STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. BUILDING _____ B. WING _____	**10/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW LONDON SUB-ACUTE AND NURSING	**88 CLARK LANE WATERFORD, CT 06385**

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 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documents, observations, and interviews for one of three sampled residents (Resident #4) reviewed quality of nursing care, the facility failed to report a Class A incident that resulted in an immediate danger of death or serious harm, and the facility failed to ensure job performance evaluations were completed in accordance with facility policies and state agency regulations. The Finding include: 1. Review of the clinical record on 9/21/20 identified Resident (R#4) admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The record identified a psych evaluation and behavioral health treatment plan dated 3/20/20 indicated a history of depression with added [DIAGNOSES REDACTED]. Physician order [REDACTED]. Subsequent behavioral health progress note dated 6/13/20 identified the chief complaint for the visit was increased periods of agitation, perseveration, anxiety, and trouble with sleep. Physician order [REDACTED]. The quarterly MDS assessment dated [DATE] identified a cognitive deficit with memory problems, inattention signs/symptoms of [MEDICAL CONDITION], and verbal behavioral symptoms directed toward others. The assessment identified R#4 required extensive assistance with activities of daily living, a wheelchair was used for mobility with assistance, and R#4 received antidepressant medications daily. The Resident Care Plan (RCP) dated 8/12/20 for an alteration in psychosocial well-being related to restriction on visitation due to COVID-19 identified interventions to monitor for psychosocial changes and to notify the physician if any change in mood, behavior and/or social status was observed. On 8/31/20 the RCP was updated to include alteration in behavioral symptoms risk of suicide related to observed suicide attempt. Review nursing progress note dated 8/31/20 at 10:00AM identified LPN #1 passed by R#4's room on 8/31/20 at 9:30AM and noted the Resident looked distressed and upon entering the room LPN #1 noted R#4 had a towel wrapped around his/her neck. The note further identified R #4 verbalized I want to kill myself; I'm done living like this, was immediately placed on a 1:1 staff observation for resident safety and was sent emergently to an acute care hospital for psych evaluation. Further review of the record identified R#4 was subsequently admitted for inpatient psych services without readmission to the facility. Review of the facility's reported event documentation dated 8/31/20 identified MD #1 and R#4's responsible party were notified, and an investigation report was initiated. Interview and review of the facility's accident or incident logs dated 77/20 through 915/20 with the Director of Nursing (DON) on 9/21/20 at 2:35PM failed to reflect the incident with R#4 on 8/31/20 was listed on the log. The DON indicated she was on vacation at the time of the incident on 8/31/20 and the responsibility of event recording and/or reporting was delegated to RN #1. Interview with RN #1 on 9/21/20 at 2:40PM identified the incident was discussed with the administration team on 8/31/20 with the determination that no injury occurred, it was classified as an event that resulted in minor injury, distress, or discomfort and therefore was not required as reportable. The DON further identified failure to include the written report on the accident or incident log was an oversight. Further review of the state department reportable event classification and description identified a suicide attempt as a Class A event that presented an immediate danger of death or serious harm that required immediate notification to the department by telephone with the written investigation report faxed or mailed to the department within seventy-two (2) hours. The facility failed to recognize a suicide attempt as a danger to life and failed to report a Class A event in compliance with state regulations. 2. Review of employee files and interview the Director of Human Resources (HR) in the presence of the Administrator on 9/23/20 at 2:20PM identified six of ten sampled employee files (DON, Dietary Manager, SS#1, NA #1, NA #2, and LPN #2) reviewed for annual job performance evaluations, the facility failed to provide the employees with a 2019 evaluation and for three employees (DON, Dietary Manager, and SS #1) a 2020 evaluation. Review of the files identified the DON's date of hire was 10/23/13 with the most recent annual job performance evaluation dated 6/7/18. The Dietary Manager's date of hire was 10/30/15 with most recent annual evaluation dated 10/12/18. SS #1's date of hire was 5/18/18. The file documented SS #1 received two new hire evaluations dated 6/20/18 and 7/9/18. Review of NA #1's file identified a date of hire on 1/2/2006. A job performance evaluation dated 2/20/20 reflected a current appraisal without the benefit of a 2019 evaluation. NA #2's date of hire was 8/22/18 and the file included a probationary evaluation dated 11/26/18 and a current evaluation dated 7/30/20 without the benefit of a 2019 appraisal. LPN #2's date of hire was 4/15/16 with annual evaluations dated 4/4/18 and 3/24/20 without a 2019 appraisal. The director of Human resources indicated employee wage increases were based on the annual performance evaluations. She identified it was her responsibility to prepare the forms and provide the forms to the facility department heads for completion with the staff that they supervise. She indicated that the corporate office determined no wage increases were projected during the [AGE] year and she understood that to mean the annual performance evaluations were not required and therefore she did not prepare the forms or provide the forms to the department heads for staff 2019 annual evaluations. The administrator identified he was responsible for the DON, Dietary Manager and SS#1 annual evaluations. He further indicated the 2020 forms were received by HR but have not been completed. Subsequent to Surveyor inquiry additional information was received on 10/13/20 that identified The DON and SS#1 were provided a performance evaluation dated 5/14/20.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on review of facility documents, observations and interviews for two of two nursing units reviewed for environmental safety, the facility failed to ensure the resident environment remained free of accident hazards. The findings include: 1. During tour of the facility on 9/23/20 at 2:50 PM in the presence of the Administrator identified hazards related to facility renovations were stored in an unsecure manner. The facility's locked memory care unit dining room was observed as being used as a storeroom for renovation construction supplies such as nails and screws placed in an open cardboard boxes, curtain rods with ropes, a large pile of sand in bags, and furniture. The dining room had three entrances into the room from the nursing unit. One of the entrances was blocked by stored furnishings that prevented the door from opening more than a few inches. Inside the dining room a door that accessed the room's kitchenette was observed without the benefit of a doorknob handle and in an ajar opened position. The third entrance from the nursing unit was identified without the benefit of a lock on the door and was observed as a pathway to a courtyard exit. The courtyard was further identified as the facility's location for memory care unit resident outdoor visitations. Review of the schedule for outdoor visits dated 9/21/20 through 9/23/20 identified ten residents from the memory care unit participated in visits that required traveling

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. BUILDING _____ B. WING _____	**10/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW LONDON SUB-ACUTE AND NURSING	**88 CLARK LANE WATERFORD, CT 06385**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) through the stored hazards in the dining room to gain access the outdoor courtyard. The Administrator identified the unit's dining room had become the construction storeroom about two weeks prior and subsequent to Surveyor inquiry ensured the doors to the dining room were secured with locks. 2. During tour of the facility's East nursing unit on 9/23/20 at 3:00PM the room identified as the beauty shop was being used by facility staff without the benefit of the door to the room maintained in a secure manner. Personal items identified as belonging to staff were stored in various locations around the room and lying on the countertop just inside the open door a sharp cutting knife was left on the countertop unattended. Interview with RN #1 identified the beauty shop was not a staff breakroom, staff were asked to collect their belongings, the door was closed, and secured in a locked manner. Review of the work environment policy identified the objective was to provide a safe and healthful work environment. To provide a safe environment accident prevention effort succeeds only with each employee's full cooperation to follow established safety rules and reporting unsafe conditions.