STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075441	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at East Hill, The	611 East Hill Road Southbury, CT 06488

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 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** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of five residents (Resident #1) reviewed for quality of care, the facility failed to ensure that the medical provider was notified timely of the inability to provide ordered tube feeding on admission. The findings include: Resident #1 was admitted to the facility with diagnoses that included protein-calorie malnutrition and dysphagia. The nursing admission form dated 2/25/2025 at 7:38 PM identified Resident #1 was admitted via ambulance, was alert with some confusion, and had a gastrostomy tube (feeding tube). A nursing admission summary written by RN #1/nursing supervisor dated 2/25/2025 at 8:04 PM identified a J-tube (Jejunostomy tube inserted into the small intestine for feeding) present in the right upper (abdomen) quadrant. Per W10 (facility transfer document) admission orders J-tube was to be flushed every hour with 15 cubic centimeters (ccs) of water. Tube feed was to be at a rate of 55 milliliters (ml) per hour. Resident #1 was also on a regular diet with pureed consistency and thin liquids, and the on-call APRN was notified and verified orders. A physician order dated 2/25/2025 directed tube feed: Vital AF 1.2 (peptide-based therapeutic liquid nutrition), 55 ml per hour for 22 hours (daily for 22 hours) for J- tube feeding. A nursing Medication Administration Record (MAR) note written by RN #2 dated 2/26/2025 at 12:21 AM (approximately 4 hours after admission) identified Vital AF 1.2 at 55 ml per hour times 22 hours for J-tube was not available and waiting for the pharmacy to deliver supplies. A nursing MAR note written by RN #2 dated 2/26/2025 12:49 AM identified the change and date (J-tube) tubing set every night shift was not completed as supplies were not on hand. (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

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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	Interview and medical record review with RN #2 on 4/14/2025 at 10:47 AM identified she worked on 2/25/2025 during the 11 PM to 7 AM shift. RN #2 stated when her shift began she tried to initiate Resident #1's tube feeding as ordered, but she could not locate the tube feeding formula and the feeding tubing required for administration, as the items had not arrived from the pharmacy. RN #2 stated she had a large syringe used for feeding tubes in house, and was able to administer the medications and flush through the J-tube as ordered. RN #2 stated she did not notify the APRN/physician of the inability to provide the ordered feeding as she had come on shift at 11:00 PM and Resident #1 had arrived during the evening shift a few hours earlier, and indicated RN #1/evening shift supervisor, was aware the tube feeding had not started. Interview and review of the medical record with RN #1 on 4/14/2025 at 11:30 AM identified he recalled Resident #1 had arrived to the facility with two (2) or three (3) containers of the Vital AF 1.2 formula. RN #1 stated the formula was not the usual tube feed containers that can be spiked with tubing for administration. RN #1 stated he did recall the tube feeding was not started on arrival but could not recall why. RN #1 stated he did not recall contacting the APRN to notify that they did not start the ordered feeding. He stated if he had notified the APRN, he would have documented in Resident #1's medical record and stated if it's not documented, it's not done. RN #1 stated he should have notified the APRN to get an alternate plan for the feeding and could not recall why he did not. Interview with LPN #1 on 4/14/2024 at 11:07 AM identified she hung (started) Resident #1's ordered tube feed after report on 2/26/2025 at around 7:30 AM (approximately 11 and ½ hours after Resident #1 was admitted). Review identified Resident #1 was without the ordered Vital AF 1.2 at 55 ml per hour times for J-tube from admission on [DATE] at 7:30 PM to 2/26/2025 at 7:30 AM, approximately 11 and ½ hours, or 660 ml of feeding. Interview with MD #1 on 4/14/2025 at 2:00 PM identified if Resident #1 could not receive an ordered tube feeding for 12 hours, the APRN or physician should have been contacted. An alternate plan would have been established to address the feeding that could have included an alternate available formula if needed. Interview with the DON on 4/15/2025 at 2:45 PM identified if a nurse cannot provide a Resident with an ordered tube feed, the APRN or physician needed to be notified, and she did not know why RN #1 and RN #2 did not notify the physician/APRN. The DON stated on 2/26/2025 when she came into work, she went to the unit and found the containers of Resident #1's tube feeding formula in the refrigerator on the unit. The DON stated the equipment/supplies needed to administer the feeding was located in the storage room on the unit. The DON stated she did not know why the nurses did not find the feeding formula and the supplies. The facility policy Notification of Changes dated 2/21/2023, directed in part, that the facility must immediately consult the resident's physician when a need to alter treatment significantly. The facility policy Enteral Feeding dated 12/3/2025 directed in part, that a resident who was fed via a gastrostomy tube received the appropriate treatment.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policies, and interviews with one of five residents (Resident #1) reviewed for quality of care, the facility failed to ensure a tube feeding was administered timely, in accordance with physician orders. The findings include: Resident #1 was admitted to the facility with diagnoses that included protein-calorie malnutrition and dysphagia. The nursing admission form dated 2/25/2025 at 7:38 PM identified Resident #1 was admitted via ambulance, was alert with some confusion, and had a gastrostomy tube (feeding tube). A nursing admission summary written by RN #1/nursing supervisor dated 2/25/2025 at 8:04 PM identified a J-tube (Jejunostomy tube inserted into the small intestine for feeding) present in the right upper (abdomen) quadrant. Per W10 (facility transfer document) admission orders J-tube was to be flushed every hour with 15 cubic centimeters (ccs) of water. Tube feed was to be at a rate of 55 milliliters (ml) per hour. Resident #1 was also on a regular diet with pureed consistency and thin liquids, and the on-call APRN was notified and verified orders. A physician order dated 2/25/2025 directed tube feed: Vital AF 1.2 (peptide-based therapeutic liquid nutrition), 55 ml per hour for 22 hours (daily for 22 hours) for J- tube feeding. A nursing Medication Administration Record (MAR) note written by RN #2 dated 2/26/2025 at 12:21 AM (approximately 4 hours after admission) identified Vital AF 1.2 at 55 ml per hour times 22 hours for J-tube was not available and waiting for the pharmacy to deliver supplies. A nursing MAR note written by RN #2 dated 2/26/2025 12:49 AM identified the change and date (J-tube) tubing set every night shift was not completed as supplies were not on hand. Interview and medical record review with RN #2 on 4/14/2025 at 10:47 AM identified she worked on 2/25/2025 during the 11 PM to 7 AM shift. RN #2 stated when her shift began she tried to initiate Resident #1's tube feeding as ordered, but she could not locate the tube feeding formula and the feeding tubing required for administration, as the items had not arrived from the pharmacy. RN #2 stated she had a large syringe used for feeding tubes in house, and was able to administer the medications and flush through the J-tube as ordered. Interview and review of the medical record with RN #1 on 4/14/2025 at 11:30 AM identified he recalled Resident #1 had arrived to the facility with two (2) or three (3) containers of the Vital AF 1.2 formula. RN #1 stated the formula was not the usual tube feed containers that can be spiked with tubing for administration. RN #1 stated he did recall the tube feeding was not started on arrival but could not recall why. Interview with LPN #1 on 4/14/2024 at 11:07 AM identified she hung (started) Resident #1's ordered tube feed after report on 2/26/2025 at around 7:30 AM (approximately 11 and ½ hours after Resident #1 was admitted). (continued on next page)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review identified Resident #1 was without the ordered Vital AF 1.2 at 55 ml per hour times for J-tube from admission on [DATE] at 7:30 PM to 2/26/2025 at 7:30 AM, approximately 11 and ½ hours, or 660 ml of feeding. Interview with MD #1 on 4/14/2025 at 2:00 PM identified if Resident #1 could not receive an ordered tube feeding for 12 hours, the APRN or physician should have been contacted. An alternate plan would have been established to address the feeding that could have included an alternate available formula if needed. Interview with MD #1 on 4/14/2025 at 2:00 PM identified if he was aware, he could have given orders for an alternate tube feeding. Interview with the DON on 4/15/2025 at 2:45 PM identified the tube feeding should have been provided as ordered. The DON stated on 2/26/2025 when she arrived at work, she looked on the unit for the tube feeding and located the formula in the unit refrigerator. Further, she located the required feeding supplies in the unit storage room. The DON stated she did not know why the nurses did not locate the formula and feeding supplies. The facility policy Enteral Feeding dated 12/3/2025 directed in part, that a resident who was fed via a gastrostomy tube received the appropriate treatment.