STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075135	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MASONICARE HEALTH CENTER	22 MASONIC AVE PO BOX 70 WALLINGFORD, CT 06492

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility documentation, review of facility policy, and interviews for 1 of 2 sampled residents (Resident #4) reviewed for an allegation of mistreatment, the facility failed to ensure care was provided in a dignified manner. The findings include: Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #4 had intact cognition, required limited assist of 1 staff member for bed mobility, transfers, ambulation in room, dressing, toilet use, and personal hygiene. Further review of the MDS identified that Resident #4 was frequently incontinent of bladder and had an ostomy for bowel function. The care plan dated 8/18/20 identified Resident #4 had self-care performance deficits related to activity intolerance and weakness with interventions that included; provide incontinent care and care related to the leaking of the ostomy, this information was also identified on the nurse aide care card. The resident's care plan did not identify that the resident had behaviors inclusive of making false accusations against staff. A nurse's note dated 8/27/20 at 3:57 PM written by LPN #3 identified that Resident #4 reported concerns with care. LPN #3 identified that the concerns were immediately reported to the nursing supervisor. Resident #4 denied any pain, discomfort, or distress. A Social Services note dated 8/27/20 at 12:34 PM written by Social Worker #3 identified that Resident #4 made an allegation of mistreatment against NA #3. Resident #4 informed Social Worker #3 that she felt bullied and intimidated by NA #3. Resident #4 reported that she'd had a wet brief since early in the morning but would not report it or ask to be changed because she/he did not want NA #3 to provide care to her/him. Resident #4 reported that when there is an issue with the ostomy bag (it breaks, leaks or needs to be changed) she/he feels that she/he is always blamed and made to feel like it is her/his vault. There were no further social work notes after 8/27/20 concerning Resident #4's concerns. An interview with Social Worker (SW)#3 on 9/28/20 at 11:45 AM identified that Resident #4 indicated that NA #3 comes into the room and blames her/him for making a mess by ripping off the ostomy bag or making it fall off. Resident #4 indicated she/he would not ring the call bell for assistance sometimes because of the way this nursing assistant treats her by being rude and rough. Social Worker #3 further identified that Resident #4 indicated she/he would rather be wet all night than ask for help because of the way this nursing assistant treats her verbally and physically. Resident #4 indicated it was easier to wait until the day shift comes in to receive the care she/he needed than to ask NA #3 for help. Social Worker #3 further indicated it was her role to initially check on Resident #4 to make sure the resident felt safe and did not fear retaliation. Social worker #3 indicated she was not aware until last week when the DNS informed her that she was supposed to document on any allegation of mistreatment for 72 hours following the incident. She noted that she was informed that she was supposed to see the resident daily to make sure their psychosocial needs were met. Social Worker #3 indicated she did not provide any further visits to the resident following the initial visit on 8/27/20. An interview with LPN #5 on 9/28/20 at 1:10 PM identified that she interviewed Resident #4 who informed her that NA #3 was quick with her movements and rough. Resident #4 was learning to care for the ostomy and sometimes does make a mess and NA #3 gets frustrated at Resident #4 for making a mess. LPN #5 further noted that the resident conveyed that NA #3 did not understand that Resident #4 was trying to learn how to do it him/herself. Additionally, Resident #4 informed LPN #5 that NA #3 yanks and pulls at the sheets and cover roughly during the night. LPN #5 indicated that she and RN #2 called NA #3 on the phone and provided education concerning speaking slowly and giving the resident more time to complete tasks. An interview with RN #2 on 9/28/20 at 1:30 PM noted, she interviewed NA #3 regarding Resident #4, and NA #3 indicated that Resident #4 made a mess with the [MEDICAL CONDITION] due to the resident playing with it, so NA #3 told Resident #4 not to touch it. She further noted that when Resident #4 was interviewed, Resident #4 informed RN #2 that she/he gets frustrated because NA #3 is hard to understand with her thick accent and NA #3 speaks so fast. In addition, Resident #4 identified that NA #3 was rough because she tries to provide care too fast. An interview with Resident #4 on 9/28/20 at 2:45 PM identified that NA #3 told her/him that she had to check her own ostomy bag every two hours throughout the night and to tell NA #3 if she/he felt it needed to be changed. Resident #4 indicated NA #3 was argumentative and felt that NA #3 was being a bully. Resident #4 indicated NA #3 was fast and rough when assisting with the care of the ostomy bag. Resident #4 further noted that NA #3 was rough at night, and since that night she/he now waits, even if she/he is wet until the next shift because she/he does not want NA #1 in his/her room. Additionally, Resident #4 indicated she/he had heard NA #3 say to her/him and others if you don't understand me then I will not talk to you. An interview with NA #3 on 10/5/20 at 11:40 AM identified that on 8/27/20, Resident #4 had taken off his/her ostomy bag and wrapped it up with towels, so NA #3 told Resident #4 she would go tell the nurse. NA #3 denied speaking to the resident in an undignified manner and denied handling the resident in a rough manner. Review of the facility's Bill of Rights policy identified, residents have the right to be treated with consideration, respect, and full recognition of their dignity, individuality, and the right to receive quality care and services. Although requested, a facility policy for the Social Workers responsibilities for any allegation of mistreatment was not provided.
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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #3 and #4) reviewed for allegation of abuse, the facility failed to follow protocol Registered Nurse assessment after allegations of abuse per facility policy and failure to provide care in a safe manner. The findings include: 1. No RN assessment timely on either resident #3 or #4 after allegation of abuse F-684 2. C.n.a did care with assist of 1 not 2 for all residents on air matress Resident #3 F-684 A. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 10/23/2019 Resident #3 had Activities of daily living self-care performance deficit due to fatigue, depression, and overall complaints of general fatigue. Interventions included assist of one for bed mobility. Care Plan last revision was 10/23/19. The care plan dated 12/20/19 identified Resident #3 had potential for impaired skin integrity related to fragile skin and decreased mobility. Interventions included air mattress to bed. The care plan dated 12/20/19 identified Resident #3 had potential for impaired skin integrity. Interventions included to have an air mattress on the bed and incontinent care every 2 hours. A physician's orders [REDACTED]. The quarterly MDS dated [DATE] identified Resident # 3 had mild 12 cognitive impairment, was always incontinent bladder and frequently incontinent of bowel and required extensive assist of 2 for bed mobility, dressing, and personal hygiene. The social services note dated 8/27/20 at 11:28 AM identified that Social Worker #3 spoke with Resident #3 about the incident and Resident #3

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	(continued... from page 1) reported she/he was scared to death and she/he felt used. Resident #3 reported that this staff is always rough with her/him. Resident #3 stated she/he did not want anything more to do with that staff member and that she/he doesn't want that staff member coming back into her/his room. Resident #3 was very quiet and withdrawn towards end of conversation. No Further notes from the Social Worker until 9/11/20 15 days later. The nurse's note by LPN # 3 dated 8/27/20 at 3:55 PM identified that Resident #3 reported concerns with care, concerns immediately reported to the supervisor, daughter was updated. Resident #3 denies any pain, discomfort, or distress. Skin clear. The hospice note dated 8/27/20 at 4:15PM identified that Resident #3 was visibly tearful and anxious. Staff reports resident #3 made complaint of abuse against a nursing assistant overnight. When asked resident how her/his night was, Resident #3 stated repeatedly she didn't know and was becoming more and more upset. The care plan dated 8/27/20 identified Resident #3 reported an incident of suspected abuse. Interventions directed that the resident will report any suspected abuse to nursing, social services, and/or responsible parties. The nurse's note by LPN #4 dated 8/28/20 at 3:17 PM identified that Resident #3 had no current complaints regarding care or staff members throughout the shift. The hospice note dated 9/1/20 at 11:55 AM identified that supportive counseling provided to clients daughter regarding clients recent allegations of abuse. The quarterly MDS dated [DATE] identified Resident # 3 had moderate 9 cognitive impairment, was always incontinent bladder and frequently incontinent of bowel and required extensive assist of 2 for bed mobility, dressing, and personal hygiene. An interview with Social Worker #3 on 9/28/20 at 11:45 AM noted she received an email from LPN #5 that Resident #3 and #4 had an allegation of abuse and that a nursing assistant on night shift was rough and rude with them. Resident #3 indicated she/he was scared to death of this nursing assistant. Resident #3 informed her that NA #3 was always rough with him/her. Resident #3 indicated she/he never wanted this nursing assistant again. Social worker #3 indicated it was her role to initially check on Resident #3 and #4 to make sure the resident feels safe and do not have a fear of retaliation. Social worker #3 indicated she was not aware until last week when the DON informed her that she was supposed to document on any allegation of abuse for the following 72 hours seeing the resident daily to make sure their needs were met. Social Worker #3 indicated she did not see Resident #3 or #4 except for the day of the allegation for abuse on 8/27/20. An interview with LPN #5 on 9/28/20 at 1:00 PM noted she was the supervisor of the unit were Resident #3 and Resident #4 reside. Resident #3 informed her that something was dropped in her/his heads but did not know what it was. LPN # Tracy indicated there was no marks on Resident #3's face or body when she spoke with her/him. LPN #5 indicated she that morning informed RN # 2 and RN #1 but could not recall what time it was. LPN #5 indicated she started the Accident and incident report, notified the physician, and social services. LPN #5 indicated Resident #3 was an assist of 2 for bed mobility and care because she/he is on an air mattress and it is our policy for anyone on an air mattress to be an assist of 2. LPN #5 indicated that nursing staff are trained to know that including herself. An interview with Resident #3 on 9/28/20 at 2:30 PM noted she/he was to tired to talk. An interview with NA #1 on 10/5/20 at 11:40 AM noted that day Resident #3 was incontinent of urine and had a bowel movement, so I had to change him/her. NA #3 indicated she used her right hand to try to hold the resident over and with her left hand use the spray bottle of peri wash to clean Resident #3 but the bottle was almost empty so NA #3 had to try to take the top off and when NA#3 tried to place the empty peri wash bottle on the night stand she dropped it hitting Resident #1 in the face. NA #3 indicated she was trying to provide care to Resident #3 by herself but it was hard because resident had a bowel movement. NA #3 indicated she does not read the nursing assistant care cards she remembers what she was told by the other nursing assistance when they trained her on the unit. NA #3 indicated she was told Resident #3 was only 1 person for care in bed. NA #3 does not remember if she was educated/trained on air mattresses and having to use 2 staff members for turning and repositioning of residents. NA #1 indicated she had never used 2 staff for Resident #3. NA #3 indicated that RN #2 called her while she was suspended and told NA #1 that she should have reported dropping the bottle on a residents' face to the nurse. RN #2 informed NA #3 that there was an education form she needed to sign when NA #3 came into work and it would be in a mailbox, but it was not there. NA #3 indicated she still had not signed anything and was still waiting for RN #2 to go over it with her. Review of the Abuse allegation Report indicated LPN # 5 notified the Physician, Director of Nursing, Administrator on 8/27/20 at 9:00 AM. LPN # 5 notified Medical Director, Family, Social Worker and DPH at 10:00 AM. Summary of finding indicated Resident #3 reported NA #3 was rough with her/him and used a loud tone. Review of facility Abuse and/or Crimes committed against residents, prevention, reporting and investigation identified the facilities residents shall be treated with dignity, [MEDICATION NAME], and respect. Residents at facility have the right to be free from exploitation and from physical, sexual, verbal, and psychological abuse. Mental Abuse includes but is not limited to humiliation, harassment, threats of punishment, subject to a person to fear isolation or serios emotional distress. Investigation and Protection includes a nursing assessment conducted by a registered nurse. Review of Safe Resident Handling for air mattress safety was education provided to nursing staff indicates that all residents utilizing an air mattress require assist of two for bed mobility. This is to protect both the resident and the integrity of the air mattress. Air mattresses surfaces can be uneven due to the redistribution of air under the resident. Due to the material of the air mattress, there is a risk of sliding off the edge of the bed. Do not put your residents at risk Always remember to use assist of 2 for help when assisting a resident on an air mattress. Although attempted, an interview with Assistant Director of Nursing (at this time was the Interm Director of Nursing) was not obtained. B. Resident # 4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #4was cognition intact, needs limited assist of 1 staff member for bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene. Additionally, Resident #4 was frequently incontinent of bladder and had an ostomy for bowel movements and required assist of one with care. The care plan dated 8/18/20 identified an activities of daily living self-care performance deficits related to activity intolerance and weakness. Interventions directed to provide incontinent care and Resident #4 had leaking of ostomy. The nurse's note dated 8/27/20 at 3:57 PM by LPN #3 identified that Resident #4 reported concerns with care. LPN #3 indicated concerns were immediately reported to supervisor. Resident #4 denied any pain, discomfort, or distress. Next nursing note wasn't until 9/19/20. The Social Services note dated 8/27/20 at 12:34 PM by Social Worker #3 identified that Resident #4 made an abuse allegation against a staff member. Resident #4 informed Social Worker #3 that she felt bullied by this staff member and also intimidated. Resident #4 reported that she had a wet brief since early in the morning but would not report it or ask to be changed because she/he did not want this staff member to provide care to her/him. Resident #4 reported that when there is an issue with the ostomy bag (it breaks, leaks or needs to be changed) she/he feels that she/he is always blamedand made to feel like it is her/his vault. There were no further social work notes after this incident. Nursing Assistant Care Card identified that Resident #4 requires incontinent care and leaking of ostomy. Resident #4 needs moderate assistance for toilet use. An interview with Social Worker #3 on 9/28/20 at 11:45 AM noted Resident #4 indicated that the same nursing assistant comes into the room and blames her/him for making a mess by ripping off the ostomy bag or making it fall off. Resident #4 indicated she/he would not ring the call bell for assistance sometimes because of the way this nursing assistant treats her by being rude and rough. Resident #4 indicated she/he would rather be wet all night than ask for help because of the way this nursing assistant treats her. Resident #4 indicated it was easier to wait until the day shift comes in to get the care, she/he needed than to ask this nursing assistant for help. Additionally, Resident #4 indicated she/he overheard NA #1 state to Resident #3 if you don't want to talk to me then I will not talk to you. Social worker #3 indicated it was her role to initially check on Resident #3 and #4 to make sure the resident feels safe and do not have a fear of retaliation. Social worker #3 indicated she was not aware until last week when the DON informed her that she was supposed to document on any allegation of abuse for the following 72 hours seeing the resident daily to make sure the their needs were met. Social Worker #3 indicated she did not see Resident #3 or #4 except for the day of the allegation for abuse on 8/27/20. An interview with LPN #6 on 9/28/20 at 12:10 PM noted the morning of 8/27/20 neither Resident #3 or #4 directly informed her of any allegation of abuse but she heard at change of shift the hospice nursing assistant come to the nursing station and told the day nurse. Resident #3 and Resident #4 have not complained about NA #3 before this but other residents have complained about NA #3 before. LPN #6 indicated she did notify the unit manager at the time. LPN #6 indicated she was educated on the air mattress and any resident that was on an air mattress was always an assist of 2 for care in bed, because the way the residents weight shifts someone could roll off the air mattress. LPN #6 indicated NA #3 did not ask her for assistance in providing incontinent care for Resident #3 on the day of the incident or any other day. An interview with LPN #5 on 9/28/20 at 1:10 PM noted LPN #5 indicated she interviewed Resident #4 and Resident #4 informed her that NA #3 was quick with her movements and Resident #4 was learning to care for the ostomy and sometimes does make a mess and NA #3 gets frustrated at Resident #4. Additionally, Resident #4 informed me that NA #3 yanks and pulls at the sheets and cover during the night. LPN #5 indicated that she and RN #2 called NA #3 on the phone and did the education with the NA #3 so she could come off suspension and return to work. An interview

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) with RN #2 on 9/28/20 at 1:20 PM noted she was informed about the allegation of abuse about 9:30 AM on 8/27/20. RN #2 and RN #4 called NA #3 and NA #3 informed them that she was putting the peri wash bottle on the nightstand and dropped the bottle hitting Resident #3 in the face. RN #2 indicated she did not do a body audit after the allegation of abuse because she was told by LPN #5 that there was no mark on Resident #3's face. RN #2 indicated she did not know if Resident #3 was an assist of 1 or 2 for incontinent care on the air mattress. An interview with RN #2 on 9/28/20 at 1:30 PM noted she interviewed NA #3 regarding Resident #4 and NA #3 indicated that Resident #4 made a mess with the [MEDICAL CONDITION] and resident was playing with it, so NA #3 told Resident #4 not to touch it. Resident #4 informed RN #2 that she/he gets frustrated because NA #3 is hard to understand with her thick accent and NA #3 speaks so fast. Additionally, that NA #3 was rough because she tries to go to fast. An interview with Resident #4 on 9/28/20 at 2:45 PM noted NA #3 told her/him that she had to check her own ostomy bag every 2 hours throughout the night and tell NA #3 if she/he felt it needed to be changed. NA #3 was so argumentative and felt that NA #3 was being a bully. NA #3 was fast and rough when assisting with the care of the ostomy bag. NA #3 was rough on that night so since that night I now wait even if I am wet until the next shift because I do not want NA #1 in my room. Resident #4 indicated a staff member told her that NA #3 wanted to talk to her/him because NA #3 wanted to know why Resident #4 did this to her and Resident #4 informed the staff member that she did not want to talk to NA #3. Additionally, Resident #4 indicated she/he heard NA #3 say to Resident #3 that if you don't understand me then I will not talk to you and heard Resident #3 say stop pushing my head down An interview with RN#1on 9/28/20 at 3:00 PM noted she did not recall being told about the allegation of abuse from LPN #5 regarding Resident #3 and Resident #4 on the day it occurred. RN #1 indicated the first time she was aware of the incident was when the DNS asked her to follow up and complete any reportable events on the DPH website, but it was not the day that it was reported. RN #1 indicated she did not do body audits on either resident, but an RN should have. RN #1 indicated that it was the policy of the facility that an resident that was on an air mattress must be an assist of 2 for bed mobility and care while in bed. RN #1 indicated that because the air mattresses are slippery, and a resident can slide off easily. An interview with RN #1 on 9/28/20 at 4:00 PM noted she was unable to provide a policy for the air mattress but was able to provide the education materials used for the education and signatures of staff educated indicting that all residents on air mattress must be cared for by 2 staff members. RN #1 was not able to explain why the MDS indicated assist of 2 staff but the nursing assistant care card indicated assist of 1. An interview with DON on 9/28/20 at 4:10 PM noted that a registered nurse should have done a full body audit on any allegation of abuse when the allegation was made unless involved in an emergency and then do the body audits right after that. DON indicated she was not able to find the RN assessment in the medical records. The DON indicated since all reisdent that are on air matresses are supposed to have assist of 2 then the NA #3 should have used assist of 2 for residents safety. NA #1 was provided education on abuse prevention on 3/11/20 and Resident Right, abuse prevention and ethics on 5/31/20 Although attempted, an interview with Assistant Director of Nursing was not obtained. Review of facility Bill of Rights identified Residents have the right to be treated with consideration, respect, and full recognition of your dignity and individuality. Additionally, had the right to receive quality care and services.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #3 and #4) reviewed for allegation of abuse, the facility failed to provide the psychosocial support needed from Social Services. The findings include: 1. No follow up by social services after initial visit failed to meet resident psychosocial needs for Resident 3 and 4 - Remove Sandra A. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 9/18/19 identified Resident #3 was at risk for depression related to mild cognitive impairment and anxiety disorder. Interventions included provide opportunity to express feelings and frustrations. The care plan dated 10/23/2019 Resident #3 had Activities of daily living self-care performance deficit due to fatigue, depression, and overall complaints of general fatigue. Interventions included assist of one for bed mobility. Care Plan last revision was 10/23/19. A physician's orders [REDACTED]. The quarterly MDS dated [DATE] identified Resident # 3 had mild cognitive impairment and has depression and anxiety disorder. The social services note dated 8/27/20 at 11:28 AM identified that Social Worker #3 spoke with Resident #3 about the incident and Resident #3 reported she/he was scared to death and she/he felt used. Resident #3 reported that this staff is always rough with her/him. Resident #3 stated she/he did not want anything more to do with that staff member and that she/he doesn't want that staff member coming back into her/his room. Resident #3 was very quiet and withdrawn towards end of conversation. No Further notes from the Social Worker until 9/11/20 15 days later. The nurse's note by LPN # 3 dated 8/27/20 at 3:55 PM identified that Resident #3 reported concerns with care, concerns immediately reported to the supervisor, daughter was updated. Resident #3 denies any pain, discomfort, or distress. The hospice note dated 8/27/20 at 4:15PM identified that Resident #3 was visibly tearful and anxious. Staff reports resident #3 made complaint of abuse against a nursing assistant overnight. When asked resident how her/his night was, Resident #3 stated repeatedly she didn't know and was becoming more and more upset. The care plan dated 8/27/20 identified Resident #3 reported an incident of suspected abuse. Interventions directed that the resident will report any suspected abuse to nursing, social services, and/or responsible parties. The nurse's note by LPN #4 dated 8/28/20 at 3:17 PM identified that Resident #3 had no current complaints regarding care or staff members throughout the shift. The hospice note dated 9/1/20 at 11:55 AM identified that supportive counseling provided to clients daughter regarding clients recent allegations of abuse. An interview with Social Worker #3 on 9/28/20 at 11:45 AM noted she received an email from LPN #5 that Resident #3 and #4 had an allegation of abuse and that a nursing assistant on night shift was rough and rude with them. Social Worker #3 indicated that during interview with Resident #3 stated she/he was scared to death of NA #3. Resident #3 informed her that NA #3 was always rough with him/her. Resident #3 indicated she/he never wanted NA #3 again. Social worker #3 indicated it was her role to initially check on Resident #3 to make sure the resident feels safe and do not have a fear of retaliation. Social worker #3 indicated she was not aware until last week when the DON informed her that she was supposed to document on any allegation of abuse that day of and for the following 72 hours seeing the resident daily to make sure their needs were met. Social Worker #3 indicated she did not see Resident #3 except for the day of the allegation for abuse on 8/27/20 and did not follow up for the required 72 hours daily. An interview with LPN #6 on 9/28/20 at 12:10 PM noted the morning of 8/27/20 Resident #3 did not directly informed her of any allegation of abuse but she heard at change of shift the hospice nursing assistant came to the nursing station and told the day nurse. Resident #3 had not complained about NA #3 before this but other residents have complained about NA #3 before. LPN #6 indicated she did notify the unit manager at the time. LPN #6 indicated NA #3 did not ask her for assistance in providing incontinent care for Resident #3 on the day of the incident or any other day. An interview with LPN #5 on 9/28/20 at 1:00 PM noted she was the supervisor of the unit were Resident #3 resides. Resident #3 informed her that something was dropped in her/his heads but did not know what it was. LPN #5 indicated there was no marks on Resident #3's face or body when she spoke with her/him. LPN #5 indicated that morning she informed RN # 2 and RN #1 but could not recall what time it was. LPN #5 indicated she started the Accident and incident report, notified the physician, and social services. An interview with Resident #3 on 9/28/20 at 2:30 PM noted she/he was to tired and did not want to talk. An interview with NA #1 on 10/5/20 at 11:40 AM noted that day Resident #3 was incontinent of urine and had a bowel movement, so she had to change him/her. NA #3 indicated she used her right hand to try to hold the resident over and with her left hand use the spray bottle of peri wash to clean Resident #3 but the bottle was almost empty so NA #3 had to try to take the top off and when NA #3 tried to place the empty peri wash bottle on the night stand she dropped it hitting Resident #1 in the face. NA #3 indicated she was trying to provide care to Resident #3 by herself and it was hard to hold her over and clean resident's bowel movement. NA #3 indicated she does not read the nursing assistant care cards she remembers what she was told by the other nursing assistance when they trained her on the unit. NA #3 does not remember if she was educated/trained on air mattresses and having to use 2 staff members for turning and repositioning of residents. NA #3 indicated she had never used 2 staff for Resident #3. NA #3 indicated that RN #2 called her while she was suspended and told NA #3 that she should have reported dropping the bottle on a residents' face to the nurse. RN #2 informed NA #3 that there was an education form she needed to sign when NA #3 came into work and it would be in a mailbox, but it was not there. NA #3 indicated she still had not signed anything and was still waiting for RN #2 to go over it with her. Review of the Abuse allegation Report indicated LPN # 5 notified the Physician, Director of Nursing, Administrator on 8/27/20 at 9:00 AM. LPN # 5 notified Medical Director,

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F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Family, Social Worker and DPH at 10:00 AM. Summary of finding indicated Resident #3 reported NA #3 was rough with her/him and used a loud tone and NA #3 was educated the report incidents to the charge nurse. B. Resident # 4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified Resident #4 was cognition intact, needs limited assist of 1 staff member for bed mobility, transfers, walking in room, dressing, toilet use, and personal hygiene. Additionally, Resident #4 had depression and anxiety disorder. Resident #4 was given antidepressants 7 days a week. The care plan dated 8/27/20 identified Resident #4 reported an allegation of abuse. Interventions directed Resident #4 will report any suspected abuse to nursing, social services, and other responsible parties. The nurse's note dated 8/27/20 at 3:57 PM by LPN #3 identified that Resident #4 reported concerns with care. LPN #3 indicated concerns were immediately reported to supervisor. Resident #4 denied any pain, discomfort, or distress. Next nursing note wasn't until 9/19/20. The Social Services note dated 8/27/20 at 12:34 PM by Social Worker #3 identified that Resident #4 made an abuse allegation against a staff member. Resident #4 informed Social Worker #3 that she felt bullied by this staff member and intimidated. Resident #4 reported that she had a wet brief since early in the morning but would not report it or ask to be changed because she/he did not want NA #3 to provide care to her/him. Resident #4 reported that when there is an issue with the ostomy bag (it breaks, leaks or needs to be changed) she/he feels that she/he is always blamed and made to feel like it is her/his fault. There were no further social work notes after this incident. Social worker #3 indicated it was her role to initially check on Resident #4 to make sure the resident feels safe and does not have a fear of retaliation. Social worker #3 indicated she was not aware until last week when the DON informed her that she was supposed to document on any allegation of abuse that day and for the following 72 hours seeing the resident daily to make sure their needs were met. Social Worker #3 indicated she did not see Resident #4 except for the day of the allegation for abuse on 8/27/20 and did not follow up for the required 72 hours daily. An interview with Social Worker #3 on 9/28/20 at 11:45 AM noted she received an email from LPN #5 that Resident #4 had an allegation of abuse and that a nursing assistant on night shift was rough and rude. The Social Worker #3 interviewed Resident #4 indicated that NA #3 comes into the room and blames her/him for making a mess by ripping off the ostomy bag or making it fall off. Resident #4 indicated she/he would not ring the call bell for assistance sometimes because of the way NA #3 treats her by being rude and rough. Resident #4 indicated she/he would rather be wet all night than ask for help because of the way NA #3 treats her/him. The Social Worker #3 stated Resident #4 indicated it was easier to wait until the day shift comes in to get the care, she/he needed than to ask NA #3 for help. Additionally, Resident #4 indicated she/he overheard NA #1 state to Resident #3 if you don't want to talk to me then I will not talk to you. Social worker #3 indicated it was her role to initially check on Resident #4 to make sure the resident feels safe and does not have a fear of retaliation. Social worker #3 indicated she was not aware until last week when the DON informed her that she was supposed to document on any allegation of abuse for the following 72 hours seeing the resident daily to make sure the their needs were met. Social Worker #3 indicated she did not see Resident #4 except for the day of the allegation for abuse on 8/27/20. An interview with LPN #6 on 9/28/20 at 12:10 PM noted the morning of 8/27/20 neither Resident #3 or #4 directly informed her of any allegation of abuse but she heard at change of shift the hospice nursing assistant come to the nursing station and told the day nurse. Resident #3 and Resident #4 have not complained about NA #3 before this but other residents have complained about NA #3 before. LPN #6 indicated she did notify the unit manager at the time. LPN #6 indicated she was educated on the air mattress and any resident that was on an air mattress was always an assist of 2 for care in bed, because the way the residents weight shifts someone could roll off the air mattress. LPN #6 indicated NA #3 did not ask her for assistance in providing incontinent care for Resident #3 on the day of the incident or any other day. An interview with LPN #5 on 9/28/20 at 1:10 PM noted LPN #5 indicated she interviewed Resident #4 and Resident #4 informed her that NA #3 was quick with her movements and Resident #4 was learning to care for the ostomy and sometimes does make a mess and NA #3 gets frustrated at Resident #4. Additionally, Resident #4 informed me that NA #3 yanks and pulls at the sheets and cover during the night. LPN #5 indicated that she and RN #2 called NA #3 on the phone and did the education with the NA #3 so she could come off suspension and return to work. An interview with RN #2 on 9/28/20 at 1:20 PM noted she was informed about the allegation of abuse about 9:30 AM on 8/27/20. RN #2 and RN #4 called NA #3 and NA #3 informed them that she was putting the peri wash bottle on the nightstand and dropped the bottle hitting Resident #3 in the face. RN #2 indicated she did not do a body audit after the allegation of abuse because she was told by LPN #5 that there was no mark on Resident #3's face. RN #2 indicated she did not know if Resident #3 was an assist of 1 or 2 for incontinent care on the air mattress. An interview with RN #2 on 9/28/20 at 1:30 PM noted she interviewed NA #3 regarding Resident #4 and NA #3 indicated that Resident #4 made a mess with the [MEDICAL CONDITION] and resident was playing with it, so NA #3 told Resident #4 not to touch it. Resident #4 informed RN #2 that she/he gets frustrated because NA #3 is hard to understand with her thick accent and NA #3 speaks so fast. Additionally, that NA #3 was rough because she tries to go to fast. An interview with Resident #4 on 9/28/20 at 2:45 PM noted NA #3 told her/him that she/he had to check his/her own ostomy bag every 2 hours throughout the night and tell NA #3 if she/he felt it needed to be changed. NA #3 was so argumentative and felt that NA #3 was being a bully. NA #3 was fast and rough when assisting with the care of the ostomy bag. Resident #4 indicated she/he felt humiliated and blamed by NA #3 for making a mess when trying to change the ostomy bag. Resident #4 indicated that NA #3 was rough on that night, so since that night she/he will now wait even if I am wet until the next shift for care because he/she does not want NA #3 in my room. Resident #4 indicated a staff member told her that NA #3 wanted to talk to her/him because NA #3 wanted to know why Resident #4 did this to her and Resident #4 informed the staff member that she did not want to talk to NA #3Additionally, Resident #4 indicated she/he heard NA #3 say to Resident #3 that if you don't understand me then I will not talk to you and heard Resident #3 say stop pushing my head down. Resident #4 indicated she/he did inform the Social Worker. An interview with RN#1on 9/28/20 at 3:00 PM noted she did not recall being told about the allegation of abuse from LPN #5 regarding Resident #3 and Resident #4 on the day it occurred. RN #1 indicated the first time she was aware of the incident was when the DNS asked her to follow up and complete any reportable events on the DPH website, but it was not the day that it was reported. RN #1 indicated she did not do body audits on either resident, but an RN should have. RN #1 indicated that it was the policy of the facility that an resident that was on an air mattress must be an assist of 2 for bed mobility and care while in bed. RN #1 indicated that because the air mattresses are slippery, and a resident can slide off easily. An interview with DON on 9/28/20 at 4:10 PM noted that a registered nurse should have done a full body audit on any allegation of abuse when the allegation was made unless involved in an emergency and then do the body audits right after that. DON indicated she was not able to find the RN assessment in the medical records. The DON indicated the Social worker should have seen both residents daily for 72 hours after the allegation of abuse. An interview with NA #3 on 10/5/20 at 11:40 AM noted that day Resident #4 took off his/her ostomy bag and wrapped it up with towels, so NA #3 told Resident #4 she would go tell the nurse. NA #3 indicated Resident #4 makes a mess when trying to change the ostomy bag. NA #3 indicated she wanted to talk to Resident #4 to find out why she said things about her and did this to her. NA #1 was provided education on abuse prevention on 3/11/20 and Resident Right, abuse prevention and ethics on 5/31/20 Review of Employee File for NA #3 there were no prior education or disciplinary actions in the file. Although attempted, an interview with Assistant Director of Nursing was not obtained. Review of facility Bill of Rights identified Residents have the right to be treated with consideration, respect, and full recognition of your dignity and individuality. Additionally, had the right to receive quality care and services. Although requested, a facility policy for the Social Workers responsibilities for any allegation of abuse or meeting the psychosocial needs of residents, it was not provided. Review of facility Abuse and/or Crimes committed against residents, prevention, reporting and investigation identified the facilities residents shall be treated with dignity, [MEDICATION NAME], and respect. Residents at facility have the right to be free from exploitation and from physical, sexual, verbal, and psychological abuse. Mental Abuse includes but is not limited to humiliation, harassment, threats of punishment, subject to a person to fear isolation or serios emotional distress. Investigation and Protection includes a nursing assessment conducted by a registered nurse. Although attempted, an interview with Assistant Director of Nursing was not obtained.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 sampled residents (Resident #1) and two of five nursing units reviewed for infection control, the facility failed to ensure that appropriate personal protective equipment (PPE) was donned in resident areas. The findings include: A. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].#1 on isolation upon admission related to COVID-19 for 14 days. The care plan dated 9/21/20 identified Resident #1was at risk for COVID-19 infection related to recent hospitalization with interventions that included, place resident on fourteen day quarantine

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	075135	A. BUILDING _____ B. WING _____	09/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MASONICARE HEALTH CENTER	22 MASONIC AVE PO BOX 70 WALLINGFORD, CT 06492

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) isolation to monitor for signs and symptoms of COVID-19. The nursing assistant care card dated 9/21/20 identified that Resident #1 was an assist of two (staff) for bed mobility and dressing. Observations on 9/24/20 at 11:00 AM with the Director of Infection Control (RN #1) identified Resident #1 had an isolation cart located outside of the room and a sign posted on the door to the room that identified that the resident was on contact and droplet precautions. NA #1 and NA #2 were observed in the resident's room standing within two to three feet of the resident. NA #1was noted to not have any PPE donned inclusive of face shield/goggles, surgical mask, isolation gown or gloves. NA #2 was wearing a surgical mask and goggles only. NA #1 and NA #2 exited the room without the benefit of washing their hands and/or utilizing hand sanitizer. Interview with RN #1 at the time of the observation indicated Resident #1 was on contact and droplet precautions as part of the facilities fourteen day quarantine policy. RN #1 identified that all new admissions are placed on the specified observational unit for a fourteen day quarantine period. She further identified that the residents are placed on isolation precautions to monitor the new admissions for signs and symptoms of COVID-19 and to protect residents and staff from the possibility of the transmission of COVID-19. RN #1 identified that the facility does not do a risk assessment for new admissions because all new admissions are placed on the observational unit. RN #1 further indicated that both staff members should have been wearing face shields or googles, surgical masks, isolation gowns, and gloves while in Resident #1's room and while providing care to the resident. In addition, RN #1 indicated that staff should not take off personal protective equipment until they are finished providing care and are exiting the room and hand sanitizer should be utilized upon exiting the room. She further noted that a mask and face shield/goggles are worn in all resident areas and that doffing should occur immediately prior to the staff member exiting the room. An interview with the DNS on 9/24/20 at 12:50 PM identified that RN #1 had implemented education with the staff regarding the donning and doffing of PPE when providing care or while in the room of a presumptive resident (resident on contact and isolation precautions/fourteen day quarantine). An interview with NA #2 on 9/24/20 at 1:20 PM indicted she/he and NA #1 were in Resident #1's room to provide care. NA #2 indicated that Resident #1 required two staff to provide care. NA #2 indicated she/he was having a personal conversation in the resident's room at the time observed. NA #2 indicated she/he was aware that she/he should have been wearing the gown and gloves while still in the room and should not remove the PPE until ready to exit the room. An interview with NA #1 on 9/24/20 at 1:30 PM indicated she/he was talking to NA #2 in Resident #1's room because they had just provided care to the resident. NA #1 indicated she/he knew she/he was supposed to leave the PPE on until exiting the room. NA #1 indicated she/he was supposed to put on googles, surgical mask, gown and gloves while in the room and remove it when she/he was ready to exit the room and wash her/his hands. B. Observations on the memory care unit with RN #1 on 9/24/20 at 11:05 AM identified twelve residents seated in the dining room. A dietary aide (DA #1) was in the dining room serving food without a face shield or goggles with a surgical mask that was positioned on the chin leaving the nose and mouth area uncovered. An interview with DA #1 on 9/24/20 at 11:08 AM identified that she/he had asthma and found it difficult to breath while wearing the surgical mask. DA #1 indicated that she/he was aware that goggles/face mask and surgical mask were supposed to be worn when in resident areas. DA #1 put a surgical mask and goggles on after surveyor inquiry. Observation of the fourth floor dining room with RN #1 on 9/24/20 at 11:15 AM identified DA #2 preparing food. DA #2 was wearing goggles but had on a surgical mask with her/his nose exposed. An interview with DA #2 on 9/24/20 at 11:17 AM indicated she/he did not realize that that the mask was not covering her/his nose. DA #2 then pulled the surgical mask up over his/her nose. An interview with RN #1 on 9/24/20 at 11:20 AM indicated that anyone that is on a resident unit should be wearing a surgical mask and a face shield or goggles. An interview with the Dietary Director on 9/24/20 at 12:00 PM identified that all the staff should be wearing a surgical mask that covers the nose and mouth and either goggles or a face shield when on resident units. C. Observation with RN #1 of the observational/exposed unit on 9/24/20 at 10:50 AM identified that there were isolation carts outside of twenty-one resident rooms. On top of the isolation carts where opened laundry bags with washable yellow gowns hanging out of the open laundry bags and some were noted to be falling over the sides of the carts touching the floor. An interview on 9/24/20 at 10:50 AM with RN #1 indicated that the washable yellow isolation gowns should always be covered. RN #1 indicated that the yellow gowns should be contained within the closed laundry bag to maintain good infection control practices. An interview on 9/24/20 at 2:00 PM with the DNS indicated that the gowns should always be covered and not draped on top of the isolation carts. She further identified that mandatory staff education was started to reinforce the requirement that all staff are required to wear a surgical mask while in the facility with the addition of a face shield or goggles when in resident areas.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Review on 9/24/20 and 9/25/20 of the staffing schedules, punch detail, and testing spreadsheet from 9/6/20 through 9/19/20 with the Registered Nurse that is responsible for Infection Control RN #1 Director of Quality and Specialty Programs and the DNS identified during week of 9/6/20 through 9/12/20 42 there were 42 staff and week 9/13/20 through 9/19/20 there were 68 staff members that had not been tested for COVID 19 and worked at least once during that time period. Interview with RN #1 on 9/24/20 at 11:30 AM indicated that the facility was still testing all employees for COVID 19 per the executive order. RN #1 indicated the testing was done all 7 days a week, but anyone swabbed for COVID 19 on Saturday was not sent out until Sunday and counted in the next weeks numbers. The(NAME)report sent on Fridays at 10:00 PM was a complete report because no other tests went out for that week. RN #1 indicated they have tried many ways to get all the employees tested for COVID 19 on a weekly basis. RN #1 indicated that if an employee gets tested somewhere outside of the facility, they are aware they need to bring in a copy of the test. RN #1 said that only one or two staff members have brought in a test. RN #1 indicated there are signs posted reminding all staff it was mandatory to be tested on a weekly basis for COVID 19. RN #1 indicated it is important to test all the staff to keep COVID 19 out of the facility. RN #1 indicated she/he really needs the help from all the Department Heads to be able to test all employees and discipline the employee if they fail to be tested . Interview with LPN #1 on 9/24/20 at 2:45 PM indicated she/he works under RN #1 in the Infection Control Department. LPN #1 indicated she/he assists in doing the staff testing and it was all their responsibility in the Infection Control Department to make sure that all staff are tested weekly. Additionally, LPN #1 indicated an email goes to the department heads every week notifying them which staff members had not been tested and the department head was then supposed to write them up as a disciplinary action. Interview with RN #1 on 9/25/20 at 10:00 AM while reviewing the names of the employees that had worked but were not tested indicated that some of the employees were per diem. Review of the punch detail showed the employee did work during that week RN #1 indicated he/she was not sure why employees were not tested . RN #1 indicated they have tried to do COVID 19 testing on staff as they enter for the beginning of their shift but then employees were getting to the unit late. RN #1 indicated they tried doing it on the units, but it was hard to catch the staff when they were not in a room and it was to time consuming. RN #1 indicated they remind staff while in the building and there are signs posted as the employees enter and are getting their temperatures taken and answering the questionnaire. RN #1 indicated the sign clearly states Please be aware that weekly testing is MANDATORY for ALL staff per executive order by the governor of the state of Connecticut. Non-compliance will result in monetary fines to the facility. Any staff in the building who have not been tested this week will be subject to disciplinary action up to and including termination. RN #1 indicated they try to test everyone on their first scheduled day each week. RN #1 indicated that(NAME)Lab still has some employees on their list that are no longer at the facility, but she had informed the lab to remove them so the(NAME)Lab report percentage may be a little off. RN #1 was aware that those employees were not counted for this review. RN #1 indicated she/he was the person that generates the list of employees that were not tested and send the list to the Department Heads so the department Head can follow up with the employee and give a disciplinary action. RN #1 indicated that once an employee was tested each week they have receive a sticker that goes on their badge with that week's date indicating they were tested . RN #1 indicated if an employee was on vacation for a week they do not get tested until the week they return to work. RN #1 indicated she/he tries to test the employee on their first day back but that doesn't always happen. Furthermore, RN #1 indicated there was an external email that all staff receive almost daily reminding them to come get tested for COVID 19 with the dates and times. RN #1 indicated the Management had a meeting this morning to change the system. Interview with the Director of Nurses (DON) on 9/25/20 at 10:30 AM indicated she/he had only been at the facility for a week. The DNS indicated she/he does know that all staff needed to be tested for 14 days with no positive cases in order to stop the weekly testing for COVID 19. The DNS indicated she/he was informed the last positive case for an employee was the end of August. The DNS indicated that all employees should be tested weekly at the facility and she/he would discuss it further with RN #1. Additionally, the DNS indicated that if an employee was on vacation the employee should be tested prior to returning to work not once the employee had returned to work. Interview with the Administrator on 9/25/20 at 3:00 PM indicated she/he receives the daily and weekly report of the number of staff

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MASONICARE HEALTH CENTER	**22 MASONIC AVE PO BOX 70 WALLINGFORD, CT 06492**

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F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) members that had been tested . The Administrator indicated that she/he was aware that they facility testes around 80 percent but believes that the number is off because there are some people that should not be on the list of employees. The Administrator was aware that the facility was not testing all their staff on a weekly basis. The Administrator indicated the facility tries to get all the staff tested for COVID 19. Review of Weekly summary of staff testing completion Report from(NAME)Lab week of 9/6/20 through 9/12/20 the facility tested 78.6 percent of the staff. Additionally, week of 9/13/20 through 9/19/20 indicated 80.5 percent of the staff were tested . The facility had a total of week one- 42 and week two- 68 employees (none of which had previously tested positive for Covid 19) that were actively working in the nursing home between 9/6 through 9/19/20 and thereafter. Although staff testing was available weekly, those employees were not tested for Covid 19 in accordance with the State of Connecticut Executive Order 7AAA issued on 6/17/20. Review of the State of Connecticut Executive order 7AAA dated 6/17/20 mandated that nursing home staff who have not previously tested positive for Covid 19, shall be tested weekly until testing identifies no new cases of Covid 19 among residents or staff over at least a 14 day period. A. Statutes and/or Regulations Violated: Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D8t (f) Administrator (3). B. Classification of Violations Class B in accordance with Section 19a-527-1(b)(3) of the Regulations of Connecticut State Agencies. B. Statutes and/or Regulations Violated: Regulation of Connecticut State Agencies (Public Health Code) violated is, Section 19-13-D8t (f) Administrator (3) . C. Classification of Violations: Class B in accordance with Section 19a-527-1(b)(3) of the Regulations of Connecticut State Agencies.