

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Avalon Health Care Center at Stoneridge		STREET ADDRESS, CITY, STATE, ZIP CODE 186 Jerry Browne Road Mystic, CT 06355	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</p> <p>Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident abuse, the facility failed to ensure Resident #1 was not verbally abused by a staff member. The findings include:</p> <p>Resident #1's diagnoses included cognitive impairment and anxiety.</p> <p>The admission Resident Care Plan (RCP) dated 2/6/25 identified Resident #1 had a mood disorder and received an antidepressant medication.</p> <p>Interventions directed to monitor targeted behaviors, provide routine and as needed psychiatric visits, and medications as ordered.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had some short and long term memory recall deficits, exhibited verbal outbursts towards others, required staff assistance with activities of daily living, and utilized a wheelchair for mobility.</p> <p>A physician's order dated 2/13/25 directed to administer a medication to help people with insomnia fall asleep slightly faster, Melatonin 5 milligrams (mg) at bedtime for sleep and an antidepressant for treating major depressive disorders, Trazadone 25 mg every four (4) hours as needed for insomnia.</p> <p>The nurse's note dated 2/14/25 written at 7:47 AM identified at the beginning of the 11PM-7AM shift on 2/13/25 Resident #1 was observed to be sitting in a recliner chair in front of the nurse's station, Resident #1 was noted to be upset and verbalized that he/she did not want to be in the hallway and he/she wanted to go back to bed. The note identified Resident #1 was assisted by two (2) staff members back to bed and was awake most of the night.</p> <p>The nurse's note dated 2/14/25 at 11:39 AM identified the psychiatric services were contacted to see Resident #1 due to an alleged verbal abuse committed by a staff member against Resident #1. The note identified Resident #1 was calm and cooperative with intermittent calling out when no one was in the room with him/her.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The psychiatric note dated 2/14/25 identified Resident #1 was seen in follow-up for an allegation of verbal abuse by a staff member. Resident #1 admitted to the incident, stated he/she was upset over the incident, and was unable to sleep last night. The note indicated medications were changed the current Trazadone 25 mg every 24 hours as needed was discontinued, Trazadone 37.5 mg every hour of sleep and Trazadone 12.5 mg every 24 hours as needed if still unable to sleep were ordered, and to continue the Melatonin 5 mg at hour of sleep.</p> <p>The Facility Reported Incident form dated 2/14/25 identified a 3-11PM nurse aide reported to the 7AM-3PM Nursing Supervisor that on 2/13/25 she witnessed another 3-11PM nurse aide, Nurse Aide (NA) #1, state to Resident #1 Well if you'd shut up, you wouldn't have to be out here. The report identified Resident #1 reported, she put me at the station for 211 minutes, she told me not to say a word, and she is mean. The report indicated NA #1 was suspended pending an investigation and all parties were notified.</p> <p>Review of the nurse's notes from 2/14/25 through 2/15/25 identified Resident #1 had no ill effects from the alleged verbal abuse.</p> <p>In a written statement dated 2/14/25 a 3-11PM nurse aide, NA #5 identified she heard NA #1 say to staff, I know he/she doesn't want to be out here, and then NA #1 said very loud to Resident #1, Well if you'd shut up, you wouldn't be out here.</p> <p>Interview with the Director of Nursing (DON) on 3/4/25 at 11:15 AM identified she was notified on 2/14/25 at approximately 11:00 AM of the allegation of verbal abuse that occurred on the 3-11PM shift on 2/13/25. The DON identified an investigation was conducted and the facility concluded NA #1 verbally abused Resident #1 and NA #1 was terminated from employment for not following the facility's core values.</p> <p>Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #2, on 3/4/25 at 11:36 AM identified on 2/14/25 Resident #1's family member approached her and reported Resident #1 told the family member that the night before, 2/13/25, Resident #1 was put at the nurse's station and told not to speak.</p> <p>Interview with NA #1 on 3/4/25 at 12:45 PM identified on 2/13/25 at approximately 10:00 PM she brought Resident #1 out to the nurse's station because he/she was screaming. NA #1 denied ever telling Resident #1 to shut up.</p> <p>Interview with NA #4 on 3/4/25 at 12:55 PM identified on 2/13/25 Resident #1 was brought out to the nurse's station because he/she was yelling and disrupting other residents that were trying to sleep. NA #4 explained when the staff were leaving at the end of their shift, she heard NA #1 say to Resident #1, Well if you shut up, you would be able to go back to bed.</p> <p>Review of NA #1's personnel file identified she last completed Elder Abuse Training on 12/27/24.</p> <p>Review of the facility policy for Abuse and Neglect identified, in part, that abuse includes verbal abuse and is a willful act.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Resident's [NAME] of Rights, identified residents have the right to be free from verbal abuse and staff will be trained on preventing, recognizing, and reporting abuse prior to providing any direct care services to residents		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</p> <p>Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident verbal abuse, the facility failed to ensure a witnessed allegation of verbal abuse was reported to the Administrator and/or designee within two (2) hours after the event occurred. The findings include:</p> <p>Resident #1's diagnoses included cognitive impairment and anxiety.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had some short and long term memory recall deficits, exhibited verbal outbursts towards others, required staff assistance with activities of daily living, and utilized a wheelchair for mobility.</p> <p>The nurse's note dated 2/14/25 written at 7:47 AM identified at the beginning of the 11PM-7AM shift on 2/13/25 Resident #1 was observed to be sitting in a recliner chair in front of the nurse's station, Resident #1 was noted to be upset and verbalized that he/she did not want to be in the hallway and he/she wanted to go back to bed. The note identified Resident #1 was assisted by two (2) staff members back to bed and was awake most of the night.</p> <p>The nurse's note dated 2/14/25 at 11:39 AM identified the psychiatric services were contacted to see Resident #1 due to an alleged verbal abuse committed by a staff member against Resident #1. The note identified resident #1 was calm and cooperative with intermittent calling out when no one was in the room with him/her.</p> <p>The Facility Reported Incident form dated 2/14/25 identified a 3-11PM nurse aide reported to the 7AM-3PM Nursing Supervisor that on 2/13/25 she witnessed another 3-11PM nurse aide, Nurse Aide (NA) #1, state to Resident #1 Well if you'd shut up, you wouldn't have to be out here. The report identified Resident #1 reported, she put her at the station for 211 minutes, she told me not to say a word, and she is mean. The report indicated NA#1 was suspended pending an investigation and all parties were notified.</p> <p>Interview with the Director of Nursing (DON) on 3/4/25 at 11:15 AM identified she was notified on 2/14/25 at approximately 11:00 AM of the allegation of verbal abuse that occurred on the 3-11PM shift on 2/13/25. The DON identified the 3-11PM nurse aides failed to notify the 3-11PM Nursing Supervising on 2/13/25 of the alleged abuse prior to leaving the facility. The DON explained that during the facility's investigation, there were other instances where NA #1 was heard talking inappropriately to residents and these instances were not reported to administration. The DON identified at the conclusion of the investigation, the facility concluded NA #1 verbally abused Resident #1 and NA #1 was terminated from employment for not following the facility's core values.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #2, on 3/4/25 at 11:36 AM identified on 2/14/25 Resident #1's family member approached her and reported Resident #1 told the family member that the night before 2/13/25, Resident #1 was put at the nurse's station and told not to speak. RN #2 indicated when NA #5 overheard the conversation she had with Resident #1's family member, NA #5 told her that she had witnessed the event the night before, 2/13/25. RN #2 identified she contacted the Director of Nursing and set up a psychiatric evaluation which was conducted that day.</p> <p>Interview with NA #4, on 3/4/25 at 12:55 PM identified on 2/13/25 she heard NA #1 say to Resident #1, Well if you would shut up, you would be able to go back to bed. NA #4 stated she did not report this to anyone.</p> <p>Review of the facility policy for Abuse and Neglect identified, in part, that suspected or identified abuse would be reported in a timely manner consistent with applicable laws and regulations.</p>		