes are recommendations and the facility is responsible for accepting those recommendations and transcribing orders into the electronic medical records. MD#3 was not involved in the resident's care in August of 2022, and MD#3 could not definitively identify the lack of dressing changes to the left heel caused further breakdown of the pressure ulcer but indicated not following the recommended treatment could have been a contributing factor to further skin breakdown. A review of the facility policy for Prevention and Management of Pressure Injuries indicated that wound treatments are done per provider orders and that the determination for the need of a dressing for stage 1 and stage 2 pressure ulcers are based on the individual provider's clinical judgement. 48880

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on interview, review of facility grievance file for 1 of 2 residents (Resident #74) reviewed for dignity, the facility failed to ensure a residents grievance was addressed timely. The findings include: Resident #74's diagnoses included neuromuscular disfunction of the bladder and diabetes mellitus The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #74 was cognitively intact. The Resident Care Plan (RCP) dated 3/4/2024 indicated ADL deficit related to generalized weakness and a neuromuscular condition with lower extremity weakness. Intervention included : to keep the call bell and needed items within reach and to provide assistance and or cueing to maximize current level of function. 0n 4/11/24 at 1:05 PM the Director of Nursing Services (DNS) was updated regarding allegations Resident #74 made regarding change of shift noise at 7:00 AM on the unit and a 3-11 PM staff member (not identified) was not answering the call light timely. The DNS indicated s/he would look into the matter. An interview with the DNS on 4/16/24 at 1:30 PM indicated s/he completed a grievance regarding the noise level and discussed the concern with Resident #74 and Staff Development was going to in-service staff. Resident #74 was unable to identify the nurse aide but the DNS recalls speaking to the nurse aide assigned to Resident #74 on the day in question. However the DNS was unable to provide evidence of the follow up with staff and would check with staff development. On 4/17/24 at 9:25 AM an interview and facility document review with the DNS indicated the grievance completed by the facility only addressed the concern made about the noise level on 7:00 AM but not the timely call bell. A second request for the documentation for addressing timely call bells were requested by was not provided.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #92) reviewed for Preadmission Screening and Resident Reviews (PASRR), the facility failed to ensure a resident had a PASRR II or Level of Care re-screen completed upon admission to the facility. The findings include: Resident #92 was admitted to the facility on [DATE] with diagnoses that included a cerebral infarction, dementia, anxiety disorder, and depressive disorder. The Notice of Care Determination dated 7/7/22 identified Resident #92 was approved for long term care based on the submission data which included the following diagnoses: cerebral infarction, atrial fibrillation, hypertensive encephalopathy, transient ischemic attack, irritable bowel syndrome, head laceration, sequela, leukemoid reaction, headache syndrome, nausea, anxiety disorder, depressive episodes, and heart failure. The Inter-Agency Patient Referral report date 8/7/23 identified Resident #92's pertinent history (including diagnosis, mental and behavioral health history, and surgical history) included delusional disorder, suicidal ideations, and dementia with an unspecified severity and other behavioral disturbances. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #92 had severely impaired cognition, was not considered by the state level 2 PASRR process to have a serious mental illness or related condition. The MDS further identified Resident #92 had active diagnoses that included non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder, and suicidal ideations and had taken medications from the following pharmacological classifications during the last 7 days: antipsychotic, antianxiety, and antidepressant. The care plan dated 8/22 identified Resident #92 uses psychotropic medications. Interventions included administering psychotropic medications as ordered by the physician, monitor, document and report adverse reactions, and monitor/record target behavior symptoms. Interview and clinical record review with the Director of Social Services (SW #1) on 4/15/24 at 11:03 AM identified Resident #92 was transferred from another long-term care (LTC) facility with long-term care approval, based on the level of care determination dated 7/7/22. SW #1 further identified Resident #92 was new to her care and at the time of his/her admission to the facility, Resident #92 was under the care of the prior Director of Social Services, who no longer works at the facility. SW #1 indicated she was unaware that Resident #92 had a history of suicidal ideation or a delusional disorder. SW #1 identified she would have to review the psychiatric evaluation notes further to identify if the delusional disorder was a result of medication side effects or a new psychiatric diagnosis. SW #1 indicated that she would have expected another level of care determination to be submitted once Resident #92 was identified as having suicidal ideations, upon admission to this facility by the social worker assigned to his/her care after reviewing his/her mental and behavioral health diagnoses. SW #1 further indicated she would resubmit a level of care evaluation, to include Resident #92's history of having suicidal ideations. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The state PASRR and Level of Care Screening Procedures for Long Term Care Services directs that a person with a known or suspected mental illness who is requesting admission to a Medicaid certified nursing facility must be evaluated through the PASRR process. Anytime a resident with mental illness or intellectual disability or related conditions experiences changes that affect his/her placement or service decisions, the nursing facility staff must contact the appropriate agency to report that change.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical records, review of policy and interviews for 1 of 5 residents reviewed for unnecessary medications(Resident #74), the facility failed to failed to ensure that the resident's care plan address the resident's use of antipsychotic medications per plan and for 1 of 5 residents (Resident #92) reviewed for PASSR, the facility failed to ensure the facility developed a comprehensive care plan for a resident with a history of mental disorder. The findings included: 1. Resident #74's diagnoses included a blood disorder not yet in remission and iron deficiency anemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #74 was cognitively intact. The care plan dated 3/4/2024 indicated Resident #74 had a blood disorder not yet achieving remission and noted utilization of medication to treat the disorder. Intervention included in part to provide medications as ordered, to encourage consumption of fluids and to report any adverse medication side effects to the physician. A physician's order dated 3/14/2024 at 8:00 AM directed to provide Zyprexa (Antipsychotic medication) Oral Tablet 5 Milligrams (MG) by mouth one time a day for secondary prophylaxes for Nausea. However, review of the care plans from 2/29/24 to present failed to identify a care plan to address the residents. An interview and record review with the RN#3 on 4/17/2024 at 11:15 AM indicated he/she did not find a care reflecting antipsychotic use for Resident #74 and indicated s/he would follow up with the care plan. The facility policy labeled Psychotropic Medication Management indicated in part to care plan for psychoactive medications and review with the plan with the interdisciplinary team when admitted , quarterly annually, and as needed for changes in resident status and revise as necessary. 2. Resident #92 was admitted to the facility on [DATE] with diagnoses that included a cerebral infarction, dementia, anxiety disorder, and depressive disorder. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #92 had severely impaired cognition, was not considered by the state level 2 PASRR process to have a serious mental illness or related condition. The MDS further identified Resident #92 had active diagnoses that included non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder, and suicidal ideations and had taken medications from the following pharmacological classifications during the last 7 days: antipsychotic, antianxiety, and antidepressant. The care plan dated 2/13/24 failed to identify Resident #92 had a comprehensive care plan addressing goals and interventions for diagnoses of suicidal ideation. (continued on next page)

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	05/02/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Social Services (SW #1) on 4/15/24 at 11:03 AM identified Resident #92 was new to her care; when Resident #92 was transferred from another facility he/she had been under the care of the prior Director of Social Services, who no longer works at the facility. SW #1 indicated she was unaware Resident #92 had a history of suicidal ideation or a delusional disorder. SW #1 identified that she would have to review the psychiatric evaluation notes further to identify if the delusional disorder was a result of medication side effects or a psychiatric diagnosis. SW #1 further indicated she would have expected the prior social worker to have created a care plan for suicidal ideation and shared the information with the interdisciplinary team. SW #1 indicated that she would update the comprehensive care plan to include interventions and goals for Resident #92's history of suicidal ideation and ensure a behavioral treatment and a safety plan were in place. Interview and clinical record review with the Director of Nursing Services (DNS) on 4/17/24 at 11:01 AM indicated Resident #92's care plan identified he/she had diagnoses of depression and anxiety, interventions included monitoring for medication side effects, including delusions and suicidal ideation, were in place. The DNS further indicated she would also expect the care plan to be inclusive of suicidal ideation as a care plan focus, with appropriate goals and interventions. Interview and clinical record review with the Corporate Registered Nurse (RN #3) on 4/17/24 at 11:38 AM identified she was a float nurse covering the primary MDS Coordinator, while she was on vacation. RN #3 identified that the process for developing and updating the comprehensive care plan is an interdisciplinary approach. Each department will evaluate and assess the resident and create a care plan for the diagnosis that falls under their specialty, then the interdisciplinary team will discuss the resident's care needs during the care plan meeting. RN #3 further identified it is ultimately the MDS Coordinator's responsibility to ensure that all resident's diagnoses have been reviewed and oversee the development and updates of the comprehensive care plan. The Comprehensive Care Plan policy directs that the comprehensive care plan is to be developed by the interdisciplinary team for each resident, including measurable objectives and timelines to accommodate preferences, special medical, nursing, and psychosocial needs identified in the resident assessment instrument and by the interdisciplinary team. Care plans are a combination of: data concerning the resident that is obtained by the physician, clinical records such as the hospital discharge summary, evaluations, resident, or family goals for treatment. 47457 48792

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 1 resident (Resident # 101) reviewed for smoking in a non-smoking facility, the facility failed to review and revise the resident's care plan to ensure safety as the resident continued to be non-compliant with smoking in the facility The finding include: Resident #101 was admitted to the facility on [DATE]. The resident's diagnoses included cellulitis of abdominal wall, alcohol abuse and nicotine dependence. Resident #101 had a conservator of both estate and person. The Admission Smoking Evaluation assessment dated [DATE] identified no desire to smoke at the time of the admission. The Resident Care Plan (RCP) dated 3/14/24 identified both short- and long-term memory loss. Interventions included referring to time of day, date, and recent events with interactions, and to utilize simple direct communication, verbal cues, and task segmentation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #101 as moderately cognitively impaired and noted the resident utilized a walker for mobility. The social service notes dated 3/15/24 at 1:40 PM identified Social Worker (SW #1) observed Resident #101 and a visitor smoking in the visitor's car in the facility's parking lot. SW #1 indicated both were informed there is no smoking on facility's grounds even if the resident signed out on a Leave of Absence (LOA). SW #1 indicated she met with Resident #101's Conservator of Person and Estate (Resident # 95) who indicated s/he was unaware of Resident #101 smoking on LOA. The charge nurse and Administrator were made aware of the incident. Additionally, SW #1 advised the charge nurse to search Resident # 101 upon return to the facility. A review of the clinical record dated 3/15/24 through 3/20/24 failed to identify the facility conducted a new Smoking Evaluation Assessment when Resident # 101 was found smoking in the car on facility grounds. The social service notes dated 3/21/24 at 10:33 AM identified SW #1 met with Resident #101 as s/he attempted to leave the building to walk over to the street to smoke a cigarette. Resident #101 was advised s/he could not leave the facility on LOA without the responsible party's permission. SW #1 also advised Resident # 101 that smoking materials are not allowed or kept on his/her person. When asked to hand over smoking materials, Resident #101 aggressively threw a bag containing 2 cigarettes. Resident # 101 emptied her/his pocket, and two cigarette butts were found but no lighting material. Resident # 101 was escorted back to her/his room and the Director of Nursing Services (DNS) was updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP dated 3/22/24 for Resident # 101 identified a history of smoking with interventions which included offering nicotine patches, social services to address smoking cessation, social service to provide emotional support to address smoking cessation and to conduct every fifteen- minute checks. The social service notes by SW#1 of 3/26/24 at 11:12 AM identified she found a lighter on Resident #101's tray table. The charge nurse, supervisor, and DNS were made aware. However, the clinical record failed to provide evidence that interventions were implemented at the time of the non-compliance with the possession of smoking materials. The social services notes by SW #1 on 4/2/24 at 3:07 PM identified she spoke to Resident # 95 (conservator for Resident # (101) about transfer to a skilled nursing facility that permits smoking and Resident # 95 indicated s/he would speak to Resident # 101. A nurse's note on 4/4/24 at 5:05 PM identified Resident #101 returned from LOA at 5:00 PM, a room search was conducted, cigarettes and a lighter were found. Resident #101 was educated on the facility's no smoking policy. The clinical record failed to provide evidence that interventions were implemented at the time of the non-compliance with the possession of smoking materials. The nurse's notes dated 4/4/24 at 7:57 PM identified Resident # 101 returned from LOA at 5:00 PM. Upon Resident # 101 returning to the facility, the charge nurse entered the resident's room and noted a strong cigarette smell. When asked if s/he (Resident # 101) was smoking s/he denied smoking in the room. The charged nurse advised the resident s/he would need to be searched for cigarettes. Upon checking Resident # 101, a pack of cigarettes and lighter were found. Resident # 101 was educated on the importance of following facility rules and no smoking as well as safety when oxygen is in use. Resident # 101 expressed s/he was going to find a facility that allows smoking, and the supervisor was updated. The nurse's notes dated 4/4/24 at 10:25 PM identified Resident # 101 was found smoking again in her/his room by the charge nurse. Resident #101 was educated again that s/he cannot smoke in the facility or on facility grounds. Resident # 101 was educated again that Resident # 95 was in the room on oxygen and her/his smoking could cause a fire while smoking. Resident #101's smoking materials were confiscated. The nurse's note on 4/4/24 at 10:58 PM identified Resident #101 was found on her/his bed smoking a cigarette, room search conducted again identified another pack of cigarettes and two liquor bottles. Resident # 101 was intoxicated, and the staff was directed to transfer the resident to an acute care facility for an evaluation. The nurse's notes dated 4/4/24 also directed to conduct every fifteen- minute check. A nurse's note on 4/4/24 at 11:27 PM identified Resident #101 refused to go to the acute care facility and 15-minute check were maintained. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services note dated 4/5/24 at 8:50 AM by SW #1 identified she and the Assistant Director of Nursing Services (ADNS) met with Resident # 101 as cigarettes, vape cartridges and empty alcohol containers were found in the resident's room. When questioned about the empty alcohol containers Resident #101 indicated s/he drank the alcohol at the facility. Resident # 101 was educated again on facility non-smoking policy. SW#1 informed Resident # 101 she had found a smoking facility that would take the resident. However, Resident # 101 declined transferring to a smoking facility. Upon further inspection of Resident # 101 bathroom, cigarettes were found in the trash and a strong smell of cigarettes was evident. Resident # 101 denies smoking in the bathroom and was educated that this behavior cannot continue. Resident # 101 was offered again a skilled nursing bed at a smoking facility which s/he declined and indicated s/he would call a friend to see if s/he could live with the friend. The social services notes by SW#1 on 4/5/24 at 12:22 PM identified she and the ADNS informed Resident #101 s/he would be receiving a room change. The reason for the room change was secondary to Resident # 101 smoking in the bathroom and Resident # 95 was on oxygen. SW#1 also explained the room change was to keep both residents safe. SW#1 discussed Resident # 101 moving to a smoking facility on Monday 4/8/24 and Resident # 101 declined and indicated s/he would sign out Against Medical Advice (AMA). Interview with SW #1 on 4/16/24 at 11:25 AM identified when Resident #101 leaves for LOA s/he returns to his/her apartment. SW #1 identified she believed Resident #101 continues to be a smoking risk and matters regarding smoking non-compliance have been reported to both Administrator and the DNS. Interview and clinical record review with the DNS 4/16/24 at 11:40 AM identified Resident #101 is conserved by Resident #95. The DNS identified Resident #101 has physician's orders for a LOA with a responsible party. The DNS also failed to identify any additional interventions to maintain safety of the residents as Resident #101 continued to smoke in the facility. The DNS identified the facility had concern with how to maintain Resident #101's Resident's Rights for LOA and safety and how to address the multiple non-compliance with smoking. The DNS indicated she recognized a pattern of non-compliance smoking shortly after Resident #101 returned from the LOAs at which time she spoke to the party who signs Resident #101 out of the facility for the LOAs. However, the DNS was unable to provide any documentation to support the conversation(s). The DNS indicated a smoking cessation patch was offered to Resident #101 however, the patch was declined. The DNS failed to provide documentation to support the cessation patch offering. The DNS also failed to provide interventions, or updates to care plan to support the facility's actions or plans to eliminate the continued possibility of Resident #101's smoking in the building. The Comprehensive Care Plan policy directs that the comprehensive care plan is to be developed by the interdisciplinary team for each resident, including measurable objectives and timelines to accommodate preferences, special medical, nursing, and psychosocial needs identified in the resident assessment instrument and by the interdisciplinary team and reviewed by the team. Care plans are a combination of: data concerning the resident that is obtained by the physician, clinical records such as the hospital discharge summary, evaluations, resident, or family goals for treatment.

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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** 48880 Based on review of the clinical record review, facility policy, and interviews for 1 of 4 residents (Resident # 418) reviewed for pressure ulcers, the facility failed to ensure wound treatments were transcribed and preformed per physician's orders. The findings include: Resident #418 was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, traumatic spinal cord dysfunction, and paraplegia (paralysis of the legs and lower body). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #418 required extensive assistance from at least two people for bed mobility and transfers. Additionally, the MDS identified Resident #418 had two stage 3 pressure ulcers. A care plan dated 6/29/22 identified Resident #418 had two stage 3 pressure ulcers to the right and left buttocks. Interventions included a low air loss mattress, turning and positioning every 2 hours, and providing treatments as ordered. The physician's order 6/17/22 through 7/27/22 directed offload heels every shift as tolerated. A wound physician progress note dated 8/2/22 identified a new wound on the left heel. The wound was described as a Deep Tissue Injury (DTI) with maroon or purple discoloration. The wound measured 0.5 CM in length x 0.5 CM in width x 0.0 CM depth. The wound was noted with no drainage. New recommendations for treatment directed the application of skin prep, an abdominal pad dressing, and a rolled gauze dressing daily and when needed. A nursing pressure injury evaluation dated 8/3/22 indicated an initial evaluation for a left heel unstageable pressure ulcer with a healthy wound edge and no drainage. The size of the wound was 0.5 CM L x 0.8 CM W x 0 CM D. The nursing evaluation further indicated the physician was notified and treatment orders included daily and as-needed dressing changes with skin prep, an abdominal pad dressing, and a kerlix (rolled gauze) dressing. The nurse's notes dated 8/3/22 at 4:13 PM identified a left heel Deep Tissue Injury (DTI) measuring 0.5 CM by 0.8 CM by 0.0 CM. Resident # 418 was seen by the wound specialist and denied pain. A new treatment order directed to apply skin prep, followed by kerlix change, encourage resident to keep heels offload and noted the resident's family and Medical Doctor (MD) was updated about left heel treatment. A nursing progress note dated 8/3/22 identified a left heel pressure injury was evaluated by a wound specialist and a wound treatment order was obtained to apply skin prep and a kerlix dressing daily and to keep the resident's heels offloaded. A nursing pressure injury evaluation dated 8/9/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with a healthy wound edge and a moderate amount of serosanguineous drainage. The size of the wound was 0.5 CM L x 0.5 CM W x 0.1 CM D. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound physician's progress note dated 8/9/22 identified a left heel pressure injury was reclassified as a stage 2 pressure ulcer. The wound physician's progress notes further identified the wound as deteriorating. The wound had a moderate amount of sero-sanguineous drainage and measured 0.5 CM L x 0.5 CM W x 0. 1 CM D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, application of alginate with silver, and application of a bordered foam dressing. A nursing pressure injury evaluation dated 8/16/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with healthy wound edge and no drainage. The size of the wound was 0.5 CM L x 0.5 CM W x 0.1 CM D. A wound physician's progress note dated 8/16/22 identified a left heel stage 2 pressure ulcer was overall stable with a moderate amount of sero-sanguineous drainage and measured 0.5 CM L x 0.5 CM W x 0.1 CM D. New recommendations for treatment included daily and as needed dressing changes with Dakin's 1/4 strength, application of alginate, application of Medihoney, and application of a bordered foam dressing. A nursing pressure injury evaluation dated 8/23/22 indicated a follow-up weekly evaluation of a left heel stage 2 pressure ulcer with an unhealthy wound edge and with moderate sero-sanguineous drainage. The size of the wound was 2.0 cm L x 2.0 cm W x 0.1 cm D. A wound physician's progress note dated 8/23/22 identified a left heel stage 2 pressure ulcer with increased drainage and maceration that measured 2.0 CM L x 2.0 CM W x 0.1 cm D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, application of Santyl, application of alginate dressing, and application of a bordered foam dressing. Additionally, the wound physician's progress note identified the wound was deteriorating and indicated facility staff were educated on proper dressing changes. A review of the nurse's notes and Treatment Administration Record (TAR) and the Medication Administration Record (MAR) from 8/1/22 through 8/30/22 failed to identify that a daily left heel dressing change was performed by staff from 8/2/22 through 8/23/22. The first documented dressing to the left heel pressure ulcer was on 8/24/22 with Santyl, calcium alginate, and a silicone dressing, 22 days after the left heel pressure ulcer was discovered and initial recommendations made by the wound specialist. On 4/16/24 at 2:39 PM, an interview and record review with the wound nurse Registered Nurse (RN#1) failed to identify physician's orders or treatment administration records for Resident #418's left heel pressure ulcer prior to 8/22/22. Additionally, RN#1 indicated although she was not the wound nurse in August 2022, she conducts rounds with the wound physician and transcribes wound orders into the computer based on physician's recommendations and progress note. On 4/17/24 at 11:32 AM, an interview and record review with the Director of Nursing Services (DNS) failed to identify dressing change orders for the left heel pressure ulcer from 8/2/22 through 8/22/23. The DNS indicated RN#1 assisted with training Registered Nurse (RN#7) who was the wound nurse in August of 2022. The DNS further indicated she would expect the process would remain the same in which the wound nurse would round with the wound physician and transcribe physician's orders from the physician's notes and recommendations. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 12:19 PM, an interview with Licensed Practical Nurse (LPN#4) who provided care to Resident #418 on 8/3, 8/4, 8/13, 8/14, 8/17, and 8/18/22 indicated she remembered the resident but did not recall the resident's wounds or treatments involved. LPN#4 indicated her practice would include following the physician's orders in the electronic medical record and the TAR to determine what treatments to perform for a specific resident. On 4/17/24 at 12:39 PM an interview with LPN#9 indicated she did not recall the resident. LPN#9 indicated she performs some dressing changes on the evening shift, and she would look at the physician orders and the TAR to determine what treatments are provided. On 4/17/24 at 1:50 PM, an interview and record review with the wound specialist (MD#3) identified wound specialist progress notes are recommendations and the facility is responsible for accepting the recommendations and transcribing physician's orders into the electronic medical records. On 5/1/24 at 1:49 PM an interview with RN#2 indicated she was training as a wound nurse in August of 2022. RN#2 indicated she would round with the wound specialist in August 2022 and transcribed orders from the wound specialist per recommendations. RN#2 indicated she remembered Resident #418 but did not remember the specifics of the resident's wounds or treatments. RN#2 was unable to indicate why the wound physician's orders were not in place for Resident #418's left heel pressure injury from 8/2/22 through 8/22/22. A review of the facility policy for Prevention and Management of Pressure Injuries indicated wound treatments are performed per physician's orders.

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	075390	A. Building B. Wing	05/02/2024

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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** 43032 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 1 resident (Resident #101) reviewed for bowel and bladder, the facility failed to assess the resident ability for self-care of a colostomy secondary to resident's refusals to allow staff to provide the care. The findings include: Resident #101 was admitted to the facility on [DATE]. The resident's diagnoses included cellulitis of abdominal wall, alcohol abuse and nicotine dependence. Resident #101 has a COP. The physician's order dated 3/11/24 directed to provide colostomy care every shift, and to apply Triad cream to macerated/reddened areas to abdomen, groin, and perineal area every shift for cellulitis. The hospital discharge summary dated 3/11/24 at 5:28 PM identified because of a wellness check, Resident #101's colostomy stoma was covered with a diaper resulting in extensive redness, and skin breakdown in the abdominal area extending to the groin. Resident #101 acknowledged consuming alcohol for pain management. Resident #101 was diagnosed with abdominal cellulitis, encephalopathy, and hypoxemic respiratory failure (insufficient oxygen in blood) secondary volume overload. The quarterly MDS assessment dated [DATE] identified Resident #101 as moderately cognitively impaired, used a walker for mobility, and noted an ostomy appliance. The care plan dated 3/14/24 identified concerns with short- and long-term memory loss. Interventions included refer to time of day, date, and recent events with interactions, and to utilize simple direct communication, verbal cues, and task segmentation. Review of the clinical record identified Resident #101 provided ostomy care multiple times (22 occurrences) independently after refusing to allow staff to provide as noted below: 1. 3/13/24 6:16 AM-refused ostomy care 2. 3/15/24 1:36 PM-uncooperative with care 3. 3/16/24 1:31 PM-allowed stoma/ostomy care 4. 3/18/24 2:49 PM uncooperative with care 5. 3/18/24 10:06 PM colostomy care done by resident, offered to provide assistance, and refused, said leave her/him alone s/he can do it her/himself. 6. 3/19/24 2:30 PM resident completed colostomy care independently refused any help from staff 7. 3/20/24 6:43 AM colostomy care provided by resident x1 8. 3/20/24 11:17 AM completed colostomy care independently, refused any help with care (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. 3/21/24 6:27 AM colostomy care provided by resident x1 10. 3/24/24 6:59 AM colostomy care provided by resident x1 11. 3/24/24 12:24 PM colostomy care provided by resident 12. 3/25/24 6:53 AM colostomy care provided by resident x1 13. 3/25/24 10:52 PM colostomy appliance changed by resident per resident request, writer offered to change appliance to observe skin and site, resident declined, stating I can do it myself. 14. 3/27/24 6:54 PM colostomy care provided by resident x1 15. 3/27/2 4 8:45 PM colostomy active and intact, appliance changed by resident 16. 3/28/24 6:57 AM colostomy care provided by resident x1 17. 3/29/24 7:18 AM colostomy care provided by resident x1 18. 3/30/24 7:04 AM colostomy care provided by resident x1 19. 4/1/24 1:15 PM refused help with colostomy care 20. 4/2/24 7:29 AM colostomy care provided by resident x1 21. 4/3/24 7:40 PM colostomy changed x1 by resident 22. 4/14/23 12:28 PM resident emptied colostomy pouch and reapplied, nurse offered to assist but the resident refused Interview and clinical record review with the DNS 4/16/24 at 11:40 AM identified Resident #101 is conserved by Resident #95. The DNS identified Resident #101 is a readmission and has had the ostomy appliance for some time. The DNS failed to provide an assessment of Resident #101's ability to care for the stoma/ostomy site, or care plans to support Resident #101's desire to provide self-care. A policy for self-care was requested, however not provided.

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	075390	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record reviews, facility policy, and interviews for 2 of 4 residents (Resident # 418) reviewed for pressure ulcers, the facility failed to perform wound care as prescribed by the physician to prevent further skin breakdown and for (Resident # 90), the facility failed to ensure weekly skin audits were completed in accordance with the facility policy. The findings included: 1. Resident #418 was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, traumatic spinal cord dysfunction, and paraplegia (paralysis of the legs and lower body). The care plan dated 6/20/22 for at risk for further skin breakdown. Interventions included to inspect skin for redness, irritation or break down during care., to apply a low air loss mattress, offer turning and repositioning approximately every two hours and when needed, pressure reducing cushion/mattress when needed, weekly skin inspections and treatment as ordered. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #418 required extensive assistance from at least two people for bed mobility and transfers. Additionally, the MDS identified Resident #418 had two stage 3 pressure ulcers. The physician's orders 6/17/22 through 7/27/22 directed to offload heels every shift as tolerated. A wound physician progress note dated 8/2/22 identified a new wound on the left heel. The wound was noted as a Deep Tissue Injury (DTI) with maroon or purple discoloration. The wound measured 0.5 cm in length x 0. 5 cm in width x 0.0 cm depth. The wound was noted with no drainage. New recommendations for treatment directed the application of skin prep, an abdominal pad dressing, and a rolled gauze dressing daily and when needed. A nursing pressure injury evaluation dated 8/3/22 indicated an initial evaluation for a left heel unstageable pressure ulcer with a healthy wound edge and no drainage. The size of the wound measured 0.5 cm L x 0.8 cm W x 0 cm D. The nursing evaluation further indicated the physician was notified and treatment orders included daily and as-needed dressing changes with skin prep, an abdominal pad dressing, and a kerlix (rolled gauze) dressing. The nurse's notes dated 8/3/22 at 4:13 PM identified a left heel Deep Tissue Injury (DTI) measuring 0.5 cm by 0.8 cm by 0.0 cm. Resident # 418 was seen by the wound specialist and denied pain. A new treatment order directed to apply skin prep, followed by kerlix change, encourage resident to keep heels offload. A wound physician's progress note dated 8/9/22 identified a left heel pressure injury was reclassified as a stage 2 pressure ulcer. The wound physician's progress notes further identified the wound as deteriorating. The wound had a moderate amount of sero-sanguineous drainage and measured 0.5 cm L x 0.5 cm W x 0.1 cm D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, silver alginate with the application of a bordered foam dressing. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound physician's progress note dated 8/16/22 identified a left heel stage 2 pressure ulcer was overall stable with a moderate amount of sero-sanguineous drainage and measured 0.5 cm L x 0.5 cm W x 0.1 cm D. New recommendations for treatment included daily and as needed dressing changes with Dakin's 1/4 strength, application of alginate, application of Medihoney, and application of a bordered foam dressing. A wound physician's progress note dated 8/23/22 identified a left heel stage 2 pressure ulcer with increased drainage and maceration that measured 2.0 cm L x 2.0 cm W x 0.1 cm D. New recommendations for treatment included daily and as-needed dressing changes with Dakin's 1/4 strength, application of Santyl, application of alginate dressing, and application of a bordered foam dressing. Additionally, the wound physician's progress note identified the wound was deteriorating and indicated facility staff were educated on proper dressing changes. A review of the nurse's notes and Treatment Administration Record (TAR) and the Medication Administration Record (MAR) from 8/1/22 through 8/30/22 failed to identify that a daily left heel dressing change was performed by staff from 8/2/22 through 8/23/22. The first documented dressing to the left heel pressure ulcer was on 8/24/22 with Santyl, calcium alginate, and a silicone dressing, 22 days after the left heel pressure ulcer was discovered and initial recommendations made by the wound specialist. On 4/16/24 at 2:39 PM, an interview and record review with the wound nurse Registered Nurse (RN#1) failed to identify physician's orders or treatment administration records for Resident #418's left heel pressure ulcer prior to 8/22/22. Additionally, RN#1 indicated although she was not the wound nurse in August 2022, she conducts rounds with the wound physician and transcribes wound orders into the computer based on physician's recommendations and progress note. On 4/17/24 at 11:32 AM, an interview and record review with the Director of Nursing Services (DNS) failed to identify dressing change orders for the left heel pressure ulcer from 8/2/2022 through 8/22/2022. The DNS further indicated she would expect the process would remain the same in which the wound nurse would round with the wound physician and transcribe physician's orders from the physician's notes and recommendations. On 4/17/24 at 12:19 PM, an interview with Licensed Practical Nurse (LPN#4) who provided care to Resident #418 on 8/3, 8/4, 8/13, 8/14, 8/17, and 8/18/22 indicated she remembered the resident but did not recall the resident's wounds or treatments involved. LPN#4 indicated her practice would include following the physician's orders in the electronic medical record and the TAR to determine what treatments to perform for a specific resident. On 4/17/24 at 12:21 PM, an interview with LPN#1, who provided care to Resident# 418 on 8/1, 8/2, 8/10, 8/11,8/15, and 8/19/22, identified s/he did not recall the resident. LPN#1 identified the TAR would direct her as to what treatments need to be performed for a specific resident. On 4/17/24 at 12:39 PM an interview with LPN#9 indicated she did not recall the resident. LPN#9 indicated she performs some dressing changes on the evening shift, and she would look at the physician orders and the TAR to determine what treatments are provided. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/17/24 at 1:50 PM, an interview and record review with the wound specialist (MD#3) identified wound specialist progress notes are recommendations and the facility is responsible for accepting the recommendations and transcribing physician's orders into the electronic medical records. MD#3 indicated although s/he was not involved in Resident # 418's care in August of 2022 s/he could not definitively identify that the lack of dressing changes to the left heel caused further breakdown of the pressure ulcer but indicated not following the recommended treatment could have been a contributing factor to further skin breakdown. On 5/1/24 at 1:49 PM an interview with RN#2 indicated she was training as a wound nurse in August of 2022. RN#2 indicated she would round with the wound specialist in August 2022 and transcribed orders from the wound specialist per recommendations. RN#2 indicated she remembered Resident #418 but did not remember the specifics of the resident's wounds or treatments. RN#2 was unable to indicate why the wound physician's orders were not in place for Resident #418's left heel pressure injury from 8/2/22 through 8/22/22. A review of the facility policy for Prevention and Management of Pressure Injuries indicated wound treatments are performed per physician's orders and the determination for dressing changes for stage 1 and stage 2 pressure ulcers are based on the individual physician's clinical judgement. 2. Resident #90's diagnoses included type 2 diabetes mellitus, quadriplegia, dissection of the vertebral artery, and stiffness of: the left and right hands, left and right elbows, and left and right shoulders. A physician's order dated 7/26/23 directed nursing staff to complete weekly skin checks on bath/shower day. The Norton Plus skin assessment dated [DATE] identified Resident #90 received a score of an 8 which indicated very high risk for pressure ulcers. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had severely impaired cognition, was dependent on staff for rolling left to right and chair to bed transfers, was frequently incontinent of bowel and bladder, was at risk for developing pressure ulcers, and noted the resident had 1 stage 3 pressure ulcer. The physician's order dated 12/29/23 directed Traid to coccyx every shift. The pressure injury evaluation dated 1/6/24, completed by the Infection Control Nurse/Wound Nurse (RN #1), identified a new facility acquired stage 2 pressure injury to the coccyx measuring 2.0 Centimeter cm x 1. 0 cm x 0.1 cm. The physician and responsible party were notified. The active physician's orders 12/20/23 through January 2024 direct for right lateral foot to cleanse with Normal Saline followed by collagen then silcone dressing daily and when needed dressing for autolytic debridement as needed for dislodgement or soilage. The care plan dated 1/16/24 identified Resident #90 at risk for skin breakdown. Interventions included: offloading heels every shift as tolerated, inspecting skin for redness, irritation, or breakdown, to offer turning and repositioning approximately every 2 hours, providing treatments as ordered, and conducting weekly skin inspections. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The care plan dated 1/16/24 for right lateral foot stage 3 pressure ulcer. Interventions included skin checks per facility protocol and weekly wound care specialist consultations. The pressure injury evaluation document dated 2/27/24, completed by RN #1, identified a new facility acquired suspected deep tissue injury (DTI) to the ball of the left foot measuring 3.0 cm x 2cm x 0.0 cm. The physician and responsible party were notified. Observation of the right lateral foot during the survey identified the wound treatment was conducted as prescribed and wound healing. The nurse's notes dated 1/6/24 through 1/30/24 failed to reflect a new facility acquired stage 2 pressure injury to the coccyx measuring 2.0 Centimeter cm x 1.0 cm x 0.1 cm. The nurse's notes dated 2/27/24 noted Resident # 90 returned from a visit with a physician at which time a new order to start betadine daily to foot wounds and to follow up in one month. The pressure injury evaluation document dated 2/27/24 identified a facility acquired Deep Tissue Injury pressure area on the ball of the left foot that measured 3.0 cm by 2.0 cm by 0.0 cm. The ball of the left foot was noted with drainage and healthy surrounding skin. The nurse's note also failed to identify if any new pressure ulcers were reported to the nursing supervisor, wound nurse, or physician. A review of the clinical record dated 12/2023 through 3/20/24 identified 12 occasions Resident # 90's weekly skin audits were not performed per facility practice. Interview and clinical record review with Registered Nurse (RN #1) on 4/17/24 at 10:09 AM failed to identify Resident #90 had weekly skin audits conducted per the physician's order. RN #1 identified that she would expect weekly skin audits to be completed per the physician's order and facility policy, by the assigned nurse; any newly identified areas should be reported to her or the nursing supervisor for an assessment. RN #1 further identified in January 2024, she had identified a problem with weekly skin audits not being completed routinely by nursing staff; she began conducting chart audits of weekly skin audits and documentation, in the resident's clinical record. RN #1 indicated Resident #90 was at risk for developing pressure ulcers due to her/his medical comorbidities and decreased functional status, multiple preventative measures were in place including: off-loading boots to be worn at all times, repositioning every 2 hours, low air loss mattress set to his/her weight, getting the resident out of bed daily to a tilt in space wheel chair, the daily application of skin protectant cream, and treatment plans for identified pressure injuries and ulcers. Interview and clinical record review with the Director of Nursing Services (DNS) on 4/17/24 at 11:09 AM failed to identify Resident #90 had weekly skin audits conducted per the physician's order. The DNS indicated her expectation is that weekly skin audits are completed and documented by the charge nurse, per the physician's order and facility policy. The DNS further identified any concerns identified during the skin audit should be reported to the wound nurse who will conduct an assessment. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN #8) on 4/17/24 at 11:28 AM identified Resident #90 was scheduled for weekly skin audits on Mondays, during the 3-11 PM shift. LPN #8 further identified the charge nurse is responsible for completing the skin audit during the scheduled shift. LPN #8 further indicated she works 7:00 AM to 3:00 PM on the unit, and there are different nurses that cover the unit during the 3-11 PM shift, including per diem nurses. LPN #8 further identified that weekly skin audits should be completed per the physician's order on the scheduled day/shift and if an area of concern is identified notifications should be made to the nursing supervisor, wound nurse, and Advance Practice Registered Nurse (APRN). Interview with the wound specialist consultant Medical Doctor (MD #3) on 4/17/24 at 12:10 PM identified Resident #90 was at risk for developing pressure injuries due to his/her lower body contractures which decreases arterial blood flow to the extremities and the contractures also limit how staff could reposition him/her. MD #3 further identified that his role at the facility relates to the treatment of pressure related wounds and injuries, but he would expect that the facility staff to follow facility's policies related to pressure ulcer prevention, including weekly skin assessments. Interview with the Medical Director (MD #1) on 4/17/24 at 12:36 PM identified Resident #90's impaired mobility and contractures were significant risk factors for developing pressure ulcers, which could take off quickly prior to detection. MD #1 further identified that he would expect weekly skin audits to be completed per the physician's order and facility policy. MD #1 indicated that pressure ulcers don't start off as stage 2 and that missing skin audits could play into later detection. The facility's Weekly Body Audit policy directs all residents to have a body audit to address any skin issues, on a weekly basis. If an alteration in skin integrity is discovered, the alteration will be documented on the weekly skin audit form as soon as the nurse observes the area. The policy further directs a licensed nurse to conduct a weekly body audit, looking for any alteration in skin integrity. It is recommended that this be completed on shower day. The licensed nurse will complete the weekly skin evaluation. In the interim, the nurse aide will report any identified skin impairment to the charge nurse. If a new area is discovered, the charge nurse is responsible for starting the appropriate documentation and notifying the unit manager or supervisor. If no alterations in skin integrity are found, the nurse will note this on the weekly body evaluation. 48880

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	05/02/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, review of facility documentation, and staff interviews for 1 of 1 sampled resident (Resident #101) reviewed for non-compliance with smoking, the facility failed to provide adequate supervision and failed to implement interventions to prevent an accident hazard after repeated incidents of noncompliance related to smoking. These failures resulted in a finding of Immediate Jeopardy. The findings include: 1. Resident #101 was admitted to the facility on [DATE]. The resident's diagnoses included cellulitis of abdominal wall, alcohol abuse and nicotine dependence. Resident #101 had a conservator of both estate and person. The Admission Smoking Evaluation assessment dated [DATE] identified no desire to smoke at the time of the admission. The Resident Care Plan (RCP) dated 3/14/24 identified both short- and long-term memory loss. Interventions included referring to time of day, date, and recent events with interactions, and to utilize simple direct communication, verbal cues, and task segmentation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #101 as moderately cognitively impaired and noted the resident utilized a walker for mobility. 2. Resident # 95 was admitted to the facility on [DATE] who shared a room with Resident # 101. The resident's diagnoses included dependency on supplemental oxygen and Chronic Obstructive Pulmonary Disease (COPD. The RCP for diagnosis of COPD dated 3/12/24 with a revision on 3/14/24. Interventions included administering oxygen at 2-3 liters/minute via nasal cannula continuously and to monitor effectiveness by checking saturation as indicated. The admission MDS assessment dated [DATE] identified the resident as cognitively intact, independent with self-care, utilized a wheelchair for mobility and noted continuous oxygen therapy. The physician admission orders dated March 3/13/24 through 4/22/24 directed to administer oxygen via nasal cannula at 2-3 liters /minute and to check pulse oximetry every shift. The social service notes dated 3/15/24 at 1:40 PM identified Social Worker (SW #1) observed Resident #101 and a visitor smoking in the visitor's car in the facility's parking lot. SW #1 indicated both were informed there is no smoking on facility's grounds even if the resident signed out on a Leave of Absence (LOA). SW #1 indicated she met with Resident #101's Conservator of Person and Estate (Resident # 95) who indicated s/he was unaware of Resident #101 smoking on LOA. The charge nurse and Administrator were made aware of the incident. Additionally, SW #1 advised the charge nurse to search Resident # 101 upon return to the facility. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the clinical record dated 3/15/24 through 3/20/24 failed to identify the facility conducted a new Smoking Evaluation Assessment when Resident # 101 was found smoking in the car on facility grounds. The social service notes dated 3/21/24 at 10:33 AM identified SW #1 met with Resident #101 as s/he attempted to leave the building to walk over to the street to smoke a cigarette. Resident #101 was advised s/he could not leave the facility on LOA without the responsible party's permission. SW #1 also advised Resident # 101 that smoking materials are not allowed or kept on his/her person. When asked to hand over smoking materials, Resident #101 aggressively threw a bag containing 2 cigarettes. Resident # 101 emptied her/his pocket, and two cigarette butts were found but no lighting material. Resident # 101 was escorted back to her/his room and the Director of Nursing Services (DNS) was updated. The RCP dated 3/22/24 for Resident # 101 identified a history of smoking with interventions which included offering nicotine patches, social services to address smoking cessation, social service to provide emotional support to address smoking cessation and to conduct every fifteen- minute checks. The social service notes by SW#1 of 3/26/24 at 11:12 AM identified she found a lighter on Resident #101's tray table. The charge nurse, supervisor, and DNS were made aware. However, the clinical record failed to provide evidence that interventions were implemented at the time of the non-compliance with the possession of smoking materials. The social services notes by SW #1 on 4/2/24 at 3:07 PM identified she spoke to Resident # 95 (conservator for Resident # (101) about transfer to a skilled nursing facility that permits smoking and Resident # 95 indicated s/he would speak to Resident # 101. A nurse's note on 4/4/24 at 5:05 PM identified Resident #101 returned from LOA at 5:00 PM, a room search was conducted, cigarettes and a lighter were found. Resident #101 was educated on the facility's no smoking policy. The clinical record failed to provide evidence that interventions were implemented at the time of the non-compliance with the possession of smoking materials. The nurse's notes dated 4/4/24 at 7:57 PM identified Resident # 101 returned from LOA at 5:00 PM. Upon Resident # 101 returning to the facility, the charge nurse entered the resident's room and noted a strong cigarette smell. When asked if s/he (Resident # 101) was smoking s/he denied smoking in the room. The charged nurse advised the resident s/he would need to be searched for cigarettes. Upon checking Resident # 101, a pack of cigarettes and lighter were found. Resident # 101 was educated on the importance of following facility rules and no smoking as well as safety when oxygen is in use. Resident # 101 expressed s/he was going to find a facility that allows smoking, and the supervisor was updated. The nurse's notes dated 4/4/24 at 10:25 PM identified Resident # 101 was found smoking again in her/his room by the charge nurse. Resident #101 was educated again that s/he cannot smoke in the facility or on facility grounds. Resident # 101 was educated again that Resident # 95 was in the room on oxygen and her/his smoking could cause a fire while smoking. Resident #101's smoking materials were confiscated. (continued on next page)

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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurse's note on 4/4/24 at 10:58 PM identified Resident #101 was found on her/his bed smoking a cigarette, room search conducted again identified another pack of cigarettes and two liquor bottles. Resident # 101 was intoxicated, and the staff was directed to transfer the resident to an acute care facility for an evaluation. The nurse's notes dated 4/4/24 also directed to conduct every fifteen- minute check. A nurse's note on 4/4/24 at 11:27 PM identified Resident #101 refused to go to the acute care facility and 15-minute check were maintained. A review of every fifteen- minutes check from 3/24/24 through 4/5/24 identified missing checks for 3/11/24 to 3/14/24, 3/22/24 to 3/31/24 and 4/1/24 to 4/3/24. The social services note dated 4/5/24 at 8:50 AM by SW #1 identified she and the Assistant Director of Nursing Services (ADNS) met with Resident # 101 as cigarettes, vape cartridges and empty alcohol containers were found in the resident's room. When questioned about the empty alcohol containers Resident #101 indicated s/he drank the alcohol at the facility. Resident # 101 was educated again on facility non-smoking policy. SW#1 informed Resident # 101 she had found a smoking facility that would take the resident. However, Resident # 101 declined transferring to a smoking facility. Upon further inspection of Resident # 101 bathroom, cigarettes were found in the trash and a strong smell of cigarettes was evident. Resident # 101 denies smoking in the bathroom and was educated that this behavior cannot continue. Resident # 101 was offered again a skilled nursing bed at a smoking facility which s/he declined and indicated s/he would call a friend to see if s/he could live with the friend. The social services notes by SW#1 on 4/5/24 at 12:22 PM identified she and the ADNS informed Resident #101 s/he would be receiving a room change. The reason for the room change was secondary to Resident # 101 smoking in the bathroom and Resident # 95 was on oxygen. SW#1 also explained the room change was to keep both residents safe. SW#1 discussed Resident # 101 moving to a smoking facility on Monday 4/8/24 and Resident # 101 declined and indicated s/he would sign out Against Medical Advice (AMA). Interview with SW #1 on 4/16/24 at 11:25 AM identified when Resident #101 leaves for LOA s/he returns to his/her apartment. SW #1 identified she believed Resident #101 continues to be a smoking risk and matters regarding smoking non-compliance have been reported to both Administrator and the DNS. Interview and clinical record review with the DNS 4/16/24 at 11:40 AM identified Resident #101 is conserved by Resident #95. The DNS identified Resident #101 has physician's orders for a LOA with a responsible party. The DNS also failed to identify any additional interventions to maintain safety of the residents as Resident #101 continued to smoke in the facility. The DNS identified the facility had concern with how to maintain Resident #101's Resident's Rights for LOA and safety and how to address the multiple non-compliance with smoking. The DNS indicated she recognized a pattern of non-compliance smoking shortly after Resident #101 returned from the LOAs at which time she spoke to the party who signs Resident #101 out of the facility for the LOAs. However, the DNS was unable to provide any documentation to support the conversation(s). The DNS indicated a smoking cessation patch was offered to Resident #101 however, the patch was declined. The DNS failed to provide documentation to support the cessation patch offering. (continued on next page)

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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator on 4/16/24 at 3:40 PM. identified she could not provide an explanation as to why a discharge notice for Resident #101 who was non-compliant with the smoking policy was not implemented and failed to provide any additional interventions to keep the residents of the facility safe. Interview and clinical record review with the DNS and the Administrator on 4/22/24 at 10:47 AM and 1:05 PM identified when Resident # 101 was admitted to the facility on [DATE] during the smoking evaluation the resident indicated s/he had no desire to smoke. Resident # 101 also refused smoking cessation patches. The DNS was unable to provide documentation that a smoking reassessment was conducted when Resident # 101 violated the smoking policy after admission. The Administrator indicated the facility was concerned with not violating Resident# 101's LOA and Residents Rights and they did not know how to manage the resident's non-compliance with smoking without violating the resident's right. The DNS indicated on 4/5/24 when Resident # 101 was noted smoking in the room with Resident # 95 who utilized continuous oxygen, the social worker offered a room change. Resident # 101 was offered several transfers to a smoking skilled nursing facility, but she kept declining. The DNS indicated although the facility had instituted every fifteen-minute checks on 3/11/24 per care plan for history of smoking, she was unable to provide the missing every fifteen-minute checks for 3/11/24 to 3/14/24, 3/22/24 to 3/31/24 and 4/1/24 to 4/3/24. The DNS also indicated s/he could not provide any additional interventions put in place to monitor the resident's non-compliance with smoking after every fifteen-minute check on 3/11/24 identified on the care plan. The DNS indicated staff did conduct occasional room searches. The DNS further indicated now that she thought about the incident, she could have instituted 1:1 monitoring for Resident # 101 smoking non-compliance. Interview with the Medical Director on 4/22/24 at 1:35 PM identified Resident # 101 was offered a nicotine patch but Resident # 101 declined because Resident # 101 did not feel s/he needed the patch. The Medical Director indicated s/he would expect the facility to follow the smoking policy as it pertains to non-compliance with smoking. The Smoke-Free Environment policy states that smoking by residents is prohibited in all indoors and on facility outdoor grounds. Residents who violate the smoking prohibition will have their contraband confiscated, counseled by social services, and be advised their right to seek alternate placement at a facility where smoking may be permitted. If the resident does not agree to observe the smoke-free environment policy and procedure, a discharge notice will be issued, and discharge planning will be implemented. The resident will be monitored to ensure compliance with the facility smoke-free environment policy until a safe discharge is arranged. The facility failure to supervise and implement interventions to address Resident # 101's several non-compliance with smoking and smoking in the presence of oxygen therapy resulting in a finding of Immediate Jeopardy. The Administrator was presented with the Immediate Jeopardy Template on 4/22/24 at 2:00 PM for F689 Free of Accident Hazards/supervision /devices. The facility submitted a removal plan on 4/22/24 with revision on 4-23-24 which included: 1. Any resident has the potential to be affected by this alleged deficient practice. 2. The facility policy titled Smoking Policy was reviewed and remains current. (continued on next page)

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	05/02/2024

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. All licensed staff prior to working were provided education on the facility smoking policy, all licensed staff was provided education on the use of oxygen present with a smoking resident, education provided on significant harm that could occurred, education provided on at risk factors involved in active smoking resident in the facility, staff educated on supervision needed to be provided with cognitively impaired residents who wishes to smoke. 4. All residents will be educated on the facility smoking policy and educated the facility is a non-smoking facility. Residents will be educated on risk factors involved with smoking materials, contraband usage in the facility. Current residents in the facility will be educated immediately, and all new admissions will be educated upon admission. 5. Smoking evaluations audits will be performed on all residents currently in the facility immediately, and quarterly, and any resident who chooses to smoke in the facility will be offered a transfer to a smoking facility, the resident will be assessed to determine if a nicotine patch is appropriate, audit will be conducted to ensure all assessments have been done for all residents, concerns for any resident will be addressed immediately and the physician and family will be notified of any concerns. 6. Random audits will be completed 5 times a week for one month, 3 times a week for one month and then weekly for 3 months. The results of the audit will be presented at Quality Assurance and Improvement Program as required. 7. The DNS or designee is responsible for the completion of this Plan of Correction. 8. The facility alleges the removal of the Immediate Jeopardy was on 4/22/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observation, clinical record review, and staff interviews for 1 of 1 resident reviewed for oxygen (Resident #80), the facility failed to ensure the resident received oxygen therapy as prescribed. The findings include: Resident #80's diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident#80 was cognitively intact and did not exhibit any behaviors of rejecting evaluation or care. Additionally, the MDS indicated the resident was independent with toileting and personal hygiene and required setup or cleanup assistance with eating and bathing. The care plan dated 2/19/24 identified a diagnosis of COPD, shortness of breath on exertion, and oxygen dependence. Interventions included: administering oxygen and monitoring effectiveness, educating on the importance of wearing a BiPAP (a machine used to help to breathe during sleep), and elevating the head of the bed to assist in avoiding shortness of breath. Additionally, the care plan dated 2/19/24 identified the resident as having altered respiratory status related to COPD, respiratory failure, and non-compliance with oxygen use. Interventions included education regarding not removing oxygen, administering oxygen by a nasal cannula per physician's order, and encouraging the use of BiPAP. A physician order dated 2/12/24 directed 2 liters of oxygen per minute (L/min) via nasal cannula every shift for preventative maintenance. The order was discontinued on 3/23/24. A physician's order dated 4/1/24 directed 2 L/min of oxygen via nasal cannula to maintain oxygen saturations greater than 92% as needed. A nursing progress note dated 4/10/24 indicated Resident #80 was on oxygen at 2 L/min via nasal cannula. No nursing progress note was noted for 4/11/24. On 4/12/24 at 10:05 AM, an interview and observation identified Resident #80 in the room, lying in bed with the head of the bed elevated. The resident was wearing a nasal cannula appropriately. The liter flow on the oxygen concentrator was noted to be set at 3 L/min. The resident indicated that s/he does not touch the oxygen flow and the facility staff are the ones who adjust the oxygen. The resident indicated that's/he thought s/he was on 2L/min at all times. A nursing note dated 4/12/24 at 10:54 AM indicated that Resident #80 was on 2 L/min via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 1:15 PM, an interview and record review with LPN#1 indicated Resident#80 was on 2L/min of oxygen via nasal cannula. LPN#1 also indicated the resident's oxygen saturation was stable and Resident # 80 did not titrate the oxygen flow him/herself. LPN#1 further indicated that for a while, the resident was non-compliant with oxygen and would take it off his/her nose or put it under the chin; however, LPN#1 indicated she had not seen the resident do this recently. LPN#1 indicated that at times, the resident would need additional oxygen up to 3 L/min when doing strenuous activity like physical therapy but would require it only for about 30 minutes and not for hours. Observation with LPN #1 in Resident#80's room identified the resident was lying in bed with the head of the bed elevated and appropriately wearing the nasal cannula. The oxygen concentrator was noted to be set at 3 L/min. LPN#1 indicated she did not know why the resident was on 3 L/min or for how long but indicated that perhaps the night shift had bumped up the resident's oxygen. LPN#1 further indicated she sometimes would go in the afternoon to check the liter flow but identified this morning, she was not able to check the liter flow due to the time it takes to complete medication passes for all the residents. After inquiry, Resident #80's order for 2L/min of oxygen was discontinued on 4/12/24 at 2:24 PM and replaced with an order for oxygen at 2-3 L/min via nasal cannula to maintain oxygen saturation of greater than 92%. On 4/15/24 at 3:00 PM an interview with the nursing supervisor (RN#4) indicated the resident was not meeting his/her oxygen saturation threshold on 2L/min of oxygen and the oxygen order was changed in consultation with the provider. RN#4 further indicated that the last time the resident had low oxygen saturation was on 4/6/24. On 4/15/24 at 3:15 PM an interview with the Advanced Practice Registered Nurse (APRN#1) identified that she was not aware of any decreased oxygen saturations on 4/12/24, additionally, APRN#1 indicated she would expect staff to notify her if there were no physician's orders for a specific situation and to follow orders in place. Additionally, APRN#1 indicated she trusted the nursing staff judgement as long as they are adjusting the oxygen within the orders given. On 4/16/24 at 11:05 AM an interview with the DNS identified the expectation is for nurses to check a residents oxygen flow to ensure settings are accurate. A review of the facility policy for oxygen administration via nasal cannula identified oxygen will be delivered per physician's order and that the oxygen liter flow should be set to the prescribed liter flow per minute.

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	075390	A. Building B. Wing	05/02/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record reviews, review of facility policy and interviews for 11 of 12 sample residents (Resident #20, Resident #21, Resident #44, Resident #45, Resident #54, Resident #61, Resident #72, Resident #76, Resident #98, Resident #102, and Resident #109) reviewed for timely physician's visits, the facility failed to ensure physician's visits were conducted timely. The findings included: 1 Resident # 20's was admitted to the facility on [DATE] with diagnoses that included respiratory failure, type 2 diabetes mellitus, dysphagia, psychosis, and depression. The quarterly MDS assessment dated [DATE] identified Resident #20 had moderate cognitive impairment, and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from August 2023 through May 2, 2024, identified Resident #20 physician's orders were not renewed and signed every 60 days. The most current physician's orders were last signed on 7/23/23. 2. Resident # 21's was admitted to the facility on [DATE] with diagnoses that included bilateral osteoarthritis of knee, congestive heart failure, anemia, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #21 had moderate cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from August 2023 through May 2, 2024, identified Resident #21 physician's orders were not renewed and signed every 60 days. The most current physician's orders were signed on 7/23/23. 3. Resident # 44's was admitted to the facility on [DATE] with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD), dysphagia, and hemiplegia and hemiparesis following cerebral infarction affect the right dominant side. The quarterly MDS assessment dated [DATE] identified Resident #44 had severe cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from 11/21/23 through 5/2/24 identified Resident #44 physician's orders were not signed on admission and not renewed every 30 days for 90 days. Additionally, for Residents # 45, # 54, # 61, # 72, # 76, # 98 the physician's orders should have been signed on 11/23/23 (48 hours after admission) and renewed every 30 days for 90 days and then 60 days thereafter. 4. Resident # 102's was admitted to the facility on [DATE] with diagnoses that included dysphagia, dementia, anxiety, psychosis, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #102 had severe cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders from August 2023 through 5/2/24 identified Resident #102 physician's orders were not renewed and signed every 60 days. The most current physician's orders were signed on 7/10/23. 5. Resident # 109's was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), heart failure, low back pain, and atrial fibrillation. The quarterly MDS assessment dated [DATE] identified Resident #109 with intact cognition and required limited assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from 12/7/23 through 5/2/24 identified Resident #109's physician's orders were not signed on admission and not renewed every 30 days for 90 days. The physician's orders should have been signed on 12/9/23 (48 hours after admission) and renewed every 30 days for 90 days and then 60 days thereafter. Review of Quality Improvement (QA) and Performance Improvement (PI) dated 4/18/24 identified the facility had an issue with physician's orders are signed timely. The facility would educate the physician to sign their orders timely, the physician orders would be audited by the medical record clerk, and the physician would be given an opportunity to sign the physician orders on paper. Interview with DNS on 5/2/24 at 2:30 PM identified the facility was responsible for tracking and ensuring the physician signed the physician's orders timely. She also identified the physician needed to sign the physician's orders on admission, and then every 30 days for the next 60 days and every 60 days thereafter and the physician should be signing the physician orders in the electronic medical record. The DNS also knew that the physician was not signing the physician orders timely and had started a QAPI to ensure the physician was signing the orders timely. She further identified that she had thought that the physician had caught up on signing the physician's orders. Although requested, the facility policy was not provided.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record reviews, review of facility policy and interviews for 11 of 12 sample residents (Resident #20, Resident #21, Resident #44, Resident #45, Resident #54, Resident #61, Resident #72, Resident #76, Resident #98, Resident #102, and Resident #109) reviewed for timely physician's orders, the facility failed to ensure physician's visits were conducted timely. The findings include: 1 Resident # 20's was admitted to the facility on [DATE] with diagnoses that included respiratory failure, type 2 diabetes mellitus, dysphagia, psychosis, and depression. The quarterly MDS assessment dated [DATE] identified Resident #20 had moderate cognitive impairment, and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from August 2023 through May 2, 2024, identified Resident #20 physician's orders were not renewed and signed every 60 days by the physician. 2. Resident # 21's was admitted to the facility on [DATE] with diagnoses that included bilateral osteoarthritis of knee, congestive heart failure, anemia, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #21 had moderate cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from August 2023 through May 2, 2024, identified Resident #21 physician's orders were not renewed and signed every 60 days by the physician. 3. Resident # 44's was admitted to the facility on [DATE] with diagnoses that included dementia, Chronic Obstructive Pulmonary Disease (COPD), dysphagia, and hemiplegia and hemiparesis following cerebral infarction affect the right dominant side. The quarterly MDS assessment dated [DATE] identified Resident #44 had severe cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from 11/21/23 through 5/2/24 identified Resident #44 physician's orders were not signed on admission and not renewed every 30 days for 90 days. Additionally, for Residents # 45, # 54, # 61, # 72, # 76, # 98 the physician's orders should have been signed on 11/23/23 (48 hours after admission) and renewed every 30 days for 90 days and then 60 days thereafter by a physician. 4. Resident # 102's was admitted to the facility on [DATE] with diagnoses that included dysphagia, dementia, anxiety, psychosis, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #102 had severe cognitive impairment and required extensive assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from August 2023 through 5/2/24 identified Resident #102 physician's orders were not renewed and signed every 60 days by the physician. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	5. Resident # 109's was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), heart failure, low back pain, and atrial fibrillation. The quarterly MDS assessment dated [DATE] identified Resident #109 with intact cognition and required limited assistance with bed mobility, toileting, hygiene, and transfer. Review of the physician's orders from 12/7/23 through 5/2/24 identified Resident #109's physician's orders were not signed on admission and not renewed every 30 days for 90 days by the physician. Review of Quality Improvement (QA) and Performance Improvement (PI) dated 4/18/24 identified the facility had an issue with physician's orders not been signed timely. The plan was the facility would educate the physician to sign their orders timely, the physician orders would be audited by the medical record clerk, and the physician would be given an opportunity to sign the physician orders on paper. Interview with DNS on 5/2/24 at 2:30 PM identified the facility was responsible for tracking and ensuring the physician signed the physician's orders timely. She also identified the physician needed to sign the physician's orders on admission, and then every 30 days for the next 60 days and every 60 days thereafter and the physician should be signing the physician orders in the electronic medical record. The DNS also knew that the physician was not signing the physician orders timely and had started a QAPI to ensure the physician was signing the orders timely. Although requested, the facility policy was not provided.

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	075390	A. Building B. Wing	05/02/2024

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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** 46046 Based on review of the clinical record, interview, and policy for 1 of 5 residents (Resident #74) reviewed for unnecessary medications, the facility failed to ensure pharmacy recommendations were obtained and reviewed and failed to ensure an AIMS assessment was completed timely for a resident who was started on an antipsychotic medication. The findings included. Resident #74's diagnoses included a blood disorder not yet in remission and iron deficiency anemia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #74 was cognitively intact. The care plan dated 3/4/2024 indicated Resident #74 had a blood disorder not yet achieving remission and noted utilization of medication to treat the disorder. Intervention included in part to provide medications as ordered, to encourage consumption of fluids and to report any adverse medication side effects to the physician. A physician's order dated 3/14/2024 at 8:00 AM directed to provide Zyprexa (Antipsychotic medication) Oral Tablet 5 Milligrams (MG) by mouth one time a day for secondary prophylaxes for Nausea. An interview with the DNS on 4/16/2024 at 1:25 PM indicated s/he was not able to locate an Abnormal Involuntary Movement Scale (AIMS) completed for Resident # 74 upon start of the Zyprexa. The DNS also indicated since psychiatric services had not ordered the medication it would be nursing's responsibility to complete the assessment. The DNS provided a copy of the AIMS assessment dated [DATE] at 11:53PM completed subject to surveyor inquiry (34 days after the initiation of the antipsychotic medication, Zyprexa). A telephone interview on 4/2/2024 at 3:13 PM with Pharmacist #1 indicated on 4/3/2024 he/she wrote recommendations for orthostatic blood pressure and for an AIMS on a separate sheet in addition to the insulin recommendation written on 4/3/2024. The facility provided as the most recent consulting pharmacy recommendation was 4/4/2024 and indicated recommendations for insulin only. Pharmacist #1 further indicated he/she would fax the additional recommendation sheet to the DNS. On 4/17/2024 at 9:40 AM and interview with the DNS indicated she/she had a conversation via phone call with the consulting pharmacist and had only received the one page of recommendations from 4/4/2024. Although the DNS indicated he/she would provide a copy of the second pharmacy recommendation from being sent by the pharmacist it was not provided. The facility policy labeled Psychotropic Medication Management indicted in part that psychoactive medication management would include adequate monitoring that complies with the federal and state guidelines and perform a baseline AIMS assessment upon initiation of any Antipsychotic medication and every 6 months thereafter.

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	075390	A. Building B. Wing	05/02/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, review of facility policy and interview for 4 nursing units, the facility failed to ensure medications stored in the medication carts were labeled, refrigerator temperatures that contain vaccines were taken and documented consistently twice daily and for 1 of 1resident (Resident #101) observed on tour, the facility failed to properly secure medications. The findings include: 1.Observation and interview of the [NAME] view medication cart on 4/16/2024 at10:20 AM with LPN#6 identified a bottle of Humalog insulin without a prescription label, box/bag or when the medication was first opened was found in the top drawer of the medication cart along with an auto injector of epinephrine 0.3mg without label, box/bag of who it belonged to. A clear bag of medications was found in the bottom of the medication cart without labels and LPN #6 indicated s/he did not know who the medication belonged to and would consult with the RN supervisor as to what to do with the medications. 2.Observation and interview with LPN #7 charge on 4/16/24 at 11:40 AM of the BB2 medication cart and nurse found one multi single dose card of Cyclosporin 0.05% ophthalmic eye drops without prescription label or who the medication belonged to in the top drawer of the medication cart. LPN #7 indicated she believed the medication belonged inside a box in the lower drawer for a particular resident and further indicated the medication should have been in the box. LPN # 7 indicated s/he had not administered the medication. 4/16/2024 at 12:10 PM interview and observation with the Supervisor RN #4 indicated the insulin and epinephrine auto injectors found without labels were most likely house stock, the insulin may have been taken from the emergency box and the epinephrine was house stock not belonging to a particular resident, all should have been labeled or in the original box with the label. RN #4 further indicated the insulin would be discarded and reordered for the emergency box. 3 a 4/16/2024 at 12:20 PM interview and observation of the Valley View Medication room with LPN #7 found refrigerator temperatures VV (Valley view Magic Chef fridge temperature log to be missing entries in the PM on 4/4, 4/5, 4/8, 4/9, 4/13, and 4/14/2024. The form labeled Medication Refrigerator Temperature Log indicated Temp checks must be done twice per day. The second medication refrigerator labeled smaller plain black, had temperature documentation missing on the medication Refrigerator Temperature Log for the PM shift on 4/4, 4/5, 4/8 and 4/9, 4/13 and 4/14/2024. Inside the Refrigerator was found an opened PPD vial opened 3/6/2024 and 3 individual doses of Prevnar 20 vaccine. b4/17/2024 at 12:10 PM interview and observation with LPN #7 of the BV unit medication room revealed Medication Refrigerator Temperature log labeled BV Bigger Plain Black noted missing refrigerator temperatures for the PM shift on 4/4, 4/5, 4/8, 4/9, 4/10, 4/13 and 4/14/2024. The Temperature log for the BV Gray Dunby medication refrigerator had temperature log omissions for 4/12, 4/13, and 4/14/2024. The forms labeled Medication Refrigerator Temperature Log indicated Temp checks must be done twice per day. Vaccines in the refrigerators were 3 Prevnar, 2 flu/RSV, and one opened PPD vial. (continued on next page)

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	075390	A. Building B. Wing	05/02/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/17/2024 at 12:25 PM indicated refrigerator temperatures need to be taken twice daily and would provide the facility policy. The facility policy labeled Medication Storage Room / Medication Cart Policy indicated in part, the facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet applicable Federal, State and Local laws, rules, and regulations. 4. Resident #101's diagnosis included cellulitis of the abdominal wall, falls, and seizure disorder. The Self Administration of Medication form dated 3/11/24 identified Resident #101 declined the desire to self-medicate. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #101 as moderately cognitively impaired and independent with personal hygiene, bathing, transfers, and toileting, Additionally the MDS identified Resident #101 required setup and clean up assistance with eating, and oral hygiene. Observations on 4/11/24 at 10:42 AM, identified a basin left on the sink in Resident #101's bathroom with a container of antifungal powder (3 ounce), Chlorhexidine Gluconate cloth containing a package of 6 wipes, and 40-ounce bottle of medicated chest rub. A second observation made with LPN #2 on 4/15/24 at 11:54 AM identified Resident #101's bathroom had one basin with a container of antifungal powder (3 ounce), Chlorhexidine Gluconate package of 6 cloth wipes, and a 40-ounce bottle of medicated chest rub. LPN#2 stated Resident # 101's roommate does not utilize that bathroom. Review of the Medication Administration Record for March 2024 and April 2024 failed to identify Resident #101 had a physician order for antifungal powder, Chlorhexidine Gluconate, or chest rub. Interview with RN #1 on 4/15/24 at 11:59 AM identified chest rub, and antifungal powder are considered medications and cannot be left at the bedside or with the resident. Review of the facilities policy for Medication Storage identified medication is stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. Storage for other medications will be limited to a locked medication room. 48950

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	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48880 Based on observation, review of facility policy and interviews, the facility failed to ensure dietary staff applied a beard guard when preparing food to ensure a sanitary environment. The findings include: Observation on 4/15/24 at 11:37 AM during the tray line with the Director of Dietary identified during plating of food from the cooking area to steam tables, [NAME] # 1 stirring a tray of beef stew at steam table #3. [NAME] #1 during the platting of food was observed with a beard and without the benefit of a beard guard. An interview with [NAME] #1 identified he had been told to wear a beard guard in the past. [NAME] #1 further indicated he had forgotten to use a beard guard since he usually does not have a long beard. After, [NAME] #1 proceeded to don a beard guard. An interview with the Director of Dietary identified Cook#1 should have been wearing a beard guard. A review of the facility's Uniform Policy notes in part that chefs or cooks should wear an apron, chef coat or shirt, chef pants, shoes, chef hat, hairnet or cap, and beard guards.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 1 resident (Resident # 101) reviewed for smoking, the facility failed to ensure that a copy of the resident's conservatorship was in the clinical record in accordance with accepted professional standards and practices of complete an accurate medical record. The findings include: Resident #101 was admitted to the facility on [DATE]. The resident's diagnoses included cellulitis of abdominal wall, alcohol abuse and nicotine dependence. Resident #101 had a conservator of both estate and person. The Admission Smoking Evaluation assessment dated [DATE] identified no desire to smoke at the time of the admission. The Resident Care Plan (RCP) dated 3/14/24 identified both short- and long-term memory loss. Interventions included referring to time of day, date, and recent events with interactions, and to utilize simple direct communication, verbal cues, and task segmentation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #101 as moderately cognitively impaired and noted the resident utilized a walker for mobility. The social service notes dated 3/15/24 at 1:40 PM identified Social Worker (SW #1) observed Resident #101 and a visitor smoking in the visitor's car in the facility's parking lot. SW #1 indicated both were informed there is no smoking on facility's grounds even if the resident signed out on a Leave of Absence (LOA). SW #1 indicated she met with Resident #101's Conservator of Person and Estate (Resident # 95) who indicated s/he was unaware of Resident #101 smoking on LOA. However, review of the clinical record during the survey failed to reflect a copy of the resident's conservatorship. Interview and clinical record review with the DNS 4/16/24 at 11:40 AM identified Resident #101 is conserved by Resident #95. The DNS also indicated the conservatorship document was unavailable at the time of the request to review the document. A request for a policy on clinical record, resident file maintenance, or conservatorship was requested but was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations, clinical record reviews, review of policy and interviews for 1 of 1 resident (Resident #74) reviewed for urinary catheter the facility failed to ensure the catheter collection bag was stored in a sanitary manner and for 1 of 1 resident (Resident # 101) observed during a tour of the facility, the facility failed to ensure that resident equipment was stored in a sanitary manner to prevent the spread of infection. The findings include: 1.Resident #74's diagnosis included neuromuscular disfunction of the bladder and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #74 was cognitively intact. The care plan dated 3/4/2024 indicated Resident #74 had a foley catheter due to neurogenic bladder and was at risk for infection. Interventions included: to change the foley catheter and bag per physician's order and the catheter monthly, to provide catheter care every shift and to attach a securement device to the foley catheter. Observation on 4/11/24 11:30AM noted Resident # 74's urinary drainage bag lying on the side on the floor in the room. On 4/11/2024 at 11:35 AM observation and interview with charge nurse LPN #3 identified the urinary drainage bag should not be on the floor and s/he would obtain a new bag to replace it. The facility policy labeled Urine Drainage Bags indicated appropriate urinary drainage bags will be used to contain urinary catheter drainage and to hang the urinary drainage bag on the residents in a privacy bag. 2. Resident #101's diagnosis included cellulitis of the abdominal wall, falls, and seizure disorder. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #101 was moderately cognitively impaired and was independent with personal hygiene, bathing, transfers, and toileting, Additionally the MDS identified Resident #101 required setup and clean up assistance. Observations on 4/11/24 at 10:42 AM, identified a basin unlabeled left on the floor in Resident #101's bathroom with a container of antifungal powder (3 ounce), Chlorhexidine Gluconate cloth containing a package of 6 wipes, and 40-ounce bottle of medicated chest rub. Another unlabeled basin was identified on the floor which was empty. A second observation made with LPN #2 on 4/15/24 at 11:54 AM identified Resident #101's bathroom had one basin left on the sink not labeled with a container of antifungal powder (3 ounce), Chlorhexidine Gluconate package of 6 cloth wipes, and a 40-ounce bottle of medicated chest rub. Another basin was noted on the floor which was not labeled. A bed pan was observed on the bedside table of Resident #101. LPN#2 stated the resident's roommate does not utilize that bathroom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 4/15/24 at 11:59 AM identified that bed pans and basin should be bagged, labeled, and not placed on the floor. Review of the facilities policy for Bedpan/Urinal Use of after use of bedpan or urinal to empty the bedpan or urinal into the toilet or designated waste area. Rinse with water and clean it thoroughly. Dry, cover, and return it to the resident's/patient's bedside stand bagged.