STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075425	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vanderman Place	595 Valley Street Willimantic, CT 06226

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for behaviors, the facility failed to ensure that behavior monitoring was completed on a resident receiving antipsychotic medications. The findings include: Resident #1's diagnoses included anxiety disorder, schizoaffective disorder and bipolar disorder. A physician's order dated 10/9/24 directed to administer Aripiprazole 5 milligram (mg) tablet by mouth at bedtime for bipolar disorder. A physician's order dated 6/11/24 directed to administer Cariprazine (an antipsychotic medication used to treat schizophrenia, bipolar disorder and major depression) 6 milligram (mg) capsule by mouth once daily. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was dependent on staff for transfer assistance. The Resident Care Plan (RCP) dated 12/26/24 identified that Resident #1 uses psychotropic medications related to diagnoses of bipolar disorder and schizoaffective disorders with interventions that included to administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness every shift and monitoring/recording occurrences of target behavior symptoms and document per facility protocol. A physician's order dated 1/27/25 and discontinued on 2/13/25 directed to administer Seroquel (an antipsychotic medication used to treat schizophrenia, bipolar disorder and depression) 25 milligram (mg) tablet by mouth at bedtime. A physician's order dated 2/13/25 directed to administer Seroquel 25 milligram (mg) tablet by mouth at bedtime. Review of physician's orders dated 1/1/25 through 2/28/25 failed to identify a physician's order directing staff to monitor Resident #1's behaviors associated with the use of antipsychotic medications. (continued on next page)

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January and February 2025 Medication Administration Records for Resident #1 failed to identify that behaviors were being monitored alongside the use of antipsychotics. Review of nurse's notes dated 1/1/25 through 2/19/25 failed to identify documentation related to behavior monitoring every shift. Interview with APRN #1 (psychiatric) on 3/6/25 at 11:40 AM identified that Resident #1 should have had behavior monitoring in place every shift, as he/she was on several antipsychotic medications. She identified that she was new to the facility, so she did not identify the omissions but stated that behavior monitoring is used to identify any increased or improved behaviors and guides a resident's treatment. She identified that at the least, the resident should have been monitored every shift for mood, anxiety, paranoia and agitation. Interview with the ADNS on 3/6/25 at 11:50 AM identified that although she was unable to locate any documented behavior monitoring on Resident #1, she would expect that a physician's order be obtained when a resident is placed on any antipsychotics and that target behaviors are monitored every shift. She reported that she was unsure why a physician's order had not been obtained and why target behaviors were not monitored on Resident #1, as they should have been. Review of the Behavioral Assessment, Intervention and Monitoring policy (undated) directed, in part, that behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. Residents will have minimal complications associated with the management of altered or impaired behavior. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Review of the Antipsychotic Medication Use policy (undated) directed, in part, that the attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms and risks to the resident and others. The attending physician and facility staff will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting why the benefits of the medication(s) outweigh the risks or suspected or confirmed adverse consequences.

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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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for hospitalizations, the facility failed to ensure complete and accurate documentation including an oxygen level when the resident was noted to have increased respirations and breathing heavily, provider notification and ensuring documentation of a physician's order related to a Emergency Department (ED) transfer. The findings include: Resident #2's diagnoses included acute and chronic respiratory failure, congestive heart failure, chronic kidney disease and kidney failure. The Resident Care Plan (RCP) dated 1/15/24 identified that Resident #2 has altered cardiovascular status related to atrial fibrillation (irregular heartbeat) with interventions that included to assess for chest pain, shortness of breath, monitor vital signs and notify the physician of significant abnormalities, and monitor/document/report as needed any changes in lung sounds on auscultation, edema and changes in weight. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required substantial assistance with bed mobility and was dependent on staff for transfers and ambulation. A nurse's note dated 2/15/24 at 5:20 AM identified that Resident #2 was scheduled for dialysis and was to be transported by his/her spouse. The note identified that it took an assist of three (3) staff to get the resident into the wheelchair and the resident was then brought out to the nurses station awaiting his/her spouse to bring the car to the side door. While waiting, the resident started breathing heavily, skin was noted to be pale and cold, the resident complained of blurry vision and weakness but denied any pain. Vital signs were obtained to include a blood pressure of 101/92, heart rate of 60 beats per minute, body temperature of 97.6 degrees Fahrenheit and respirations between 24 and 28. The note identified that the nursing supervisor was present and 911 was called at 5:40 AM and the ambulance arrived and transported Resident #2 to the hospital. Review of nurse's notes dated 2/15/24 through 2/16/24 failed to identify any additional notes or documentation that an RN assessment was completed, the provider was notified or that an oxygen (Sp02) level was obtained. Review of physician's orders dated 2/15/24 through 2/16/24 failed to identify a physician's order directing staff to transfer the resident to the hospital for an evaluation. A social service note dated 2/16/24 at 8:07 AM identified that per nursing, Resident #2 was transferred to the hospital on 2/15/24 and passed away at the hospital. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 (Nursing Supervisor) on 3/6/25 at 1:19 PM identified that staff identified promptly that Resident #2 had a change in condition, as he/she had a very brittle health status stating she was notified by RN #1, and the resident was immediately sent to the ED for evaluation. She reported that although she did not document a note and she should have, she assessed the resident to include lung sounds and stated they obtained an oxygen level on the resident but stated she was unsure why it wasn't documented in the clinical record. She identified that she also notified the provider of the change and obtained a physician's order to transfer the resident to the ED but stated that she must have forgotten to enter the order and document who she notified and at what time, stating it was a hectic morning. RN #2 reported that it was facility practice that the assessment, provider notification and time of transfer for a change in condition was to be documented in a nurse's note, stating they didn't have a SBAR assessment in their system. Interview with RN #1 on 3/6/25 at 1:52 PM identified that as soon as Resident #2's spouse went to get the car, the resident became pale, diaphoretic and his/her respirations increased. She identified that although the vitals were documented except for the oxygen level, she was aware the resident appeared to be short of breath and they would have checked his/her oxygen and must have forgot to document the result. She identified that RN #2 was responsible for notifying the physician and obtaining and entering the order to transfer the resident to the ED for evaluation. Interview with the ADNS on 3/6/25 at 3:3 PM identified that all care provided to a resident and communication with a provider regarding a resident should be documented in the clinical record timely. Review of the Change in a Resident's Condition or Status policy (undated) directed, in part, that the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition or the need to transfer the resident to a hospital/treatment center. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.