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	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation and staff interviews for 5 of 5 residents (Residents 24, 55, 56 and # 73) reviewed for Psychotropic medications, the facility failed to ensure informed consent for the use of a new psychotropic medication was obtained from the responsible party prior to the use of the medication. The findings included: 1. Resident #22's diagnosis included cognitive deficits following a cerebral infarction, unspecified intellectual disabilities and major depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #22 had severe cognitive impairment, The care plan dated 1/14/2025 indicated in part Resident #22 had a communication problem related to history of intellectual disability and cognitive deficits. Interventions included: to anticipate and meet needs, speech therapy as indicated, use of communication techniques which enhance interaction. A psychiatric prescribers note dated 2/05/2025 indicated Resident #22 was able to express his/her needs through gestures and limited verbalizations, reports feeling depressed over medical limitations, and appeared mildly depressed. Additionally, given Resident #22's symptoms and willingness to initiate treatment a trial of antidepressant will be initiated with monitoring of side effects. A physician's order dated 2/5/2025 directed to administer Sertraline HCL(Antidepressant) 25 Milligram (MG) tablet by mouth once daily for depression. An interview with the Director of Nursing Services (DNS) on 5/22/2025 at 12:28 PM indicated the psychotropic consent forms were in a binder in the MDS nurse's office but not available. The DNS also indicated this process is somewhat new; I will let you know what I find. An interview on 5/22/2025 1:30 PM with the Director of Nursing [NAME] (DNS) indicated even though Resident #22 had been receiving Sertraline since 2/5/2025 (105 days since medication was started) the informed consent for use of Sertraline for Resident #22 slipped through the cracks and staff is working on consent at this time. The DNS further indicted she/he was unable to find a progress note stating staff contacted Resident #22's Conservator for informed consent (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075425	A. Building B. Wing	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/22/2025 at 1:10 PM the administrator approached the surveyor with the 2/05/2025 psychiatric provider note that indicated Resident #22 gave permission for use of the antidepressant. The surveyor pointed out Resident #22 has a conservator of person and requested documentation that informed consent for use of psychotropic medication was provided to the conservator. On 5/22/2025 at 1:20 PM the Administrator indicated the inability to find any documentation the conservator had been informed of and provided consent for use of psychotropic medication. On 5/23/2025 at 9:21 AM a consent form for Resident #22 obtained via phone on 5/22/2025 (106 days after the medication was started) not signed by the person who obtained consent. 2. Resident #24's diagnosis included unspecified dementia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #24 was cognitively intact. A physician's order dated 11/14/2024 directed to administer Citalopram Hydrobromide (antidepressant) 20 MG tablet once daily by mouth along with a 10 MG tab for a 30 MG dose. The care plan dated 12/17/2024 indicated Resident #24 had a behavior problem being accusatory related to dementia. Intervention included anticipating needs, assisting to develop more appropriate methods of coping with and interacting with staff. A physician's order dated 2/3/2025 directed to administer risperidone (antipsychotic) tablet 1 MG once daily for behavioral disturbances related to dementia. An interview on 5/22/2025 at 1:30 PM with the Director of Nursing [NAME] (DNS) indicated staff is working on consents for many residents at this time. An interview on 5/23/2025 at 08:38AM with Registered Nurse (RN #8) the MDS Nurse indicated the scheduler had the psychotropic medication book with the consents. An interview and review of clinical documents of various residents kept in a binder on 5/23/2025 at 8:40 AM with the scheduler identified she and a nurse aide were assigned about 2 weeks ago to call the families of the residents on the list and obtain consent over the phone for medications. They also indicated if the family had questions they would be directed to a nurse. The scheduler provided 2 psychotropic medication consent forms, one for Citalopram (antidepressant and the other for Risperdal (antipsychotic) each dated 5/08/2025 indicating verbal consent was obtained on this date. (190 days and 107 days respectively after starting the medication) An interview on 5/23/2025 at 9:11 AM with the Administrator identified she/he was waiting for the facility psychotropic medication policy. At 9:40 AM the Administrator indicated s/he had called the DNS (not in the facility) who indicated there was no policy for psychotropic medications. 3. Resident #55 's diagnoses included unspecified dementia, paranoid schizophrenia and depression. (continued on next page)

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	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #55 was cognitively impaired and required supervision/ touching assistance with eating, oral hygiene and maximal assistance for personal hygiene. The care plan dated 4/1/25 identified Resident #55 requires psychotropic drugs for dementia schizophrenia and appetite stimulant (Haldol, Prozac, Remeron, trazadone). Interventions included administering medications as ordered; monitor for therapeutic effect and side effects of medication; complete behavior monitoring sheets every shift. A physician's order dated 3/15/23 directed mirtazapine 15 MG tab give 1 tablet orally at bedtime for antidepressant, an order dated 9/5/24 directed Fluoxetine HCl Oral Tablet 10 MG (Fluoxetine)Give 3 tablet by mouth one time a day for depression and anxiety and an order dated 4/10/25 directed Haloperidol Tablet 0.5 MG Give 1 tablet by mouth at bedtime for anxiety, insomnia. (consent signed for 5/8/25) The Medication Administration Records March 2023 through May 2025 indicated the following medications administered prior to consent: Fluoxetine; started 9/5/24 consent obtained 5/8/25. Haloperidol Tablet: started 4/10/25 consent obtained 5/8/25 and mirtazapine, started 3/15/23 consent obtained on 5/8/25. The interview with ADNS on 5/23/25 at 10:34AM indicated the DNS is responsible for obtaining concerns and new staff are being trained to assume the role. She is unable to explain why consents were not obtained prior to admission. Review of the Psychoactive Drug System policy dated October 2019 directed a consent from the resident and or responsible party will be obtained when a resident is started on a psychoactive medication and the resident or responsible party will be notified when the dose of the psychoactive medication has been changed by the practitioner. 4. Resident #56's diagnoses included metabolic encephalopathy, anxiety disorder, and dementia with psychotic disturbance. A physician's order dated 6/21/23 directed to administer Olanzapine (Zyprexa) 5 MG by mouth two times a day and 2.5 MG by mouth every eight hours as needed for psychotic disorder. The quarterly MDS assessment dated [DATE] identified Resident #56 had severe cognitive impairment and required set-up assistance with oral hygiene, personal hygiene, and moderate assistance with toileting hygiene, shower, and lower body dressing. The Resident Care Plan (RCP) dated 3/13/25 identified Resident #56 with impaired cognition related to dementia. Intervention directs the conservator to remain involved and intervene as needed. The RCP dated 3/13/25 also identified Resident #56 used psychotropic medications related to history of agitated behaviors and delusions. Interventions included: to administer psychotropic medications as ordered by physician and monitor side effects, and discuss with Medical Doctor, family the need for use of medication. (continued on next page)

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	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Psychotropic Medication Therapy Informed Consent Form dated 5/19/25 for medication Olanzapine identified verbal consent from the conservator of person (COP) and no signature from the person who obtained verbal consent from the facility. Interview with the Nurse Scheduler on 5/23/25 at 10:21 AM identified that a request was made by the Director of Nursing Services to help and assist with making phone calls to family and responsible parties to obtain verbal consent for psychotropic medications. Nurse Scheduler indicated she was not aware of the process for obtaining consent for psychotropic medication and commented she was only asked to help and did not think, she was responsible for signing the form once she received a verbal consent. Nurse Scheduler identified she was not aware of the Psychoactive Drug System policy. Interview on 5/23/25 at 10:34 AM with the Assistant Director of Nursing Services (ADNS) identified she was not aware of the process for obtaining consent from the responsible parties for psychotropic medications. She identified the Director of Nursing Services (DNS), and RN #1 were the ones responsible for the completion. The ADNS further indicated she was not familiar with the Psychoactive Drug System policy. An interview on 5/23/25 at 11:06 AM with RN #1 identified the process for obtaining consents from responsible parties for psychotropic medications was a new project started at the beginning of the week. She identified the Nurse Scheduler and a Certified Nurse Aide (CNA) who was on light duty were asked to call family and responsible parties to obtain verbal consent, and they were not aware that the form required a signature. RN #1 identified she was not aware of the Psychoactive Drug System policy. DNS was unavailable for an interview. 5. Resident #73's diagnoses included Alzheimer's disease, depression, and Post- Traumatic Stress Disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #73 had severe cognitive impairment and required supervision (helper provides verbal cues and assistance) with oral hygiene, toileting hygiene, upper & lower body dressing, and toilet transfer. The RCP dated 12/5/24 identified Resident #73 had a new onset of antipsychotic medication related to an increase in behavioral symptoms and agitated behavior. Interventions included: discussing with Medical Doctor and family the ongoing need for use of medication, monitor and record target behavior symptoms, and monitor and report adverse reactions to Psychotropic medications A physician's order dated 11/20/24 directed to administer buspirone 5 MG by mouth one time a day for anxiety. A physician's order dated 12/5/24 directed to administer quetiapine fumarate (Seroquel) 25 MG by mouth in the morning for psychotic behaviors related to dementia. A physician's order dated 2/3/25 directed to administer trazodone 50 MG by mouth one time a day for anxiety. (continued on next page)

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	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 3/26/25 directed to administer Seroquel 25 MG by mouth in the evening for restlessness and agitation. A physician's order dated 3/28/25 directed to administer buspirone 7.5 MG by mouth three times a day for agitation/anxiety. A physician's order dated 4/9/25 directed to administer escitalopram oxalate (Lexapro) 20 MG by mouth one time a day for depression. . A physician's order dated 6/4/24 directed to administer Memantine 10 MG by mouth one time a day for anxiety/agitation. However, a review of the Psychotropic Medication Therapy Informed Consent Forms for Resident #73 dated 5/21/25 for medications; quetiapine, trazodone, escitalopram, and buspirone, identified verbal consent from the responsible party and no signature from the person who obtained verbal consent from the facility. Interview on 5/23/25 at 10:34 AM with the Assistant Director of Nursing Services (ADNS) identified she was not aware of the process for obtaining consent from the responsible parties for psychotropic medications. She identified the Director of Nursing Services (DNS), and RN #1 were the ones responsible for the completion. The ADNS further indicated she was not familiar with the Psychoactive Drug System policy. An interview on 5/23/25 at 11:06 AM with RN #1 identified the process for obtaining consents from responsible parties for psychotropic medications was a new project started at the beginning of the week. She identified the Nurse Scheduler and a Certified Nurse Aide (CNA) who was on light duty were asked to call family and responsible parties to obtain verbal consent, and they were not aware that the form required a signature. RN #1 identified she was not aware of the Psychoactive Drug System policy. Review of the Psychoactive Drug System policy dated October 2019 directed a consent from the resident and or responsible party will be obtained when a resident is started on a psychoactive medication and the resident or responsible party will be notified when the dose of the psychoactive medication has been changed by the practitioner.

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, facility policy review and staff interviews for 3 out of 6 residents (Residents #30, # 75, 193) reviewed for abuse, the facility failed to ensure each resident was free from abuse. The findings included. 1. a. Resident #30's diagnosis included hemiplegia, hemiparesis, aphasia and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated mild cognitive impairment. The care plan dated 3/3/2025 indicated Resident #30 was involved in an altercation with roommate (Resident #31) on 12/23/2024. Interventions included 1:1 visits with the social worker, offer a room change and place with an appropriate roommate, refer to psychiatric services for follow up and for staff to monitor for signs and symptoms of any changes in resident's moods or behaviors and address promptly. b. Resident #33's diagnosis included adjustment disorder and depressive episodes. The quarterly MDS assessment dated [DATE] indicated Resident #31 was cognitively intact. The care plan dated 2/25/2025 indicated Resident #33 had a history of agitation. Interventions included: to continue with medication as ordered 1:1 visits with the social worker as needed and refer to psychiatric services for follow up as needed. The care plan further indicated Resident #33 had potential for trauma related to history of being assaulted. Interventions included: to assist residents in identifying triggers and measures to relieve anxiety and to observe adjustment difficulties. The facility Incident Report indicated a Resident-to-Resident altercation occurred on 12/23/2024 at 6:15 PM where roommates (Resident #30 and #33), were witnessed arguing over closet space, came out of the room continuing to argue, Resident #30 allegedly grabbed Resident #33's arm over closet space and Resident #33 was observed striking Resident #30 in the face. The report further indicated that the supervisor (RN #4) notified the Director of Nursing Services immediately after placing the residents on 1:1 supervision, a room change was completed, the local police were notified, and an investigation was initiated. On 5/23/25 at 11:27 AM an interview and review of written statement with a charge nurse (LPN #8) who witnessed what transpired during the incident identified Resident #30 stated clothing in the shared closet each resident shared were claiming to be their own, Resident #33 was attempting to leave the room but Resident #30 was trying to block his/her exit. LPN #8 indicated s/he allowed Resident #33 to leave the room. Resident #30 followed Resident #33 out of the room, and both started to argue again, Resident #30 attempted to stop Resident #33 again while trying to get away from the situation at which time LPN #8 and other staff tried to separate the residents. LPN #8's statement indicated she/he saw Resident #33 strike Resident #30 in the cheek twice while he/she tried to separate them. LPN #8 further indicated the supervisor was notified and arrived on the unit and notified who needed to be called and the police came in. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Attempts to reach NA #7 on 5/23/25 at 11:41 AM and NA# 9 05/23/25 11:47 AM who written statements indicated observing Resident #31 strike Resident #30 were not successful. On 5/23/25 at 1:34 PM an interview with the Nursing Supervisor (RN #4) indicated she/he did not recall to anything about the incident and was out of the country on vacation . RN # 4 asked the surveyor to refer to the written statement. 2. Resident #75 's diagnoses included vascular dementia, difficulty in walking and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #75 was cognitively impaired and required partial assistance with bed mobility and sit to stand transfers. MDS identified Resident #75 requires a manual wheelchair to ambulate. The care plan dated 8/23/24 identified Resident #75 is at risk for changes in mood/behavior. impaired cognition. Interventions included: to provide comfort and emotional (support) as needed and to refer to psychiatric services for intervention as needed. A nurse's note dated 9/23/24 at 5:48 PM identified Charge nurse reported resident was hit by another resident in the face. This incident was witnessed by nursing assists who stated resident when in the other person's bedroom and hit her/him in the face with her/his hands. Residents couldn't recall what happened due to cognitive loss dementia. On assessment no signs or symptoms of injury noted. The phone interview with NA #1 on 5/22/25 at 12:22 PM indicated Resident #75 and Resident #63 lived on different units at the time of the incident. NA#1 reported Resident #63 was a known wander who often wanders into other resident's room, particularly Resident # 63 wandered into Resident #75's room due to the room being at the end of the hallway, where Resident #63 likes to hangout. NA#1 stated the day of the incident she heard Resident #75 screaming stop bumping into me. She reported upon entering the room Resident #63 grabbed Resident #75s by the hair and pulled. NA#1 reported she was able to intervene and separate them. Interview with ADNS on 5/22/25 01:55 PM indicated any resident with known wandering behaviors should have been cued and supervised. She reported subsequent to the incident on 9/23/24 interventions were put in place to prevent Resident #63 from wandering into Resident #75's room. Facility abuse policy indicates in part It is the policy of the facility that each resident has the right to be free from abuse . it is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe place. 3 a. Resident #81's diagnosis included adjustment disorder with mixed anxiety and depressed mood. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The care plan dated 4/14/2025 indicated Resident #81 had a diagnosis of major depression, sad and anxious mood. Interventions included: 1: 1 visit by the social worker for venting, socialization and emotional support. The care plan further indicated Resident #81 had potential for trauma related to medical condition, pending surgical procedure and depression/anxiety. Interventions included: to assist the resident to identify triggers and measures that relieve anxiety and to observe for adjustment difficulties. The care plan further indicated Resident #81 stated difficulty sleeping through the night. Interventions included: to evaluate room for noise, darkness, temperature and comfort and offer sleep aid as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #81 was cognitively intact. b. Resident #193's diagnosis included dementia, Parkinsons disease, and syncope with collapse(fall). A nursing progress note dated 5/20/2025 at 11:30 PM indicated Resident #193 arrived via ambulance from the hospital for admission. The resident was oriented to name and date of birth but otherwise confused. The Nursing admission /readmission Evaluation dated 5/21/2025 at 2:10 AM indicated in part Resident #193 was oriented to person, confused and cognitively impaired. The care plan dated 5/21/2025 indicated in part Resident #193 had impaired cognitive function. Interventions included: keeping the routine consistent and trying to provide consistent caregivers. The care plan further indicated Resident #193 was at risk for falls. Interventions included: to anticipate needs, call bell within reach, and to provide a safe environment. An observation 5/21/25 at 06:49 AM identified Resident #193 in the lounge in a reclining wheelchair with NA #8 present who indicated Resident #193 had come out of his/her room and she/he had been attempting to place the resident back to bed secondary fall risk and confused. On 5/21/2025 at 6:52 AM and interview and observation with the nursing supervisor (RN #) indicated NA#8 had been watching Resident #193 for safety due to agitation as Resident #193 had a verbal altercation with a threat made to Resident # 81 with the roommate last night so the staff brought Resident #193 out of the room. After being asked what process was followed the altercation RN #1 indicated to refer to the charge nurse for more information and her/his nurses note. On 5/21/25 at 6:53 AM an interview with charge nurse LPN #6 indicated the roommate, Resident #81 said s/he was going to strangle Resident #193. NA #8 stayed with the residents while LPN #6 obtained a wheelchair and brought it to the NAs in the room who then transferred Resident #193 into the wheelchair and brought Resident # 193\ to the lounge where NA #8 stayed with Resident # 193 for safety. LPN #6 further indicated Resident #81 was very unhappy. (continued on next page)

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	05/23/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 5/21/25 at 06:54 AM with NA #8 with LPN #6 present indicated Resident #193 was in his/her room yelling and attempting to get out of bed. The roommate (Resident #81) indicated she/he did not want Resident #193 in the room and the resident should be somewhere else. NA #8 indicated she/he told Resident #81 s/he would need to speak with the social worker in the morning. NA#8 indicated while Resident #193 was yelling, Resident #81 told Resident #193 to shut the fuck up or I will strangle you. Resident #193 was brought out to the lounge in a wheelchair where NA#8 stayed with the resident. LPN #6 added the supervisor (RN#1) came to the unit. When asked what the process was when an altercation between two residents occurs, LPN #6 indicated she/he was taught to call the supervisor and separate the residents. LPN #6 and NA#8 indicated the supervisor suggested brining the resident to the lounge and asked what happened, no statements in writing were requested from them. A nursing note dated 5/21/2025 at 2:21:00 written by RN #1 indicated (Resident #193) was yelling and not getting along with roommate (Resident #81) Resident #193 was found walking in room, confused and placed in a wheelchair and indicated Resident # 193 was monitored by nurse aides. An interview with the DNS on 5/23/2025 at 2:12 PM indicated the incidents of abuse (Resident #30, #31 and #81, #193) were found to be substantiated. The facility policy labeled Abuse indicated in part notes verbal abuse is defined as oral written that willfully includes disparaging and derogatory terms to residents or within their hearing distance regardless of age, ability to comprehend, or disability. The policy further indicated some examples of verbal abuse include threats of harm and saying things to frighten a resident. The policy also indicated that allegations or observation of abuse must be reported immediately to the administrator and the DNS. After notification is made to the administrator and the DNS, the administrative staff or the nursing supervisor will assume responsibility for notifying the physician and conducting an immediate investigation into the alleged incident (during the shift it occurred). The incident needs to be reported to the state agency and the local law enforcement need to be notified within 2 hours of the abuse allegation or observed abuse.

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	05/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, review of policy and interviews for 1 out of 6 residents (Resident #193) reviewed for abuse, the facility failed to ensure staff immediately reported an episode of verbal abuse to the Administrator, the Director of Nursing Services, local authorities, start the investigation and timely report the abuse to the state agency. The findings included: 1 a Resident #81's diagnosis included adjustment disorder with mixed anxiety and depressed mood. The care plan dated 4/14/2025 indicated Resident #81 had a diagnosis of major depression, sad and anxious mood. Interventions included: 1:1 visits by the social worker for venting, socialization and emotional support. The care plan further indicated Resident #81 had potential for trauma related to medical condition, pending surgical procedure and depression/anxiety. Interventions included: to assist the residents to identify triggers and measures that relieve anxiety and to observe for adjustment difficulties. The care plan further indicated Resident #81 stated difficulty sleeping through the night. Interventions included: to evaluate room for noise, darkness, temperature and comfort and offer sleep aid as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #81 was cognitively intact. b. Resident #193's diagnosis included dementia, Parkinsons disease, and syncope with collapse(fall). A nursing progress note dated 5/20/2025 at 11:30 PM indicated Resident #193 arrived via ambulance from the hospital for admission to the facility. The resident was oriented to name and date of birth but otherwise confused. The Nursing admission /readmission Evaluation dated 5/21/2025 at 2:10 AM indicated in part Resident #193 was oriented to person, confused and cognitively impaired. The care plan dated 5/21/2025 indicated in part Resident #193 had impaired cognitive function. Intervention included: to keep the routine consistent and try to provide consistent caregivers. The care plan further indicated Resident #193 was at risk for falls. Interventions included: to anticipate needs, call bell within reach, and to provide a safe environment. An observation 5/21/25 at 6:49 AM identified Resident #193 in the lounge in a reclining wheelchair with NA #8 present who indicated Resident #193 had come out of his/her room and she/he had attempted to put the resident back to bed secondary to fall risk and confusion. On 5/21/2025 at 06:52 AM and interview and observation with the nursing supervisor (RN #1), indicated NA#8 had been watching Resident #193 for safety due to agitation as Resident #193 had a verbal altercation with a threat made to Resident #193 with the roommate (Resident # 81) last night. The staff brought Resident #193 out of the room due to the threat. After being asked what process was followed after the altercation RN #1 indicated to refer to the charge nurse for more information and her/his nurses notes. (continued on next page)

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	05/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25 at 06:53 AM an interview with charge nurse LPN #6 indicated the roommate (Resident #81) said s/he was going to strangle Resident #193 so while NA #8 stayed with the residents LPN #6 obtained a wheelchair. LPN # 6 brought the wheelchair to the nurse aides in the room and Resident #193 was transferred into the wheelchair and brought to the lounge where NA #8 stayed with Resident # 193 for safety. LPN #6 further indicated Resident #81 was very unhappy. An interview on 5/21/25 at 06:54 AM with NA #8 with LPN #6 present indicated Resident #193 was in his/her room yelling and attempting to get out of bed. The roommate (Resident #81) indicated not wanting Resident #193 in the room and the resident should be somewhere else. NA #8 indicated telling Resident #81 s/he would need to speak with the social worker in the morning. NA#8 indicated while Resident #193 was yelling, Resident #81 told Resident #193 to shut the fuck up or I will strangle you. Resident #193 was brought out to the lounge in a wheelchair where NA#8 stayed with the resident. LPN #6 added the supervisor (RN#1) came to the unit. When asked what the process was when an altercation between two residents occurs, LPN #6 indicated she/he have been taught to call the supervisor and separate the residents. LPN #6 and NA#8 indicated the supervisor suggested brining the resident to the lounge and asked what happened, no statements in writing were requested from them. A nursing note dated 5/21/2025 at 9:21 PM written by RN #1 indicated (Resident #193) was yelling and not getting along with roommate (Resident #81) Resident #193 was found walking in room, confused and placed in a wheelchair where she/he could be monitored by the nurse aides. An interview with the Director of Nursing Services (DNS) on 5/21/25 at 7:39 AM upon arrival at the facility indicated she/he had not received any calls from the nursing supervisor overnight. An interview and clinical record review with RN#1 on 5/21/25 at 7:45 AM identified she/he did not write any details about the altercation between the two residents because s/he did not hear Resident #81 threaten Resident #193. RN #1 response to being asked if s/he documented in the aggressor's clinical record (Resident #81) RN#1 indicated no note was written and verified during the record review no other staff members wrote any notes related to the incident. An interview and record review on 5/21/25 at 8:49 AM with the DNS indicated s/he would have expected a phone call to her/him immediately and separation of the residents for safety. If the residents are under control, call the physician and report the incident if not, send the resident(s) to the hospital for an evaluation. The DNS further indicated she/he would report the incident to the state agency after the interview, since she/he was just informed (7.5 hours after it occurred). The DNS further indicated a room change for Resident #193 was completed this am and she/he would be reaching out to psychiatric services for both residents. An interview with the DNS on 5/23/2025 at 02:12 PM indicated the incidence of abuse for (Residents #81, #193) was substantiated. (continued on next page)

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	05/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Abuse indicated in part that allegations or observation of abuse must be reported immediately to the administrator and the DNS. After notification is completed to the administrator and the DNS, the administrative staff or the nursing supervisor will assume responsibility for notifying the physician and conduct an immediate investigation into the alleged incident (during the shift it occurred). The incident needs to be reported to the state agency and the local law enforcement within 2 hours of the observation or allegation of abuse.

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	05/23/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy and interviews for the only residents (Resident # 87), reviewed for hospitalization, the facility failed to ensure staff notified the resident and responsible party in writing of reason for transfer/discharge to the hospital. The findings include. Resident #87's diagnosis included Gastroesophageal Reflux (GERD) without bleeding, gastrostomy status, dysphagia and cerebral infarction. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #87 had moderate cognitive difficulty. The care plan dated 5/22/2025 indicated Resident # 87 had a potential for bleeding secondary to use of anticoagulation therapy secondary to a new Cerebrovascular Accident (CVA). Intervention included: to administer medication as ordered, laboratory work as ordered, observe for adverse side effects and notify the physician immediately. The progress note dated 5/23/2025 at 5:36 AM indicated Resident #87 vomited a large amount of dark black emesis, the provider and responsible party were notified, and Resident #87 was sent to the hospital. An interview and record review on 5/23/25 at 2:27 PM with the Administrator and the Assistant Director of Nursing Services (ADNS), indicated the ADNS did not know what the process was for informing the resident and responsible party of a bed hold when a resident is transferred to the hospital. The ADNS also was unable to locate any documentation in the clinical record indicating verbally or in writing the responsible party had been notified of the bed hold options. The Administrator indicated there was a process and she/he would talk with the social worker and the Business Office Manager. On 5/23/25 at 2:37 PM the Administrator found information regarding the bed hold process on page 11 of the admission packet. However, the Administrator was unable to indicate how the facility informs the resident and/or responsible party of bed hold options in writing when a resident is transferred to the hospital. An interview with the Business Office Manager on 5/23/25 at 2:45 PM indicated the social worker would oversee notification in writing to the resident/responsible party and the ombudsman when there is a bed held, the bed hold information with payment option is in the admission packet. An interview on 05/23/25 2:50 PM with the Administrator indicated when she/he spoke to the social worker she/he indicated there was no form or documentation for tracking bed hold notification. The Administrator indicated the facility always holds each resident's bed. The facility policy labeled Bed-Holds and Returns indicated in part prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy.

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	05/23/2025

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 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** Based on clinical record reviews, observation, record review, and staff interviews for 1 of 4 residents reviewed for Abuse (Resident # 63),the facility failed to ensure a person-centered care plan with identified interventions for known behaviors and for 1 of 1 resident reviewed for positioning (Resident #30), the facility failed to develop and implement a care plan that addressed the resident's refusal of a hand splint. The findings included: 1.Resident #63's diagnoses included dementia, anxiety disorder and Alzheimer's disease. The care plan initiated 1/9/25 and revised on 3/25/25 identified, Resident #63 has the potential for elopement; wanders self-propelling in wheelchair, at times can be intrusive wandering, disrupting others and poor self-awareness. Interventions include attempting to redirect when wandering, encouraging participation in recreational activities, and observing for safety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was cognitively impaired. The MDS identified the resident uses walker and [NAME] chair to ambulate and noted the resident exhibited wandering behaviors that occurred daily. A physician's order dated 9/5/24 directed to assess placement of wander guard every shift. A nurse's note dated 9/23/24 at 4:59 PM identified in part Resident #63 hit another resident in the face (Resident # 75). On assessment resident with increased agitation talking loudly . both residents were separated immediately and aggressor (Resident #63) placed on 1.1 supervision. A review of the Interview with Assistant Director of Nursing Services (ADNS) on 5/22/25 1:55 PM indicated any resident with known wandering behaviors should have been cued and supervised. She also reported after the incident on 9/23/24 interventions were put in place to prevent Resident #63 from wandering into Resident #75's room Interview with on LPN #8 on 5/23/25 at 2:29 PM indicated, given the behaviors were identified prior to incident, there should have been a care plan with interventions to address the behavior. She also indicated that the staff or department who triggered the behaviors on the MDS should have ensured it was included on the care plan. Facilities Comprehensive Person-Centered care plan policy indicates in part Disciplines will be responsible for updating the care plan when there is a new problem that requires that discipline to intervene. : 2.Resident #30 was admitted with diagnoses that included right-sided paralysis, stroke, and difficulty speaking. (continued on next page)

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	05/23/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/13/2024 directed Resident #30 to wear a right wrist/hand orthosis daily: on at noon meal and off after evening meal. The physician's order identified the resident was able to don and doff the orthosis independently and further directed to remind Resident #30 daily at noon meal to put on the splint and help per resident preference. The quarterly MDS assessment dated [DATE] identified Resident #30 had unclear speech and moderate cognitive impairment. Additionally, the MDS assessment indicated Resident #30 had not exhibited behaviors of rejecting evaluation or care. A care plan revised on 4/1/2025 identified Resident #30 required a splint to the right hand worn continuously. Interventions included a resting hand split placed at noon meal if it was not already in place and removed at bedtime, to assist the resident as needed for proper application. A review of the Treatment Administration Record (TAR) from 5/1/2025 through 5/21/2025 indicated Resident #30 had refused the right-hand splint on 5/6/2025, 5/10/2025, 5/16/2025, and 5/19/2025. A nursing note dated 5/16/2025 indicated Resident #30 refused his/her hand splint twice. An observation on 5/19/2025 at 12:09 PM identified Resident #30 as not wearing a right-hand split. An observation on 5/20/2025 at 12:00 identified the resident was not wearing a right-hand splint. On 5/22/2025 at 12:45 PM, an interview with LPN #3 identified the LPN thought that Resident #30 had a splint on and the aides were responsible for applying splints. On 5/22/2025 at 12:47 PM, an interview with NA #5 indicated Resident #30 does not like to wear the right-hand splint and the resident removes it when it is placed by the nurse aides. NA#5 indicated she had not offered the splint on 5/22/2025 and indicated she was not aware of when the resident should be reminded to apply the hand splint. On 5/22/2025 at 1:01 PM, an observation with NA#5 identified that NA#5 had difficulty in locating Resident #30's splint and eventually found it in the resident's wardrobe on the top drawer. Resident #30 was observed applying the hand splint independently. On 5/22/2025 at 1:30 PM, Resident #30 was observed in the hallway wearing the right-hand splint. On 5/23/2025 at 11:21 AM, an interview with the ADNS indicated although the resident has a physician's order to remind to wear right hand splint, she would not have expected staff to remind the resident to put on the right-hand splint because the resident is alert and oriented. Additionally, the ADNS indicated that if the resident was refusing the splint, as staff had identified, then there should have been a care plan addressing the resident's refusal of the right-hand splint. The facility policy for the use and monitoring of splinting devices indicated that it was the nursing unit's responsibility to ensure that the splint was worn and cared for properly.

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	05/23/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on review of the clinical record and interviews for the only resident (Resident # 5) reviewed for Bowel and Bladder Incontinence (Resident #5), the facility failed to ensure the care plan was updated to include offering a bowel and bladder retraining trial and any refusals related to participation in a retraining program. The findings include. Resident #5's diagnosis included unspecified dementia with behavioral disturbances, anxiety, and diabetes. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 as moderately cognitively impairment, uses a wheelchair and a walker, noted independence for toilet transfers and frequently incontinent of bowel and bladder. The Care plan dated 3/25/25 indicated Resident #5 was incontinent of bowels related to impaired mobility and cognition. Interventions included: to check resident every 2 hours and assist as needed and observation of pattern of incontinence and to initiate toileting schedule if needed. The care plan further indicated Resident #5 has functional mixed bladder incontinence related to impaired mobility and cognition. The care plan also indicated Resident #5 was resistant to care including refusing weights, medication and care An interview and record review on 5/20/25 at 10:10 AM with RN #1 supervisor and MDS nurse indicated the MDS assessment dated [DATE] indicate Resident #5 was frequently incontinent of urine and bowels. However, there was no evidence that Resident #5 was offered a voiding trial or bowel and bladder retraining programs or that the resident refused to participate in any of the above. RN #1 indicated the quarterly nursing assessments documented Resident #5 as continent, but the MDS which looked at all documentation indicated Resident #5 was frequently incontinent of bowel and bladder. Although RN #1 indicated Resident #5's care plan included a specific care plan indicating resistance to care nowhere in the complete care plan where it mentioned the resident was offered bowel bladder retraining program and the resident refused.

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	05/23/2025

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 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 1 of 5 residents reviewed (Resident # 55) reviewed for unnecessary medication, the facility failed to ensure medications were given according to physician's orders. The findings include: Resident #55 's diagnoses included unspecified dementia, paranoid schizophrenia and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 was cognitively impaired and required supervision/ touching assistance with eating, oral hygiene and maximal assistance for personal hygiene. The care plan dated 4/1/25 identified Resident #55 requires psychotropic drugs for dementia schizophrenia and appetite stimulant (Haldol, Prozac, Remeron, trazadone). Interventions included administering medications as ordered; monitor for therapeutic effect and side effects of medication; complete behavior monitoring sheets every shift. a.A physician's order dated 4/10/25 directed Haloperidol Tablet 0.5 MG Give 1 tablet by mouth at bedtime for anxiety, insomnia. The Medication Administration Records (MAR) for May 2025 identified the following medication were not given on 5/5/25: Haloperidol, Melatonin, Mirtazapine, Trazadone HCL, Guaifenesin ER, Acetaminophen Extra strength in accordance to physician's orders. May 2025 MAR also noted the following were not given on 5/7/25: Trazadone and Morphine. A review of the nursing notes for the month of May 2025 did not identify Resident #55 refusing any medications. b The MAR for May 2025 also identified the following were not performed for Resident # 55) on May 5, 2025. Ensure Plus, assessing pain, assessing for shortness of breath, assessing signs and symptoms of antidepressant. Compression stockings/ ace wraps were not applied according to order. The MAR for May 2025 noted the following were not performed on 5/7/25 Ensure Plus, assessing pain, assessing for shortness of breath. A review of the nursing notes for the month of May 2025 did not identify Resident #55 refusing any supplements or assessments. The interview with the ADNS on 5/23/25 at 10:27 AM indicated the expectation is that the MAR should be signed off if the medications are administered. She further indicated if the resident refuses, then it should be documented. Facilities Administering Medications policy identifies in part Medications are administered in a safe and timely manner, and as prescribed. If drug is withheld, refused, or given at a time other than scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.

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	05/23/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record reviews, observations and staff interviews for 3 of 3 (Residents #25, #63 and #78) with a history of wandering, the facility failed to ensure soiled utility on Units 1, 2, and 3 were not accessible to residents to prevent an accident.The findings included: 1. Resident #25's diagnosis includes Alzheimer's disease. Resident #25's Nursing Quarterly Evaluation dated 3/08/2025 at 11:18 AM indicated Resident #25 wanders without purpose. 2. Resident #63's diagnosis includes dementia with behavioral disturbance. Resident #63's Nursing Quarterly Evaluation dated 3/29/2025 at 7:46 PM indicated Resident #63 wanders without purpose, oblivious to needs and safety, and is confused. 3. Resident #78's diagnosis includes dementia with psychotic disturbance. Resident #78'sNursing quarterly evaluation indicted Resident #78 wanders without purpose, is oblivious to needs or safety and is disoriented and exit seeking An observation on 5/20/25 at 8:34 AM identified the dirty utility rooms on each unit accessible by pushing the door handle. Inside the soiled utility rooms were garbage cans and soiled linen in bags not covered, hazardous waste containers and equipment. Wing 1 had a specimen refrigerator with no lock and placed on an uneven surface when the door pulled open causing the person to tip forward (no specimens were in the refrigerator at this time). An observation and interview of each soiled utility room with the Director of Nursing Services (DNS) on 5/20/25 at 10:39 AM identified wing 1 had dirty linen, garbage, a hazardous waste box and a specimen refrigerator without a lock on an unsteady surface. The DNS indicated the refrigerator could be secured with a lock and a stable surface to sit on. Unit 2 had the same soiled linen, trash, hazardous waste container, no refrigerator but a small sink and a hopper (large open toilet bowl, no lid with a large sprayer to clean bed pans). Unit 3 had no refrigerator, a vacuum cleaner and a machine used for snaking pipes on the floor (per the DNS), a sink, and a hopper, several trash cans filled with bags, dirty linens with cans uncovered and one loose face cloth on top of the dirty bags. The DNS indicated the team had never really thought about the potential for residents who wander to enter the dirty utility rooms as no residents had ever tried. The DNS further indicated s/he would provide a list of all residents who wander and would meet with the Administrator and Maintenance Director about their concerns. An interview on 5/20/2025 at 2:00 PM with the Administrator indicated all 3 units soiled utility room doors now have passcode locks so only staff can enter.

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	05/23/2025

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 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** Based on observations of Wings 2 and 3 and staff interviews, the facility failed to ensure the medication refrigerator was free of food items and failed to keep medication rooms clean. The facility failed to ensure a medication cart was secure and accessible to only licensed staff. The findings included: 1 a. Observation on 5/23/25 at 11:45 AM of Wing 3 medication room with LPN #5 identified the following: The bottom door shelf of the medication refrigerator was observed to have an opened 12-ounce bottle of a tan-colored drink that had a manufacturer label indicating 20 grams of protein and with vanilla cream flavor. LPN #5 indicated the drink was not an item used by the facility. There were no labels indicating if the drink belonged to a resident. The shelf in the medication refrigerator was also noted to be stained with orange and tan residue. The medications stored in the refrigerator included: 2 boxes of formoterol fumarate 20mg/2ml vials (a medication used to treat respiratory conditions like asthma and COPD), two vials of latanoprost eye drops, 12 vials of insulin, seven bags of insulin pens, and four boxes of acetaminophen suppositories. b. The cabinet above the sink of Wing 3 medication room was observed to have a black plastic bottle, a purple plastic bottle, and a grey tumbler-style bottle with no labels. The grey-colored tumbler was noted to be stuck onto the shelf of the cabinet, and when removed, it left a sticky residue on the cabinet shelf. In addition to the bottles and a tumbler in the cabinet, there was also a tube of open toothpaste with blue residue on the opening of the tube. There was also a 30-gram tube of opened Lidocaine/Prilocaine 2.5%/2.5% cream with an expiration date of 2/2025. The tube of cream had a pharmacy label that was torn, and no resident name or prescription information was able to be read. Observation of the sink further identified sticky brown and white residue near an appliance used to crush resident medications. Behind the entry door of the medication room, there were eight jackets/sweatshirts that did not have resident labels on them. An interview with LPN #5 indicated she did not know who the water bottles and tumbler belonged to or how long they were there. LPN #5 also indicated she was not sure what the sticky residue in the cabinet and the sticky brown and white residue around the sink were at time of the observation. LPN #5 further indicated she did not know who the jackets and sweatshirts belonged to. LPN #5 did indicate that the staff had a locker room and break room to use. c.On 5/23/2025 at 12:28 PM, the Wing 2 medication room observed with LPN #4 identified the following: Next to the sink in the medication room, there was one pink-colored travel mug with a brown residue on the clear mug cover, a pink travel mug with a pink lid, and a pink ceramic-like mug with no lid. Behind the door, there were seven jackets with no resident labels. In the cabinet under the counter, there was a backpack and a black purse. An interview with LPN #4 indicated the purse belonged to her (LPN #4). LPN# 4 further indicated she did not know who the jackets belonged to, and the jackets had been there since she had started working at the facility about a year ago. (continued on next page)

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	05/23/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/23/2025 at 12:53 PM, an interview with the ADNS indicated the vanilla cream protein drink in the Wing 3 medication refrigerator should not have been stored there. The ADNS did not know whether jackets and personal belongings such as mugs or cups should have been stored in medication rooms. Additionally, the ADNS indicated that housekeeping cleaned the medication room and refrigerator but were not able to clean the room on the day in question yet. The facility policy for the Storage of Medications directs nursing staff to be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs are returned to the pharmacy or destroyed. Medications requiring refrigeration are stored separately from food. Although requested, the facility was unable to provide a policy for the storage of personal belongings in the medication rooms. 2.Observation on 5/19/25 outside room [ROOM NUMBER] from 120 PM to 1:28 PM identified medication cart outside room [ROOM NUMBER] unlocked and licensed staff not within eyesight of the medication cart. No residents were noted in the area. However, Nurse Aide (NA) 8 was noted entering and exiting room [ROOM NUMBER] while surveyor was present with the unlocked medication cart but did not alert LPN # 8 the medication cart was unlocked. LPN # 8 was noted talking to a resident in the bathroom at the time of the incident. Interview with LPN # 8 on 5/19/25 at time of the incident identified she ran to assist a resident in room [ROOM NUMBER] and forgot to lock the medication cart. LPN # 8 indicated she had been locking the medication cart all day but did not do so this one time. Surveyor: [NAME], Cesar

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	05/23/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the tour of the kitchen, observations, review of facility policy and staff interviews, the facility failed to ensure hair coverings were worn while in the kitchen. The facility failed to ensure food was consistently labeled and dated and expired foods were discarded. The findings included: Tour of the kitchen on 5/19/25 at 9:57 AM during the initial walk through with the Administrator identified the following: 1.an Observation on 5/19/25 at 9:57 AM of Cook#1 in the kitchen without hair covering. Interview with Cook#1 on 5/19/25 at 9:57 AM indicated hair covering should be on while in the kitchen. [NAME] #1 also indicated he/she had a hat on but forgot to put it back on when he/she reentered the kitchen. b. Observation on 5/19/25 at 10:05 AM of the walk-in refrigerator identified 3 bags of waffles were opened with no labels of when it was opened or used by date. Observation further identified cooked turkey dated 5/16/25 with no label of a used by date. Interview with [NAME] #1 on 5/19/25 at 10:05 AM indicated food items should indicate when they were cooked and when items should be used by. c. Observation on 5/19/25 at 10:08 AM of the walk-in freezer identified frozen burgers with a use by date of 3/31/25. Interview with the Administrator and [NAME] #1 on 5/19/25 at 10:08 AM identified foods should be discarded by the use by date. They both were unable to explain why the burgers were not discarded. 2. Observation on 5/19/25 at 10:30 AM of the dry storage room identified 10 cases of expired California Farms evaporated milk can with expiration date August 2024. A telephone interview with the Food Service Director on 5/21/25 at 8:44 AM identified all kitchen staff should be checking dates to ensure food is not expired. She also indicated that her expectation is that food contains labels and dates once opened and a discarded date. The Food Service Director further indicated that a hair net or hat should be worn in the kitchen at all times. A request for the facility food service policy was made on 5/19/25 at 10:00 AM and on 5/22/25 at 10:30 AM, however, no policy was provided.

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	05/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations , review of the facility Infection Control program, review of policy and interviews, the facility failed to ensure staff performed hand hygiene after providing care to a resident on Enhanced Barrier Precautions [EBP] and for 1 of 1 resident reviewed for wounds (Resident #52), the facility failed to ensure staff disposed of used gloves in a sanitary manner and failed to perform appropriate hand hygiene during a dressing change and failed to wear appropriate Personal Protective Equipment (PPE) for a resident on precaution. The findings included: 1.An observation on 5/21/2025 at 6:25 AM identified NA #1 and NA #2 coming out of Resident #22 and roommate's room (signage for Enhanced Barrier Precautions [EBP] and Personal Protective Equipment (PPE) set up were noted outside the room) and into the hallway starting to walk down the hall. NA #1 had a used glove in his/her right hand, and nurse aides had not completed hand hygiene before coming out of the room. An interview with NA#1 identified she/he did not know when the sign went up outside the door of Resident # 22's room and s/he was not sure what had to be done. NA# 2 after thought indicated there was hand sanitizer on the wall inside the doorway and both staff members utilized the hand sanitizer to complete hand hygiene. The charge nurse LPN #1 then came out of the resident room without completing hand hygiene and told Nurse Aides # 1 and # 2 I am going to go to the nurse's station to make a note and proceeded to go down the hall. Upon the surveyor's inquiry, LPN #1 answered the isolation sign was for the roommate and after reading the sign motioned in a scrubbing motion with hands indicated she/he used hand sanitizer going in and out of the room then immediately. LPN #1 went to use the hand sanitizer for hand hygiene. The 3 staff members were assisting Resident #22 with care at the time of the observations. 2. Observation on 5/19/25 at 12:58 PM of Droplet precaution sign posted on a resident's room noted all people entering the room should put on Personal Protective Equipment (PPE). Observation on 5/19/25 at 12:58 PM identified two nurse aides entered the room with no PPE (Gloves, gown or mask). Interview with NA#2 identified PPE does not apply given they were just going in to drop off the meal. Interview with ADNS on 5/19/25 at 2:48 PM indicated if a Resident is on precaution staff entering the room should use the appropriate PPE. The DNS indicated staff have been educated on droplet precautions but would reeducate them again. 3. Resident #52's diagnoses included lymphedema (a chronic condition characterized by swelling in the soft tissues of the body) and neuropathy (nerve damage that can cause pain, numbness, tingling, or weakness in different parts of the body). The quarterly MDS assessment dated [DATE] indicated Resident #52 was cognitively intact and did not have any open lesions or ulcers. The MDS assessment further indicated the resident required substantial/maximal assistance to put on and take off shoes and socks. (continued on next page)

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	05/23/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note dated 4/6/2025 indicated Resident #52 was noted to have a scab to the left second toe and indicated the supervisor was made aware. A wound provider note dated 4/16/2025 indicated the wound was not pressure-related, and contributing factors were the resident's lymphedema and neuropathy. A physician's order dated 4/30/2025 directed the application of a betadine external solution of 5% to the left second toe every day and evening shift, letting it dry and covering with a band-aid. On 5/22/2025 at 2:22 PM, LPN #4 was observed performing Resident #52's left second toe dressing. LPN #4 set up her working area prior to the surveyor entering the resident's room. Dressing materials were set up on an overbed table; there were food items such as an open tea, a pitcher of water, and unopened packages of cookies on the overbed table next to the clean dressing materials. LPN #4 donned clean gloves, removed the old dressing, and cleaned the area with saline. LPN #4 removed the gloves, inverted them, and placed them on the resident's bed. LPN #4 then donned new, clean gloves (hand hygiene was not observed). LPN #4 applied betadine to the wound area, removed her right-hand glove, and placed it on the resident's bed. LPN #4 donned a new glove on the right hand (hand hygiene was not observed). LPN #4 applied a skin protectant around the wound area and applied a new band-aid to the resident's left second toe. LPN #4 removed both gloves, placed them on the resident bed, reached into her pocket to grab a pen, and dated the band-aid. LPN #4 donned new, clean gloves (hand hygiene was not observed) and replaced the resident's sock. An interview with LPN #4 indicated she had cleaned the overbed table with an alcohol cleaner prior to placing the clean dressing change items on the table. Additionally, LPN #4 indicated hand hygiene should have been done after removing the old dressing. LPN #4 also indicated she was not aware that hand hygiene should be done after removing gloves and before putting on new gloves. On 5/23/2025 at 11:08 AM, an interview with the ADNS and the Wound Nurse (RN#2) identified having food items on the same overbed table as the clean dressing change items was acceptable if food items were closed and kept away from the dressing items. The ADNS and RN#2 further indicated LPN #4 should have performed hand hygiene after removing gloves. The facility policy titled Specific Personal Protective Equipment directed employees to wash their hands after removing gloves.

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	05/23/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of the facility Infection Control Program, facility documents and interview, the facility failed to ensure staff were offered education regarding the Covid 19 vaccination and alternative locations to receive the vaccine if the facility was unable to obtain the vaccine to offer to staff. The findings include: An interview with the Infection Control Nurse, Assistant Director of Nursing Services (ADNS) on 5/21/2025 at 11:50 AM identified she/he was not offered the Covid-19 immunization, and no education was provided about the Covid-19 vaccine or where the vaccine could be obtained if the facility was unable to offer and provide the vaccine. The ADNS further indicated the facility was unable to obtain the Covid 19 vaccine from the pharmacy for facility staff.