STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075135	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare Health Center	22 Masonic Avenue 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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy/procedures, and interviews for one sampled resident (Resident #25), reviewed for personal funds, the facility failed to ensure funds were deposited into the resident fund account in a timely manner. The findings include: Resident #25 was admitted to the facility in January 2024 with diagnoses that included type 2 diabetes mellitus, major depressive disorder, and Wernicke's encephalopathy. The quarterly MDS assessment dated [DATE] identified Resident #25 was cognitively intact, dependent on care with toileting hygiene, lower body dressing, personal hygiene and transfers. The assessment further identified the resident was non-ambulatory and utilized a wheelchair for mobility. Interview with Person #10 (Resident #25's responsible party) on 12/4/24 at 11:15 AM identified that Resident #25 was owed money from Social Security, which the Business Manager identified the facility had not received the funds and was advised that the delay was a result of the Social Security office. Further, Person #10 indicated he/she would be visiting the Social Security office to find out the cause of the delay. Review of Resident #25's applied income and resident fund accounts with the Business Manager on 12/4/24 at 1:15 PM identified the applied income account had a deposit from the US Treasury on 9/30/24 in the amount of $280.46, however the amount of $280.46 was not deposited into Resident #25's resident fund account. Interview with the Business Manager on 12/4/24 at 1:15 PM identified Resident #25 was owed $286.46 from Social Security based on a balance owed to the resident from his/her previous facility and she was waiting for the payment from Social Security. The Business Manager identified that the process for depositing funds into resident accounts includes the funds being first sent to the facility's trust account from the corporate office, and once it is there, she is then responsible for transferring the appropriate funds to the resident fund accounts. She further identified that she was unaware of monies being deposited into the resident's personal fund account because it was done by the corporate office, and she was waiting for a written check to arrive from social security. She added that both Resident #25 and Person #10 had visited her office frequently to inquire on the status of the $286.46. She noted that she had told them she was waiting for the funds to be sent from social security. (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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Cash Specialist in the corporate office on 12/6/24 at 8:15 AM identified she had received a US Treasury paper check along with 5 other checks from the Business Manager on 9/30/24 that were deposited in the trust account and the Business Manager was supposed to disperse the funds to the various resident fund accounts. The corporate Cash Specialist further noted that it is the responsibility of the Business Manager to transfer the appropriate funds into the appropriate accounts when funds are transferred into the facility's trust account. The Cash Specialist identified that the $286.46 for Resident #25 did belong to the facility but were owed to the resident. A second interview with the Business Manager on 12/6/24 at 11:41 AM identified she had written a handwritten note on the lower right side of the check from the US Treasury in the amount of $286.46. She indicated that the word insurance on the check had confused her, although she was aware she was awaiting a check in the exact amount for Resident #25. Additionally, she identified she is responsible for depositing the residents' applied income monies into the individual resident fund accounts on a monthly basis. On 12/4/24, subsequent to surveyor's inquiry, the Business Manager transferred $286.46 to the Resident #25's resident fund account with interest for the period of 9/1/24 to 11/30/24. The Personal Funds of Residents policy identified that individual accounts will be maintained for each resident and will be sufficient in composition to provide adequate detail for each resident and is reconciled on a monthly basis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on clinical record review, review of facility documentation, and interviews for one of three sampled residents (Resident #169) reviewed for accidents, the facility failed to provide a safe transfer for the resident to prevent a skin injury. The findings include: Resident #169 had diagnoses that included dementia, muscle wasting and atrophy, atrial fibrillation, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #169 had moderate cognitive impairment, was dependent on staff for transfers, and utilized a wheelchair for mobility. The nurse's notes dated 7/16/24 at 8:51 PM written by RN #2 identified he was called into Resident #169's room related to an open area to the lower right lateral leg. Resident #169 was not able to determine the cause of the injury to the lower right leg. He also identified Resident #169 was sitting in his/her wheelchair and NA #3 was assisting Resident #169 back to bed when the injury was noted. A steri-strip (wound closure tape) was applied, and responsible party was updated. The electronic version of accident and incident summary report dated 7/16/24 identified Resident #169 had a skin tear to his/her right lower leg that measured 3cm in length by 1.5 cm in width and 0.1 cm in depth. The facility investigation identified Resident #169's skin tear occurred while the resident was being transferred to bed. Physician's orders dated 7/16/24 directed to keep steri-strips in place and cover with non-stick dressing and wrap with a stretch gauze daily. The RCP dated 7/17/24 identified Resident #169 had a self-care deficit related to activity intolerance and impaired balance. Care plan intervention directed to transfer resident with assist of 2 people. The weekly wound assessment dated [DATE] identified Resident #169 had a skin tear to the right lower leg. The wound size was documented as 2.2 cm in length by 1.9 cm in width and 0.2 cm in depth and noted with intact steri-strip. Further review of the weekly wound assessment dated [DATE] identified Resident #169 skin tear to the right lower leg was resolved. Interview with ADNS on 12/5/24 at 10:15 AM identified Resident #169 required 2-person assist for transfers and NA #3 transferred the resident with two people. He could not verify whether NA #3 removed the leg rest of the wheelchair prior to transferring Resident #169. Although the facility could not ascertain whether the leg rests were removed prior to transfer, the multi-disciplinary team determined the cause of Resident #169 skin tear to the lower right leg occurred when NA #3 was transferring Resident #169 back to the bed. He further identified that Resident #169 skin tears should not have occurred during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 12/5/24 at 2:30 PM identified that he could not recall the details of Resident #169 skin tear to the lower right leg. He identified that Resident #169 wheelchair was on his/her bedside, but he could not remember whether Resident #169 skin tear to lower right lower was noted while the resident was sitting in his/her wheelchair, or it was noted after the resident was transferred from the wheelchair to the bed. He further identified that he did not notice any broken or sharp edges in the wheelchair. Attempts to interview NA #3 were unsuccessful. Although requested, a policy for accident prevention was not provided.