STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075352	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for 1 of 4 residents (Resident #10) reviewed for accidents, the facility failed to complete neurological vital signs after an unwitnessed fall, and for the only sampled (Resident #54) reviewed for a non-pressure skin condition, the facility failed to ensure weekly skin audits were completed, per the physician's order. The findings include: 1. Resident #10 was admitted to the facility with diagnoses that included dementia, osteoarthritis, hard of hearing, and diabetes. The care plan dated 1/2/24 identified Resident #10 was at risk for falls. Interventions included close supervisor while awake and encourage common areas when in wheelchair for close supervision. The fall risk assessment dated [DATE] identified Resident #10 was at high risk for falls. The quarterly MDS dated [DATE] identified Resident #10 had moderately impaired cognition, had no behaviors and required maximum assistance with toileting, bathing, and dressing. A reportable event form dated 3/31/24 at 3:50 PM identified Resident #10 was awake and alert with confusion, had an unwitnessed fall in his/her bedroom and indicated that he/she slid out of wheelchair attempting to take his/her off shoes. Resident #10 required the assistance of 1 for transfers. A nurses note dated 3/31/24 at 4:25 PM identified Resident #10 was found sitting on the floor in his/her room in front of the wheelchair at 3:50 PM. Resident #10 indicated that he/she was trying to take off his/her shoes and slid off wheelchair. The care plan dated 3/31/24 identified the resident had a fall from wheelchair. Interventions included that if staff see the resident removing shoes while in the wheelchair, attempt to provide assistance or redirect the resident. Interview with the DNS on 6/2/24 at 12:28 PM indicated that with all witnessed and unwitnessed falls, the nurses must follow the neurological assessment policy for vital signs and neurological assessments. The DNS indicated that if a resident has intact cognition with no diagnosis of dementia and can state they did not hit their head during a fall, then the nurses do not have to do the neurological assessments per the policy. The DNS indicated the completed neurological assessment sheets after a fall after are placed in the resident's medical record. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 6/2/24 at 12:55 PM, after review of the clinical record, identified the neurological assessments after the unwitnessed fall on 3/31/24 were not done. Review of the post fall neurological assessment policy identified the post-fall assessment is critical for identifying injuries and guiding appropriate treatment, emphasizing safety and optimal care. If a fall is witnessed and the head was not involved, or a resident is cognitively intact and denies hitting their head then neurological assessments do not need to be done. Neurological checks will be conducted and documented on the Neurological Assessment Sheet until completed. The Neurological Assessment Sheet included the date and time of the fall, the level of consciousness, pupils, hand grasps, blood pressure, pulse, respirations, temperature, oxygen saturation level, and signs or symptoms of headaches, nausea, or vomiting every 15 mins for 1 hour, every 30 minutes for 2 hours, every 2 hours for 8 hours, every 4 hours for 24 hours, and every 8 hours for 2 days. 2. Resident #54 was admitted to the facility on [DATE] with diagnoses that included dementia, sepsis, and difficulty in walking. A physician's order dated 10/27/23 directed to conduct a skin assessment every week, on shower day. The annual MDS assessment dated [DATE] identified Resident #54 had severely impaired cognition, was always incontinent of bladder, and was dependent for toileting hygiene. The care plan dated 1/28/24 identified Resident #54 was at risk for pressure ulcer development and skin impairment related to impaired mobility and incontinence. Interventions included weekly skin assessment on shower days and notifying the charge nurse of any skin issue. Review of Resident #54's weekly skin evaluations dated 2/1/24 through 3/31/24 failed to identify that a skin assessment was completed by the nurse (5 out of 10 weeks) on the following shower days: 2/19/24 2/26/24 3/11/24 3/18/24 3/25/24 The reportable event form dated 3/31/24 identified Resident #54 was observed with a bruise to the right forearm measuring 2.8cm x 3.0cm during bedtime care. The physician and family were notified, and his/her name bracelet was removed. Interview with RN #4 on 6/4/24 at 9:50 AM identified that it is the responsibility of the charge nurse to complete weekly skin assessments on the scheduled shower days. RN #4 further identified Resident #54's scheduled shower day was Monday during the day shift, and even if a resident refuses the shower, a skin assessment should still be completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 6/4/24 at 10:00 AM identified that the nurses on the units are responsible for completing weekly skin assessments on the resident's shower days. The DNS further identified that she would expect to see weekly skin audits completed per the facility policy and that she plans to re-educate nursing staff to complete the skin assessments weekly. The facility's Skin Assessment policy directs that residents are assessed on admission using the Braden Scale, and they are reassessed by a licensed nurse using this tool quarterly and with a significant change in their status. The skin is also assessed weekly with their shower and documented on the weekly shower assessment sheet.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 4 residents (Resident #42, 9 and 7), reviewed for accidents, for Resident #42 who had severely impaired cognition, a history of falls and was at high risk for elopement, the facility failed to monitor and accurately document the residents location in the facility every 15 minutes according to the plan of care which resulted in the resident being able to exit the facility (elope) unsupervised. These failures to properly monitor and accurately document the resident's location in the facility allowed the resident to elope the facility and resulted in a finding of Immediate Jeopardy. Additionally, for Resident #9, the facility failed to ensure the resident was transferred according to the physician's order resulting in a fall with an injury, and for Resident #7 the facility failed to ensure the staff used a gait belt during a transfer. The findings include: 1. Resident #42 was admitted to the facility with diagnoses that included Alzheimer's disease, anxiety, dementia with behavioral disturbances, violent behaviors, and difficulty walking. The quarterly MDS dated [DATE] identified Resident #42 had severely impaired cognition, rejects care, has behaviors such as pacing 1 - 3 days a week and ambulates with supervision or touching assistance with a walker. The care plan dated 1/12/24 identified Resident #42 wanders, was at risk of elopement and has a history of attempts to leave the facility unattended. Interventions included ensuring a stop sign on the exit door to the stairwell, monitoring the resident's location every 15 minutes and documenting the wandering behavior and attempted diversional interventions on the log. Elopement/wander assessment dated [DATE] identified Resident #42 was at high risk for elopement. The physician's order dated 5/6/24 directed Resident #42 required supervision for transfers and ambulation with a wheeled walker. Review of the every 15 minute check form dated 6/1/24 at 4:00 PM, completed by NA #6, identified Resident #42 was in his/her bed in his/her room. (This is in conflict with the surveillance video that shows that at 3:59 PM Resident #42 was walking in the hallway, rounding the corner toward the residential care unit). Review of the every 15 minute check form dated 6/1/24 at 4:15 PM, completed by NA #6, identified Resident #42 was in a chair in his/her room. (This is in conflict with the surveillance video that shows that at 4:01 PM Resident #42 exited a door to the patio area outside). Review of the every 15 minute check form dated 6/1/24 at 4:30 PM, completed by NA #6, identified Resident #42 fell outside. (This is in conflict with the surveillance video that shows that at 4:34 PM Resident #42 was outside, alone, walking down the driveway that goes up a hill to the residential houses and at 4:35 PM Resident #42 gets down the driveway, passes the trees and went out of camera sight). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurses note, written by RN #1, dated 6/1/24 at 11:41 PM identified that at approximately 4:30 PM a nurse aide informed this writer that Resident #42 was outside the building and possibly fell . This writer checked on the resident, who was laying on the grass outside. Per the nurse aide, Resident #42 was seen holding a pillow while walking outside the building near the residential living parking lot area. Assessment indicated no abrasions or bruises noted to body. Resident #42 was assisted off the ground with a gait belt, was able to stand and walk without issue, ambulated back to the building, and was placed in a wheelchair. The resident will continue to be closely monitored for safety every 15 minutes. Resident representative updated and verbalized concern with resident's safety. The DNS was made aware of the incident and resident representative's concerns. Interview with the DNS on 6/3/24 at 8:15 AM indicated that she feels the facility has used all interventions related to Resident #42's falls and wandering and that was why Resident #42 was placed on every 15-minute checks for safety. The DNS indicated that Resident #42 doesn't come out of the room during the day but in the evening sometimes will sit in the hallway in a common area. The DNS indicated that the wander guard system is only for residents on the 3rd floor, long term care unit. Interview with NA #6 on 6/3/24 at 9:05 AM indicated that she worked on Saturday 6/1/24 from 3:00 PM until 11:00 PM. NA #6 indicated when she came in at 3:00 PM Resident #42 was wandering in and out of his/her room and wandering back and forth near the nursing station. NA #6 indicated she started rounds and was making the bed in a room at the end of hallway when she saw Resident #42 through the window walking outside in the rear parking lot with his/her pillow. NA #6 got NA #4 and they went down the stairwell outside to find Resident #42 across the parking lot from the facility laying down on the grass under a tree with the pillow completely under his/her back. NA #6 indicated that Resident #42 indicated he/she was sleeping there. NA #6 indicated she ran back to the facility to get the charge nurse. NA #6 indicated they used the gait belt and assisted Resident #42 off the ground and Resident #42 walked back to the building almost to the back door and turned around to go back away from the facility. NA #6 indicated the nurse went into the facility to get a wheelchair for the resident. NA #6 indicated that Resident #42 was all the way on the other side of the back parking lot, over the curb in the grass under the tree near the driveway to the residential houses. NA #6 indicated she did not see when or where Resident #42 had left the facility. Interview with RN #3 on 6/3/24 at 9:50 AM indicated Resident #42 was at high risk for elopement. RN #3 indicated that Resident #42 was at the end of the hallway but wandered up and down the hallway and almost daily would try to go out through the stairwell at the end of hallway by his/her room. Staff put up a stop sign across the stairwell door until the lock with a keypad came in, so Resident #42 couldn't open the door. RN #3 indicated that Resident #42 has attempted to leave the unit before but had not had an elopement and that was why Resident #42 was on every 15-minute checks to monitor his/her location. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DNS on 6/3/24 at 10:30 AM indicated that Resident #42 did not elope on 6/1/24 because he/she never left the facility property and did not fall because Resident #42 indicated that he/she laid down with the pillow. The DNS indicated that Resident #42 had severe cognitive impairment but to her it was obvious that Resident #42 had taken the pillow to purposefully go outside to lay down in the grass with the pillow. The DNS indicated that Resident #42 was on every 15-minute checks for safety due to wandering. The DNS indicated that she did not know how big the property was other than it had a short and long-term care facility, residential living facility, and up in the back area were residential homes. The DNS indicated that she believes Resident #42 was last seen on 6/1/24 at 4:15 PM and was then seen outside at 4:30 PM. The DNS indicated that she could not say how long Resident #42 was outside before NA #6 saw Resident #42 through the second-floor window. Interview with the DNS on 6/4/24 at 10:28 AM indicated that since admission Resident #42 has been at high risk for elopement and interventions were to try to keep him/her in common areas while awake, have him/her join activities, land redirect if walking around. The DNS noted on 8/21/23 Resident #42 was found outside of facility. The DNS indicated that Resident #42 was placed on every 15-minute checks and a stop sign on the stairwell door until the lock could be installed. The DNS indicated that she had not done an investigation or watched the video surveillance to investigate when Resident #42 had left the facility and when he/she was found. The DNS indicated that the nursing supervisor had called and informed her that Resident #42 had left the facility out the residential living exit doors and a nurse aide had seen Resident #42 in the parking lot outside of the facility walking. When staff arrived outside Resident #42 was found lying on the grass under a tree with a pillow. The DNS assumed it was the tree closest to the exit door approximately 30 feet from exit door. The DNS indicated that the expectation was that the nurse aides would visually check and see Resident #42 every 15 minutes, and then would document the location and what Resident #42 was doing. Observation of the surveillance video for 6/1/24 with the DNS and the Maintenance Director on 6/4/24 at 11:15 AM identified the following: At 3:59 PM Resident #42 was walking in the hallway, rounding the corner toward the residential care unit with a pillow and without a walker. At 4:01 PM Resident #42 exited the right-hand side door to the patio area outside and then was out of camera surveillance site. At 4:28 PM the resident was seen on the camera on the parking lot side looking down to the end of the building where the maintenance garage area is. At 4:29 PM Resident #42 appears and stopped when walking in the parking lot against the stone wall on the opposite side of the facility. At 4:29 and 45 seconds Resident #45 stumbles twice and lays down on the small grassy area in the parking lot away from the facility. At 4:34 PM Resident #42 was back to standing position and started walking down the driveway that goes up a hill to the residential houses towards the other end of the facility. At 4:35 PM Resident gets down driveway, passes the trees and went out of camera sight. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 4:37 PM and 30 seconds a staff member is seen coming from the end of the driveway towards the facility. The DNS indicated that was the nurse aide coming into the facility to get the nurse. At 4:47 PM the nurse exited the facility with the wheelchair, had Resident #42 sit in the wheelchair and was seen pulling Resident #42 backwards in the wheelchair into the facility. The DNS indicated that Resident #42 was to ambulate with supervision using a wheel walker and during video there was no walker or staff assistance. The DNS indicated that Resident #42 does not remember to take the walker that staff must give it to him/her. The DNS indicated that Resident #42 had left the facility at 4:01 PM and was not seen by the staff until at least 4:36 PM. The DNS indicated that no one had witnessed Resident #42 go from a standing position to laying on the ground, but she felt Resident #42 did it on purpose. The DNS indicated that she was not aware prior to watching the video with the surveyor how long Resident #42 had been unattended outside of the facility. Although attempted, an interview with NA #6 was not obtained. Review of the facility Elopement Policy identified the facility strives to promote resident safety and protect the rights and dignity of the residents. Elopement is defined as the ability of a resident who is not capable of protecting him/herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter harm's way. Prevention would include frequent monitoring of the resident's whereabouts to assure he/she remains in the facility with every 15-minute checks, cameras are in place that continually monitor all the exits in the building, elevator controls, restricted window openings. When a resident has been found the search Director or DNS will notify all staff that the resident has been found and the charge nurse will examine the resident for injuries. The Physician and resident representative will be notified. The care plan will be updated. Implement every 15-minute checks for safety. Complete a Missing Resident form and required staff present and involved to sign the form. Report the incident to the state authorities as required. 2. Resident #9 was admitted to the facility in November 2019 with diagnoses that included hemiplegia and hemiparesis affecting left non-dominant side, cerebral infarction, heart failure, and atrial fibrillation. A physician's order dated 1/12/23 directed to provide the assistance of 2 for transfers from bed to/from wheelchair with hemi walker. The care plan dated 3/22/23 identified Resident #9 was at risk for falls related to gait/balance problems and left sided weakness. The April 2023 monthly physician's orders directed to transfer the resident with the assistance of 2 from bed to/from wheelchair with hemi walker, no ambulation. The fall assessment dated [DATE] identified Resident #9 was at high risk for falling. The annual MDS dated [DATE] identified Resident #9 had intact cognition and required extensive 2-person assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care card, without a revision date, identified to transfer Resident #9 with the assistance of 2 with hemi walker. The May 2023 monthly physician's orders directed to transfer the resident with the assistance of 2 from bed to/from wheelchair with hemi walker, no ambulation. The nurse's note dated 5/11/23 at 11:46 PM identified RN #1 was notified by LPN #1 at 6:30 PM that Resident #9 had fallen. RN #1 observed Resident #9 on the bedroom floor with an L shape laceration on the left mid part of the head that measured 5cm x 0.2cm with moderate amount of bleeding. Resident #9 was alert and verbally responsive complaining of pain to the head and back area with no shortening/lengthening of bilateral legs. A cold compress was applied to the wound area to control the bleeding. Neurological checks and vital signs were initiated and were within normal limits. The physician was notified and ordered Resident #9 to be sent to the hospital for further evaluation. The reportable event form dated 5/11/23 at 6:30 PM identified Resident #9 was being assisted with a transfer of 1 staff and the hemi walker from the wheelchair to the bed and lost his/her balance, struck his/her head on the floor and sustained a laceration on the back of the head. Pressure was applied to the back of the head and Resident #9 was transferred to the hospital for treatment. Review of a statement written by NA #1 dated 5/11/23 identified she was transferring Resident #9 from the wheelchair to the bed. NA #1 indicated she was in front of Resident #9 holding on to his/her clothing. Resident #9 was holding onto the hemi walker and lost his/her balance and fell on his/her back. Review of the hospital inter-agency patient referral report (W-10) dated 5/11/23 identified Resident #9 was seen for a fall and head laceration repair. Resident #9 is to follow up with primary physician regarding wound and staples removal. The revised care plan dated 5/11/23 identified Resident #9 was at risk for falls related to gait/balance problems and left sided weakness. Resident #9 fell on [DATE] and sustained an injury to the head. Interventions included transferring Resident #9 to the hospital for evaluation and treatment. Physical therapy to evaluate and treat as indicated. Review of the education sheet dated 5/12/23 identified the use of gait belt was reviewed with NA #1. All residents that are ambulated and transfer with assist of 1 or 2 must have a gait belt placed around them and used to guide and stabilize the resident. If the nurse aide gait belt is not available there are gait belts at the nursing station for use. NA #1 was given a gait belt. The care plan dated 5/12/23 identified Resident #9 sustained a laceration on the left side of the head that required 10 staples to repair. Interview with MD #1 on 6/3/24 at 10:55 AM identified the nursing staff should have followed the physician's order to provide assistance of 2 when transferring the resident. Interview and review of the clinical record with the Physical Therapy Director on 6/3/24 at 11:00 AM identified Resident #9 was on therapy with activity orders to provide the assistance of 2 for transfers bed to/from wheelchair with hemi walker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #1 on 6/4/24 at 10:40 AM identified she was only employed at the facility for 1 month when Resident #9 fell , and it was her first-time providing care to Resident #9. NA #1 indicated she did not read the care card before transferring Resident #9 and she did not utilize a gait belt during the transfer. NA #1 indicated she did not check the care card and does not know what the care card directs for transfers for Resident #9. NA #1 indicated Resident #9 stood up and let go of the hemi walker and fell backward on the floor. NA #1 indicated Resident #9 was bleeding from his/her head. Interview and review of the clinical record with the DNS on 6/4/24 at 11:43 AM identified while conducting the investigation she called NA #1 who stated she transferred Resident #9 by herself and without a gait belt. The DNS indicated NA #1 should have used a gait belt and had the assistance of 2 persons with the transfer from the wheelchair to bed. The DNS indicated she educated NA #1 regarding the gait belt and reviewing the care card before providing care to a resident. The DNS indicated NA #1 was unable to state the reason why she did not use a gait belt and read Resident #9 care card. Review of the fall management and prevention policy identified to ensure that all residents are assessed for fall risk and that adequate measures are taken to prevent injuries due to falls. Residents will be assessed for fall risk using the Morse fall risk assessment form on admission, quarterly thereafter and with a change of condition. If the resident is at risk for falls, interventions to reduce this risk will be included in the resident's care plan. Review of the facility safe patient/resident handling policy identified to enhance the safety of the work environment for resident care providers and promote a safe, secure and comfortable experience for residents who require partial or full transfer assistance. An interdisciplinary team will evaluate and assess each resident's individual mobility needs. Resident mobility assessments will be performed or reviewed on admission, after a significant change in condition or based on direct care staff recommendations. Safe resident handling and moving requirements: All lifting and transferring of patients/residents will be performed according to their individual plan of care. Gait belts are a tool for gait stabilization - not lifting or moving residents. 3. Resident #7 was admitted to the facility on [DATE] with diagnoses that included stroke, osteoarthritis, hypertension. The care plan dated 12/12/23 identified Resident #7 was at high risk for falls due to deconditioning. Interventions included dycem to wheelchair to prevent sliding and call light in reach. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, required maximum assistance with personal hygiene, toileting, bathing, and dressing, was totally dependent on staff for transfers and utilized a wheelchair for mobility. Further, Resident #7 had no behaviors and no history of falls in the last 6 months. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's order dated 2/14/24 directed to provide the assistance of 1 for transfers from the bed to the wheelchair and to utilize a 1/2 lap tray. A reportable event form dated 3/3/24 at 2:00 PM identified Resident #7 slid and bumped his/her right knee while being transferred. Resident #7 is alert and forgetful, has complaints of pain and swelling to the right knee. Subsequent to physician notification, a new order was obtained to provide the assistance of 2 for transfers. The nurse's note dated 3/3/24 at 3:44 PM identified that Resident #7 is reporting pain in the right knee and the right knee appears swollen. Review of a written statement by NA #7 dated 3/6/24 indicated that on 3/3/24 she was attempting to transfer Resident #7 when she realized she could not transfer the resident without help. NA #7 pressed the call light and asked for the nurse to help her while Resident #7 was sitting on her lap until the nurse came in to assist. Review of a written statement by RN #4 dated 3/6/24 indicated that on 3/3/24 she responded to a call for help at approximately 6:15 AM in Resident #7's room. Upon entering the room, she observed NA #7 sitting on the side of the bed holding the resident on her lap. NA #7 informed RN #4 that she was having difficulty transferring Resident #7 into the wheelchair. RN #4 indicated that she assisted NA #7 to put Resident #7 back into the bed. RN #4 indicated that she straightened out Resident #7's clothes and then assisted transferring Resident #7 from the bed into the wheelchair. A written statement by the DNS on 3/6/24 indicated NA #7 was unable to say how Resident #7's knee was injured or bumped during the transfer. A physician order dated 3/7/24 directed Resident #7 be non-ambulatory with an assist of 2 with a mechanical lift from bed to custom wheelchair. The nurse's note dated 3/7/24 at 11:00 PM identified Resident #7 was seen by physical therapy and having difficulty transferring back to bed. The right knee remains red and swollen. Resident #7 has discomfort when leg is touched. The APRN was notified and ordered a right patella x-ray. Radiology report dated 3/8/24 at 7:29 AM indicated that Resident #7 had a fracture of the distal femoral shaft with malalignment with mild soft tissue swelling. Acute femoral fracture. A reportable event form dated 3/8/24 at 7:30 AM indicated that Resident #7 was complaining of right knee pain and the physician ordered an x-ray. The injury was an acute femoral fracture. Resident #7 was sent to the emergency room . The nurse's note dated 3/9/24 at 2:40 PM identified this nurse received a call from the hospital that indicated the resident's representative declined surgery due to residents advanced age and overall prognosis. Resident #7 arrived at the facility wearing a right knee immobilizer and a new order for narcotics. The hospital discharge summary dated 3/9/24 at 11:43 AM indicated that Resident #7 had a closed bicondylar fracture of the distal right femur. (continued on next page)

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	075352	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Connecticut Baptist Homes, Inc	292 Thorpe Avenue Meriden, CT 06450

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN #4 on 6/4/24 at 11:50 AM indicated on 3/3/24 the call light came on from Resident #7's room. RN #4 indicated she got up and went to the room and saw NA #7 sitting on the edge of the bed in the center of the mattress with Resident #7 sitting on her lap with the resident's right shoe partially hanging off. RN #4 indicated NA #7 reported that she thought she could transfer Resident #7 by herself. RN #4 indicated she picked Resident #7's legs up and moved them back into the bed and NA #7 was then able to stand up. RN #4 and NA #7 [NAME] fixed Resident #7's clothes and shoes and transferred resident into the wheelchair. RN #4 indicated that the gait belt was not around Resident #7's waist during the transfer. RN #4 indicated that it was the facility policy that the nurse aide must place a gait belt on the resident for transfers and ambulation. Review of the facility Safe Resident Handling Policy identified to enhance the safety of the work environment for resident care providers and promote a safe, secure, and comfortable experience for resident's who require partial or full transfer assistance. All staff who participate in resident handling activities are required to use a mechanical assistive device for every resident handling activity when residents require partial or full assistance. Gait belts are a tool for gait stabilization and not lifting or moving residents. Definition of a resident that is an assist of 1 with or without a walker the transfer requires physical assistance of 1 staff member. These transfers are always a stand and pivot transfer with the use of a gait belt. 42117

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Residents #20 and 42) reviewed for unnecessary medications, the facility failed to ensure orthostatic blood pressure monitoring was completed per the physician's order for a resident receiving an antipsychotic medication. The findings include: 1. Resident #20 was admitted to the facility on [DATE] with diagnoses that included dementia, panic disorder, and a history of repeated falls. The quarterly MDS assessment dated [DATE] identified Resident #20 had intact cognition, sustained 2 or more falls with no injury and 1 fall with injury since the prior assessment, and received antipsychotic medications on a routine basis. The care plan dated 3/18/24 identified Resident #20 had a behavior problem related to hallucinations, accusatory behavior, and anxiety/panic disorders. Interventions included administering medications as ordered and monitoring for side effects and effectiveness. A physician's order dated 4/16/24 directed to obtain orthostatic blood pressures weekly, times 4 weeks. The April and May 2023 MAR's failed to identify that orthostatic blood pressures were obtained. The nurse's note dated 4/16/24 through 5/11/24 failed to identify that orthostatic blood pressures for the weeks of 4/16/24 and 5/7/24 were obtained or refused. Interview and clinical record review with LPN #4 on 6/4/24 at 9:30 AM failed to identify orthostatic blood pressures were completed on Resident #20 during the weeks of 4/16/24 and 5/7/24. LPN #4 indicated that it is the responsibility of the floor nurse to complete the task. LPN #4 completed the orthostatic blood pressures on 4/23/24 but did not work on the days that the orthostatic blood pressures were not completed. LPN #4 further indicated that Resident #20's blood pressure was documented in the electronic health record on 5/7/24, but only in a laying down position. Interview and clinical record review with the DNS on 6/4/24 at 9:53 AM failed to identify that 4 weekly orthostatic blood pressures were obtained, per the physician's order. The DNS indicated that it is the responsibility of the unit nurse to complete orthostatic blood pressures, and she would educate the nursing staff to complete orthostatic blood pressures, per the physician order. The DNS further indicated that she would ensure the order for orthostatic blood pressures weekly times four, would be completed for Resident #20. The facility's Use of Psychotropic Medication policy directs that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Orthostatic Blood Pressure policy directs that orthostatic blood pressures will be taken weekly for one month on all residents receiving new antipsychotic medications, an increase in dosage of an antipsychotic medication, if symptoms of orthostatic hypotension are present, and as ordered by their physician. 2. Resident #42 was admitted to the facility with diagnoses that included Alzheimer's disease, anxiety, dementia with behavioral disturbances, and violent behaviors. The quarterly MDS assessment dated [DATE] identified Resident #42 had severely impaired cognition, rejects care and has behaviors such as pacing 1 - 3 days a week. Resident #42 requires maximum assistance with bathing and putting on footwear, and maximum assistance with toileting and personal hygiene. Resident #42 ambulates with supervision or touching assistance with a walker. Resident #42 is taking high risk drug class of antipsychotic, antianxiety, and antidepressants daily. The care plan dated 1/12/24 identified Resident #42 had impaired cognition with behaviors of wandering and looking for rides home. Interventions included administering medications as ordered and redirecting the resident when wandering in hallway. The psychiatric APRN note dated 3/5/24 indicated a GDR (gradual dose reduction) of the Seroquel was attempted and was unsuccessful, and the dose of Seroquel was increased. A physician order dated 3/5/24 directed to perform orthostatic blood pressures every month. A physician's order dated 3/8/24 directed to administer Seroquel (antipsychotic) 25 mg at 6:30 AM and 1:00 PM, Seroquel 100mg at bedtime, Ativan (antianxiety) 0.5mg twice a day, and Lexapro (antidepressant) 20 mg daily. A physician order dated 3/9/24 directed to increase Seroquel to 50 mg at 6:00 AM and 1:00 PM. A physician order dated 3/19/24 directed to discontinue Lexapro 20mg related to falls and increased cardiac concerns when used with high doses of Seroquel. Start Lexapro 15 mg daily for anxiety. Review of the electronic medical record from 4/1/24 - 4/30/24 identified no documentation of orthostatic blood pressures. Review of April 2024 TAR failed to reflect documentation of the orthostatic blood pressure. A physician order dated 4/11/24 directed to add Seroquel 50 mg at 5:00 PM daily. Review of the electronic medical record from 5/1/24 - 5/31/24 identified no documentation of orthostatic blood pressures. Review of April 2024 TAR failed to reflect documentation of the orthostatic blood pressure. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 6/3/24 at 1:22 PM indicated that on 3/5/24 she had put in the order for orthostatic blood pressures weekly times 4 weeks, because anytime there is a change with an antipsychotic medication, she was trained to order the weekly orthostatic blood pressures. APRN #1 indicated that Seroquel can lower the blood pressure and that's why they do the orthostatic blood pressures. APRN #1 indicated that if the nursing facility as a nursing measure or physicians order wants to continue orthostatic blood pressures monthly for the antipsychotics they can. Interview with the DNS on 6/4/24 at 10:50 AM indicated that any antipsychotic medications are followed by the psychiatric APRN. The DNS indicated the expectation was the nurses would follow the physician's orders for the weekly times 4 weeks orthostatic blood pressures, then monthly orthostatic blood pressures for residents that were on antipsychotic medications. The DNS indicated that if Resident #42 had refused, her expectation was the nurse would write refused on the Kardex and then put in a progress note as to why the resident had refused. After clinical record review, the DNS indicated that there was a physician's order for monthly orthostatic blood pressures due to Resident #42 being on antipsychotic medications, and they were not done for April and May 2024. Review of the facility Use of Psychotropic Medication Policy identified residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. A psychotropic drug affects the brain activity associated with mental processes and behaviors. Psychotropic drugs include but are not limited to antipsychotics, antidepressants, anti-anxiety, and hypnotics. The facility's Orthostatic Blood Pressure policy directs that orthostatic blood pressures will be taken weekly for one month on all residents receiving new antipsychotic medications, an increase in dosage of an antipsychotic medication, if symptoms of orthostatic hypotension are present, and as ordered by their physician. 47457

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of facility documentation, facility policy, and interviews the facility failed to ensure that an accurate record of an effective training program for all staff was maintained. The findings include: The Facility assessment dated [DATE] directed that every staff member has knowledge competency in: infection control, bed rails, body mechanics, confidentiality, corporate compliance, harassment, hospitality, lock out tag out, mission and values, hazard communication, abuse, neglect, exploitation and misappropriation; resident rights; identification of condition change; resident preferences and workplace violence. Additional knowledge competencies for all staff include dementia management, infection transmission and prevention, immunization, QAPI, and OSHA hazard communication. Hand hygiene return demonstration competencies and observed knowledge competencies for emergency response are also required. Competencies are based on current standards of practice and may include knowledge and a test, knowledge and return demonstration, knowledge and observed ability, knowledge and observed behavior, and annual performance evaluation. Upon the survey team's request for documentation of the completion of employee's annual in-servicing and competency training, the facility was unable to provide sufficient documentation, including completed and signed Annual Inservice Education Fair 12/11/23 through 12/29/23 packets and competency forms. Interview with the Administrator on 7/8/24 at 11:25 AM identified that the facility was unable to locate staff competency forms and tracking documentation supporting the required annual 12-hour nurse aide training. The Administrator further identified that the documentation had been missing since November of 2023, when the former Staff Development Nurse resigned. The Administrator indicated that starting next week, the facility will begin utilizing online educational modules. Interview with the DNS on 7/8/24 at 12:09 PM indicated that the facility was unable to locate the signed Annual Inservice Education Fair 12/11/23 through 12/29/23 packets and competency forms. The DNS further indicated that the in-service and competency documents had been stored together in a box, and that she had not seen the box since the former Staff Development Nurse had left the position, in November. The DNS identified that the facility had hired a new Infection Control/Staff Development Nurse, and she has been allotted 8 hours per week to oversee the on-going education of the facility staff, including the roll-out and utilization of a new online education program. The Staff Development Nurse was unavailable for an interview. The facility's Annual Education policy directs the facility to develop, implement, and maintain an effective training program for all new and existing staff. The intent is to improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Competency Evaluation policy directs the facility to evaluate employees to assure appropriate competencies and skills for performing his or her job and to meet the needs of the facility residents. The policy further directs that initial competencies are evaluated during the orientation process and subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations, and checklists are used to document training and competency evaluations.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47457 Based on review of facility documentation, facility policy, and interviews reviewed for training requirements the facility failed to ensure that an accurate record of continuing nurse aide competence of no less than 12 hours per year, including dementia management training and resident abuse prevention training, was maintained. Upon the survey team's request for documentation of the completion of 12 hours of nurse aide annual in-servicing and competency training, the facility was unable to provide sufficient documentation, including completed and signed Annual Inservice Education Fair 12/11/23 through 12/29/23 packets and competency forms. Interview with the Administrator on 7/8/24 at 11:25 AM identified that the facility was unable to locate staff competency forms and tracking documentation supporting the required annual 12-hour nurse aide training. The Administrator further identified that the documentation had been missing since November of 2023, when the former Staff Development Nurse resigned. The Administrator indicated that starting next week, the facility will begin utilizing online educational modules. Interview with the DNS on 7/8/24 at 12:09 PM indicated that the facility was unable to locate the signed Annual Inservice Education Fair 12/11/23 through 12/29/23 packets, as well as, other in- servicing and competency forms. The DNS further indicated that the in-service and competency documents had been stored together in a box, and that she had not seen the box since the former Staff Development Nurse had left the position, in November. The DNS identified that the facility does complete 12 hours of in-service training, annually, for nurse aides and that there are specific educational requirements that need to be met within a designated timeframe including but not limited to topics like fear of retaliation, abuse, neglect, resident's rights, and dementia care. The DNS further identified that the annual 12 hours of nurse aide training was achieved using poster boards, lectures by department heads and the Staff Development Nurse, demonstrations, and videos. The DNS indicated that the facility had hired a new Infection Control/Staff Development Nurse, and she has been allotted 8 hours per week to oversee the on-going education of the facility staff, including the roll-out and utilization of a new on-line education program. The Staff Development Nurse was unavailable for an interview. The facility's Annual Education policy directs the facility to develop, implement, and maintain an effective training program for all new and existing staff. The intent is to improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications. The policy further directs that certified nursing assistants will receive a minimum of 12 hours of education annually. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Competency Evaluation policy directs the facility to evaluate employees to assure appropriate competencies and skills for performing his or her job and to meet the needs of the facility residents. The policy further directs that initial competencies are evaluated during the orientation process and subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations, and checklists are used to document training and competency evaluations.