STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075106	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MIDDLESEX HEALTH CARE CENTER	**100 RANDOLPH RD MIDDLETOWN, CT 06457**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy and staff interviews for one sampled resident (Resident #1) reviewed for abuse, the facility failed to ensure a staff member reported an allegation of sexual abuse in a timely manner. The findings include: Resident #1's [DIAGNOSES REDACTED]. The Care Plan dated 8/28/20 identified Resident #1 was transferred from another long-term care facility, had history of agitation and restlessness and may have difficulty adjusting. Interventions directed to encourage expression of feelings, provide safe, nonthreatening environment, accept feelings as normal and to provide supportive counseling as needed. The care plan further identified alteration in thought process with interventions that included psychiatric consult regarding medication use, observe for signs and symptoms of disease, monitor for changes in mental status and administer medications as ordered. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 with severe impaired cognition, required extensive assistance with bed mobility, transfer, dressing and toilet use. A Reportable Event dated 9/1/20 identified an allegation that Resident #1 was raped by staff member (NA #1). Additionally, the Reportable Event identified that the resident verbalized the allegation to another staff member (DR #1). The resident was sent to the hospital for evaluation and returned to the facility on [DATE]. Interview with DR #1 on 9/4/20 at 11:00 AM identified that on 9/1/20 shortly before 9:00 AM, Resident #1 was sitting in the hallway by the nurse's station with breakfast on a tray table. NA #1 was giving the resident orange juice. DR #1 commented on how nice it was for NA #1 to give her/him the juice, and the resident responded No he's/she's not. He/she raped me. Additionally, DR #1 stated she/he went to the morning meeting, got distracted and reported the allegation of sexual abuse to the DNS at about 10:00 AM, (approximately an hour later). Interview with NA #1 on 9/4/20 at 11:15 AM identified while Resident #1 was sitting in the hallway, he/she assisted the resident with breakfast. The resident was talking with DR #1 and he/she walked away to feed a resident and assisted other residents in their rooms. Additionally, NA #1 identified that at 9:00 AM he/she went outside to supervise residents smoking and after returning around 10:00 AM, he/she was called to the DNS office and was sent home shortly before 10:30 AM. Interview with the DNS on 9/4/20 at 12:30 PM identified the allegation of sexual abuse was not reported to him/her until 10:00 AM on 9/1/20, over an hour after Resident #1 stated that she/he was raped. The DNS identified although after investigation, the alleged abuse was not substantiated, he/she would have expected DR #1 to report the incident to administration immediately when it was reported to her/him and this was not done. The DNS further identified the facility policy was to protect all residents and if the allegation of sexual abuse was reported to him/her timely, NA #1 would have been suspended immediately pending investigation. The DNS indicated that DR #1 received on the job training related to importance of timely reporting of any allegation of abuse. Review of a facility policy on Abuse Prohibition identified any incidents of actual or suspected abuse must have an incident report completed. In addition to the incident report, the supervisory personnel are responsible to ensure that the initial investigation regarding the incident occurs timely and appropriate interventions are put into place to ensure resident safety or protect the resident from additional harm. The Administrator and DNS or their designee should be notified as soon as possible.
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** Based on clinical record review, review of facility documentation and staff interviews for one sampled resident (Resident #1) receiving antipsychotic medications, the facility failed to administer medications as ordered by the physician. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the discharge MDS dated [DATE] completed prior to admission to facility by the discharging facility, identified Resident #1 with moderately impaired cognition and no behavioral symptoms were exhibited. The admission physician's orders [REDACTED]. Review of Resident #1's History and Physical dated 8/25/20 identified that resident's Medication List included Pimavanserin 34 mg. Review of Circulatory Condition Nurses Note dated 8/27/20 identified Resident #1 did not have Nuplazid from pharmacy yet, so RN #1 called to inquire. Per pharmacy, this medication needed a prior authorization which pharmacy faxed the request directly to the resident's physician. RN #1 placed a note for Psychiatry Specialist MD #2. Review of Behavioral Health Visit Request/Follow up entry dated 8/27/20 identified Resident #1's Nuplazid needed prior authorization and pharmacy stated it was faxed to MD. Further review identified that the request for follow up lacked clinician initials to identify that the note was reviewed. The Care Plan dated 8/28/20 identified Resident #1 was transferred from another long-term care facility, had history of agitation and restlessness and may have difficulty adjusting. Interventions directed to encourage expression of feelings, provide safe, nonthreatening environment, accept feelings as normal and to provide supportive counseling as needed. The care plan further identified alteration in thought process with interventions that included psychiatric consult regarding medication use, observe for signs and symptoms of disease, monitor for changes in mental status and administer medications as ordered. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 with severe impaired cognition, required extensive assistance with bed mobility, transfer, dressing and toilet use, and the resident exhibited behavioral symptoms. Review of a 2nd request in Behavioral Health Visit Request/Follow up dated 9/2/20 identified Resident #1 had an order for [REDACTED]. Further review identified that the request for follow up lacked clinician initials to identify that the note was reviewed. A Report on Medication Incidents dated 9/2/20 identified Resident #1 did not receive Nuplazid medication as ordered. Further review of the report identified the medication was not available and was omitted for 8 days (from 8/26 to 9/2/20). The report further identified that the resident had change in behavior as evidence by increased delusions and hallucinations. The report identified that error could have been avoided by nurses following up with pharmacy when medication still had not arrived. Review of MAR indicated [REDACTED]. Review of the clinical record from 8/25/20 through 9/2/20 failed to reflect that Resident #1's physician had been informed of the psychiatric medication not being available. Review of APRN #2's Psychiatric Note dated 9/2/20 identified the resident had made sexual allegations against staff who she/he stated touched her/his breasts inappropriately in the elevator as she/he was getting ready to go to church. Resident also was hallucinating today, stated that decorative star in the hallway was the devil and was not able to be convinced otherwise, stated to you it may be a star, to me it's the devil. Resident #1 then stated the incident happened yesterday in the elevator as she/he was going to choir practice. The resident then called APRN #2 over in the hallway to state that she/he forgot to mention that there were other people involved. The note further identified that the resident appeared somehow paranoid and APRN #1 recommended trial of Trazadone for anxiety and restlessness. During interview with LPN #1 on 9/23/20 at 10:00 AM, LPN #1 was unable to explain why she/he signed that she/he administered the antipsychotic medication when the medication was not available at the facility. Interview with DNS on 9/23/20 at 10:20 AM identified the resident was admitted from another facility without medications being transferred

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and the antipsychotic medication was not available until 9/3/20, therefore the resident did not receive the Nuplazid for 8 days. The DNS further identified the nurse who was administering medications was responsible for notifying the nursing supervisor, pharmacy, and the physician when the medication was not available. Interview with Pharmacist #1 on 9/23/20 at 10:40 AM identified that the pharmacy communicated to the facility that in order to dispense Nuplazid, prior authorization was needed. The Pharmacist #1 further identified that sometimes if a resident was receiving medication and was transferred to another facility, it takes time for the information to be registered and expected the facility to notify the pharmacy if the medication was not available. On 9/2/20 at 11:59 AM, LPN #1 called the pharmacy for Nuplazid and the medication was delivered to the facility on [DATE] at 5:30 PM. The Pharmacist #1 identified that for resident with [MEDICAL CONDITION], omission of the medication for about a week may cause increased [MEDICAL CONDITION]. Interview with APRN #2 on 9/23/20 at 11:00 AM identified she/he was unaware that Nuplazid was omitted for 8 days. Omission of this medication for about a week may cause increase [MEDICAL CONDITION] and maybe that is why the resident was making the sexual accusations. Interview with Psychiatry Specialist MD #2 on 9/23/20 at 2:20 PM identified the resident had [MEDICAL CONDITION] and delusions and he/she was unaware that Nuplazid was omitted for 8 days. The Psychiatry Specialist MD #2 further identified it was possible that omission of this medication caused the resident to have increased [MEDICAL CONDITION]. If notified MD #2 stated, he/she would call the pharmacy. Further interview with MD #2 identified he/she always initials Behavioral Health Visit Request/Follow up notes when actually reviewed. Interview with MD #1 on 9/24/20 at 2:00 PM identified he/she was not notified that Nuplazid was not available and did not receive any notification from the pharmacy. MD #1 identified that he/she expected to be notified. If notified he/she would have called the pharmacy immediately himself/herself and if unable to obtain the medication he/she would evaluate a different approach immediately. MD #1 further identified that the failure to administer the medication for about a week might have caused the resident's increase [MEDICAL CONDITION]. Review of Pharmacy Policy and Procedure Manual related Medication Administration and Documentation directed staff to immediately notify nursing supervisor if medication is unavailable for administration.