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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075411	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matulaitis Rehabilitation & Skilled Care	10 Thurber Rd Putnam, CT 06260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for skin alterations, the facility failed to review and revise the care plan timely to include surgical incisions present on admission and the identified risk for further skin impairment. The findings include: Resident #1's diagnoses included fusion of the spine, chronic congestive heart failure, history of Urinary Tract Infections (UTI's), functional urinary incontinence, muscle weakness and the need for assistance with personal care. The admission Observation dated 9/23/24 identified that Resident #1 was alert and oriented to person, place, time and situation, displayed weakness to both the right and left lower extremities and was observed with a mid-back surgical incision. A physician's order dated 9/23/24 directed to monitor the surgical incision to Resident #1's back for signs and symptoms of infection every shift. A nurse's note dated 9/23/24 at 7:02 PM identified that Resident #1 was admitted to the facility at 2:30 PM with a midline back incision with an intact dressing. The note reported that the resident's family member refused to allow staff to remove the dressing to assess the area. Review of the Resident Care Plans for Resident #1 failed to identify an actual skin impairment due to the surgical wound. Interview with the DNS on 12/09/24 at 11:51 AM identified that there should have been a care plan for surgical skin impairments for Resident #1. She reported that the admitting nurses should have initiated the care plans on admission. She identified that the care plans must have been missed and she was unsure why. Interview with RN #6 (MDS Coordinator) on 12/9/24 at 1:40 PM identified that the care plan for the surgical incision for should have been initiated on admission. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Person-Centered Care Plans policy dated 04/2021 directed, in part that the comprehensive, person-centered care plan will include measurable objectives and time frames, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals, timetables and objectives in measurable outcomes, identify the professional services that are responsible for each element of care and aid in preventing or reducing decline in the resident's functional status and/or functional levels.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) residents (Resident #1 and #2) reviewed for altered skin integrity, the facility failed to measure two (2) incisional wounds from admission through discharge , failed to ensure that an external catheter device had a physician's order, and failed to ensure that a pressure ulcer risk scale was completed in accordance with facility policy.The findings include: 1) Resident #1's diagnoses included fusion of the spine, chronic congestive heart failure, history of Urinary Tract Infections (UTI's), functional urinary incontinence, muscle weakness and the need for assistance with personal care. The admission Observation dated 9/23/24 identified that Resident #1 was alert and oriented to person, place, time and situation, displayed weakness to both the right and left lower extremities and was observed with a mid-back surgical incision. The Resident Care Plan (RCP) dated 9/23/24 identified that Resident #1 had a self-care deficit related to weakness and recent spinal surgery with interventions that included extensive staff assist of two (2) for bed mobility and performing weekly skin checks on bath day, documenting the findings in a progress note and updating the provider and family as needed. a) A nurse's note dated 9/23/24 at 7:02 PM identified that Resident #1 was admitted to the facility at 2:30 PM with a midline back incision with dressing intact. The note reported that the resident's family member refused to allow staff to remove the dressing to assess the area. Review of the clinical record from admission on 9/23 through discharge to the hospital on [DATE] failed to identify measurements of the two (2) surgical incisions to the back. Interview with APRN #1 on 12/06/24 at 2:26 PM identified that the facility should be following their wound protocol and measuring any skin irregularities, including surgical wounds on admission and weekly so that they can accurately monitor the improvement or decline of the area. Interview with the DNS on 12/09/24 at 11:51 AM identified that she expects all skin areas, including surgical incisions are measured on admission and weekly and signed off in the MAR. Additionally, she was unsure why no measurements were obtained of the surgical incisions. Review of the Wound Care Standard policy dated 08/2000 directed, in part, that a wound assessment will be done weekly by licensed nursing staff documenting the location, size and appearance of the wound, amount, color and odor of any drainage and any presence of redness, swelling, warmth and change in appearance should also be included in the documentation. b) Review of 09/2024 and 10/2024 nurse's notes identified that Resident #1 was utilizing an external catheter within the facility, which was first documented on 9/24/24 at 3:00 AM and last documented on 10/7/24 at 5:36 AM before his/her 10/08/24 discharge. Review of physician's orders dated 9/23/24 through 10/08/24 failed to identify an order for the external catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 12/06/24 at 1:44 PM identified that Resident #1 did utilize the external catheter, and that the family member would apply it at night and would then pay a private aide to come into the facility in the morning and remove it. She identified that the aide would then take pictures of the canister and send them to the family everyday. She reported that staff did not apply or remove the catheter but that they would turn it on/off and empty it if needed. Interview with APRN #1 on 12/06/24 at 2:26 PM identified that the external catheter system should not have been utilized within the facility without a physician's order, as it is a medical device. Additionally, she reported that staff should be trained on the device, as it poses a risk for infections if not cleaned appropriately. Interview with RN #4 on 12/06/24 at 2:54 PM identified that staff did not take apart or manage the external catheter, reporting that they only turned it on/off as needed. He identified that there had been no staff training on the external catheter system. Interview with the DNS on 12/09/24 at 11:51 AM identified that although there was no policy or staff training, the facility allowed Resident #1 to utilize the external catheter device throughout his/her stay at the facility and also allowed the family and a private aide to manage the device. She reported that there should have been a physician's order for the external catheter system and they should not have allowed the family and private aide to manage it without oversight. She identified that she was unsure why staff may have turned on/off the device or emptied the device without proper training. Although requested, a policy on an external catheter system was not obtained. 2) Resident #2's diagnoses included fracture of the right femur, Parkinson's disease, dementia without behavioral disturbances, a stage 4 pressure ulcer of the sacral region (an ulcer at the base of the spine that is down to the bone), anemia and thrombocytopenia (low platelets in the blood that can cause a person to bleed or bruise easily). The admission Observation dated 8/9/21 identified Resident #2 was alert to person, place, time and situation, required assistance with Activities of Daily Living (ADLs) and was admitted to the facility with a pressure ulcer to the coccyx measuring 1.5 centimeters (cm) by 1 cm (not staged, please referemce F 686). A nurse's note dated 8/9/21 at 9:55 PM identified that Resident #2 arrived at the facility from the hospital at 3:30 PM and was noted with a pressure sore to the coccyx measuring 1.5 cm by 1 cm with a dry protective dressing in place and calmoseptine (barrier cream) applied as ordered. A physician's order dated 8/9/21 directed to apply calmoseptine to thearea and cleanse the coccyx with normal saline, pat dry and then apply protective dressing to the area daily and as needed. A care plan dated 8/10/21 identified that the resident was at risk for pressure ulcers due to decreased mobility, poor nutrition, and a pressure ulcer present on admisssion with interventions that directed to have a pressure relieving mattress and cushion for chair, and to encourage turning and repositioning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A focused observation dated 8/12/21 at 10:20 AM identified that the pressure ulcer to the coccyx measured 6 cm by 3.5 cm and the depth was unable to be determined due to a large, darkened area. It identified that an air mattress would be put in place (3-days after admission, the area was not staged). A physician's order dated 8/12/21 directed to reposition the resident every two (2) hours every shift. A nurse's note dated 8/23/21 at 10:27 AM identified that Resident #2 was increasingly confused and had refused breakfast. It reported that the pressure sore on his/her buttocks appeared to have gotten worse with a large, reddened area measuring 13 cm by 7 cm with a moderate amount of yellow/green drainage and small necrotic areas had been noted. The note reported that the physician was notified, and a new order had been obtained to send the resident to the Emergency Department (ED) for further evaluation, as there was question of sepsis. A Braden Scale for Predicting Pressure Sore Risk dated 9/1/21 (25 days after admission) identified that Resident #2 was at very high risk for pressure sores. Interview with the DNS and RN #3 on 12/09/24 at 1:01 PM identified that per policy, Braden Scale Assessments are to be done on all residents on admission, quarterly and with a change in condition. They reported that although Resident #2 should have had a Braden completed on 8/9/21 and 8/23/21, a Braden wasn't completed until 9/1/21 and they were unsure why. Interview with MD #2 (current wound doctor) on 12/09/24 at 12:36 PM identified that the facility should be following their Wound Protocol and Braden Risk policies at all times. Review of the Braden Scale Assessment policy dated 7/2020 directed, in part, that the Braden Scale Observation is used to assess a resident's risk of developing a pressure ulcer. All residents will be assessed upon admission, readmission, quarterly and at each change in condition to assess the potential for skin breakdown. A score of 18 or below will indicate the need for preventative intervention. All assessments and interventions will be documented in the Electronic Health Record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for pressure ulcers, the facility failed failed to place additional interventions timely for a resident identified on admission to have a pressure ulcer, failed to ensure that the pressure ulcers were staged and assessed in accordance with facility policy. The findings include: Resident #2's diagnoses included fracture of the right femur, Parkinson's disease, dementia without behavioral disturbances, a stage 4 pressure ulcer of the sacral region (an ulcer at the base of the spine that is down to the bone), anemia and thrombocytopenia (low platelets in the blood that can cause a person to bleed or bruise easily). The admission Observation dated 8/9/21 identified Resident #2 was alert to person, place, time and situation, required assistance with Activities of Daily Living (ADLs) and was admitted to the facility with a pressure ulcer to the coccyx measuring 1.5 centimeters (cm) by 1 cm (not staged). The clinical record lacked a timely Braden Scale (identifies risk for pressures ulcers) identified upon admission (please cross reference F 684). A nurse's note dated 8/9/21 at 9:55 PM identified that Resident #2 arrived at the facility from the hospital at 3:30 PM and was noted with a pressure sore to the coccyx measuring 1.5 cm by 1 cm with a dry protective dressing in place and calmoseptine (barrier cream) applied as ordered (the clinical record failed to identify the pressure ulcer stage). A physician's order dated 8/9/21 directed to apply calmoseptine (a moisture barrier),cleanse the coccyx with normal saline, pat dry and then apply protective dressing to the area daily and as needed. A care plan dated 8/10/21 identified that the resident was at risk for pressure ulcers due to decreased mobility, poor nutrition, and a pressure ulcer present on admisssion with interventions that directed to have a pressure relieving mattress and cushion for chair, and to encourage turning and repositioning. A focused observation dated 8/12/21 at 10:20 AM identified that the pressure ulcer to the coccyx measured 6 cm by 3.5 cm (larger than on admission) and the depth was unable to be determined due to a large, darkened area (not staged). The observation identified that an air mattress would be put in place (3-days after being admitted with a pressure ulcer, and no staging of pressure ulcer was identified). A physician's order dated 8/12/21 directed to reposition the resident every two (2) hours every shift (3 days after being admitted with a pressure ulcer) There were no measurements identified in the clinical record from 8/12 through 8/22/24 (10 days). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 8/23/21 at 10:27 AM identified that Resident #2 was increasingly confused and had refused breakfast. The pressure ulcer on his/her buttocks appeared to have gotten worse with a large, reddened area measuring 13 cm by 7 cm with a moderate amount of yellow/green drainage and small necrotic areas had been noted. The note reported that the physician was notified, and a new order had been obtained to send the resident to the Emergency Department (ED) for further evaluation, as there was question of sepsis. A nurse's note dated 8/23/21 identified that Resident #2 was transferred back to the facility at 4:45 PM and had been diagnosed with anemia and mental status change. Imaging to the head (CT scan) had been performed and was negative. No new orders were obtained. A physician's order dated 8/24/21 directed that Resident #2 may have a wound consult with the wound care group for pressure area on the buttocks until resolved. A wound physician's note dated 8/24/21 identified that the resident was seen for initial visit and was noted to have a sacral wound measuring 10 cm by 3.5 cm by 0.1 cm with noted slough and necrotic tissue. The note identified the area was debrided and Santyl (a wound product used to remove dead tissue from a wound) was applied to the wound bed followed by a dry protective dressing. The note reported that he wound follow-up with the resident weekly but that the prognosis was poor due to the resident's diagnoses and limited mobility. A nurse's note dated 8/24/21 at 1:13 PM identified that a new physician's order was obtained to apply Santyl to the wound bed, skin prep around the wound and then cover with a foam dressing daily and as needed. Interview with the DNS and RN #3 on 12/09/24 at 1:01 PM identified that for all residents that are admitted to the facility with a pressure ulcer, an air mattress is placed to their bed prior to their arrival. She statted that if a pressure ulcer is not communicated on report, they will place one on the bed after the resident's arrival and they were unsure why Resident #2 did not receive an air mattress until 8/12/21, after the pressure area had increased in size. The DNS identified that residents admitted to the facility with a pressure ulcer should be seen on the wound doctor's next visit to the facility but reported that the delay in the order and the initial visit was most likely due to COVID, reporting they didn't have a stable wound doctor during that time. The DNS identified that Resident #2 had treatment orders for the pressure ulcer, and the nurses were completing the treatment daily, however, the wounds should be staged and assessed per the facility policy (weekly). The DNS further identified that RN #3 identified that her documentation in the 8/12/21 focused assessment that referred to the area as 'darkened' meant it was red and not normal skin color, but not necrotic and that's why she obtained orders for the air mattress and turning and repositioning the resident every two (2) hours reporting that they should have been done on admission. Interview with MD #2 (current wound doctor) on 12/09/24 at 12:36 PM identified that with the resident's diagnoses and the fast decline of the wound, it was possible that the resident had developed Kennedy ulcers but reported that she would have expected that the resident received an air mattress and a turning schedule on admission. She identified that the facility should be following their Wound Protocol and Braden Risk policies at all times, but identified she was not working at the facility during Resident #2's admission in 2021 so she was unsure of all the specifics. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Braden Scale Assessment policy dated 7/2020 directed, in part, that the Braden Scale Observation is used to assess a resident's risk of developing a pressure ulcer. All residents will be assessed upon admission, readmission, quarterly and at each change in condition to assess the potential for skin breakdown. A score of 18 or below will indicate the need for preventative intervention. All assessments and interventions will be documented in the Electronic Health Record. Review of the Pressure Ulcer policy dated 4/2023 directed, in part, that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure sore. All residents will have a pressure redistribution mattress and position and reposition the resident with pillows and other supportive devices as needed. The nurse will notify the physician anytime the pressure sore is showing signs of non-healing or infection and request treatment order changes.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for incontinence, the facility failed to provide staff education to ensure competent nursing staffing related to an external catheter system. Resident #1's diagnoses included fusion of the spine, chronic congestive heart failure, history of Urinary Tract Infections (UTI's), functional urinary incontinence and the need for assistance with personal care. The admission Observation dated 9/23/24 identified that Resident #1 was alert and oriented to person, place, time and situation, displayed weakness to both the right and left lower extremities and had urinary incontinence with no catheters in place. The Resident Care Plan (RCP) dated 10/01/24 identified that Resident #1 was incontinent of urine with interventions that included approaching resident and providing incontinent care during rounds and as needed, assess if the resident is wet/soiled and assess for any redness or breakdown and notifying the nurse of any changes. Review of 09/2024 and 10/2024 nurse's notes identified that Resident #1 was utilizing an external catheter within the facility, which was first documented on 9/24/24 at 3:00 AM and last documented on 10/7/24 at 5:36 AM before his/her 10/08/24 discharge. Review of physician's orders dated 9/23/24 through 10/08/24 failed to identify an order for the external catheter. Interview with LPN #1 on 12/06/24 at 1:44 PM identified that Resident #1 did utilize the external catheter, and that the family member would apply it at night and would then pay a private aide to come into the facility in the morning and remove it. She identified that the aide would then take pictures of the canister and send them to the family everyday. She reported that staff did not apply or remove the catheter but that they would turn it on/off and empty it if needed. Interview with APRN #1 on 12/06/24 at 2:26 PM identified that the external catheter system should not have been utilized within the facility without a physician's order, as it is a medical device. Additionally, she reported that staff should be trained on the device, as it poses a risk for infections if not cleaned appropriately. Interview with RN #4 on 12/06/24 at 2:54 PM identified that staff did not take apart or manage the external catheter, reporting that they only turned it on/off as needed. He identified that there had been no staff training on the external catheter system. Interview with the DNS on 12/09/24 at 11:51 AM identified that although there was no policy or staff training, the facility allowed Resident #1 to utilize the external catheter device throughout his/her stay at the facility and also allowed the family and a private aide to manage the device. She identified that the facility should not have allowed the family and private aide to manage the external catheter without oversight. She identified that she was unsure why staff may have turned on/off the device or emptied the device without proper training. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a policy on an external catheter system was not obtained.