STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075432	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattatuck Health Care Facility, Inc.	9 Cliff St Waterbury, CT 06710

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #14) reviewed for hospitalization , the facility failed to immediately notify the physician and the resident representative when the resident's thumb was cut during nail care and later became infected. The findings include: Resident #14 was admitted to the facility in March 2016 with diagnoses that included schizoaffective disorder, bipolar disorder, and cellulitis. The care plan dated 4/4/24 identified a concern with activities related to cognitive impairment with intervention which included provide brief activities for resident. The quarterly MDS dated [DATE] identified Resident #14 had moderately impaired cognition, was wheelchair bound, had peripheral vascular disease and was dependent on staff for toileting, hygiene, showering or bathing, body dressing, and personal hygiene. The nurse's note dated 6/29/24 identified that during nail care, the tip of the resident's right thumb was clipped by NA #1. The area was cleansed and bandaged by the DNS and there were no signs of infection. The nurse's note dated 7/1/24 identified the residents right thumb continued to ooze after the dressing was pulled off. Bacitracin and a bandage were applied to the top of the thumb, no swelling, discoloration or infection were noted, and the nail has fungus. The nurse's note dated 7/2/24 identified the resident's thumb was discolored, inflamed. Staff questioned cellulitis, or allergic reaction to the ointment. The physician was notified, and the resident was started on Keflex (antibiotic) 500mg every 4 times daily for 7 days. The nurse's note dated 7/6/24 identified resident's thumb was swollen, appeared blistered towards the base of first knuckle and the resident verbalized pain when the thumb was moved. The physician was notified, and Resident #14 was sent to the emergency room for evaluation. The note identified that the resident representative was notified. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 9/9/24 at 11:00 AM identified the tip of Resident #14's thumb was cut on 6/29/24 during nail care. The DNS indicated she notified the physician on 7/2/24 as the thumb presented as discolored and inflamed. On 7/6/24 the DNS indicated the thumb was swollen and had blisters and subsequent to physician notification, the resident was sent to the hospital. Although the cut to the thumb occurred on 6/29/24, and the area was oozing by 7/1/24, the physician was not notified until 7/2/24, 3 days later. Further, the resident representative was not notified until 7/6/24, 7 days later. The policy on change in condition directs to ensure that each patient will receive the best nursing and medical care available during critical illness, the charge nurse will notify the physician, Director of Nursing, family and Administrator in the event of transfer or change in resident's condition.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #2) reviewed for unnecessary medications the facility failed to ensure that the resident's care plan was updated with interventions following a self-inflicted injury, and for 1 resident (Resident #29) reviewed for accidents, the facility failed to ensure the resident's care plan was revised with interventions following an elopement from the facility and an attempt at self-harm. The findings include: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, lymphedema, and hyperlipidemia. The annual MDS dated [DATE] identified Resident #2 had intact cognition, was always continent of bowel, frequently incontinent of bladder, required supervision with bathing, and was independent with transfers and dressing. Review of the clinical record during the survey identified Resident #2's care plan dated 5/21/24 identified the resident had a history of schizophrenia with behaviors that included withdrawal from activities and social isolation. Interventions included behavior monitoring. Although requested, the facility failed to provide a copy of Resident #2's care plan. A nurse's note dated 7/16/24 at 11:30 AM identified Resident #2 sustained a head injury to top of the head after intentionally hitting his/her head against a concrete wall in his/her room. A psychiatric note dated 7/16/24 by APRN #1 identified Resident #2 was found banging his/her head against a concrete wall after lunch and had an open area to the top of his/her head that was actively bleeding. The note identified Resident #2 reported that food caused jerking movements. The note identified Resident #2 was being sent to the hospital for evaluation of the head injury and psychiatric evaluation. A nurse's note dated 7/16/24 at 8:15 PM identified Resident #2 returned to the facility from the hospital with staples in place to the head. The note further identified that the staples were to be removed within 5 - 7 days and staff was to monitor the wound for signs of infection. The note further identified that Resident #2 had no medication changes and would continue to be monitored. Review of Resident #2's care plan during a record review conducted 9/9/24 failed to identify any documentation or interventions related to self-injury behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 9/10/24 at 7:15 AM identified she had been employed at the facility for 2 years and since she started working at the facility, Resident #2 had a history of hitting his/her head. NA #1 identified Resident #2 bangs his/her head all the time and says sugar makes him/her do it, but it's psych related. The resident had to go out to the hospital last month and had a couple of staples. NA #1 identified that the facility staff had stopped giving Resident #2 sugary foods and drinks to help with the behavior, since Resident #2 reported it was caused by sugar. NA #1 reported that the intervention did not work, and Resident #2 continued to hit his/her head. NA #1 reported that she was not aware of any additional interventions in place. Interview with APRN #1 on 9/10/24 at 9:34 AM identified that Resident #2 had a history of behaviors that included head banging which the resident reported was due to sugar in his/her diet. APRN #1 reported that on 7/16/24 Resident #2 had a head laceration as a result and was sent to the hospital for psychiatric evaluation and treatment of the head wound. APRN #1 identified she saw Resident #2 for follow up on 8/20/24 but she did not follow up with the facility or the hospital regarding the outcome of the psychiatric evaluation that was requested and was not aware the hospital had recommended crisis intervention. APRN #1 also identified she did not recommend any additional behavior monitoring related to self-injury behaviors for Resident #2 but should have requested this specific behavior monitoring be implemented following Resident #2's return to the facility on [DATE]. Interview with the DNS on 9/10/24 at 11:00 AM identified that she provided direct care for Resident #2 following readmission to the facility on [DATE]. The DNS identified that Resident #2's care plan was not updated to reflect a history of self-injury following the residents return to the facility on [DATE]. The DNS identified that the facility should have updated the care plan to reflect a history of behaviors related to self-inflicted head injuries. Although attempted, an interview with Resident #2 was not obtained. 2. Resident #29 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, major neurocognitive disorder, and hypertension. The annual MDS dated [DATE] identified Resident #29 had intact cognition, was always continent of bowel and bladder and required staff assistance for set up and supervision with dressing, bathing, and set up only for meals. The MDS also identified Resident #29 had not exhibited any behaviors related to wandering and had not reported or exhibited any thoughts or behaviors related to self-harm. The care plan dated 6/23/23 identified Resident #29 had a history of suicidal ideations. Interventions included to monitor for behavioral changes. The care plan also identified that Resident #29 was not at risk for elopement. Review of the state agency reportable event database identified that on 8/7/23 at 5:00 PM the facility reported that Resident #29 was identified as missing from the facility. The reportable event form dated 8/7/23 identified that at approximately 5:00 PM, Resident #29 could not be located for dinner and following notification to the police, the resident representative, and medical director were notified. A review of the facility's security cameras identified that Resident #29 exited the facility through the front entrance at approximately 2:00 PM. The documentation identified that the facility was notified Resident #29 was located on 8/8/23 at 4:00 PM at a hospital emergency department located 22 miles from the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified that a 9/1/23 hospital psychiatry discharge summary identified Resident #29 initially presented to the hospital emergency department after being found by local law enforcement at a gas station after attempting suicide by overdosing on Benadryl (an over-the-counter antihistamine used for allergies) and alcohol. The note also identified Resident #29 was in psychosis and required inpatient psychiatric admission and treatment from 8/9/23 - 9/1/23. The note identified that the hospital staff contacted the DNS regarding discharge on 9/1/23 and the interventions discussed included relocating Resident #29's room to a location within direct eyesight of the nurse's station, increasing the frequency of psychiatric APRN visits to twice monthly, and increasing the frequency of social work visits. The note identified Resident #29 was euthymic with no overt psychosis and not at imminent risk for self-harm or others at the time of discharge. Review of the clinical record failed to identify any revisions to Resident #29's care plan following readmission to the facility on [DATE] related to elopement from the facility and suicide attempt. A psychiatric APRN note dated 9/6/23 by APRN #1 identified Resident #29 was seen following elopement from the facility and suicide attempt with hospitalization . The note further identified Resident #29 had a previous history of suicidal ideation with a plan to jump from a bridge. The note also identified Resident #29 had no history of any prior attempts at elopement. The note identified Resident was not at current risk for self-harm and the treatment plan included to monitor for changes in mood and behaviors. Review of the nurse aide care cards for residents of the facility on 9/10/24, located on the nurse's station, failed to identify a care card for Resident #29. Interview with NA #1 on 9/10/24 at 7:15 AM identified she had been employed at the facility for 2 years and was aware of Resident #29's elopement from the facility on 8/7/23. NA #1 identified Resident #29 had a room previously located next to the front entrance door of the facility and following the elopement, was relocated to a room directly next to the nurse's station. NA #1 identified that the staff routinely kept an eye on Resident #29's location, which was usually in his/her room, and that she was not aware of any other elopement attempts since 8/7/23. NA #1 also identified that she was aware of Resident #29's history of suicidal ideations, however her understanding was Resident #29 had discussed this at some point in the past 'in passing' but had never verbalized anything related to suicidal thoughts or self-harm to her. NA #1 identified that she had not been notified of, or ever heard, that Resident #29 had ever attempted suicide or self-harm since admission to the facility, and the only incident she was aware of was elopement on 8/7/23. Interview with APRN #1 on 9/10/24 at 9:34 AM identified that Resident #29 did not have a prior history of elopement from the facility prior to 8/7/23. APRN #1 identified that Resident #29 had not had any further attempts at elopement or self-harm that she had been notified of by the facility or resident. APRN #1 identified that elopement assessments and interventions would be based on the facility's policy, and she would not direct that. APRN #1 also identified that there would not be any specific monitoring of Resident #29's behaviors related to self-harm other than monitoring behavior. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 9/10/24 at 11 AM identified that she provided direct care for Resident #29 on 8/7/23. The DNS identified that Resident #29 had a history of suicidal ideation prior to admission to the facility but had not verbalized or exhibited any behaviors related to self-harm. The DNS also identified prior to Resident #29's elopement from the facility on 8/7/23, Resident #29 had not attempted to leave the building, including going outside to resident areas on the facility premises. The DNS identified Resident #29's care plan should have been updated to reflect the elopement as well as the suicide attempt as these were both new issues for Resident #29. The DNS also identified that Resident #29's nurse aide care card should have been included for the residents on the unit and she would ensure that these items would be addressed. Although attempted, an interview with Resident #29 was not obtained. The facility assessment tool directed that the facility would identify and provide specific resources to its residents that required management and specific interventions for psychiatric symptom and behaviors. The facility assessment tool also directed the facility would provide person centered care, which included incorporating specific care needs of the resident into the care plan, including identification of hazards and risks. Although requested, the facility failed to provide policies related to care planning or self-injury.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of facility documentation and interviews, the facility failed to ensure that licensed nurses were certified in cardiopulmonary resuscitation (CPR) for Healthcare Providers and were available immediately (24 hours per day) to provide basic life support, including CPR. The findings include: Interview and review of facility documentation related to competent nurse staffing with the DNS on [DATE] at 6:26 AM the DNS did not have documentation of current CPR certifications for the licensed nurses. The DNS indicated that the facility was not a sub-acute unit and while the staff had been appropriately trained in emergency situations, the expectation is that 911 is called during any crisis. The DNS further indicated that while she does not have a policy that speaks to CPR or documentation of CPR competencies, the licensed staff know that unless a resident has an advance directive identifying him/her as a Do Not Resuscitate (DNR), they would immediately start CPR and call 911when someone is pulseless and not breathing. Further, the DNS identified that she does not hold a current CPR certification. Subsequent to surveyor inquiry, documentation of the following CPR certifications was provided: a. RN #1 completed the American Heart Association Basic Life Support CPR and AED (automated external defibrillator) program; a certification was issued on [DATE] and was valid for 2 years (expired ,d+[DATE]). b. RN #3 completed the American Heart Association Heartsaver CPR AED program; a certification was issued on [DATE] and renewal is required by ,d+[DATE]. c. RN #4 completed the American Heart Association Basic Life Support CPR and AED program; a certification was issued on [DATE] and renewal is required by ,d+[DATE]. d. RN #5 completed the American Heart Association Basic Life Support CPR and AED program; a certification was issued on [DATE] and renewal was required by ,d+[DATE], expired over 6 months. The DNS indicated that RN #5 had recently taken a BLS recertification program, but had not received the updated certificate, yet. Although requested a policy related to CPR certification requirements was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 46040 Based on review of the clinical record, facility policy, and interviews for 1 of 5 residents (Resident #1) reviewed for unnecessary medications, the facility failed to ensure blood glucose levels were reassessed following high readings, and for 1 of 5 residents (Resident #2) reviewed for unnecessary medications, the facility failed to ensure that appropriate behavior monitoring was implemented related to episodes of self-harm, that neurological monitoring was completed following a head injury, and a wound was assessed and documented in the medical record following a head injury and for 1 resident (Resident #14) reviewed for hospitalization , the facility failed to do ongoing assessments of the resident's thumb which was discolored and inflamed and being treated with antibiotics. The findings include: 1. Resident #1 was admitted to the facility in February 2009 with diagnoses that included type 2 diabetes mellitus, hypertension, and breast cancer. The quarterly MDS dated [DATE] identified Resident #1 had severely impaired cognition and received Insulin injections 7 of the last 7 days. Although requested, a copy of Resident #1's diabetes care plan was not provided. Physician's orders for May 2024 (original date 8/25/09) directed to administer Humalog 100 units/ml for coverage at 4:30 PM only per Accucheck (blood glucose check). 400 - 450, give 2 units. 451 - 500, give 4 units. 501 - 550, give 6 units. High, give 15 units. Physician's orders for May 2024 (original date 6/16/10) directed an Accucheck every day at 6:00 AM. The Medication Administration Records dated 5/1/24 through 9/8/24, 5 months, identified that Resident #1 had blood glucoses readings that read high, requiring the administration of 15 units of Humalog insulin on: 5/13/24, 5/14/24, 5/20/24, 6/11/24, and 7/5/24. The nurse's notes dated 5/13/24, 5/14/24, 5/20/24, 6/11/24, and 7/5/24 failed to identify that Resident #1's blood glucose was reassessed following a high reading and the administration of 15 units of Humalog Insulin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 9/9/24 at 7:45 AM failed to identify that the nurses reassessed Resident #1's blood glucose following a high reading and the administration of 15 units of Humalog Insulin on 5/13/24, 5/14/24, 5/20/24, 6/11/24, and 7/5/24. The DNS indicated the blood glucose levels were next assessed the following morning during the 6:00 AM Accucheck, per the physician's order. Interview with APRN #2 identified that she would expect the nurse to recheck a high blood glucose reading, approximately 1.5 - 2 hours after the appropriate sliding scale dose was administered and she would have expected to have been notified of a blood glucose that read high, because she would potentially have increased the sliding scale, in addition to wanting the blood glucose rechecked. Interview with MD #1 on 9/9/24 at 1:13 PM identified that he would expect a blood glucose recheck 2 - 4 hours after administering the sliding scale, following a reading greater than 500 high. MD #1 indicated that he would not expect a notification call for a high reading unless the resident was symptomatic. Interview with the DNS on 9/9/24 at 2:43 PM identified that Resident #1 is a brittle diabetic and can be non-compliant with his/her diet. The DNS further identified that Resident #1 had never been symptomatic when his/her blood sugars were reading high and could answer questions appropriately and would deny symptoms of hyperglycemia. The DNS indicated that she does not have a policy that directs when to recheck a high blood glucose or notify the provider, unless parameters were written in the physician's orders, but in the absence of parameters she would expect the physician to be notified of a high blood glucose reading during rounds, if the resident was asymptomatic, or to notify the physician at the time of the high blood glucose reading, if the resident was symptomatic or had a mental status change. The DNS identified that she would expect the nurse to recheck a high blood glucose level, approximately 30 minutes after the administration of the Insulin sliding scale. The DNS further identified if resident's blood glucose recheck remained greater than 500, she would expect the nurse to notify the physician, in case he/she wanted to provide additional insulin coverage. Interview with RN #1 on 9/9/24 at 4:09 PM identified that she mostly works the 3:00 PM - 11:00 PM shift at the facility, and she was familiar with Resident #1's history of high blood glucose readings. RN #1 indicated that she did not recheck Resident #1's high blood glucose readings if he/she was asymptomatic; she would administer 15 units of Insulin per the sliding scale order, the blood glucose would be rechecked at 6:00 AM the next day, per the physician's order. RN #1 identified that she usually rechecks blood glucose levels, if they are too low and an intervention was implemented to make the sugar come back up. The facility's Policy for Accucheck (glucose monitoring) directs all residents receiving hyperglycemic agents, will have an Accucheck done at least 2 times weekly unless otherwise specified by the medical doctor. Any resident having a blood sugar of 70 or below, the medication will be held and the medical doctor contacted for further orders. 2. Resident #2 was admitted to the facility in June 2020 with diagnoses that included schizophrenia, lymphedema, and hyperlipidemia. The annual MDS dated [DATE] identified Resident #2 had intact cognition, was always continent of bowel, frequently incontinent of bladder, required with supervision with bathing, and was independent with transfers and dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record during the survey identified Resident #2's care plan dated 5/21/24 identified the resident had a history of schizophrenia with behaviors that included withdrawal from activities and social isolation. Interventions included behavior monitoring. Although requested, the facility failed to provide a copy of Resident #2's care plan. A nurse's note dated 7/16/24 at 11:30 AM identified Resident #2 sustained a head injury to top of the head after intentionally hitting his/her head against a concrete wall in his/her room. A psychiatric note dated 7/16/24 by APRN #1 identified Resident #2 was found banging his/her head against a concrete wall after lunch and had an open area to the top of his/her head that was actively bleeding. The note identified Resident #2 reported that food caused jerking movements. The note identified Resident #2 was being sent to the hospital for evaluation of the head injury and psychiatric evaluation. A nurse's note dated 7/16/24 at 8:15 PM identified Resident #2 returned to the facility from the hospital with staples in place to the head. The note further identified that the staples were to be removed within 5 - 7 days and to monitor the wound for signs of infection. The note further identified that Resident #2 had no medication changes and would continue to be monitored. Review of the clinical record failed to identify any documents or discharge summary related to Resident #2's hospital evaluation on 7/16/24. Review of the clinical record failed to identify any neurological monitoring related to Resident #2's self-inflicted head injury on 7/16/24. Review of the clinical record failed to identify any documentation related to Resident #2's self-inflicted head injury following return to the facility on [DATE], including the number of staples in place to the head, wound appearance, when the staples were removed, and wound status following staple removal. Review of the behavior monitoring flowsheets for Resident #2 for 7/2024, 8/2024, and 9/2024 failed to identify any behavior monitoring implemented related to self-harm or self-injury following Resident #2's self-inflicted head injury on 7/16/24. A psychiatric note dated 8/20/24 by APRN #1 identified Resident #2 was seen for follow up to assess mood and self-injury behaviors. The note further identified that Resident #2 denied any recent head banging and that staff had reported redirection with head banging at times with good effect. Subsequent to surveyor inquiry on 9/9/24, the facility provided a hospital initial evaluation assessment dated [DATE]. The documentation identified that Resident #2 was seen in the emergency department for evaluation of a self-inflicted head laceration measuring approximately 2 centimeters to the back of the head with bleeding that was controlled, and the facility also requested a psychiatric evaluation. The evaluation further identified Resident #2 had a psychiatric history, was a poor historian, and was unable contribute significant details. The evaluation also identified that head CT was not done, and treatment included placement of one staple to the laceration at the posterior occiput (the back upper portion of the head) and a crisis evaluation. The evaluation failed to identify any additional information. (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 NA #1 on 9/10/24 at 7:15 AM identified she had been employed at the facility for 2 years and since she started working at the facility, Resident #2 had a history of hitting his/her head. NA #1 identified Resident #2 [NAME] his/her head all the time and says sugar makes him/her do it, but it's psych related. Resident #2 had to go out to the hospital last month and had a couple of staples. NA #1 identified that the facility staff had discussed interventions, and they had stopped giving Resident #2 sugary foods and drinks to help with the behavior, since Resident #2 reported it was caused by sugar. NA #1 reported that the intervention did not work and Resident #2 continued to hit his/her head. NA #1 reported that she was not aware of any additional interventions in place. NA #1 reported that the wound from 7/16/24 was treated and assessed by the DNS, and that the DNS also removed the staples applied at the hospital. Interview with APRN #1 on 9/10/24 at 9:34 AM identified that Resident #2 had a history of behaviors that included head banging with Resident #2 had reported was due to sugar in his/her diet. APRN #1 reported that on 7/16/24 Resident #2 had a head laceration as a result and was sent to the hospital for psychiatric evaluation and treatment of the head wound. APRN #1 identified she saw Resident #2 for follow up on 8/20/24. APRN #1 identified that she did not follow up with the facility or the hospital regarding the outcome of the psychiatric evaluation that was requested and was not aware the hospital had recommended crisis intervention. APRN #1 also identified she did not recommend any additional behavior monitoring related to self-injury behaviors for Resident #2 but should have requested this specific behavior monitoring be implemented following Resident #2's return to the facility on [DATE]. Interview with the DNS on 9/10/24 at 11:00 AM identified that she provided direct care for Resident #2 following readmission to the facility on [DATE]. The DNS identified she was aware that Resident #2 was sent to the hospital for evaluation of the head laceration and psychiatric evaluation due to self-injury but did not follow up with the hospital regarding the outcome of the psychiatric evaluation of Resident #2's behaviors. The DNS identified that she completed the daily wound care and assessments of Resident #2's head laceration, and removed a single staple on 7/24/24, 8 days after Resident #2 returned to the facility, but did not document any of the information in Resident #2's clinical record. The DNS also identified that Resident #2's care plan was not updated to reflect a history of self-injury following Resident #2's return to the facility on [DATE]. The DNS also identified that the facility did not complete any neurological checks on Resident #2 following his/her return to the facility on [DATE]. The DNS identified that Resident #2 should have had neurological checks initiated following return to the facility for 72 hours after the head injury occurred, should have had behavior monitoring implemented related to self-injury behaviors following return to the facility, and that she should documented the wound status and assessments for Resident #2's head injury in Resident #2's medical record. The DNS also identified that the facility should have ensured that the hospital discharge documentation from 7/16/24 was obtained and in Resident #2's medical record. The facility policy on head injury directed that it was the policy of the facility to provide monitoring for any resident who received a head injury and that a head injury was classified as a blow to the head. The policy further directed that monitoring that would be done including vital signs, level of consciousness, and pupil reactivity every hour x 4, then every 2 hours x 4, then every 4 hours x 3, then every shift x 3. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility assessment tool directed that the facility would identify and provide specific resources to its residents that required management and specific interventions for psychiatric symptom and behaviors. The facility assessment tool also directed the facility would provide person centered care, which included incorporating specific care needs of the resident into the care plan, including identification of hazards and risks. Although requested, the facility failed to provide policies related to wound care, documentation in the clinical record, behavior monitoring, or self-injury. 3. Resident #14 was admitted to the facility on in March 2016 with diagnoses that included schizoaffective disorder, bipolar disorder, and cellulitis. The care plan dated 4/4/24 identified a concern with activities related to cognitive impairment with intervention which included provide brief activities for resident. The quarterly MDS dated [DATE] identified Resident #14 had moderately impaired cognition, was wheelchair bound, had peripheral vascular disease and was dependent on staff for toileting, hygiene, showering or bathing, body dressing, and personal hygiene. The nurse's note dated 6/29/24 identified that during nail care, the tip of the resident's right thumb was clipped by NA #1. The area was cleansed and bandaged by the DNS and there were no signs of infection. The nurse's note dated 7/1/24 identified the right thumb continued to ooze after the dressing was pulled off. Bacitracin and a bandage were applied to the top of the thumb, no swelling, discoloration or infection were noted, and the nail has fungus. The nurse's note dated 7/2/24 identified the resident's thumb was discolored, inflamed. Staff questioned cellulitis, or allergic reaction to the ointment. The physician was notified, and the resident was started on Keflex (antibiotic) 500mg every 4 times daily for 7 days. Review of the clinal record failed to reflect any assessments or documentation of the condition of the resident's thumb on 7/3/24, 7/4/24 and 7/5/24. The nurse's note dated 7/6/24 identified resident's thumb was swollen, appeared blistered towards the base of first knuckle and the resident verbalized pain when the thumb was moved. The physician was notified, and Resident #14 was sent to the emergency room for evaluation. The hospital discharge summary dated 7/7/24 identified Resident #14 was diagnosed with right thumb Paronychia and Felon of the finger. The discharge summary identified Resident #14 underwent bedside incision and drainage without complication and was administered empiric antibiotics (Vancomycin 1mg via IV on 7/6/24 at 8:36 PM, Zosyn 4.5mg via IV 7/7/24 at 7:06 PM, on 7/7/24 at 12:40 AM and 6:11 AM), Morphine 2mg (pain relief), Lidocaine 10mg/ml 20ml injection (local anesthetic), and Atarax 25mg (antihistamine). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 9/9/24 at 11:00 AM identified the tip of Resident #14's thumb was cut on 6/29/24 during nail care. The DNS indicated NA #1 advised her of the cut, as DNS she cleansed the area and applied a dressing. The DNS indicated she documented an assessment on 7/1/24 and notified the physician on 7/2/24 as the thumb presented as discolored and inflamed. The physician prescribed Keflex 500mg every 12 hours for 7 days. On 7/6/24 the DNS indicated the thumb was swollen and had blisters; she notified the physician who ordered the resident be sent to the ER for evaluation. The DNS stated her expectation was that the condition of the finger should have been assessed and that assessment be documented in the clinical record from 7/3/24 - 7/5/24. A policy for antibiotic monitoring was requested, however not provided. 47457

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #29) reviewed for accidents, the facility failed to complete an elopement assessment following an elopement from the facility and failed to ensure staff monitored behaviors related to an attempt at self-harm. The findings include: Resident #29 was admitted to the facility in July 2021 with diagnoses that included major depressive disorder, major neurocognitive disorder, and hypertension. The annual MDS dated [DATE] identified Resident #29 had intact cognition, was always continent of bowel and bladder and required staff assistance for set up and supervision with dressing, bathing, and set up only for meals. The MDS also identified Resident #29 had not exhibited any behaviors related to wandering and had not reported or exhibited any thoughts or behaviors related to self-harm. The care plan dated 6/23/23 identified Resident #29 had a history of suicidal ideations. Interventions included to monitor for behavioral changes. The care plan also identified that Resident #29 was not at risk for elopement. Review of the state agency reportable event database identified that on 8/7/23 at 5:00 PM the facility reported that Resident #29 was identified as missing from the facility. The reportable event form dated 8/7/23 by the DNS identified Resident #29 had not exhibited any behaviors in the 3 days prior to the elopement. The DNS identified she assisted with Resident #29's care on 8/7/23 and at 1:00 PM assisted with set up for a shower. The documentation further identified that after Resident #29 finished showering, he/she was seen at the nurse's station at 1:45 PM and returned to his/her room where he/she was seen by his/her roommate, and then left the room. The documentation identified that at approximately 5:00 PM, Resident #29 could not be located for dinner and following notification to the police, the resident representative, and medical director, a review of the facility's security cameras identified that Resident #29 exited the facility through the front entrance at approximately 2:00 PM. The documentation identified that the facility was notified Resident #29 was located on 8/8/23 at 4:00 PM at a hospital emergency department located 22 miles from the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified that a 9/1/23 hospital psychiatry discharge summary identified Resident #29 initially presented to the hospital emergency department after being found by local law enforcement at a gas station after attempting suicide by overdosing on Benadryl (an over the counter antihistamine used for allergies) and alcohol. The note identified Resident #29 reported worsening depression 3 - 6 months with increased thoughts of suicide in the 2 months prior to elopement from the facility. The note also identified Resident #29 was in psychosis and required inpatient psychiatric admission and treatment from 8/9/23 - 9/1/23. The note identified that the hospital staff contacted the DNS regarding discharge on 9/1/23 and the interventions discussed included relocating Resident #29's room to a location within direct eyesight of the nurse's station, increasing the frequency of psychiatric APRN visits to twice monthly, and increasing the frequency of social work visits. The note identified Resident #29 was euthymic with no overt psychosis and not at imminent risk for self-harm or others at the time of discharge. Review of the clinical record failed to identify any revisions to Resident #29's care plan following readmission to the facility on [DATE] related to actual elopement from the facility and suicide attempt with hospitalization . A psychiatric APRN note dated 9/6/23 by APRN #1 identified Resident #29 was seen following elopement from the facility and suicide attempt with hospitalization . The note further identified Resident #29 had a previous history of suicidal ideation with a plan to jump from a bridge. The note also identified Resident #29 had no history of any prior attempts at elopement. The note identified the resident was not at current risk for self-harm and the treatment plan included to monitor for changes in mood and behaviors. Review of the behavior monitoring record for Resident #29 for 9/2023, following readmission to the facility, identified monitoring included unauthorized exit, hearing voices, poor personal hygiene, lack of motivation, and refusal to get out of bed. Review of the clinical record failed to identify any elopement risk assessments completed for Resident #29 from 9/2023 - 9/2024. Review of the nurse aide care cards for residents of the facility on 9/10/24, located on the nurse's station, failed to identify any care card documentation or interventions for Resident #29. Interview with NA #1 on 9/10/24 at 7:15 AM identified she had been employed at the facility for 2 years and was aware of Resident #29's elopement from the facility on 8/7/23. NA #1 identified Resident #29 had a room previously located next to the front entrance door of the facility and following the elopement, was relocated to a room directly next to the nurse's station. NA #1 identified that the staff routinely kept an eye on Resident #29's location, which was usually in his/her room, and that she was not aware of any other elopement attempts since 8/7/23. NA #1 also identified that she was aware of Resident #29's history of suicidal ideations, however her understanding was Resident #29 had discussed this at some point in the past in passing but had never verbalized anything related to suicidal thoughts or self-harm to her. NA #1 identified that she had not been notified of, or ever heard, that Resident #29 had ever attempted suicide or self-harm since admission to the facility, and the only incident she was aware of was elopement on 8/7/23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 9/10/24 at 9:34 AM identified that Resident #29 did not have a prior history of elopement from the facility prior to 8/7/23. APRN #1 identified that Resident #29 had not had any further attempts at elopement or self-harm that she had been notified of by the facility or resident. APRN #1 identified that elopement assessments and interventions would be based on the facility's policy, and she would not direct that. APRN #1 also identified that there would not be any specific monitoring of Resident #29's behaviors related to self-harm other than monitoring behavior overall, but that there would not be any specific monitoring that she could think. Interview with the DNS on 9/10/24 at 11 AM identified that she provided direct care for Resident #29 on 8/7/23. The DNS identified that Resident #29 had a history of suicidal ideation prior to admission to the facility but had not verbalized or exhibited any behaviors related to self-harm. The DNS also identified prior to Resident #29's elopement from the facility on 8/7/23, Resident #29 had not attempted to even leave the building, including going outside to resident areas on the facility premises. The DNS identified that Resident #29 should have had an elopement assessment completed following return to the facility on [DATE] as he/she would have been an elopement risk at that point, and Resident #29's care plan should have been updated to reflect the elopement as well as the suicide attempt as these were both new issues for Resident #29. The DNS also identified that Resident #29's nurse aide care card should have been included for the residents on the unit and she would ensure that these items would be addressed. Although attempted, an interview with Resident #29 was not obtained. The facility policy on unauthorized exits directed that it was the policy of the nurse aides to know where all residents in their care were always, and that the charge nurse would have an idea of where each resident in their care was located. Although requested, the facility failed to provide policies on elopement, close monitoring, or self-harm.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 47457 Based on review of facility documentation and interviews, the facility failed to obtain registry verification that a nurse aide (NA #2) had received a nurse aide certification. Review of NA #2's personnel file identified an Application for Employment dated 4/7/20 that failed to identify NA #2 had completed a nurse aide training program. The personnel file further identified that NA #2 was hired on 4/13/20. The Connecticut State Nurse Aide Registry Verification Reports dated 10/31/23 and 9/10/24 identified that registry inquiry results for NA #2 were not found. Interview with the Office Manager on 9/10/24 at 12:09 PM identified that NA #2 was initially hired on 4/13/20 and that she had taken a nurse aide training course, but due to the Covid-19 pandemic, she was not able to take the certification test. The Office Manager indicated that subsequently, NA #2 left the facility to work at another facility that provided free nurse aide training with a one-year work commitment. The Office Manager identified that after NA #2 finished out her contract with the other facility she returned to this facility (date unknown). The Office Manager indicated that she was under the impression that NA #2 had completed the course and earned the nurse aide certification. The Office Manager further indicated that she did not run a nurse aide verification report when NA #2 returned to work at the facility because NA #2 had finished out her contract at the other facility and did not think she would have been accepted to come back to this facility if she didn't have her nurse aide certification. The Office Manager indicated that it was her responsibility to ensure verification of a nurse aide certification, and she could not recall why that wasn't completed at the time of rehire, but that NA #2 had returned from the other facility with a nurse aide training program. Interview with the DNS on 9/10/24 at 1:08 PM indicated that NA #2 completed the nurse aide training course at another facility. The DNS further indicated that yesterday, NA #2 had reassured her that she did complete the nurse aide training course, had earned a nurse aide certification, and that there was a difference in the spelling of her name which may have been creating the problem with the registry search. The DNS identified that NA #2 would provide the facility with a copy of her nurse aide certification. Although requested a policy for competent nurse staffing was not provided. Follow-up interview with the DNS on 9/16/24 at 2:29 PM identified that she had not received a copy of NA #2's nurse aide certification because NA #2 had been in an accident was not able to return to work. The DNS further indicated that NA #2 would not be allowed to return to work at the facility without verification of her nurse aide certification, and if she was not able to provide that documentation her employment would be terminated.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47457 Based on review of facility documentation and interviews, the facility failed to ensure accurate staffing data was entered in the Payroll-Based Journal (PBJ). The findings include: Review of the PBJ Staffing Data Report dated FY Quarter 1 2024 (October 1 - December 31) identified that the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following infraction dates: 10/9/23, 10/14/23, 10/15/23, 10/18/23, 10/19/23, 10/27/23, 11/21/23, 11/23/23, 11/25/23, 11/30/23, and 12/16/23. Review of the PBJ Staffing Data Report dated FY Quarter 2 2024 (January 1 - March 31) identified that the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following infraction dates: 1/6/24, 1/14/24, 1/19/24, 1/20/24, 1/25/24, 2/10/24, 2/13/24, 3/15/24, and 3/22/24. Review of the PBJ Staffing Data Report dated FY Quarter 3 2024 (April 1 - June 30) identified that the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following infraction dates: 4/12/24, 4/13/24, 5/7/24, 5/15/24, 5/17/24, 5/23/24, 5/24/24, and 6/20/24. Review of the PBJ Staffing Data Report dated FY Quarter 4 2024 (July 1 - September 30) identified that the facility had excessively low weekend staffing and failed to have licensed nursing coverage 24 hours/day on the following infraction dates: 7/5/24, 7/9/24, 7/26/24, 7/29/24, 8/11/24, 8/20/24, 8/30/24, and 9/8/24. Nurse staffing was reviewed for the period of 8/25/24 through 9/10/24, the facility met the rest home with nursing supervision standards. Interview with the DNS on 9/10/24 at 11:17 AM identified that she was not responsible for the PBJ reporting, but at no point in her tenure at the facility had there been a gap in licensed nurse coverage. The DNS indicated that there was always a licensed nurse working at the facility 24 hours a day, and as a working DNS she ensured 24-hour coverage. The DNS further indicated the data related to no licensed nursing coverage 24 hours/day must have been entered incorrectly. The DNS identified that occasionally the facility would have sick calls from nurse aides on the weekends, and while they would attempt to cover the sick calls, at times they would have to operate with one less nurse aide. The DNS indicated that the facility is a rest home with nursing supervision, so given most resident's higher level of functioning and independence, the team was always able to meet residents' needs, even if there was a call out. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with the Office Manager on 9/10/24 at 12:09 PM identified that the PBJ trigger for failure to have licensed nursing coverage 24 hours/day must have been a typographical error because the facility always had 24 hours/day licensed nurse coverage. The Office Manager further identified that because the facility does not use electronic records, the process of submitting the data was challenging and that she tried to enter the data accurately and to the best of her ability. The Office Manager indicated that she enters the PBJ data quarterly; first she manually enters the hours worked from the timecards to a spreadsheet and then enters the data into the PBJ program, individually, creating multiple areas for a typographical error. The Office Manager identified that after reconciling the timecards and nursing schedule with the infraction dates identified on the PBJ report, she had accidentally omitted information or entered information under incorrect dates, and moving forward she would attempt to submit the PBJ data more frequently than quarterly to hopefully decrease typographical errors. Review of the facility assessment failed to reflect documentation regarding PBJ.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 37293 Based on review of facility documentations and interviews the facility failed to designate a specific individual (with the required training and qualification) to oversee the infection control program and the facility failed to designate an Infection Preventionist that is at least part-time who was physically working on site at the facility. The findings include: Interview with the DNS on 9/9/24 at 11:00 AM identified she has a contracted Infection Preventionist for the facility since 12/2021 who works approximately 5 hours a month in the position. Further, the DNS indicated although she had been functioning in the role of infection control nurse, she is not certified in infection prevention and had not completed the specialized training. The DNS indicated she worked as the infection control nurse, supervisor, charge nurse, and staff development (provides in-services). Interview with RN #2, the contracted Infection Preventionist, on 9/10/24 at 10:58 AM identified she works approximately 5 hours a month and indicated the DNS oversees the infection control program on a daily basis. Review of facility billing documentation identified RN #2 works approximately 5 hours a month in the Infection Preventionist position. Review of the facility assessment tool identified the infection prevention and control position is approximately 5 - 8 hours depending on outbreaks, identification and containment of infections, prevention of infections. The facility assessment tool further identified no outbreaks in the past 6 months.