STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075443	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John L. Levitow Health Care Center	287 West St Rocky Hill, CT 06067

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, review of facility documentation, facility policy and interviews for 1 resident (Resident # 19) reviewed for abuse, the facility failed to ensure the alleged perpetrator (staff) was removed from the premises during an abuse investigation to protect the safety of other residents. the findings include: Resident # 19's diagnoses included Parkinson's disease, osteoarthritis, gout, and Peripheral Vascular Disease (PVD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired and required two persons assistance with personal hygiene. A Reportable Event report dated 10/9/22 indicated an allegation of staff to resident abuse occurred on 10/9/2022 at 3:30 AM. The report further indicated Resident #19 reported the nurse (RN#6) grabbed Resident #19's right arm while the resident was ambulating to the bathroom independently without any assistive devices. A written statement dated and timed 10/9/2022 at approximately 3:10 AM identified the alleged perpetrator (RN #6) identified Resident #19 was walking to the bathroom without assistance, without a walker and was unsafe at the time of the incident. RN #6 further indicated in his statement he did not grab Resident #19 but instead their hands touched when placing the walker in Resident #19 ' s path. A written statement by RN #7 dated and timed 10/9/2022 at 5:00 AM indicated RN #6 informed the nursing supervisor (RN#7) Resident #19 was picking up the phone to call 911 to report s/ he was assaulted by RN #6. The statement further indicated RN#7 obtained a statement from Resident #19 and completed a RN assessment, notified the Director of Nursing Services (DNS), security, and the covering physician. RN #7 further indicated Resident #19 requested waiting until after 10 :00 AM to notify a family member about the incident. RN #7 indicated in the written staff statements that was obtained RN #6 was moved to another unit to work for the rest of the night shift. RN #7 also indicated the DNS was informed of this move. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 10/9/2022 at 5:06 AM indicated RN #7 went to speak with Resident #19 regarding a complaint the nurse (RN # 6) had grabbed Resident # 19's right arm trying to prevent the resident from going to the bathroom. The note further indicated the DNS, security and the on call Medical Doctor (MD) were notified and the security officer notified the state police. The nurse's note also indicated there were no new physician orders at that time. The Reportable Event report indicated that the event occurred on 10/9/2023 at 3:30 AM, the physician was notified at 5:00 AM and the summary report was submitted to the state facility on 10/9/2023 at 1:02 PM (10 1/2 hours after the incident.). Attempts to interview RN #6 and RN #7 via telephone on 2/16/2023 between 11:07 AM and 12:12 PM were unsuccessful. On 2/16/2023 at 10:20 AM an interview with the ADNS indicated her investigation concluded that the resident indicated to her the Nurse (RN # 6) did not put hands on her/his person as s/he initially claimed so the claim of abuse was unsubstantiated. An Interview with the DNS on 2/16/2023 At 12:00 PM indicated that she would have expected that the alleged perpetrator (RN #6) would have been taken off the schedule during the investigation and not allowed to remain at work. An interview on 2/16/2023 at 1:00PM with the Assistant Director of Nursing Services (ADNS) (acting DNS at the time of the incident) indicated she needed to look at the schedule to determine where RN #6 (the accused) was assigned to finish the shift in the building after the incident occurred. Upon request, the ADNS provided a time punch for 10/9/2022 for RN #6 which indicated RN #6 was on duty from 10:45 PM 10/8/2022 and punched out on 10/9/2022 at 7:15 AM(approximately 4 hours) after the incident occurred and 2.5 hours after RN #7 wrote the nurse's note and written statement. The DNS was informed of the incident and that RN #7 was moved to another unit in the building for the rest of the shift). Although a request was made for the exact location where RN #6 was assigned to for the remainder of the shift after the incident, it was not provided. The ADNS and staff development RN were able to provide evidence of annual abuse training completed in 2022 and 2023 by all staff members including those working on the unit with Resident #19 on 2/9/2023. The facility The Health Care Center Abuse Policy and Procedure dated 7/26/19 with a 2/9/2023 version 10.0 notes the facility developed policy and procedures to prohibit and prevent abuse, neglect, exploitation of resident's and misappropriation of resident's property. The facility has written procedures that ensure all patients are protected from physical and psychosocial harm during and after the investigation. This procedure includes responding immediately to protect the alleged victim and integrity of the investigation and the alleged perpetrator (if staff) will be removed from the premises during the investigation. Additionally, the policy noted training would be provided to all staff upon hire and then annually for abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, review of facility documentation and interviews for 1 resident for (Resident # 19) reviewed for abuse, the facility failed to report a suspicion of abuse to the state agency without two hours. The findings include: Resident # 19's diagnoses included Parkinson's disease, osteoarthritis, gout, and Peripheral Vascular Disease (PVD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired and required two persons assistance with personal hygiene. A Reportable Event report dated 10/9/22 indicated an allegation of staff to resident abuse occurred on 10/9/2022 at 3:30 AM. The report further indicated Resident #19 reported the nurse (RN#6) grabbed Resident #19's right arm while the resident was ambulating to the bathroom independently without any assistive devices. A written statement dated and timed 10/9/2022 at approximately 3:10 AM identified the alleged perpetrator (RN #6) identified Resident #19 was walking to the bathroom without assistance, without a walker and was unsafe at the time of the incident. RN #6 further indicated in his statement he did not grab Resident #19 but instead their hands touched when placing the walker in Resident #19 ' s path. A written statement by RN #7 dated and timed 10/9/2022 at 5:00 AM indicated RN #6 informed the nursing supervisor (RN#7) Resident #19 was picking up the phone to call 911 to report s/ he was assaulted by RN #6. The statement further indicated RN#7 obtained a statement from Resident #19 and completed a RN assessment, notified the Director of Nursing Services (DNS), security, and the covering physician. RN #7 further indicated Resident #19 requested waiting until after 10 :00 AM to notify a family member about the incident. RN #7 indicated in the written staff statements that was obtained RN #6 was moved to another unit to work for the rest of the night shift. RN #7 also indicated the DNS was informed of this move. The Reportable Event report indicated that the event occurred on 10/9/2023 at 3:30 AM, the physician was notified at 5:00 AM and the summary report was submitted to the state facility on 10/9/2023 at 1:02 PM (10 1/2 hours after the incident.). Interview with the DNS on 2/15/2023 at 3:00 PM indicted that she was not working at the time of the incident and indicated the ADNS was charge at that time. She further indicated the ADNS was the acting DNS who was not present in the building at the time of the incident. On 2/16/2023 at 10:20 AM an interview with the ADNS identified she was able to provide documentation the state agency was notified at 9:17AM (approximately 5 3/4 hours after the incident). The ADNS indicated the delay in reporting was due to the nursing supervisor on duty was unable to access the state agency site and she the (ADNS) was unable to access the site from home therefore she came into the facility to complete the reporting. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and facility document review with the DNS on 2/16/2023 At 12:00 PM verified that the state agency was notified of the incident on 10/9/2022 at 9:17 AM approximately 5 3/4 hours after the incident. The DNS also indicated that she would have expected reporting to the state agency within 2 hours of the incident.

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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** 46046 Based on clinical record review, facility policy review, and interviews for 1 of 3 residents (Resident # 19), reviewed for pressure ulcers, the facility failed to ensure the Resident Care Plan (RCP) and Nurse Aide (NA) assignment card were updated regarding recommended shoe use and the resident's refusal to wear an orthopedic shoe. The findings include: Resident #19's diagnoses included Parkinson's Disease, osteoarthritis, gout, peripheral vascular disease, and hammertoes (per podiatry). A podiatry consultation dated 6/30/2022 directed an order for orthopedic shoes for Resident #19 secondary to peripheral neuropathy and hammer toes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was moderately cognitively impaired and required two persons assistance with personal hygiene. A podiatry consultation dated 8/23/2022 indicated Rigid Hammer toes and no open areas. A podiatry consultation dated 10/27/2022 indicated Resident #19 complained of pain to the 3rd and 5th toes of the left foot, noted contracted and rigid digits and hammer toes. A podiatry consultation dated 11/8/2022 indicated Resident #19 showed the podiatrist new shoes that were missing the inserts. The podiatrist was unclear if the shoes ever came with the insert. The podiatry consultation dated 11/8/2022 further indicated Resident #19 required inserts for the shoes to accommodate his/her hammer toe deformities and indicated the podiatrist would investigate into the matter. A podiatry note dated 11/29/2022 indicated the inserts were noted in the shoe box, the podiatrist placed the inserts into the resident's shoes and gave instructions to Resident #19 to start wearing the shoes when walking and weight bearing. A podiatry note dated 12/13/2022 indicated rigid overlapping hammer toes and Resident #19 had not been wearing the orthopedic shoes. The podiatry note further instructed resident to wear the shoes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 had no cognitive impairment and required limited assistance of one person for dressing. A podiatry note dated 1/31/2023 indicated a visit for consultation was due to painful right toes and recommended separate bandage to each of the toes and to separate the toes with lamb's wool. A nurse's note dated 1/28/2023 at 6:52 AM indicated Resident # 19 had surrounding redness at the blister area on the right toe potentially from an ingrown toenail, treatments were ordered and provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's orders dated 1/31/2023 directed to apply SM antibiotic ointment 500 units/gram to the right great toe open blister area twice daily. A physician's order dated 2/10/2023 directed to apply lambs' wool every shift between toes on the right foot. A nurse's note dated 2/10/2023 at 3:14 PM identified Resident #19 had a stage 2 pressure ulcer to the right inner great toe measuring 2.0 Centimeter (CM) x 0.5 CM x 0.1 CM in size and treatment was rendered as ordered. The nurse's note also indicated Resident # 19 tolerated the treatment well. The Resident Care Plan (RCP) updated 2/10/2023 indicated Resident #19 had a potential for skin breakdown with a noted blister to top of the right toe on 1/27/2023 that opened on 1/30/23. Interventions included: skin assessment facility per protocol, a pressure relieving mattress on the bed to relieve pressure from heels. The RCP further indicated on 2/10/2023 Resident #19 had a stage 2 pressure ulcer with intact blister to the right great toe with rigid hammer toe and rigid overlapping. The interventions included weekly skin assessment and to monitor for signs of infection. Interview on 2/16/23 at 9:00 AM with Resident # 19 indicated s/ he had received specialty shoes in the past that did not fit, and s/he recently received some sneakers that s/he still has to try on. Resident #19 was noted to be wearing nonskid socks on both feet and indicated that they are comfortable as s/ he has sores on her/ his toes. An interview and record review on 2/16/23 at 9:50 AM with RN #3 indicated she was unable to find a care plan or notation on the care card indicating a need for special shoes, foot concerns or evidence of resident refusal to wear shoes. RN #3 indicated that she had reported the resident's refusal to the supervisor in the past but did not recall when at the time of the interview. On 2/16/2023 10:15 AM review of Resident#19's clinical record with RN #2 identified she noted Resident #19 had a blister that was found 1/28/2023 and nurse's note at 6:52 AM indicated that there was surrounding redness at the blister area on the toe potentially from an ingrown toenail, treatments were ordered and provided, and weekly documentation was completed. RN#3 further indicated she saw the podiatrist on 2/10/2023 who had recommended lamb's wool for in between the toes and staged the blister as a stage 2 and started a care plan. RN #3 further indicated information regarding the resident's shoes should have been in the care plan as indicated by the podiatrist in February 2023. 0n 2/16/23 at 12:20 PM RN #3 indicated that the MDS nurse had presently updated the care plan regarding the resident shoe use. Review of the facility A Person-Centered Care Plan Policy and Procedure given to the surveyor dated 2/16/2023 notes every patient in the facility will have a patient-centered comprehensive and interim care plan developed by the interdisciplinary team, treating the resident. The policy further indicated that incidents/changes or updates would be started on a paper care plan and brought to morning report for an interim care plan meeting to assess the appropriate interventions and approaches and indicated this process will continue for any change in patient status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 19953 Based on observation, staff interview, review of the clinical record and facility policy for 1 of 8 sampled residents (Resident #45) observed smoking, the facility failed to ensure Resident #45 was adequately supervised and provided smoking receptacles during the smoking session. The findings include: Resident #45's diagnoses included chronic kidney disease, post traumatic stress disorder and nicotine dependence. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 had intact cognition and was independent with set up for bed mobility, transfers and eating. The MDS further identified Resident #45 required extensive assistance of one for dressing and personal hygiene. A physician order dated 1/3/23 directed Resident #45 was not to have smoking materials with patient. A Smoking Safety Assessment Tool dated 1/27/23 identified Resident #45 was a smoker that could hold a cigarette easily and had no evidence of burn marks/holes on clothing or skin. The Smoking Safety Assessment Tool further identified Resident #45 was noted to properly extinguish cigarette butts. A Resident Care Plan dated 2/13/23 identified Resident #45 was to comply with smoking policy with interventions to not have Resident #45 have ignition sources in his/her possession, Resident #45 would relinquish any ignition source in his/her possession upon request, Resident #45 will smoke only in designated areas at designated times and complete a smoking assessment as per facility policy. On 2/14/23 at 1:00 PM, observation of the facility smoking group identified 8 residents seated under a gazebo located in a patio area, outside the Foxtrot Unit. Nurse Aide (NA) #1 was assigned to supervise the smokers, and was observed to provide cigarettes to the residents. The gazebo's sides consisted of an opaque, vinyl type material which didn't allow for visualization through the vinyl. Resident #45 was observed to be self mobile in an electric wheelchair, enter the patio area at 1:07 PM, NA #1 provided and then lit a cigarette for Resident #45. Resident #45 was then observed to wheel him/herself around the outside back of the gazebo, and place him/herself with his/her back towards the gazebo (approximately 8 feet from the back of the gazebo) and in front of the black metal fence (which was out sight from NA #1 who was the only staff present supervising the smoking session). Additionally, there was not an ashtray within the vicinity of Resident #45 and he/she was observed to flick ashes from the cigarette into the air. At 1:15 PM, Resident #45 was then observed to be self mobile and move him/herself around the outer aspect of the gazebo to the opening of the gazebo, receive another cigarette from NA #1 who then lit the cigarette. Resident #45 was observed to re-locate him/herself back around the outside of the gazebo, and place him/herself with his/her back towards the gazebo (approximately 8 feet from the back of the gazebo). Resident #45 continued to flick the cigarette ashes into the air. After he/she finished smoking, 2 cigarette butts were noted on the cement area where Resident #45 had been seated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation of Resident #45 with Registered Nurse #1 on 2/14/23 identified that where Resident #45 was positioned, NA #1 could not visualize him/her because of the opaqueness of the plastic sides of the gazebo. Interview with NA #1 on 2/14/23 at 1:30 PM identified she was the only staff member supervising smoking and that she did not visualize Resident #45 at all while the resident was smoking. Additionally, NA #1 identified that Resident #45 likes to sit in that location but she could not visualize him/her because of the inability to see through the gazebo due to the opaqueness of the sides. Facility policy regarding Smoking identified Healthcare Center staff will supervise smoking to ensure the safety of all Veteran Patients. Interview and review of the smoking policy with the DNS on 2/15/23 at 8:50 AM identified that supervision of smoking means having the resident in eyesight, and further identified Resident #45 was not in NA #1's view and not being supervised based on where Resident #45 was positioned.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 47490 Based on staff interview and record review for 2 of 4 Nurse Aides (NA #2 and NA #3) reviewed for employment eligibility, the facility failed to verify the Nurse Aide Registry prior to date of hire. The findings include: 1. NA #2's official start date was 9/23/22 and the Connecticut State Nurse Aide Registry Verification Report was dated 10/19/22, 26 days after NA #2's date of hire. NA #2's employee schedule and timecard identified that she worked for 17 orientation days from 9/23/22 to 10/19/22 which included working on resident units. 2. NA #3's official start date was on 9/23/22 and the Connecticut State Nurse Aide Registry Verification Report was dated 10/19/22, 26 days after NA #3's date of hire. NA #3's employee schedule and timecard identified that she worked for 17 orientation days from 9/23/22 to 10/19/22 which included working on resident units. Interview with RN #5 who was responsible for staff education on 2/15/23 at 2:36 PM identified that she was responsible to complete the NA verification checks and that it should be completed at least 2 days prior to hire. She further identified that she pulled the record from the Nurse Aide Registry for NA #2 and NA #3 but that it should have been done prior to their hire date. Interview with Human Resources (HR) #1 on 2/15/23 at 3:00 PM identified that NA's are verified by facility staff under the state registry prior to hire because it's a requirement. Interview with the DNS on 2/16/23 at 10:28 AM identified that RN #5 and HR #1 were responsible for Nurse Aide verification through the State Nurse Aide Verification Registry. She further identified that it should be done prior to the date of hire. Facility policy regarding Abuse identified that it was the policy of the facility to screen potential employees by checking with the appropriate licensing boards and registries, which included verification of NA certification.