STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075441	A. Building B. Wing	11/22/2022

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46663 Based on observations, clinical record review and interviews for one of four residents (Resident #268) reviewed for choices, the facility failed to honor resident choice related to morning care. The findings include: Resident # 268's diagnoses included Rhabdomyolysis and diabetes mellitus. The admission MDS assessment dated [DATE] identified the resident was moderately cognitively impaired, had memory problems and indicated the resident required extensive assistance with ADL. The care card dated 11/7/22 identified the resident required the assistance of one staff member for bathing and dressing on the 7:00 AM - 3:00 PM shift, and failed to identify the resident's preference to be bathed, dressed and out of bed by 9:00 AM. Observation on 11/16/22 identified Resident 268 at 9:45 AM was observed in bed in her/his clothes. The resident was alert, and a family member was sitting in chair at bedside. Resident # 268 indicated s/he was not happy. Both the resident and the family member expressed concerns that Resident # 268 was still in bed and was not dressed. Resident # 268 indicated s/he usually has a private aide that comes from 9:00 AM - 12:00 PM but the private aide was not able to come today. Resident # 268 indicated s/he usually wake up at 6:00 AM and wanted to be out of bed and dressed soon after or at least definitely by 9:00 AM. Resident # 268 further indicated when s/he asked the staff about getting him/her dressed and out of bed they told her/him they having a rough morning. On 11/16/22 NA #1 entered the resident's room at 10:10 AM to provide morning care which included assisting her/him with dressing and getting out of bed and into the chair. Interview with Licensed Practical Nurse (LPN #1) at 2:30 PM on 11/16/22 identified s/he gave the resident his/her medications at 7:30 AM and Resident # 268 did not indicate to him/her that s/he wanted to get dressed and out of bed. LPN #1 further indicated staff have been made aware the resident sometimes liked to get out of bed before 8:00 AM but they could not always accommodate him/her due to staffing, and sometimes Physical Therapy (PT) wanted the resident to be in bed when they provided her/his therapy. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/22 at 9:50 AM Resident # 268 was observed dressed and sitting in chair in the room. S/he indicated s/he sometimes would have to wait until noon for staff to help her/him get dressed and out of the bed, although s/he had told a nurse (s/he was unsure of who s/he told) s/he wanted to get out of bed every morning by 9 :00AM. Interview with LPN #3 on 11/17/22 at 1:30 PM identified s/he was aware Resident # 268 wanted to get out of bed early and they tried to accommodate him/her as best they could. It depended on the NA assignments. Interview with Social Worker #1 on 11/17/22 at 10:35 AM identified s/he was unaware Resident #268 was not pleased with care. If s/he was made aware, the social worker department would have filed a grievance, review it with the DNS and nursing supervisor. Social Worker #1 further indicated s/he would resolve the issue as soon as possible by discussing it with nursing and try to accommodate the resident's wishes. S/he was going to write it up as a grievance today. On 11/21/22 at 10:30 AM Resident # 268 was observed dressed and in a wheelchair in the community area during recreation activity. Private NA from agency was sitting beside the resident. Resident# 268 indicated s/he had been receiving care by 8:00 AM each morning subsequent to inquiry by surveyor.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46663 Based on clinical record reviews, facility policy review and interviews for two of five residents (Residents #270 and 271) reviewed for grievances, the facility failed to provide documented evidence that grievances were resolved to the satisfaction of the resident or his/her representative within accordance to facility policy. The findings included: A review of the facility grievance file dated 1/1/21 through 11/16/22 during the survey identified the following. 1. Resident #270 was admitted on [DATE] with a diagnosis include left hip joint replacement. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #270 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicating intact cognition. The admission assessment also noted the resident required extensive assistance with transfers, limited assistance with activities of daily living (ADL), always continent of bowel and indicated Resident # 270 had an indwelling urinary catheter. Resident #270 filed a grievance on 9/20/22 which identified the resident rang his/her call bell at 2:00 AM on 9/20/22 and the call bell was not answered until 5:00 AM (a two-hour delayed response) The grievance form resolution on 9/21/22 identified the call bell was checked and was functioning and directed staff to round frequently on the resident. However, the facility failed to provide documented evidence that the resident was satisfied with the outcome of the resolution. 2. Resident #271 was admitted on [DATE] with diagnoses that included disruption of a surgical wound of his/her left foot, abnormal levels of serum enzymes, and metabolic encephalopathy. Resident #271's family member filed a grievance on 9/15/22 indicating the resident's bowel device had 'exploded' during the night and the 11:00 PM-7:00 AM nurse did not change it. According to the grievance report, the following 7:00 AM - 3:00 PM shift Nurse Aide (NA) observed that the bowel device was off. The facility resolution directed to check the resident's bowel device every two hours. However, the facility failed to provide documented evidence that the resident's family member was satisfied with the resolution. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #271 had a Brief Interview for Mental Status (BIMS) score of thirteen out of fifteen, indicating intact cognition. The resident required extensive assistance with activities of daily living (ADL), always incontinent of bladder, and noted the utilization of bowel elimination device. Interview with Social Worker #1 on 11/17/22 at 10:35 AM indicated s/he worked to resolve grievances as soon as possible. Social Worker #1 also indicated s/he tries to contact complainants to follow up regarding satisfaction with the resolutions to grievances but have not always been successful. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 11/17/22 at 12:30 PM identified Social Worker #1 as the facility's Grievance Official. The Administrator indicated s/he was not able to provide documentation of Residents #270 and # 271 the resident and /or the representatives satisfaction with the resolutions to their grievances. The Administrator indicated the facility's grievance report did not provide a place on the form to document the grievance being resolved to the satisfaction of the complainant. The facility failed to follow their policy for following up with the person and or the representative to ensure satisfaction to grievance resolutions. Review of facility Concern/Grievance Policy directed in part, for the Grievance Official to inquire with the individual presenting the grievance to determine if resolution had been obtained to the persons satisfaction.

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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** 37721 Based on review of the clinical record, facility documentation review, facility policy and interviews, for 1 of 5 residents, (Resident #3) reviewed for unnecessary medications, the facility failed to follow approved pharmacy recommendation from the physician regarding Vitamin D3 and accurately transcribe the physician's orders to meet professional standards of practice and prevent a medication error. The findings include: Resident #3's diagnoses included cerebral infarction, atrial fibrillation, chronic kidney disease, polyneuropathy, and spinal stenosis. The admission MDS assessment dated [DATE] identified Resident #3 had severe cognitive impairment and required extensive assistance of 2 person with transfer, dressing and toileting, hygiene, and non-ambulatory. The pharmacy recommendation dated 10/12/22 identified pharmacy recommendation to change Vitamin D 2000 International Unit (IU) by mouth once daily to Vitamin D3 50,000 IU by mouth once a month and indicated the physician approved the pharmacy recommendation. The physician's order dated 10/16/22 directed that Resident #3 receive vitamin D3 50,000 IU by mouth once a week instead of monthly. Resident #3 had received 5 doses instead of 2 doses. The Medication Administration Record (MAR) for the month of October and November 2022 identified Resident # 3 had received the Vitamin D3 50,000 IU on 10/16, 10/23, 10/30, 11/6 and 11/13/22. Interview and facility documentation review with RN # 1 (Assistant Director of Nursing Services) identified that she received the physician's order from the pharmacy recommendation. The pharmacy recommendation record was reviewed with RN #1, and she stated she would follow the approved recommendation from the pharmacy. Subsequent to inquiry, RN#1 corrected the vitamin D3 50,000 IU by mouth to be given once a month instead of weekly. She further indicated the error was an oversight and a mistake in transcribing the physician's order. The facility failed to follow the pharmacy recommendation approved the physician and transcribe accurately in the plan of care. A review of facility nursing policy title Physician's Orders identified in part it is the facility policy to obtain a current physician's order from the attending physician and the nurse that received the medication order would make an entry in the MAR for the specific resident so that the resident can receive the medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on review of the clinical record, facility documentation review, facility policy, and interviews, for 1 of 5 residents, (Resident #1) reviewed for unnecessary medications, the facility failed to follow physician's order to complete quarterly laboratory bloodwork. The findings include: Resident #1 was admitted to the facility with diagnoses that included hemiplegia and hemiparesis following a stroke, stage IV chronic kidney disease, diabetes mellitus and congestive heart failure. A quarterly MDS assessment dated [DATE] identified Resident #1 had moderate cognitive impairment and the resident required extensive assistance of 2 staff for transfers and extensive assist of staff for personal hygiene. The care plan revised on 3/22/22 for self-care deficit and needed assistance with ADL to include bed mobility with an assist of 2 staff and the Sara lift (sit to stand) lift, transfer assist of 2 and no ambulation. Additionally, the care plan identified that Resident #1 had a potential for fluid deficit due to use of a diuretic with an intervention to obtain and monitor laboratory bloodwork as ordered. A physician's order dated 5/30/22 directed for Resident #1 to have quarterly Laboratory bloodwork: Nephrology Laboratory - Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Lipids, Albumin, Pre-Albumin, Iron, Total Iron Binding Capacity (TIBC), Phosphorus, PTH, Ferritin, Vitamin D, HgbA1 one time a day every 4 month(s) starting on the 1st for 1 day(s) for quarterly laboratory test. The physician's order further identified the order was entered in to the electronic medical by LPN #2 on 5/30/22 at 10:54 PM with an order type of standard laboratory bloodwork order with a start date of 6/1/22. A laboratory report on 6/2/22, laboratory as ordered on 5/30/22 Nephrology laboratory- CBC, CMP, Lipids, Albumin, Pre-Albumin, Iron, TIBC, Phosphorus, PTH, Ferritin, Vitamin D, HgbA1 were drawn, and results were faxed to the provider on 6/3/22. The medical record lacked any evidence of an additional CMP, Lipids, Albumin, Pre-Albumin, Iron, TIBC, Phosphorus, PTH, Ferritin, Vitamin D, HgbA1 since the 6/2//22 laboratory bloodwork were drawn. (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 Registered Nurse (RN #1) on 11/21/22 at 12:00 PM identified that any licensed staff member can enter a physician's order when it is received into the electronic medical record. She continued by stating that a laboratory order would be entered as an order type of other, then would be identified in the system as a laboratory order. If entered as order type other, the nurse would select laboratory which would initiate that order as a task on the Medication Administration Record (MAR)/ Treatment Administration Record (TAR) when due and initiate an auto-reminder for the staff 24 hours prior to the next scheduled laboratory blood draw to cue the nursing staff to make sure the laboratory test was scheduled. Additionally, the nurse entering the order would place a reminder in the unit calendar. RN #1 further identified the day supervisor would review all physician's orders for the past 24 hours to ensure the orders were entered correctly. She continued by stating the vendor for the electronic medical record had upgraded the system and the laboratory order should not have been entered as an order type of standard laboratory bloodwork. RN #1 further indicated s/he had emailed the vendor on 7/8/22 to inform them of the issue. RN #1 stated that is why the physician's order dated 5/30/22 directed for Resident #1 to have quarterly Laboratory: Nephrology Laboratory (CBC, CMP, Lipids, Albumin, Pre-Albumin, Iron, TIBC, Phosphorus, PTH, Ferritin, Vitamin D, HgbA1) one time a day every 4 month(s) starting on the 1st for 1 day(s) for quarterly laboratory was only completed once on 6/2/22. Review of the medical record and interview with RN #1 on 11/21/22 at 12:05 PM identified that the next ordered Nephrology laboratory blood draw should have been completed on October 1, 2022 and indicated this was not done as ordered. She also could not recall if the transcribing nurse had placed the order into the unit calendar or why the order must have been missed by the day supervisor on the next day review. Subsequent to inquiry, the Nephrology laboratory bloodwork were re-entered into the electronic medical record using the correct order type. The facility policy Skilled Nursing physician's order in part directs that the nurse will transcribe the physician's order into the resident's medical record. 46117

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37721 Based on observation, facility policy review and interviews, the facility failed to ensure medications were stored in a secure manner and not left unattended on the medication cart. The findings include: Observation on 11/17/22 at 5:40 AM identified a medication cart in the hallway on the short unit left unattended with 3 loose medications placed on top of the cart in medication cups and the cart unlocked. There were no residents or nursing staff in in the immediate area. An interview on 11/17/22 at 5:40 AM with RN #1 (ADNS) identified medications should not be left unattended on top of the cart and the cart should be lock when unattended. An interview on 11/17/22 at 5:40 AM with RN #2 identified she was the assigned nurse for the unit. RN #2 indicated she left the cart briefly to obtain water and should not have left the medication cart unlocked and with medications on top. An interview on 11/22/22 at 8:29 AM with the Administrator identified it would be her expectation that all medications be stored in a safe and secure manner when the medication cart was left unattended. The facility policy for Medication Administration directs during administration of medications, the medication cart is to be kept closed and locked when out of sight of the medication nurse. No medications are to be kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37721 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure waste was disposed of within accordance with infection control practices to prevent the spread of infection. The findings include: An observation on 11/17/22 at 5:45AM identified NA#2 exiting RM #11 with gloved hands, soiled incontinent material in a clear plastic bag carried in the right hand, a package of clean incontinent material carried in the left hand and a spray bottle also in the left hand. NA #2 then entered RM #10, close the door, then re-opened the door to exit the room with the same materials in the right and left gloved hand in less than 30 seconds. NA #2 placed the soiled waste on the floor with the right hand outside the door, closed the door using her right hand, pick up the soiled waste using the same right gloved hand. Placing both hands closer together with the same items in each hand, NA#2 then went across the hall to RM #3, pushed the door to the room with her left elbow, placed the clean and dirty items on the floor, entered the room, turned to pick up the items to bring into the room and then push the door in a slightly closed position. Surveyor entered the room just behind NA #2 and observed her raising the bed of the resident using the same left gloved hand. Task interrupted by surveyor and NA#2 asked to exit after lowering the bed for safety. An interview on 11/17/22 at 5:45AM with NA #2 identified she had no bins available to her to take room to room during rounds. NA #2 indicated that although she had worn the same gloves going from room to room carrying the soiled waste, she had donned a new pair of gloves before initially exiting RM #11 and felt she had not cross contaminated any surfaces. NA #2 indicated that although she used the same gloves to raise the resident bed in RM # 3, her intent was to perform hand hygiene and change gloves prior to initiating care. An interview and facility documentation review on 11/17/22 at 5:51AM with RN #1 identified she was responsible for providing education to the nurses regarding infection control practices. RN #1 indicated NA #2 should not have been brought the soiled waste from room to room with the same gloved hands. RN #2 further indicated she had previously provided NA #2 with education on the use of gloves and hand hygiene on 10/20/22 and would provide re-education. An interview on 11/22/22 at 9:37 AM with the Administrator identified her expectation would be that staff remove waste from the resident room and discard the waste in trash bins located in the dirty utility room and perform hand hygiene before entering another resident room. The facility policy Hand Hygiene directs to wear gloves to be worn when in contact with blood or potentially infectious material. Gloves to be removed after caring for a resident and do not wear the same pair of gloves to care for another resident. Standard precautions direct gloves to be changed and hand hygiene performed when moving from a contaminated to clean site during patient care and in between patient contact to avoid cross contamination.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 37721 Based on observation, facility documentation, facility policy, and interviews the facility failed to ensure essential equipment was maintained in safe operable condition and failed to ensure daily temperature checks were recorded for essential equipment. The findings included. 1. Work Order history dated 5/17/21 through 5/22/22 noted the following: A Work Order dated 5/7/20 noted the hydrocollator in the Outpatient department was not working. A power cord was ordered. A Work Order dated 6/9/21 noted the hydrocollator was broken and could not be fixed. A Work Order dated 12/14/21 noted (2) Hydrocollators were delivered to the facility. A Work Order dated 12/16/22 noted a Hydrocollator was replaced in the Outpatient Therapy department. A Work Order dated 5/22/22 noted the hydrocollator was not heating further noting the issue was corrected. An observation and facility documentation review on 11/21/22 at 1:45PM identified the hydrocollator on the counter and powered on. 2. The temperature logs dated 6/2/22 through 11/16/22 noted daily temperature checks were not recorded from 6/23/22 through 10/12/22, from 10/15/22 through 1/16/22 with no recorded temperatures thereafter. The comments section noted an alternate (hydrocollator) was being used from another unit. An interview on 11/21/22 at 3:55PM and 11/22/22 11:49 AM with the Director of Rehabilitation identified the hydrocollator had not been in use since May 2022. A work order was generated through the front desk with a request to repair. The Rehabilitation Director indicated she was never made aware the hydrocollator had been fixed however, through intermittent temperature checks identified the temperature never came up. In the meantime, an alternate hydrocollator was being used when needed. An interview on 11/21/22 at 2:45PM and 11/21/22 at 3:05PM with the Physical Plant Director identified the hydrocollator was not working in May of 2021. The unit was replaced December 16, 2021. There were no reported issues until 5/22/22 when there was a report of no heat. The issue was corrected and there had been no reported issues since. The Physical Plant Director indicated a ticket system was in place to report concerns. If no ticket was generated, it would be difficult to know what the reported issues were. An interview on 11/22/22 at 8:29AM with Physical Plant Staff #1 identified he was the overseeing supervisor in the Director of Physical Plant's absence. Physical Plant Staff #1 indicated environmental rounds were to be completed monthly by physical plant staff to ensure essential equipment was functioning properly and that the outpatient department should have been included in those rounds. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 11/22/22 at 8:29AM with Physical Plant Staff #2 identified there were issues with purchasing a replacement hydrocollator due to Covid. However, Physical Plant Staff #2 was unable to provide documentation detailing delays or efforts to purchase the hydrocollator from an alternate vendor. An interview on 11/22/22 at 8:29AM and 11/22/22 at 10:50AM with the Administrator identified she reviewed the environmental rounds noting that the outpatient department was not included. The Administrator indicated her expectation would be that any faulty essential equipment be identified and repaired. Going forward the outpatient department would be included on environmental grounds. The facility policy for Hydrocollator Maintenance directed water temperature be maintained at 160-165 degrees Fahrenheit (F). 2. Work Order dated 12/4/21 noted the freezer in the outpatient therapy department was not working. Comments indicated the freezer was checked and cleaned. Reading at 0 degrees F with frozen bottles inside. A Work Order dated 12/8/21 noted the freezer in the outpatient therapy department was still not working. Comments indicated the freezer was checked and tested at 0 degrees F with frozen water. A Work Order dated 5/26/22 noted the freezer in the outpatient room was broken. Comments indicated the issue was documented as done. An observation of the freezer identified the freezer at 10 degrees F. A frozen pack was the only item in the freezer. A review of the temperature log noted no recorded temperatures since 2/5/22. An interview on 11/21/22 at 3:55 PM and 11/22/22 11:49 AM with the Director of Rehabilitation identified the temperatures had not been recorded since February 2022 due to the freezer not working. The Director of Rehabilitation indicated she had not been notified the freezer had been fixed and had used an alternate freezer to store items. She had only incidentally learned the freezer was functioning the week prior. There was no staff on the weekend and the staff who worked the previous day should have recorded the freezer temperatures in the log. An interview on 11/21/22 at 2:45 PM and 11/21/22 at 3:05 PM with the Physical Plant Director identified a ticket system was in place to report faulty equipment. The last known reported problem was in December 2022 which was addressed. If no ticket was generated, it would be difficult to know what the reported issues were. An interview on 11/22/22 at 8:29AM with Physical Plant Staff #1 identified he was the overseeing supervisor in the Director of Physical Plant's absence. Physical Plant Staff #1 indicated environmental rounds were to be completed monthly by physical plant staff to ensure essential equipment was functioning properly and that the outpatient department should have been included in those rounds. An interview on 11/22/22 at 8:29AM with Physical Plant Staff #2 identified the last known issue related to the outpatient freezer not functioning properly was December 8, 2021. The issue was addressed then. Once completed the appropriate department was notified. (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 11/22/22 at 8:29 AM and 11/22/22 at 10:50 AM with the Administrator identified she reviewed the environmental rounds noting that the outpatient department was not included. The Administrator indicated her expectation would be that any faulty essential equipment be identified and repaired. Going forward the outpatient department would be included on environmental grounds. Although a policy recording freezer temperature was requested, none was provided.