STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075313	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observations, clinical record review, review of facility policy,and interviews for 2 of 4 residents, (Resident #8 and Resident #20) reviewed for dignity, and for 1 of 3 residents, (Resident #105), reviewed for abuse, the facility failed to ensure Residents #8 and #105 were treated in a dignified manner when spoken to and for Resident #20, failed to provide a dignified experience for a resident who could not eat. The findings include. 1. Resident #8's diagnoses include multiple sclerosis, coronary artery disease and hypertension. The annual Minimum Data Set assessment dated [DATE] identified Resident #8 had no cognitive impairment and was totally dependent on staff for transfers, bathing, and dressing. Additionally, Resident #8 had functional limitation to range of motion on both sides to the upper and lower extremities. Interview with Resident #8 on 11/19/24 at 12:15 PM indicated that LPN #11 was not nice and had poor communication skills. Resident #8 stated he/she had seen LPN #11 treat other residents in an undignified manner, including hearing this LPN say to another unidentified resident, what do you want abruptly. Additionally, Resident #8 indicated that LPN #11 had come into the room, when his/her roommate was not present, and turned up the television volume to a loud tone intentionally to annoy him/her. Resident #8 further indicated that when he/she requested the volume be lowered, LPN #11 responded abruptly and using a strong tone, that his/her roommate had the right to watch television too. Resident #8 indicated this was reported to a staff member but was unable to recall their name, and that LPN #11's actions feel retaliatory. Resident #8 thought that he/she had shared reporting these incidents to the DNS in the past. 2. Resident #20's diagnoses include Cerebral Palsy, vascular dementia, and a developmental disorder of speech and language. The physician's order dated 9/6/24 directed for Resident #20 to be NPO (nothing by mouth), totally dependent, and assist of one with enteral/tube feeding related to dysphagia due to cerebral palsy. The Resident Care Plan dated 9/10/24 identified Resident #20's only source of nutrition and hydration was via feeding tube, and she/he does not take anything by mouth. Interventions included for the feeding tube to be flushed and free water given as ordered, and to report any signs of aspiration or difficulty with feeding tolerance to the doctor. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was severely cognitively impaired and was dependent for eating, toileting and transfers. The MDS further identified Resident #20 had a feeding tube while a resident at the facility. Observation on 11/18/24 at 12:15 PM identified Resident #20 sitting in her/his wheelchair in the hallway across from the dining room during lunch time, with a clear view of residents eating lunch. No other residents were noted to be in the hallway at the time. Observation on 11/19/24 at 12:14 PM identified Resident #20 sitting in her/his wheelchair in the hallway outside of the dining room, next to the steam table, while facility staff was placing lunch orders and plating the meals. Resident #20 was noted to have her/his right index finger in her mouth, and no other residents were in the hallway at the time. Observation on 11/20/24 at 12:18 PM identified Resident #20 sitting in her/his wheelchair in the hallway across from the dining room during lunch time, with a clear view of residents eating lunch. No other residents were noted to be in the hallway at the time. An interview with Licensed Practical Nurse (LPN) #4 on 11/20/24 at 12:18 PM identified Resident #20 always sits outside of the dining room during lunch time for socialization, otherwise she/he was in her/his room listening to music, additionally putting her/his fingers in her/his mouth was a behavior and not an indication of hunger. Additionally, LPN #4 stated she felt it was alright for Resident #20, who cannot eat by mouth, to be watching others eat because Resident #20 does not recognize what she/he can and cannot do. Subsequent to surveyor interview, LPN #4 stated she was moving Resident #20 into the resident's room to administer medication and have her/him listen to music. An interview with the DNS on 11/20/24 at 1:25 PM identified it was appropriate for Resident #20 to be sitting outside of the dining room watching others eat, even though Resident #20 cannot eat because it was something Resident #20 had always done, otherwise she/he was in her/his room listening to music. When questioned about the reasonable person concept relating to the dignity of placing an individual in view of others eating when she/he cannot eat, the DNS responded that this was what Resident #20 had always done. Although requested, a facility policy for a Dining Experience was not provided. 3. Resident #105's diagnoses include congestive heart failure, cirrhosis of liver, adjustment disorder with anxiety, and type 2 diabetes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #105 had no cognitive impairment, required assist of 2 to transfer, and was fully dependent on staff assistance to mobilize his/her wheelchair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #105 on 11/18/24 at 12:20 PM identified that a couple of months ago LPN #11 had been standing at the end of his/her bed and stated, I don't like you to him/her, to which Resident #105 replied I don't like you very much. Resident #105 indicated that this was reported to the RN Supervisor and his/her family member. Additionally, Resident #105 reported an incident which occurred the evening of 11/17/24 at unknown time with LPN #11 when he/she wanted to know who his/her NA was as he/she was ready for bed. LPN #11 responded what do you want, in a harsh, stern tone and added that everyone was busy and didn't have time for him/her. Resident #105 indicated that this incident had not been reported to facility staff. The DNS was immediately notified by the surveyors, of Resident #105's statements. The APRN psychiatric evaluation and consultation note dated 11/18/24 documented that Resident #105 reported a nurse came in, was terse in her speech and does not talk with him/her like other nurses. Interview with LPN #11 and the DNS on 11/18/24 at 3:45 PM identified that she did have an interaction with Resident #105 the evening prior when Resident #105 asked who his/her NA was because he/she wanted to go to bed. LPN #11 indicated her response was the NA's were passing trays, when they were done, they would come in to put him/her to bed. Further, LPN #11 stated that a few months ago as she was walking out of the resident's room, he/she heard Resident #8 state I don't like her, but there was no one else in the room, LPN #11 did not respond and did not report the incident to any supervisory or managerial staff. Review of a social work note dated 11/18/24 indicated she was asked to see Resident #105 secondary to a complaint made against a nurse. Resident #105 stated that last night he/she was ringing his/her call bell to find out who the NA was for the night. Resident #105 indicated that LPN #11 came in and yelled at him/her stating you better not give my aides a hard time, that he/she wanted LPN #11 to stay away from him/her, and that all the other staff were wonderful. Interview with NA #4 on 11/22/24 at 8:30 AM identified that Resident #105 had discussed feeling threatened and disrespected by LPN #11. NA #4 indicated that she had reported this to the nurse on the shift weeks ago but could not recall their name due to the frequency of changes to nurses working on that unit. The facility Abuse policy indicated that should a resident make a complaint of abuse, an investigation will take place, staff in question would be suspended pending the outcome of the investigation. 51867

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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** 50249 Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 residents (Resident #38 and Resident #95) reviewed for nutrition, the facility failed to notify the provider in a timely manner when there was a change in condition and a significant weight loss. The findings included: 1. Resident #38's diagnoses included interstitial pulmonary disease, dysphagia with gastrostomy status and traumatic brain injury (TBI). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #38 was cognitively intact but without speech, was dependent with toileting and transfers and required moderate assistance with bed mobility. The MDS assessment indicated Resident #38 had a feeding tube and received tube feedings for 51% or more of calories. The Resident Care Plan dated 10/7/24 identified dysphagia with gastrostomy tube (G-tube) and a history of respiratory arrest and aspiration pneumonia. Interventions included to report any signs and symptoms of aspiration, increased shortness of breath or dyspnea (difficulty breathing) to the medical doctor (M.D). A nurse's note dated 11/15/24 at 10:33 PM identified Resident #38 had a congested cough, complaints of shortness of breath (SOB) and was requesting to go to the hospital. The nurse's note indicated that Resident #38 had diminished lung sounds (LS) throughout and shallow respirations. Additionally, the nurse's note identified that the supervisor (RN #2) was made aware. A nurse's note dated 11/16/24 at 1:08 AM identified Resident #38 was alert and non-verbal, had an occasional cough with no complaints of respiratory distress and a slightly distended abdomen. A nurse's note dated 11/17/24 at 2:06 AM identified Resident #38 was alert and non-verbal with no respiratory distress and a slightly distended abdomen. An observation on 11/18/24 at 11:30 AM, identified Resident #38 was in bed with a cough and audible congestion. LPN #4 was made aware, entered the room, and utilized a communication board to further evaluate the resident. A nurse's note written by LPN #4 on 11/18/24 at 2:55 PM identified Resident #38 had a deep congested cough, was suctioned for a minimum amount of phlegm, and had an expiratory wheeze with a nebulizer treatment given with some effect. LPN #4's nurses note indicated the supervisor (RN #1) was made aware. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Advanced Practice Registered Nurse (APRN #1) progress note dated 11/19/24 at 8:40 AM identified Resident #38 had a cough and shortness of breath, was ill appearing with an irregular heart rhythm, tachypnea (increased respiratory rate) and respiratory distress. APRN #1's progress note indicated Resident #38 appeared uncomfortable and had decreased breath sounds in the right and left lower lung fields. APRN #1's assessment further reflected Resident #38 was not communicating with his/her board, had an altered mental status, his/her skin was flushed and warm to the touch with pneumonia suspected. The APRN's progress note identified Resident #38 was transferred to the ED (emergency department) with respiratory distress. A physician's order dated 11/19/24 directed to transfer to ED with respiratory distress, resident to be evaluated in ER (emergency room). An interview and clinical record review with the 7:00 AM to 3:00 PM Registered Nurse supervisor (RN #1) on 11/21/24 at 1:30 PM, identified that Resident #38 had respiratory distress and was evaluated by the APRN on the morning of 11/19/24. Subsequently, Resident #38 was transferred to the hospital and was admitted to the hospital with pneumonia. RN #1 indicated that Resident #38 had a history of respiratory distress and aspiration and had recently returned from a hospitalization for aspiration. RN #1 further identified that Resident #38 was a fragile individual whose status could change on the drop of a dime. Review of the clinical record with RN #1 identified that, although the nursing supervisor (RN #2) had been notified of Resident #38's change in condition on 11/15/24, RN #2 failed to notify the provider. RN #1 indicated that although she was notified of Resident #38's change in condition on 11/18/24, she had failed to notify the provider. RN #1 indicated that when notified of a resident's change in condition, the nursing supervisor should inform the provider of the change in condition. RN #1 was unable to identify a reason RN #2 did not notify the provider of Resident #38's change in condition on 11/15/24. Additionally, RN #1 was unable to identify the reason she failed to notify the provider of Resident #38's change in condition on 11/18/24. Interview and record review with the 3:00 PM to 11:00 PM Registered Nurse Supervisor (RN #2) on 11/21/24 at 3:10 PM identified although Resident #38 had complaints of shortness of breath and asked to go to the hospital on 11/15/24, she did not notify the provider because Resident #38 was not in distress when she saw him/her and there was no reason to transfer the resident out. Interview and record review with the DNS on 11/22/24 at 9:41 AM identified that when the Registered Nurse supervisors (RN #1 and RN #2) were notified of Resident #38's change in condition, on 11/15/24 and 11/18/24 respectively, they should have notified the APRN. Review of the clinical record with the DNS at that time indicated that, although Resident #38 should have been evaluated by a provider after his/her change in condition on 11/15/24, the resident was not evaluated by the APRN until the morning of 11/19/24, when Resident #38 was found in respiratory distress and subsequently transferred to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with APRN #1 on 11/22/24 at 10:00 AM identified that she was not notified of Resident #38's change in condition on 11/15/24 or 11/18/24. APRN #1 indicated that if she had been notified on 11/15/24 and 11/18/24, she would have asked for further RN assessment and, based on the assessments, she would have given additional orders and/or sent Resident #38 to the hospital. APRN #1 identified that the Registered Nurse supervisors (RN #1 and RN #2) should have notified her of the residents change in condition on 11/15/24 and 11/18/24. APRN #1 indicated that Resident #38 should have had close monitoring and lung assessments in the days after his/her change in condition on 11/15/24 and that, she evaluated Resident #38 on the morning of 11/19/24, he/she was found in respiratory distress and required transfer to the hospital. Review of the facility's, Observation & Recording Change of Resident's Condition policy, undated, directed to ensure that when a resident has a change in condition that timely notification of physician, APRN and responsible party occur. 2. Resident #95 was admitted to the facility in April 2022 with diagnoses that included vascular dementia with psychotic disturbances, Down syndrome, depression, and hypothyroidism. A Resident Care Plan dated 2/19/24 identified a problem with Resident #95 having a significant weight loss in 6 months (weight of 195.4 pounds/lbs). Interventions included to start on nutritional supplements, encourage food/fluids, and obtain weights as ordered. Physician orders dated 3/14/24 directed weekly weights to be obtained every Friday. The annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident # 95 was severely cognitively impaired and required total dependence from staff for eating. A review of Resident #95's weight identified a weight of 190.1 pounds (lbs) on 6/23/24 and a weight of 177.6 lbs on 7/20/24 (a 12.6 lb/6.5 % loss in less than a month). APRN #1's progress notes dated 7/30/24 identified a weight of 177 lbs. but did not identify Resident #95 had a significant weight loss. Physician's orders dated 8/15/24 directed to administer house supplements 3 times a day (26 days after Resident #95 had a significant weight loss). Observations of Resident #95 on 11/18/24 at 12:25 PM and 11/20/24 at 8:15 AM and 12:30 PM, identified he/she received a regular diet and needed to be fed by nursing staff. Interview with APRN #1 on 11/21/24 at 11:30 AM noted she could not recall if she was made aware of Resident #95's weight loss from 7/20/24 by staff as she was new to the facility and had just started in July of 2024. A review of the APRN communication book from 7/20/24 through 11/21/24 indicated that there were no entries to update the APRN regarding Resident #95's significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An APRN #1 progress note dated 9/10/24 identified Resident #95 was seen for weight loss with no new orders and to continue with supplement orders from 8/15/24 as Resident # 95 was starting to trend up in weights with a weight of 179 lbs (APRN #1 did not address weight loss in the progress notes until 53 days after the initial weight loss was documented on 7/20/24). A review of the facility's Weight Policy dated 12/20/23 directed in part, MD or APRN will be notified of any significant weight loss or gain of 5% in one month or 10% in 6 months unless expected. Consult with Dietitian if loses or gains more than normal range. The Dietitian is available in building 2-3 times weekly. A review of the facility's Change of Condition Policy revised 6/2017 directed in part, to clearly document date and time the physician/APRN was notified of change and notifications are done in a timely manner after a change in condition. 51756

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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** 51182 Based on observation, staff interview, review of the clinical record, and facility policy for 1 of 3 residents (Resident #91) reviewed for accidents, the facility failed to ensure the Resident Care Plan (RCP) was comprehensive to include a known behavioral issue. The findings include: Resident #91's diagnoses included cerebral palsy, neuromuscular dysfunction of the bladder, and anxiety. The annual Minimum Data Set assessment dated [DATE] identified Resident #91 was cognitively intact, was dependent on chair/bed to chair transfers, and used a motorized wheelchair. The RCP dated 10/9/24 identified Resident #91 had a history of crying with a goal of initiating a conversation with staff when tearful, and a history of impaired physical mobility with an intervention of transferring him/her to and from the wheelchair using a mechanical lift. An observation and interview with Resident #91 on 11/18/24 at 11:14 AM identified he/she was wheelchair bound and his/her legs were positioned in a tucked-up position, not outward facing from the body. Resident #91 stated that a prior injury to his/her left foot and knee occurred from a mechanical transfer that occurred approximately 2 to 3 months ago, x-rays were performed that showed no broken bones, and now he/she received daily pain patches for the injury which was not needed before the mechanical lift accident. Resident #91 could not identify the exact date or time of the alleged accident nor who was transferring him/her in the mechanical lift. A nursing note dated 8/9/24 at 11:05 AM identified that Resident #91 approached an LPN and reported he/she had been experiencing left leg pain over a period of several days. The note further indicated the Advanced Practice Registered Nurse evaluated him/her on 8/9/24 and ordered an x-ray of Resident #91's left leg. A review of APRN and MD progress notes failed to identify documentation of an evaluation by a provider on 8/9/24 for Resident #91. Radiology results on 8/10/24 at 12:51 PM, of an X-ray of the left leg and left knee for complaint of severe pain to Resident #91's left lower leg, identified no new fractures. An interview with the Director of Nursing Service (DNS) on 11/21/24 at 2:55 PM identified that she did not fill out an accident and incident form for Resident #91's complaint of being injured from a mechanical lift transfer because she was not made aware of an incident. The DNS further identified that Resident #91 had a history of confabulating complaints for attention and the Social Worker (SW) would be responsible to include those behaviors in the RCP. SW notes dated 12/22/23 through 11/14/24 failed to identify documentation of Resident #91's alleged history of confabulation or false reporting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with SW #2 identified that she was aware of a history of manipulation of staff and confabulation by Resident #91. SW #2 failed to identify that these behavioral issues were included in the RCP and indicated they should be, stating she would incorporate them into the RCP moving forward. She was unable to identify the reason the behaviors were not previously included within the RCP. Request for the facility's policy on Care Plans identified the facility has no policy on Care Plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on interviews, review of facility documentation and facility policy for 1 of 1 sampled resident (Resident #38) reviewed for a change of condition, the facility failed to ensure the Registered Nurse (RN) completed and documented an assessment and during a review of the Intravenous program, the facility failed to ensure that an RN and not a Licensed Practical Nurse (LPN) assessed and evaluated RNs as being competent to administer IV medications and fluids using IV infusion pumps. The findings included: 1. Resident #38's diagnoses included interstitial pulmonary disease, dysphagia with gastrostomy status and traumatic brain injury (TBI). The annual Minimum Data Set assessment dated [DATE] identified Resident #38 was cognitively intact but without speech, was dependent with toileting and transfers and required moderate assistance with bed mobility. The MDS assessment indicated Resident #38 had a feeding tube and received tube feedings for 51% or more of calories. The Resident Care Plan dated 10/7/24 identified dysphagia with gastrostomy tube (G-tube) and a history of respiratory arrest and aspiration pneumonia. Interventions included to report any signs and symptoms of aspiration, increased shortness of breath or dyspnea (difficulty breathing) to the medical doctor (M.D). A nurse's note dated 11/15/24 at 10:33 PM identified Resident #38 had a congested cough, complaints of shortness of breath (SOB) and was requesting to go to the hospital. The nurse's note indicated that Resident #38 had diminished lung sounds (LS) throughout and shallow respirations. Additionally, the nurse's note identified that the supervisor (RN #2) was made aware. A nurse's note dated 11/16/24 at 1:08 AM identified Resident #38 was alert and non-verbal, had an occasional cough with no complaints of respiratory distress and a slightly distended abdomen. A nurse's note dated 11/17/24 at 2:06 AM identified Resident #38 was alert and non-verbal with no respiratory distress and a slightly distended abdomen. An observation on 11/18/24 at 11:30 AM, identified Resident #38 was in bed with a cough and audible congestion. LPN #4 was made aware, entered the room, and utilized a communication board to further evaluate the resident. A nurse's note (LPN #4) on 11/18/24 at 2:55 PM identified Resident #38 had a deep congested cough, was suctioned for a minimum amount of phlegm, and had an expiratory wheeze with a nebulizer treatment given with some effect. LPN #4's nurses note indicated the supervisor (RN #1) was made aware. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Advanced Practice Registered Nurse (APRN #1) progress note dated 11/19/24 at 8:40 AM identified Resident #38 had a cough and shortness of breath, was ill appearing with an irregular heart rhythm, tachypnea (increased respiratory rate) and respiratory distress. APRN 1's progress note indicated Resident #38 appeared uncomfortable and had decreased breath sounds in the right and left lower lung fields. APRN #1's assessment further reflected Resident #38 was not communicating with his board, had an altered mental status, his/her skin was flushed and warm to the touch with pneumonia suspected. The APRN's progress note identified Resident #38 was transferred to the ED (emergency department) with respiratory distress. A physician's order dated 11/19/24 directed to transfer to ED with respiratory distress, resident to be evaluated in ER (emergency room). An interview and clinical record review with the 7:00 AM to 3:00 PM Registered Nurse supervisor (RN #1) on 11/21/24 at 1:30 PM, identified that Resident #38 had respiratory distress and was evaluated by the APRN on the morning of 11/19/24. Subsequently, Resident #38 was transferred to the hospital and was admitted to the hospital with pneumonia. RN #1 indicated that Resident #38 had a history of respiratory distress and aspiration and had recently returned from a hospitalization for aspiration. RN #1 further identified that Resident #38 was a fragile individual whose status could change on the drop of a dime. Review of the clinical record with RN #1 identified that, although the nursing supervisor (RN #2) had been notified of Resident #38's change in condition on 11/15/24, RN #2 had failed to complete and document an assessment of Resident #38. RN #1 further identified that although she was notified of Resident #38's change in condition on 11/18/24 she failed to complete and document an assessment of Resident #38. RN #1 indicated that when notified of a resident's change in condition, the nursing supervisor should complete and document an assessment of the resident. RN #1 was unable to identify a reason why RN #2 failed to complete and document an assessment of Resident #38's change in condition on 11/15/24. Additionally, RN #1 was unable to identify a reason why she failed to complete and document an assessment of Resident #38's change in condition on 11/18/24. Interview and record review with the 3:00 PM to 11:00 PM Registered Nurse supervisor (RN #2) on 11/21/24 at 3:10 PM identified that although she was notified and saw Resident #38 on 11/15/24 for a change in condition, she did not listen to the resident's lungs, take his/her vital signs or write a progress note in Resident #38's clinical record. RN #2 indicated that she should have completed and documented an assessment of Resident #38 on 11/15/24 but had made a mistake. RN #2 identified that although Resident #38 had complained of shortness of breath and asked to go to the hospital on the evening of 11/15/24, she thought there was no reason to transfer the resident out because he/she frequently asked to go to the hospital. Interview and record review with the DNS on 11/22/24 at 9:41 AM identified that when the RN supervisors (RN #1 and RN #2) were notified of Resident #38's change in condition, on 11/15/24 and 11/18/24 respectively, they should have assessed the resident and documented their assessments in the clinical record. Review of the clinical record with the DNS at that time failed to reflect documentation that lung assessments were completed on Resident #38 on 11/16/24, 11/17/24 and 11/18/24 and failed to reflect that vital signs were completed on Resident #38 on 11/15/24 and 11/18/24. (continued on next page)

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	075313	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with APRN #1 on 11/22/24 at 10:00 AM identified the RN supervisors (RN #1 and RN #2) should have completed a comprehensive assessment of Resident #38 and written a nursing note on 11/15/24 and 11/18/24. APRN #1 further indicated that Resident #38 should have had close monitoring and lung assessments in the days after his/her change in condition on 11/15/24 and that, although she evaluated Resident #38 on the morning of 11/19/24, he/she was found in respiratory distress and required transfer to the hospital. Review of the facility's, Observation & Recording Change of Resident's Condition policy, undated, directed to ensure that when a resident has a change in condition that appropriate assessments are performed and documented. The policy further directed that when a change of condition occurs the licensed nurse will perform an assessment and vital signs will be included as part of all change in condition assessments and documentation should be in the narrative nurse's notes. 2. On 11/22/24 at 11:30 AM, a review of annual IV competencies for IV infusion pump use for licensed nursing staff with LPN #5 (who is the Infection Control Preventionist and Staff Development Nurse) indicated that she completed IV competencies for the RNs and was not aware that it was beyond the LPN's scope of practice to deem an RN competed for IV skills. Interview with the DNS on 11/22/24 at 11:45 AM indicated she was unaware that LPN #5 was not able to complete competencies for RN staff and that she oversees LPN #5 in her role but was not present when LPN #5 was completing competencies for RNs. A review of the IV Long Term Care manual effective January 2022 on 11/22/24 at 12:00 PM provides a form to complete IV skills for Infusion Pump administration for IV medications and fluids for licensed nursing staff. The form has a signature and date line for the nurse evaluator and for the nurse being evaluated for his/her IV skills. 51756

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of the clinical record, facility policy, and interviews for 3 of 5 residents (Resident #21, Resident #73, and Resident #77) reviewed for Activities of Daily Living (ADL's), the facility failed to provide timely assistance with fingernail care to dependent residents. The findings include: 1. Resident #21's diagnoses included vascular dementia, metabolic encephalopathy and major depressive disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #21 was moderately cognitively impaired and was dependent with toileting, bed mobility and transfers. The Resident Care Plan dated 9/24/24 identified that Resident #21 was dependent with ADL's and had longstanding upper extremity contractures with interventions that included a rehabilitation screen and evaluation as needed and to allow resident choices. Review of the Nurse Aide Care Card for Resident #21 identified that shower and weights were to be completed on Wednesdays on the 3:00 PM to 11:00 PM shift. Observation and interview with Resident #21 on 11/19/24 at 11:53 AM, identified had very lengthy, untrimmed, and jagged fingernails with a dark colored substance beneath them. Resident #21 indicated that he/she preferred his/her fingernails kept short and clean but when he/she received a shower or bath staff did not clean or trim them. Resident #21 was observed with 4 fingers of his/her bilateral hands contracted when at rest with the ability to straighten them upon request. Observation and interview with Nurse Aide (NA) #4 on 11/20/24 at 1:40 PM identified that she was familiar with Resident #21 and had frequently provided him/her care. NA #4 indicated that Resident #21 had dirty and long fingernails on both hands and that they should not have appeared that way. NA #4 further identified that under Resident #21's contracted right hand 4th finger was a dark substance on the skin. NA #4 indicated that although she or another NA were responsible for fingernail cleaning and trimming for residents on bath day or when needed, she had too many tasks to complete and there was not enough time in the day to get it done. Observation and interview with LPN #4 on 11/20/24 at 1:45 PM identified Resident #21's fingernails on both hands were very filthy and long and should absolutely not look that way. LPN #4 indicated there was a dark substance under Resident #21's right 4th finger and the skin on the palm of his/her right hand was also very dirty. LPN #4 identified that although fingernails should be cleaned and trimmed on a resident's scheduled shower day or if they are long, the NA's responsible did not complete the task. LPN #4 further indicated that if Resident #21 did not get out of bed for a shower due to his/her condition, his/her fingernails should have still been cleaned and trimmed. Subsequent to surveyor inquiry, an observation on 11/20/24 at 2:30 PM identified Resident #21 was having his/her hands cleaned and his/her fingernails cleaned and trimmed by NA #4. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the 7:00 AM to 3:00 PM nursing supervisor (RN #1) on 11/20/24 at 2:00 PM identified Resident #21's shower day was on Wednesday on the 3:00 PM to 11:00 PM shift and on Wednesday 11/13/24 the NA assigned to Resident #21 was NA #5. Interview with NA #5 on 11/20/24 at 3:15 PM identified that she took care of Resident #21 on Wednesday 11/13/24 from 3:00 PM to 11:00 PM, which was Resident #21's scheduled shower day. NA #5 indicated Resident #21 preferred a bed bath, which she gave him/her, but that she did not clean or trim Resident #21's fingernails last week because she was never told to do that on scheduled shower days. NA #5 further identified that she thought Resident #21's fingernails were cleaned and trimmed during the day or by recreation and that she did not usually work this shift so needed to check with the nursing supervisor. Subsequent to surveyor inquiry, on 11/21/24 at 10:15 AM, RN #1 identified that she had conducted an in-service with the NA staff on her unit regarding required fingernail cleaning and trimming on a resident's scheduled shower day. 2. Resident #73's diagnoses included Parkinson's disease, congestive heart failure, and gastro-esophageal reflux disease. The quarterly MDS assessment dated [DATE] identified Resident #73 was moderately cognitively impaired, required moderate/total assist of 1 for bathing, dressing, personal care, and was totally dependent on staff for personal hygiene. The Resident Care Plan dated 9/25/24 identified Resident #73 was dependent with bathing, dressing, hygiene, and incontinent care. Interventions included to set up for hygiene, dressing, and assist as needed for completion. Observations on 11/18/24 at 11:55 AM and 2:10 PM and 11/19/24 at 10:00 AM identified Resident #73's fingernails (3) on the left hand were noted to have a brown material under the fingernails, were long, and in need of trimming. Interview and observation with LPN #1 on 11/21/24 at 12:35 PM identified Resident #73's nails were long and noted to have brown material under his/her fingernails. LPN #1 identified that the facility policy was to provide nail care on the resident's shower day and as needed. LPN #1 identified that although Resident #73 had received a shower on 11/19/24, the resident's fingernails had not been cleaned and trimmed according to the facility policy. Interview with NA #4 on 11/21/24 at 12:41 PM identified she did not have time to provide Resident #73 with fingernail care since first the first observation on 11/18/24. NA #4 reported that although nailcare should be provided during the Resident's shower, however, she did not have enough time to provide Resident #73 with nail care. NA #4 indicated she reported this to the unit nurse but could not recall which nurse due the frequency of changes to nurses working on that unit and added she felt like a 1-man show. Additionally, NA #4 indicated there were other staff on the unit and throughout the 3 shifts who could have provided nail care. Subsequent to surveyor inquiry, Resident #73's fingernails were cleaned and trimmed. 3. Resident #77's diagnoses included multiple sclerosis, dementia and depression. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #77 was cognitively intact and was dependent with toileting, bed mobility and transfers. The Resident Care Plan dated 10/2/24 identified that Resident #77 had an alteration in mobility and independence. Interventions included to assist resident with ADL's and to offer the resident a choice between a shower, bed bath or comfort bath. Review of the Nurse Aide Care Card for Resident #77 identified that showers/bathing were to be completed on Tuesdays on the 7:00 AM to 3:00 PM shift. Observation and interview on 11/18/24 at 11:40 AM identified Resident #77 had lengthy and jagged fingernails with a brown substance underneath the fingernails on his/her bilateral hands. Resident #77 indicated that he/she preferred to have his/her fingernails kept short but that he/she was unable to clean or trim them. Resident #77 identified that although he/she had asked staff to clean and trim his/her fingernails when he/she was bathed, it was not done. Observation and Interview with NA #3 on 11/20/24 at 2:10 PM identified that she frequently took care of Resident #77 and his/her fingernails on both hands appeared long, jagged, and had a brown substance underneath them. NA #3 indicated Resident #77's shower/bath day was on Tuesday on the 7:00 AM to 3:00 PM shift and that she worked with him/her every other Tuesday and would clean and trim his/her nails then. NA #3 identified that Resident #77's nails should have been cleaned and trimmed on his/her last scheduled shower/bath day on 11/19/24, but that she was not working that day. Additionally, NA #3 was unable to recall if she cleaned and trimmed Resident #77's fingernails on the resident's last scheduled shower/bath day when she was assigned. Observation and Interview with the 7:00 AM to 3:00 PM nursing supervisor (RN#1) on 11/21/24 at 11:00 AM identified Resident #77's fingernails on both hands were long and jagged and needed to be cleaned and trimmed. RN #1 indicated that Resident #77's fingernails should have been cleaned and trimmed by the assigned NA on his/her shower/bath day. Although RN #1 was unable to identify why Resident 77's fingernails were not cleaned and trimmed on his/her scheduled shower/bath day on 11/19/24, she indicated she would have a NA complete the task for Resident #77 now. Review of the facility policy, Personal Care Routine, dated 05/03, directed that a bath was to cleanse, refresh and soothe the resident and care of the fingernails was part of the bath and to be certain nails are clean. 51867

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observations, interviews and record review for 2 of 2 residents (Resident #6 and Resident #81), reviewed for positioning, the facility failed to ensure hand rolls were in place for Resident #6 and a lap tray was applied consistently for Resident #81 in accordance with the physician's order. The findings include: 1. Resident #6 's diagnoses included a contracture of unspecified joint, peripheral vascular disease, diabetes, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #6 was severely cognitively impaired and was totally dependent on facility staff for dressing, eating and personal hygiene. The Resident Care Plan dated 9/9/24 identified that Resident #6 was at risk for skin breakdown related to impaired mobility. Interventions included to apply bilateral palm guards and check skin integrity per the physician orders. A physician's order dated 10/8/24 directed to place rolled up washcloths in the palms of Resident #6's hands every shift. An Occupational Therapist (OT) #2's note dated 10/8/24 identified that Resident #6 had bilateral hand contractures upon admission in May of 2024. Bilateral hand splints were trialed at admission with the subsequent development of a wound on 10/8/24. Resident #6 was noted to be resistant to the hand splints increasing the risk for skin breakdown and rolled washcloths were ordered by the physician. Observation on 11/19/24 at 9:57 AM, identified Resident #6 sitting in a chair without the benefit of washcloths in his/her hands. Observation on 11/20/24 at 5:58 AM identified Resident #6 in bed, his/her left hand above the covers, without the benefit of a rolled washcloth in place. A second observation on 11/20/24 at 7:45 AM identified Resident #6 lying on his/her back with both hands above the covers, without the benefit of a rolled washcloth in either hand. Observations of Resident #6 on 11/21/24 at 11:42 AM and 1:30 PM identified the resident lying in bed, both hands above the blankets, without the benefit of a washcloth in either hand. Interview with LPN #7 on 11/21/24 at 1:30 PM identified that the order for rolled washcloths was entered in Resident #6's chart and added to the Treatment Administration Record. The RN or LPN assigned to Resident #6 each day was responsible to ensure the rolled washcloth placement. Interview on 11/21/24 at 1:34 PM with LPN #13 identified that she was aware of the order and would place the rolled washcloths after she had completed her noon medication rounds. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility policy for hand splints or rolled washcloth splinting was not provided. 2. Resident #81's diagnoses included spastic hemiplegia (paralysis) affecting the left nondominant side, unspecified osteoarthritis, and unspecified cataracts. The quarterly Minimum Date Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, requiring partial/moderate assistance for eating and dependent for toileting and transfers. The Resident Care Plan dated 9/4/24 identified Resident #81 as having an alteration in physical mobility and independence with daily activities relating to impaired mobility, hemiplegia and apraxia (a neurologic disorder that makes it difficult to make certain movements), in addition Resident #81 transferred with an assist of 2, does not ambulate, had left upper extremity contractures and a lap tray was to be in the wheelchair to improve left upper extremity positioning. Interventions included to don a left resting hand splint with AM care and the lap tray to be in the wheelchair as ordered, out of bed to modified custom wheelchair as tolerated/desired with 1/2 lap tray to be in place at all times. A physician's order dated 11/1/24 directed Resident #81 to be out of bed to a modified custom wheelchair as desired/tolerated with the lap tray in place at all times. The Resident Care card located in Resident #81's room directed for the lap tray to be in the wheelchair as ordered and 1/2 lap tray to be in place at all times. Observations of Resident #81 identified her/him sitting in a modified custom wheelchair in the hallway on 11/18/24 at 12:15 PM, 11/19/24 at 9:30 AM, and 11/21/24 at 9:17 AM without the benefit of the lap tray being in place. Observation of Resident #81 on 11/19/24 at 10:13 AM identified the DNS approached the resident who was in the hallway at the time without the benefit of a lap tray being in place and stated let me fix your arm while repositioning Resident #81's arm that kept slipping down the side of the chair. An interview with the DNS on 11/20/24 at 11:14 AM identified it was facility policy for the therapy department to write custom/adaptive wheelchair orders, with the therapy and nursing departments responsible for applying positioning devices such as lap trays. She could not identify the reason Resident #81 was not provided with the lap tray. An interview and record review with Occupational Therapist (OT) #1 on 11/21/24 at 10:02 AM identified the physician's order was put in place by therapy, with the nursing department responsible for ensuring the lap tray was on. The expectation of the order in place was that Resident #81 should have a lap tray on at all times for pelvic positioning and to prevent her/his left arm from sliding down and potentially getting caught or injured. Furthermore, without the benefit of the lap tray, Resident #81 would have to be repositioned throughout the day and due to her/his hemiparesis the left arm could come in contact with something that could potentially cause skin breakdown. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and care card review with Nurse Aid (NA) #4 on 11/21/24 at 10:18 AM identified the therapy department writes orders relating to positioning and wheelchairs, and the instructions were on the care card located in the resident's closets. The care card for Resident #81 identified the lap tray to be on at all times. NA #4 identified that although nursing was responsible for putting on the lap tray it was not on because third shift gets Resident #81 up and out of bed. Although requested, a facility policy for customized wheelchairs and positioning was not provided. 51313

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #95) reviewed for nutrition, the facility failed to identify when a significant weight loss occured and implement nutritional supplements in a timely manner. The findings included: Resident #95 was admitted to the facility in April 2022 with diagnoses that included vascular dementia with psychotic disturbances, Down syndrome, depression, and hypothyroidism. A Resident Care Plan dated 2/19/24 identified a problem with Resident #95 having a significant weight loss in 6 months (weight of 195.4 pounds/lbs). Interventions included to start on nutritional supplements, encourage food/fluids, and obtain weights as ordered. Physician orders dated 3/14/24 directed weekly weights to be obtained every Friday. The annual Minimum Data Set assessment (MDS) dated [DATE] identified Resident # 95 was severely cognitively impaired and required total dependance from staff for eating. Physician's orders dated 8/15/24 directed to administer house supplements 3 times a day. A review of Resident #95's weight identified a weight of 190.1pounds (lbs) on 6/23/24 and a weight of 177.6 lbs on 7/20/24 (a 12.6 lb/6.5 % loss in less than a month). APRN #1's progress notes dated 7/30/24 identified a weight of 177 lbs. but did not identify Resident #95's significant weight loss. A review and interview with the Dietitian on 11/21/24 at 10:00 AM identified a progress note dated 8/15/24 that identified Resident #95's weights continued to slowly decrease. The Dietitian obtained a new order on 8/15/24 to increase house supplements to 3 times a day (27 days after the initial significant weight loss was identified). The Dietitian stated that the intervention to increase supplements was not implemented timely and should have been in place when weight loss was initially identified. Physician's orders dated 8/15/24 directed to administer house supplements 3 times a day. An APRN #1 progress note dated 9/10/24 identified Resident #95 was seen for weight loss with no new orders and to continue with supplement orders from 8/15/24 as Resident # 95 was starting to trend up in weights with a weight of 179 lbs. A review of the facility's Supplement Nutritional Program Policy dated 6/30/06 directed in part, that nursing and the Dietitian will identify residents who would benefit from supplements to provide calorically dense oral supplements for residents at risk for weight loss. Nursing and Dietary will evaluate the effectiveness of the program at weekly standards of care meetings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observation, interviews, record and policy review for 1 of 3 residents, (Resident #52), reviewed for respiratory care, the facility failed to follow physician's order for oxygen administration. The findings include: Resident #52's diagnoses included congestive heart failure, chronic kidney disease and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #52 was severely cognitively impaired, independent for eating, and required partial/moderate assistance for toileting and transfers. The Resident Care Plan dated 9/3/24 identified Resident #52 had a potential for alteration in respiratory status related to a diagnosis of asthma. Interventions included to administer oxygen per orders and monitor oxygen saturations per orders and as needed. The physician's order dated 11/1/24 directed to administer oxygen at 2 liters per nasal cannula at bedtime for shortness of breath. Observations on 11/18/24 at 2:23 PM, 11/19/24 at 10:17 AM, and 11/19/24 at 12:27 PM identified Resident #52 was receiving 4 liters of oxygen per minute (Lpm) via nasal cannula and on 11/21/24 at 2:54 PM receiving 3.5 Lpm via nasal cannula. An interview and record review with Licensed Practical Nurse (LPN) #1 on 11/21/24 at 2:55 PM identified Resident #52 should receive oxygen therapy continuously at 2 liters per minute, at which point LPN #1 turned the oxygen down from 3.5 Lpm to 2 Lpm. Physician's order review with LPN #1 failed to identify an order for oxygen to be received continuously and failed to identify oxygen saturation levels consistent with a need for oxygen (although not documented LPN #1 stated Resident #52's oxygen saturation earlier that day was 95%). LPN #1 could not identify the reason Resident #52 was receiving oxygen therapy other than at bedtime. An interview and record review with Registered Nurse (RN) #1 on 11/21/24 at 3:00 PM identified the facility policy was that residents who had oxygen saturations below 92% would be assessed and receive oxygen per physician's orders, with the floor nurse responsible for putting the oxygen in place. Physicians order review failed to identify an order for Resident #52 to receive oxygen during the day, or to titrate oxygen per oxygen saturation levels. Additionally, RN #1 stated she did not know the reason Resident #52 was currently receiving oxygen because Resident #52 had no indication for it. An interview and record review with APRN #1 on 11/22/24 at 9:56 AM identified Resident #52 should have a physician's order to be on oxygen therapy during the day, and an as needed (prn) oxygen order to maintain oxygen saturation above 92%, but did not . Review of oxygen saturation levels for the last 3 month with APRN #1 failed to identify levels below 92%. Subsequent to surveyor inquiry, APRN #1 stated she would assess Resident #52 for oxygen therapy needs. (continued on next page)

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	075313	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Oxygen Therapy Policy directed in part that oxygen therapy is provided upon written order of the physician, and administered then monitored by the licensed nurse.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 51182 Based on staff interview, review of the clinical record, and facility policy for 3 of 3 Nurse Aides reviewed for sufficient staffing (NA #4, NA #9 and NA #10), the facility failed to complete a yearly performance evaluation. The findings include: 1. NA #4's employee file identified a date of hire as 8/1/23. There had been no yearly performance evaluation completed during the length of NA #4's employment with the facility. 2. NA #9's employee file identified a date of hire as 11/13/17. There had been no performance evaluation completed during the length of NA #9's employment. 3. NA #10's employee file identified a date of hire as 5/7/02. The last performance evaluation was completed on 6/29/15 (over 9 years ago). Interview with the Administrator on 11/21/24 at 3:14 PM identified that in the past, supervisors were responsible for performance evaluations, but now department heads were responsible for conducting performance evaluations. The Administrator further identified that performance evaluations had not been completed for NAs since 2015 because the facility had been overwhelmed with other things, for example Covid and Legionnaires Disease. In lieu of performance evaluations, the Administrator indicated that 30 day action plans for problems were being completed. Request for the Facility's policy on Performance Evaluations identified there was no policy for performance evaluations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on observations, review of clinical record, facility documentation, facility policy and interviews for medication administration, the facility to ensure that medication error rate of less than 5%. The findings include: 1. Resident #84 was admitted to the facility in February 2022 with diagnoses that included dementia with other behavioral disturbances and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #84 was severely cognitively impaired. Physician orders dated 11/12/24 directed to administer Trazodone 50 mg (milligrams) 2 times a day, Namenda 5 mg 2 times a day, Depakote 125 mg sprinkles 1 capsule in AM and 2 capsules at bedtime. The times of administration for the morning medications were to be given at 8:00 AM. Observation of medication administration with Licensed Practical Nurse (LPN) #8 on 11/20/24 at 10:30 AM identified Trazodone, Namenda and Depakote were due to be administered at 8:00 AM and medications were administered at 10:30 AM, an hour and a half after the allowed timeframe. Interview with LPN #8 at that time identified he would make APRN #1 aware of the late medication pass and that he was an agency nurse and this was his first time working in the facility. Interview with the DNS on 11/20/24 at 10:45 AM identified that no one had made her aware that LPN #8 was late with the medication pass otherwise she would have assigned someone to assist him. The DNS indicated that she would have LPN #7 assist LPN #8 with finishing the medication pass and would notify APRN # 1. Interview with LPN #7 on 11/20/24 at 11:00 AM indicated that she assisted LPN #8 to finish the medication pass and if LPN #8 made her aware earlier she would have provided him with assistance to finish the medication pass timely. 2. Resident #102 was admitted to the facility in February 2023 with diagnoses that included anemia and delusional disorder. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #102 was moderately cognitively impaired. Physician's orders dated 11/7/24 directed to administer Magnesium Oxide 400 mg (milligrams) 2 times a day, Hiprex 1 gm (gram) 2 times a day and Bactrim DS q 12 hours 2 times a day for 7 days with a start date of 11/17/24. Observation on 11/21/24 at 9:45 AM of medication administration with LPN #9 identified Resident #102's 8:00 AM medications were administered at 9:45 AM, 45 minutes after the allowed timeframe. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 11/21/24 at 10:00 AM indicated that LPN #9 was very busy and a resident on the unit had vomited which caused a delay in her medication pass. DNS indicated that APRN #1 would be made aware of the medication pass time. An interview with APRN #1 on 11/21/24 at 11:30 AM indicated that she was notified of the medications being administered late and that she had no new orders. APRN #1 indicated that she did not think they were significant medication errors causing any ill effects. The observed medication pass error rate was 17.6 %. A review of the Medication Administration Policy dated 2017 directed in part, medications are administered within 60 minutes of scheduled time, except before, with or after meals ordered which are administered according to the established medication administration time for the facility.

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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. 51182 Based on observation, staff interview, and facility policy for medication storage and labeling, the facility failed to ensure medication carts were locked when unattended and narcotics were secured properly. The findings include: a. An observation on 11/20/24 at 5:04 AM identified that the third floor rolling medication cart was located outside of the third-floor dining room in the lobby, was unlocked. There was one resident, unsupervised in a wheelchair, approximately 15 feet from the unlocked rolling medication cart. An interview with Licensed Practical Nurse (LPN) #10 on 11/20/24 at 5:08 AM identified that she was aware the medication cart was unlocked and she left it unlocked and unattended to attend to a resident's care down one of the hallways. The narcotics within the rolling cart were only secured with a single lock, as the main lock to the rolling cart was unlocked. An observation on 11/20/24 at 5:45 AM identified that 2 second floor rolling medication carts, located on the outside right-hand side of the nursing station, were unlocked. LPN #12 was sitting behind the nursing station, on the left-hand side of the nursing station, with his back to the medication carts. There were two residents seated in a wheelchair within 10-15 feet from the medication carts. An interview with Licensed Practical Nurse (LPN) #12 on 11/20/24 at 5:45 AM identified that he was aware the medication cart was unlocked and he left it unlocked and unattended to finish typing his nursing notes from his last medication pass. The narcotics within the rolling cart were only secured with a single lock, as the main lock to the rolling cart was unlocked. An observation on 11/22/24 at 8:00 AM of the second floor rolling medication cart with the Assistant Director of Nursing (ADN) identified that the medication cart was unlocked. There were 6 residents in the lobby within 10-15 feet of the unlocked cart. The ADN noted it was the nurse's responsibility to keep the cart locked while not in use. The narcotics within the rolling cart were only secured with a single lock, as the main lock to the rolling cart was unlocked. An observation on 11/22/24 at 8:04 AM identified that the third floor rolling medication cart, located outside of the third-floor dining room in the lobby, was unlocked. There were 5 residents, unsupervised in a wheelchair, approximately 10 feet from the rolling medication cart. No staff members were located within eyesight of the cart. An interview with Licensed Practical Nurse (LPN) #14 on 11/22/24 at 8:08 AM identified that she was aware the medication cart was unlocked and she left it unlocked because the cart was being shared between two LPNs and there was only one key. The narcotics within the rolling cart were only secured with a single lock, as the main lock to the rolling cart was unlocked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. An observation on 11/21/24 with LPN #9 and the Assistant Director of Nurses (ADNS) on 11/21/24 at 12:35 PM identified that 2 of 2 narcotic medication boxes located within the third-floor medication refrigerator (the refrigerator was not locked or didn't have the capability to be locked) had a dangling chain attached to the back of the boxes, but the chains were not affixed to the refrigerator. Each of the two boxes contained one 30 milliliter bottle of Lorazepam (a schedule IV controlled substance). The ADNS noted that maintenance was responsible for ensuring the boxes were chained to the refrigerator. Subsequent to surveyor inquiry, the chains were affixed to the inside of the refrigerator with a screw by maintenance. Review of the facility's Medication storage policy identified that medications should only be accessible to licensed nursing personnel or other staff members lawfully authorized to administer medications, and those medications subject to abuse or diversion are to be stored in a double locked compartment. Controlled substances stored in the refrigerator must be in a locked box that is permanently affixed to the refrigerator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51313 Based on observations, staff interviews, and review of facility policy, the facility failed to ensure foods were dated when opened and expired food was disposed of timely. The findings include: On [DATE] at 10:52 AM, a tour of the Dietary Department with the Food Service Director (FSD) identified the following: a. In the dry storage area there was an opened and undated ,d+[DATE] bag of granola and 3 open bags of hamburger rolls. Attached to the ceiling to the right of the hamburger rolls was an approximate 12 inch section of fly paper with a dead fly attached. b. In the main freezer there was an opened and undated package of pancakes, 1 bag of imitation crabmeat, 1 bag of frozen shrimp, ,d+[DATE] package of cookies, ,d+[DATE] package of blueberries, 1 gallon of leftover soup dated [DATE], and 1 bag of pizza dough. c. In the walk-in refrigerator there was a gallon container that was ,d+[DATE] full of Feta cheese that was dated [DATE], containing a greenish mold like substance. Interview with the FSD on [DATE] at 11:15 AM indicated that he or the chef were responsible for dating items when the packaging was opened. He was unable to explain the reason the identified items were opened and undated, but if staff did not know the expiration dates, they could be accessed via the US Foods website. Additionally, he indicated that he hung fly paper in the bread storage area in [DATE] because of a problem with having flies in the Dietary Department but did not contact the pest control vendor. Interview with the Administrator on [DATE] at 12:30 PM identified that he was not made aware of the issue of flies in the Dietary Department and had he been made aware, he would have contacted the pest control vendor for treatment. Review of the facility food storage policy directed that dry storage foods would be dated as appropriate and cold foods would be labeled and dated.

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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** 48950 Based on observations, clinical record review, review of facility documentation, facility policy, and interviews for 1 of 3 sampled residents (Resident #7) reviewed for nebulizer equipment the facility failed to ensure the equipment was not on the floor, the mask was covered and tubing was dated when changed. Additionally, for 1 of 5 residents (Resident #85) observed for medication administration, the facility failed to ensure appropriate hand hygiene was performed during medication administration and for 2 of 4 sampled residents (Resident #7 and Resident #101) reviewed for pressure ulcers, the facility failed to ensure appropriate personal protective equipment (PPE) was donned for a resident on precautions and failed to ensure hand hygiene was performed in accordance with infection control standards (Resident #101). Also, the facility failed to ensure personal care equipment was stored to maintain infection control. The findings include: 1. Resident #7 was admitted to the facility in July 2023 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), pneumonia, and chronic pressure ulcer on coccyx. a. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #7 was severely cognitively impaired and was dependent on staff for activities of daily living. A Resident Care Plan dated 4/19/24 identified that Resident #7 was on Enhanced Barrier Precautions for a history of a multidrug resistant organism (MDRO) infection and for a suprapubic urinary tube. Interventions included wearing a gown and gloves for any high contact activities. Physician's orders dated 10/22/24 directed to use Enhanced Barrier Precautions (PPE) for MDRO colonization of bacteria for Extended-spectrum beta-lactamases (ESBL) in urine, a chronic wound on the coccyx and having a urinary catheter. Physician's orders dated 11/14/24 direct to cleanse the stage 2 wound on the coccyx, apply Triad paste to peri wound area, Silvadene to the base of the wound, secure with a dry, clean dressing daily. The physician order further directed to change the dressing as needed for soiling, saturation, or accidental removal. Observation on 11/19/24 at 11:15 AM identified signage was posted on Resident #7's door that Resident #7 was on Enhanced Barrier Precautions and directed staff to wear gloves and a gown for high-contact resident care activities including dressing, bathing and wound care. Additionally, LPN #6 was observed performing wound care to Resident #7's coccyx without the benefit of wearing a gown. Interview with LPN # 6 on 11/19/24 at 12:10 PM identified that she did not see the Enhanced Barrier Precaution sign outside the door and that she should have worn a gown when completing Resident #7's treatment. LPN # 6 indicated that she had provided care for Resident # 7 on several different occasions. Interview with LPN # 7 on 11/19/24 at 12:30 PM indicated that any direct care needed for Resident #7 such as treatment, the nurse would need to wear PPE which consist of a gown and gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Enhanced Barrier Policy dated August 2022 directed in part, EBPs employ target gown and glove use for high contact resident care activities when contact precautions do not otherwise apply such as wound care (any skin opening requiring a dressing) and for residents infected or colonized with ESBL. b. A quarterly Minimum Data Assessment (MDS) assessment dated [DATE] identified Resident #7 was moderately cognitively impaired and required assistance of 1 for medication administration and bed mobility. The Resident Care Plan dated 8/31/24 identified an exacerbation of COPD with interventions that included oxygen as needed, monitor respiratory status and administer medications as ordered. Physician's orders dated 9/17/24 directed to administer Ipratroplum-Albuterol Solution 0.5-2.5 (3) mg/3 ml 1 vial inhale orally 2 times a day (use of nebulizer machine) related to COPD. Observations on 11/18/24 at 11:00 AM, 12:30 PM, and 2:30 PM identified a nebulizer machine on top of Resident #7's floor mat beside his/her bed with the mask and tubing hanging off the wall without the benefit of being bagged or labeled. Observation on 11/19/24 at 8:30 AM, 12:00 PM and 2:00 PM noted the nebulizer machine remained on top of the floor mat with the mask and tubing hanging off wall without the benefit of being bagged or labeled. Interview with LPN # 7 on 11/20/24 at 12:00 PM indicated that nebulizer equipment should be on the bedside table and the tubing should be dated with mask in a bag. Interview with LPN #5 (the Infection Preventionist) on 11/22/24 at 11:30 AM identified that nebulizer equipment should not be on the floor, the mask in a bag and the tubing should be dated when changed. Although requested, a policy for nebulizer and/or oxygen tubing was not provided as the facility did not have a policy. 2. Resident #85's diagnoses included diabetes, depression, and heart disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #85 had no cognitive impairment, required extensive assistance with bed mobility, and was dependent for transfers. The Resident Care Plan dated 11/13/24 identified Resident #85 had a diagnosis of diabetes with interventions to obtain finger sticks (blood sugar test) as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LPN #1 on 11/19/24 at 9:45 AM, identified she was preparing Resident #85's medications for administration. LPN #1 was observed to drop a medication package onto the floor, picked the container up, placed it on top of the cart, and resumed medication preparations. Although LPN #1 had picked up the container from what was considered a dirty surface (floor), she failed to sanitize or wash her hands prior to proceeding. LPN #1 was then observed to place on gloves, drew up insulin into a syringe, removed her gloves and placed a clean pair of gloves on without the benefit of sanitizing or washing her hands. At the bedside, just prior to medication administration, the surveyor stopped LPN #1 and brought her out of the room. Interview with LPN #1 identified that the facility policy directed staff to perform hand hygiene in between glove changes and after contact with the environment and that she was nervous during the time of Resident #85's medication preparation. Subsequent to surveyor inquiry, LPN #1 washed her hands and placed on clean gloves. Review of the Medication Administration-General Guidelines policy, dated 2017, directed hand hygiene performance before beginning a medication pass; before handling medications; and after contact with patient. Additionally, the policy directed staff to perform hand hygiene before putting on examination gloves and after gloves are removed. 3. Resident #101's diagnoses included congestive heart failure, chronic kidney disease and type 2 diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #101's cognition was intact, was independent for eating and dependent for toileting and transfers. The Resident Care Plan dated 11/5/24 identified Resident #101 was at risk for infection requiring enhanced barrier precautions (EBP) related to an indwelling urinary catheter. Interventions included enhanced barrier precautions: use a gown and gloves during high-contact activities: dressing, hygiene, toileting, transferring, bathing/showering, changing linens, device care and wound care, as well as to perform hand hygiene prior to and after providing care to residents. A physician's order dated 11/12/24 directed that every shift follow enhanced barrier precautions. Observation on 11/20/24 at 12:27 PM identified an enhanced barrier precaution sign posted next to Resident #101's door, and a precaution cart with personal protective equipment (PPE) supplies consisting of gown and gloves was noted to be in the hallway, a couple rooms away. The sign identified that staff must wear gloves and a gown for high-contact activities including dressing, changing linens and wound care. Observation on 11/20/24 at 12:28 PM identified Licensed Practical Nurse (LPN) #2 and LPN #3 enter Resident #101's room and don gloves without the benefit of hand hygiene, and without the benefit of PPE (a gown) as indicated. LPN #2 was on Resident #101's right side, while LPN #3 was on the left side preparing wound care supplies on a sterile field on top of the treatment cart, alcohol based hand rub (ABHR) was noted to be attached to the left side of the treatment cart. LPN #3 removed the dressing dated 11/19 located on Resident #101's coccyx, and discarded the gloves and dressing, she then applied a clean pair of gloves without the benefit of performing hand hygiene, and cleaned the coccyx with the wound cleanser, removed her gloves and applied a clean pair of gloves without the benefit of performing hand hygiene. LPN #3 then applied Silver Alginate to the wound and covered it with a dry clean dressing that was dated 11/20, then she removed and discarded her gloves without the benefit of hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #2 on 11/20/24 at 12:40 PM identified she was unaware of the policy on hand hygiene between glove changes, but she had received education on EBP and that she should have worn a gown but did not because she was just there to help. Interview with LPN #3 on 11/20/24 at 12:40 PM identified she was unaware of the policy on hand hygiene between glove changes but added that it made sense to perform hand hygiene after removing soiled gloves so that the clean pair would not be contaminated. LPN #3 identified she had received education on EBP but did not don a gown because she was stressed. Interview with the LPN #5 (the Infection Preventionist) on 11/20/24 at 1:30 PM identified it was facility policy to perform hand hygiene between glove changes, and the facility policy for residents on EBP precautions was that staff had to don PPE that consisted of gloves and gowns when performing any high contact activities such as wound care. In addition, she identified that staff is educated on the above policies. Review of the Hand Hygiene Policy directed in part that ABHS is most effective in reducing the number of germs on the hands of health care providers and should be performed immediately upon removal of gloves or PPE. Review of the Glove Technique (non-sterile) directed in part that hand hygiene be performed after the removal of gloves. Review of the Enhanced Barrier Precautions Policy directed in part that enhanced barrier precautions are used as an infection control prevention and control intervention to reduce the spread of multi drug resistant organisms to residents and that gowns and gloves should be applied prior to performing high contact activities, such as wound care. 4. Observations made on 11/18/24 during initial tour 11:00 AM identified the following: a. room [ROOM NUMBER] had a urinal not bagged b. room [ROOM NUMBER] had 3 basins on the floor along with a urinal bed pan and emesis basin that was also uncovered. c. room [ROOM NUMBER] had a basin on the floor, unbagged. d. room [ROOM NUMBER] had a basin on the floor. e. room [ROOM NUMBER] had a basin on the floor. f. room [ROOM NUMBER] had a basin on the floor. g. room [ROOM NUMBER] had a basin on the floor. h. room [ROOM NUMBER] had a basin on the floor. i. room [ROOM NUMBER] had a urinal and urinary cylinder that were not bagged and 6 basins on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075313	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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	j. room [ROOM NUMBER] had 2 urinals unbagged, and a basin on the floor. k. room [ROOM NUMBER] had a urinal, bed pan, and basin unbagged and on the floor. l. room [ROOM NUMBER] had a basin on the floor. m. room [ROOM NUMBER] had a basin on the floor. n. room [ROOM NUMBER] had a basin on the floor. o. room [ROOM NUMBER] had a basin on the floor. p. room [ROOM NUMBER] had a basin on the floor. q: room [ROOM NUMBER] had a basin on the floor. r: room [ROOM NUMBER] had a urinal and a basin unbagged and on the floor. A second tour of the facility's second and third floor rooms on 11/20/24 at 10:00 AM identified that personal care equipment continued to be on the floor not bagged or labeled. In an interview with LPN #5 (the Infection Preventionist) on 11/20/24 at 11:15 AM identified that personal care equipment (basins, urinary cylinders, bed pans, emesis basin, and urinary collection devices) should be labeled, and bagged, stored hung up or in the resident's bedside table. She also identified that the Nurses Aids (NA) were responsible for this, education had been provided and that this was the facility policy. In an interview with NA #1 on 11/20/24 at 1:45 PM identified that all personal care equipment should be labeled and bagged, that was the facility policy. Further identifying that it was an oversight. In an interview with NA #2 on 11/20/24 at 2:00 PM identified that all personal care equipment should be labeled, bagged and placed in the resident's bedside table drawer. NA #2 further identified that she was unsure of the reason this was not done. Review of the facility policy for Giving and Removing the Bedpan and Urinal date 6/97 directed that the personal care equipment be cleansed, protective cover placed followed by placing into the bedside table. 51102 51756 51867

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	075313	A. Building B. Wing	11/22/2024

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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48950 Based on initial tour, observation, and interviews the facility failed to provide a safe, sanitary environment in varies common areas noted throughout the building. The findings include: Initial tour on 11/18/24 at 11:00 AM with Licensed Practical Nurse (LPN) #5 identified with the following: a. The second floor shower room was observed to have ceiling tiles that were torn, a broken/cracked ceiling light fixture that was located in the main area of the shower room. The drain cover was not secured into the floor and a drain cover not secured into the floor. b. The third floor dining room was noted with discolored, brown ceiling tiles and numerous ceiling light bulbs were burnt out. c. The third floor shower room was observed with a black substance on the floor tiles. A second tour, observation and interview made on 11/21/24 at 1:30 PM with the Maintenance Director identified that the ceiling tiles needed to be replaced in the common areas, and the light fixture needed to be replaced. Further identifying that things were not being repaired timely, the same repairs were listed on the environmental round logs month after month, and he only started 7 days ago. He was unsure of the reason repairs were not getting completed or replaced in a timely manner. The second-floor shower room drain had since been secured in place subsequent to surveyor inquiry on 11/20/24 with LPN #5 which was identified on 11/21/24 at 2:00 PM. An interview with the Administrator on 11/22/24 at 10:30 AM identified that he had not seen the environmental round logs done by LPN #5. He reviewed the logs and identified that the same rooms were listed from one month with the same repairs needing to be completed. The Administrator identified that ceiling tiles seemed to be an issue within the building and that going forward he will be reviewing the environmental rounds with LPN #5. The Administrator identified that the facility had spent a great deal of money on the mechanicals of the building over the past year and that the facility plans on performing the cosmetic repairs and replacements going forward.