STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075001	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Center	6448 Main Street Trumbull, CT 06611

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy/procedure, and interviews for four sampled residents (Resident #50, Resident #81, Resident #110 and Resident #155) reviewed for advanced directives, the facility failed to ensure consents were obtained and a physician's order was in place regarding the resident's wishes regarding advance directives and decisions related to cardiopulmonary code status. The findings include: 1. Resident #50's diagnoses included cerebral infarction, chronic respiratory failure and aphasia. The physician's order dated [DATE] directed full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive including cardiopulmonary resuscitation (CPR)). The admission MDS assessment dated [DATE] identified Resident #50 was cognitively intact, required maximum assistances for toileting hygiene, personal hygiene, dressing, transfers, and bed mobility. The assessment further identified a wheelchair was utilized for locomotion. The care plan dated [DATE] identified Resident #50 had an established advance directive and noted the resident had a code status of full code with interventions that included activate resident's advance directive as indicated. Review of Resident #50's physical chart and the electronic health record failed to identify a signed Resident/Patient Health Care Instructions form signed by the resident/resident representative to indicate what the resident's wishes were pertaining to code status. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Unit Manager (RN #6) on [DATE] at 11:49 AM identified that if Resident #50 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the physical chart under the advance directive tab and in the electronic health record to determine the resident's code status. RN #6 reviewed the physical chart and the electronic health record and noted Resident #50 did not have a complete Resident/Patient Health Care Instructions form. RN #6 identified the Resident/Patient Health Care Instructions form should be completed on admission and based on what the resident/resident representative selected the physician's order written. In addition, RN #6 indicated that when a resident is admitted , the nursing supervisor is responsible for reviewing the hospital discharge paperwork to determine what the code status is and then completing the Resident/Patient Health Care Instructions form with the resident/resident representative. Once the form is completed it should be kept in the physical chart and the electronic health record. RN #6 further identified she is responsible for auditing the resident's chart to ensure the Resident/Patient Health Care Instructions form is completed and, in the chart, but had failed to audit Resident #50's clinical record. Interview with the DNS on [DATE] at 12:16 PM identified the Resident/Patient Health Care Instructions form is completed on admission by the resident/responsible party and the completed form is then kept in the resident's chart or scanned into the electronic health record system. Interview with the Social Worker (SW #2) on [DATE] at 10:44 AM identified the nursing staff is responsible for obtaining code status by ensuring the Resident/Patient Health Care Instructions form is completed by the resident/responsible party on admission or with any changes. Interview with the Medical Records staff (MR#1) on [DATE] at 10:15 AM identified the Resident/Patient Health Care Instructions form is kept in the chart and at one point they were scanned into the electronic health record but noted there was no current set process. She further identified the Resident/Patient Health Care Instructions form should be kept in the chart and is not removed even when the chart is thinned. Subsequent to surveyor's inquiry, a new Resident/Patient Health Care Instructions form for Resident #50 was completed on [DATE] indicating a code status of Full Code. Review of the Health Care Decision Making policy identified the facility/center must approach a capable patient who does not have an advanced directive upon admission; the patient will be approached by the social worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive. The policy further identifies that the facility/center must inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law. Additionally, the facility must establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care. The Thinning of Health Information Records policy identified that the most current advance directives/consent form must be kept in the chart to identify CPR/DNR status. 2. Resident #81's diagnoses included unspecified psychosis, anxiety disorder, and major depressive disorder. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated [DATE] directed full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). The admission MDS assessment dated [DATE] identified Resident #81 had severely impaired cognition and required maximal assistance with dressing, personal hygiene, transfers and bed mobility. The care plan dated [DATE] identified Resident #81 had an established advanced directive with the code status choice of full code with interventions that included activate resident's/patients advance directive as indicated. Review of Resident #81's physical chart and the electronic health record failed to identify a signed Resident/Patient Health Care Instructions form signed by the resident/resident representative indicating the resident's/representative's wishes for code status. Interview with the Unit Manager (RN #6) on [DATE] at 11:49 AM identified that if Resident #81 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the physical chart under the advance directive tab and in the electronic health record to determine the resident's code status. RN #6 reviewed the physical chart and the electronic health record and noted Resident #81 did not have a complete Resident/Patient Health Care Instructions form. RN #6 identified the Resident/Patient Health Care Instructions form should be completed on admission and based on what the resident/resident representative selected the physician's order written. In addition, RN #6 indicated that when a resident is admitted , the nursing supervisor is responsible for reviewing the hospital discharge paperwork to determine what the code status is and then completing the Resident/Patient Health Care Instructions form with the resident/resident representative. Once the form is completed it should be kept in the physical chart and the electronic health record. RN #6 further identified she is responsible for auditing the resident's chart to ensure the Resident/Patient Health Care Instructions form is completed and, in the chart, but had failed to audit Resident #81's clinical record. Interview with the DNS on [DATE] at 12:16 PM identified the Resident/Patient Health Care Instructions form is completed on admission by the resident/responsible party and the completed form is then kept in the resident's chart or scanned into the electronic records system. Interview with the Social Worker (SW #2) on [DATE] at 10:44 AM identified the nursing staff is responsible for obtaining code status by ensuring the Resident/Patient Health Care Instructions form is completed by the resident/responsible party on admission or with any changes. Interview with the Medical Records staff (MR#1) on [DATE] at 10:15 AM identified the Resident/Patient Health Care Instructions form is kept in the chart and at one point they were scanned into the electronic health record but noted there was no current set process. She further identified the Resident/Patient Health Care Instructions form should be kept in the chart and is not removed even when the chart is thinned. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Health Care Decision Making policy identified the facility/center must approach a capable patient who does not have an advanced directive upon admission; the patient will be approached by the social worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive. The policy further identifies that the facility/center must inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law. Also, the facility/center must establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care. The Thinning of Health Information Records policy identified that the most current advance directives/consent form must be kept in the chart to identify CPR/DNR status. 3. Resident #110's diagnoses included multiple sclerosis, malignant neoplasm of brain and traumatic subarachnoid hemorrhage. The admission MDS assessment [DATE] identified Resident #110 was cognitively intact, and required maximum assistance for dressing, personal hygiene and bed mobility. Review of the care plan dated [DATE] failed to identify that an advanced directive was established for Resident #110. Review of physician's orders for the period of February 1, 2025, to February 24, 2025, failed to identify an order regarding Resident #110's advance directives and decisions related to cardiopulmonary code status. Review of Resident #110's physical chart and the electronic health record failed to identify a signed Resident/Patient Health Care Instructions form signed by the resident/resident representative indicating the resident's/representative's wishes for code status. Interview with the Unit Manager (RN #6) on [DATE] at 11:49 AM identified that if Resident #110 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the physical chart under the advance directive tab and in the electronic health record to determine the resident's code status. RN #6 reviewed the physical chart and the electronic health record and noted Resident #110 did not have a complete Resident/Patient Health Care Instructions form. RN #6 identified the Resident/Patient Health Care Instructions form should be completed on admission and based on what the resident/resident representative selected the physician's order written. In addition, RN #6 indicated that when a resident is admitted , the nursing supervisor is responsible for reviewing the hospital discharge paperwork to determine what the code status is and then completing the Resident/Patient Health Care Instructions form with the resident/resident representative. Once the form is completed it should be kept in the physical chart and the electronic health record. RN #6 further identified she is responsible for auditing the resident's chart to ensure the Resident/Patient Health Care Instructions form is completed and, in the chart, but had failed to audit Resident #110's clinical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on [DATE] at 12:16 PM identified the Resident/Patient Health Care Instructions form is completed on admission by the resident/responsible party and once signed a physician's order is obtained and transcribed into the resident's electronic medical record (EMR). The DNS further added that the unit managers on the units are responsible for auditing new admission charts for advance directives consent and orders. She also added that the Resident/Patient Health Care Instructions form is then kept in the resident's chart or scanned into the electronic health record. Interview with Resident #110 on [DATE] at 12:30 PM identified he/she cannot recall signing a form regarding code status nor did anyone at the facility have had a discussion regarding advance directives since being admitted to the facility. Subsequent to surveyor's inquiry, a Resident/Patient Health Care Instructions form for Resident #110 was completed and signed on [DATE] indicating a code status of Full Code. Interview with the Social Worker (SW #2) on [DATE] at 10:44 AM identified Resident #110 did not have a code status, and it was the responsibility of the nursing staff to obtain the code status by ensuring the Resident/Patient Health Care Instructions form is completed by the resident/responsible party and a physician's order was in place. Review of the Health Care Decision Making policy identified the facility/center must approach a capable patient who does not have an advanced directive upon admission; the patient will be approached by the social worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive. The policy further identifies that the facility/center must inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law. Also, the facility/center must establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care. 4. Resident #155's diagnoses included peripheral vascular disease, dysphagia, and embolism and thrombosis of arteries of the upper extremities. The admission MDS assessment dated [DATE] identified Resident #155 was cognitively intact, required maximal assistance with dressing, bed mobility, and dependent on care for personal hygiene transfers and toileting hygiene. The care plan dated [DATE] identified Resident #155 had an established advanced directive of full code with interventions that included activate resident's/patients advance directive as indicated. The physician's order dated [DATE] directed full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). Review of Resident #155's physical chart and the electronic clinical record system both failed to identify a signed Resident/Patient Health Care Instructions form signed by the resident/resident representative indicating the code status of Full Code was completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Unit Manager (RN #6) on [DATE] at 11:49 AM identified that if Resident #155 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the physical chart under the advance directive tab and in the electronic health record to determine the resident's code status. RN #6 reviewed the physical chart and the electronic health record and noted Resident #155 did not have a complete Resident/Patient Health Care Instructions form. RN #6 identified the Resident/Patient Health Care Instructions form should be completed on admission and based on what the resident/resident representative selected the physician's order written. In addition, RN #6 indicated that when a resident is admitted , the nursing supervisor is responsible for reviewing the hospital discharge paperwork to determine what the code status is and then completing the Resident/Patient Health Care Instructions form with the resident/resident representative. Once the form is completed it should be kept in the physical chart and the electronic health record. RN #6 further identified she is responsible for auditing the resident's chart to ensure the Resident/Patient Health Care Instructions form is completed and, in the chart, but had failed to audit Resident #155's clinical record. Interview with the DNS on [DATE] at 12:16 PM identified the Resident/Patient Health Care Instructions form is completed on admission by the resident/responsible party and the completed form is then kept in the resident's chart or scanned into the electronic records system. Interview with the Social Worker (SW #2) on [DATE] at 10:44 AM identified the nursing staff is responsible for obtaining code status by ensuring the Resident/Patient Health Care Instructions form is completed by the resident/responsible party on admission or with any changes. Interview with the Medical Records staff (MR#1) on [DATE] at 10:15 AM identified the Resident/Patient Health Care Instructions form is kept in the chart and at one point they were scanned into the electronic health record but noted there was no current set process. She further identified the Resident/Patient Health Care Instructions form should be kept in the chart and is not removed even when the chart is thinned. Review of the Health Care Decision Making policy identified the facility/center must approach a capable patient who does not have an advanced directive upon admission; the patient will be approached by the social worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advanced directive. The policy further identifies that the facility/center must inquire with the individual's patient representative if the patient is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law. Also, the facility/center must establish mechanisms for documenting and communicating the patient's choices to the interprofessional team and staff responsible for the patient's care. The Thinning of Health Information Records policy identified that the most current advance directives/consent form must be kept in the chart to identify CPR/DNR status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure the room temperatures, and the heating elements were maintained at comfortable and safe temperature levels. The findings include: Observation on 2/20/25 at 11:50 AM identified RM 366 had an old leak of some sort down the outside wall (the wall with the window) where the paint has bubbled, and peeling off of the wall. Observation on 2/28/25 at 11:37 AM of RM 415 identified the window wall appears to have an old water leak with bubbled paint and cracks in the wall to the right above the window. Observation on 2/24/25 at 12:00 PM of the resident rooms in the facility identified the rooms had wall radiators with metal covers that spanned 3 feet up on the wall and were 3 feet wide. Radiators were accessible to contact by the residents. Some rooms had beds against the wall with the radiator on it. The resident hallways have radiators at the end of each hallway underneath the windows. They are covered with a metal cover and are accessible to residents. Interview on 2/26/25 at 12:52 PM with the Maintenance Director who identified he had not toured the entire building but was familiar with about 90% of the building indicated that most of the outside walls including room [ROOM NUMBER] probably had a steam leak and indicated the building had a lot of steam leaks from the boiler system. He identified that staff was responsible for putting work requests into the system when something is identified but he failed to provide an outstanding list of items that were reported for repair. Additionally, he indicated that his days are filled with putting out fires and he is inundated with the day-to-day work and is not able to complete some of the bigger projects that need to be completed. The Maintenance Director identified that the facility owes outstanding money to vendors, and it is difficult to get vendors into the facility and to get projects approved by corporate. Observation on 2/26/25 at 2:05 PM of the radiator and ambient temperatures obtained with the facilities' infrared thermometer, identified the following: room [ROOM NUMBER] - radiator showed 101 degrees Fahrenheit and the ambient air temperature was 82 degrees Fahrenheit. room [ROOM NUMBER] - radiator was 130 degrees Fahrenheit and the ambient air temperature was 82 degrees Fahrenheit with the room windows open. room [ROOM NUMBER] - radiator was 91 degrees Fahrenheit and the ambient air temperature was 82 degrees with the room windows open. room [ROOM NUMBER] - radiator temperature was 101 degrees At the end of the 4th floor Hallway A - radiator temperature was 97 degrees Fahrenheit and ambient air temperature was 85 degrees Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] - radiator temperature was 96 degrees and ambient air temperature was 85 degrees Fahrenheit. The bed placement in the room was against the radiator. room [ROOM NUMBER] - radiator temperature was 96 degrees Fahrenheit, and the ambient air temperature was 82 degrees Fahrenheit with the windows of the room open. room [ROOM NUMBER] - radiator temperature was 89 degrees Fahrenheit, and the ambient air temperature was 87 degrees Fahrenheit with the windows open and a circulating fan running. Interview on 2/26/25 at 2:56 PM with the Administrator identified the facility was having boiler issues and had just shut one of the boilers off in order to cool down the building. They have been off for approximately one hour and there was no way to regulate the heat, which is why the floors were warm. The HVAC company is onsite to see what can be done to fix it. Interview on 2/26/25 at 2:45 PM with the Corporate Resource Operator and the Administrator identified the Administrator is coming up with an interim plan for education of staff and residents and monitoring of residents regarding potential heat issues both in the air and the physical temperatures of the radiators accessible to residents. The CRO identified that while there is only one boiler running, the facility should cool down and if the temps drop outside we can turn the other boiler on. Additionally, the administrator would send out a blast on the regroup system to educate staff and family and conduct frequent monitoring of resident areas and move items in the rooms, so the radiators are not accessible to residents. The administrator indicated the facility would provide Education of residents who are able to be educated and monitoring of other residents until the system is fixed or taken off line.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility documentation, and interviews for two of three sampled residents (Resident #34 and Resident #81) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the comprehensive assessments were accurately coded to reflect the residents had a positive Level II PASRR assessment. The findings include: 1. Resident #34's diagnoses included bipolar disorder, anxiety disorder, and Parkinsonism. The clinical record identified a Level II PASRR assessment dated [DATE] with a determination date of 6/13/23 with an outcome of Level II approved no specialized services. The significant change MDS assessment dated [DATE] identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment and a yes would have led to more questions that pertain to why the resident has a Level II PASRR assessment. Interview with the MDS Coordinators LPN #4 and RN #5 on 2/26/25 at 10:14 AM identified that the comprehensive MDS assessment dated [DATE] was coded incorrectly because Resident #34 has a positive Level II PASRR. They further identified that assessment should have reflected yes instead of no. They further identified that the PASRR information in section A (question 1500, 1510 and 1550) of the MDS assessment is completed by the social worker, however the MDS Coordinator can complete any of the sections. RN #5 identified that it is the responsibility of the individual completing the MDS to ensure the information is accurate as her responsibility is to ensure the MDS is completed. Interview with LPN #3 at 2:41 PM identified she gathers information from the PASRR and resident's diagnosis to complete various sections of the MDS. She further identified she had completed section A as it relates to PASRR inaccurately based on the resident's positive Level II PASRR. LPN #3 indicated she should not have completed the PASRR section as it was the social worker's responsibility to complete that section. Although requested, a facility policy for the Resident Assessment Instrument (RAI) was not provided. In an interview with RN #5 on 3/4/25 at 1:18 PM she identified it was the practice of the facility to utilize the guidelines of the RAI manual when completing the MDS. 2. Resident #81's diagnoses included unspecified psychosis, anxiety disorder, and major depressive disorder. Review of the clinical records of Resident #81 identified a Level II PASRR evaluation was completed on 12/16/2024 with an outcome of Level II approved no specialized services. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The admission MDS assessment dated [DATE] identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment and a yes would have led to more questions that pertain to why the resident has a Level II PASRR assessment. Interview with the MDS Coordinators LPN #4 and RN #5 on 2/26/25 at 10:14 AM identified that the comprehensive MDS assessment dated [DATE] was coded incorrectly because Resident #34 has a positive Level II PASRR. They further identified that assessment should have reflected yes instead of no. They further identified that the PASRR information in section A (question 1500, 1510 and 1550) of the MDS assessment is completed by the social worker, however the MDS Coordinator can complete any of the sections. RN #5 identified that it is the responsibility of the individual completing the MDS to ensure the information is accurate as her responsibility is to ensure the MDS is completed. Interview with LPN #3 at 2:41 PM identified she gathers information from the PASRR and resident's diagnosis to complete various sections of the MDS. She further identified there was a delay in the records as the PASRR was not in the resident's record at the time of the assessment, but she should have gone back as the resident did have a diagnosis which would indicate a positive PASRR. She indicated that she should not have completed the PASRR section as it was the social worker's responsibility to complete that section. Although requested, a facility policy for the Resident Assessment Instrument (RAI) was not provided. In an interview with RN #5 on 3/4/25 at 1:18 PM she identified it was the practice of the facility to utilize the guidelines of the RAI manual when completing the MDS. The RAI instructions identify that the questions related to PASRR are only indicated on the admission, annual or significant change assessments.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, clinical record reviews, facility policy review, and interviews for one of six sampled residents (Resident #3) who received oxygen therapy, the facility failed to ensure a physician's order was in place for a resident who required the use of continuous oxygen. The findings include: Resident #3's diagnoses included chronic respiratory failure with hypoxia, heart failure, and chronic obstructive pulmonary disease (COPD). The quarterly MDS assessment dated [DATE] identified Resident #3 had severe cognitive impairment, required total assistance with toileting, dressing, bed mobility, transfers and utilized oxygen therapy. The care plan dated 2/20/25 identified Resident #3 had COPD. Care plan interventions directed to administer oxygen per physician's order, obtain pulse oximetry every shift, assess resident for shortness of breath, and notify the physician for any changes in condition. Observation on 2/20/25 at 10:45 AM identified Resident #3 lying in bed with oxygen in place via nasal cannula with the oxygen concentrator set to 3 liters/minutes. A review of the current physician's orders failed to identify Resident #3 had a physician's order for use of oxygen. Interview with LPN #5 (a 7-3 shift charge nurse) on 3/4/25 at 10:30 AM identified Resident #3 used oxygen at 3 liters/minute via nasal cannula continuously related to COPD. She further identified that there should be a physician's order indicating the usage of continuous oxygen; however, she could not find the physician's order for the continuous oxygen for Resident #3. Interview with the DNS on 3/4/25 at 11:00 AM identified that there should be a physician's order indicating the use of continuous oxygen. She identified that a nurse could apply oxygen to a resident without a physician's order during an emergency situation, but continuous usage of oxygen requires a physician's order. She further identified that the physician's order should include the method of the oxygen delivery and the rate of how much oxygen should be administered. Subsequent to surveyor inquiry, a physician's order for continuous oxygen use for Resident #3 was obtained. Review of oxygen administration policy identified the guidelines for safe oxygen administration is to verify that there is a physician's order for the oxygen administration. 695 notes (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, clinical record reviews, facility policy review, and interviews for one of six sampled residents (Resident #3) who received oxygen therapy, the facility failed to ensure a physician's order was in place for a resident who required the use of continuous oxygen. The findings include: Resident #3's diagnoses included chronic respiratory failure with hypoxia, heart failure, and chronic obstructive pulmonary disease (COPD). The quarterly MDS assessment dated [DATE] identified Resident #3 had severe cognitive impairment, required total assistance with toileting, dressing, bed mobility, transfers and utilized oxygen therapy. The care plan dated 2/20/25 identified Resident #3 had COPD. Care plan interventions directed to administer oxygen per physician's order, obtain pulse oximetry every shift, assess resident for shortness of breath, and notify the physician for any changes in condition. Observation on 2/20/25 at 10:45 AM identified Resident #3 lying in bed with oxygen in place via nasal cannula with the oxygen concentrator set to 3 liters/minutes. A review of the current physician's orders failed to identify Resident #3 had a physician's order for use of oxygen. Interview with LPN #5 (a 7-3 shift charge nurse) on 3/4/25 at 10:30 AM identified Resident #3 used oxygen at 3 liters/minute via nasal cannula continuously related to COPD. She further identified that there should be a physician's order indicating the usage of continuous oxygen; however, she could not find the physician's order for the continuous oxygen for Resident #3. Interview with the DNS on 3/4/25 at 11:00 AM identified that there should be a physician's order indicating the use of continuous oxygen. She identified that a nurse could apply oxygen to a resident without a physician's order during an emergency situation, but continuous usage of oxygen requires a physician's order. She further identified that the physician's order should include the method of the oxygen delivery and the rate of how much oxygen should be administered. Subsequent to surveyor inquiry, a physician's order for continuous oxygen use for Resident #3 was obtained. Review of oxygen administration policy identified the guidelines for safe oxygen administration is to verify that there is a physician's order for the oxygen administration.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48335 Based on review of facility documentation, review of facility policy and interviews for three Nurses' Aides (NA #3, NA #4 & NA #5) the facility failed to ensure annual performance reviews were completed, the findings include: Review of NA #3's employee file identified that he/she was hired on 4/26/2011. The file failed to contain an annual performance evaluation for 2023 or 2024. Review of NA #4's employee file identified that he/she was hired on 8/11/2006. The file failed to contain an annual performance evaluation for 2023 or 2024. Review of NA #5's employee file identified that he/she was hired on 11/28/2006. The file failed to contain an annual performance evaluation for 2023 or 2024. Interview on 2/28/25 at 10:42 AM with the Staff Development nurse (RN#3), indicated, competencies for nursing staff were completed quarterly on Health Stream, A web-based education platform. There is also an annual skills fair at the facility. RN #3 was planning to hold the Skills Fair in March of this year. She noted that Health Stream contains modules that the staff complete. Each module may have a couple of questions to gauge the employees' level of understanding and at the end of each module there are tests and if an employee requires further education or have difficulty with test taking, RN #3 provides additional training during the Skills Fair. RN #3 identified she was hired in January of 2025. RN #3 was not able to verify when the Skills Fair occurred in 2024 or where any of the employee sign off sheets/competencies were kept for 2024. Interview on 2/28/25 at 11:03 AM with Administrator indicated the performance reviews for 2024 were not completed or located and was not sure why they had not been completed. She further noted that the unit managers and the DNS help to complete annual performance reviews. Interview on 2/28/25 at 1:38 PM with the Administrator and the DNS indicated there had been an agency DNS and supervisor at the facility prior to both of their hiring in November of 2024. The Human Resources (HR) person had also been on a Family Medical Leave Act (FMLA). They noted the process for annual reviews is HR emails the Administrator and the unit managers to notify them when a performance review is due. The unit managers are responsible for completing them. Review of the Performance Appraisal policy dated 7/1/2022, identified that managers will meet with their regular full-time, regular part time and regular causal employees at least annually to conduct a performance appraisal/review or have a performance-based conversation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure a system was in place to account for the receipt, usage, disposition and reconciliation of all controlled medications and failed to ensure the shift-to-shift narcotic counts were signed off by two nurses. The findings included: Observation on 2/25/25 at 12:06 PM with LPN #8 identified the unit 5B medication cart had 3 missing signatures out of 146 signatures on the February 2025 narcotic shift to shift sign off sheet. Observation on 2/25/25 at 12:46 PM with LPN #7 identified the unit 4 C medication cart identified 10 missing signatures out of 146 signatures on the February 2025 narcotic shift to shift sign off sheet. Observation on 2/25/25 at 1:13 PM with LPN#6 identified the unit 3 C/D medication cart identified 13 missing signatures out of 146 signatures on the February 2025 narcotic shift to shift sign off sheet. Interview on 2/25/25 at 1:41 PM with the ADNS identified that the shift-to-shift signature sheets should be signed when the counts are completed by the two nurses and the form should be signed by both nurses performing the shift-to-shift count. Additionally, she identified that she has worked at the facility for 3 months and has tried to come up with the best process for narcotic reconciliation in the facility. The ADNS indicated it was her responsibility to conduct the reconciliations. She indicated that when she took the job, she had to locate all of the yellow drug disposition records, organize them and began matching them to the white drug disposition records that were in the office. The ADNS failed to identify when the last facility narcotic audit had been completed at any point in the past two years. Additionally, the ADNS identified that the binder for the yellow drug disposition records that she created was kept in the supervisor's office and the supervisors were responsible for matching the white drug disposition records to the yellow sheets once the medication is finished, or taken out of circulation, and that there were at least six people that had access to the yellow drug disposition records binder. Interview on 2/28/25 at 10:52 AM with RN #6 identified that the narcotics are the responsibility of nursing. The counts should be done at every shift change and the nurses should sign the paper. If someone discharges or there are left over narcotics, they are brought to the DNS office. RN #6 indicated that the supervisors check the deliveries, and they sign but do not keep a copy of the delivery slip with all of the listed medications. RN #6 identified when she delivers the medications to the floors she has the receiving nurse sign and leaves the medication with the white drug disposition records on the medication cart and places the yellow drug disposition records in the binder in the supervisor's office. Observation on 2/28/25 at 11:19 AM with LPN#9 of medication cart 4 A identified 6 missing signatures out of a possible 164 signatures on the February 2025 narcotic shift to shift sign off sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/28/25 at 12:09 PM with LPN#10 of med cart 5 C identified 32 missing signatures out of a possible 164 signatures on the February 2025 narcotic shift to shift sign off sheet. Additionally, one administered narcotic had not been signed out and was missing from the count and there was a signature in the off-going spot at 3pm, and shift change had not yet happened. Interview on 2/28/25 at 12:12 PM with LPN#10 identified the shift-to-shift signoffs should not be signed until the shift-to-shift counts are completed. LPN#10 indicated Narcotic administration should be documented when administered and that rushing in the morning to administer medication to a dialysis resident and she forgot to sign out the medication. It was documented as administered in the EHR. Interview with 2/28/25 on12:26 PM with the DNS, who started [DATE], identified she assists with the narcotic destruction. The reconciliation and audits are the responsibility of the ADNS. The DNS indicated that the narcotic binder was kept in the ADNS office as there was no longer a supervisor's office. The DNS indicated that as of the end of January there is a book for each unit and the master list of what was delivered to the facility goes to the ADNS so that she can do the reconciliations and audits but failed to identify when the last facility audit had been completed. Review on 2/28/25 at 1:00 PM of the narcotic shift to shift sign-off sheets for the facility medication carts for the months of December 2024, January 2025, and February 2025 revealed the following: 1. Med cart 3 C/D December 2024 - 3C missing 23 of 186 signatures/3D missing 37 of 186 signatures January 2025 - 3C/D missing 20 of 186 signatures February 2025 - 3C/D missing 17 of 164 signatures 2. Med cart 4 C December 2024 - 4 C missing 13 of 186 signatures January 2025 - 4 C missing 14 of 186 signatures February 2025 - 4 C missing 13 of 164 signatures 3. Med cart 5 B January 2025 - Missing all signatures January 1st through 9th and missing 23 of the remaining 132 signatures February 2025 - Missing 3 of 168 signatures 4. Med cart 5 C December 2024 - missing 21 of 186 signatures (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2025 - missing 12 of 186 signatures February 2025 - missing 32 of 168 signatures The facility policy for management of controlled drugs identified a complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel per state regulations. Additionally, the policy indicated that the management of controlled substances, including the ordering, receipt, storage, administration, ongoing inventory, and destruction, is conducted under the direction and ultimate responsibility of the Administrator and Director of Nursing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47489 Based on observations, review of facility documentation, review of facility policy and interviews failed to ensure discontinued, expired medications were removed from the medication carts and disposed of appropriately. The findings include: Observation on 2/25/25 at 1:13 PM with LPN#6 identified the C/D medication cart contained the following resident specific (with current active orders for the medication) expired medications: 1. Simvastatin 10mg with (7 tablets) with an expiration date of 12/31/24 2. Lisinopril 10mg (9 tablets) with an expiration date of 1/25/25 3. Amlodipine Besylate 5mg (7 tablets) with an expiration date of 11/30/24 Observation on 2/25/25 at 12:46 PM with LPN#7 identified the 4C medication cart contained a blister pack of Sertraline 100 (29 tablets) with an expiration date of 1/25/25. Interview on 2/25/25 at 1:41 PM with the ADNS identified that expired medications should be removed from circulation and taken out of the cart and placed in the medication rooms to be disposed of. The nurses are responsible for removing the medications that are expired or not in use anymore. Interview on 2/28/25 at 10:52 AM with RN #6 identified that when a resident discharges, the left-over medications should be removed from the medication cart and placed in the bins for destruction or return to the pharmacy. RN #6 identified the DNS takes care of the destruction or returns. RN#6 indicated that there should not be expired medications, nor medications from discharged residents in the medication carts. Interview on 2/28/25 at 12:26 PM with the DNS identified that expired medications should not be left in the cart and that if the resident discharges, the medications should be removed and not used for another resident. Review of the facility policy for medication storage identified outdated or discontinued medication should be immediately removed from stock and disposed of according to procedures for medication disposal. Additionally, the outdated medication should be stored in a secured area separate from active orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of facility policy and interviews, the facility failed to ensure food items stored in the refrigerator, freezer, kitchen and dry storage areas were labeled, dated, and removed once out of date or expired, and failed to ensure dietary staff's personal food items were not stored in the refrigerator used by the kitchen and in the refrigerator on resident's unit. The findings include: A tour of the kitchen on [DATE] at 10:36 AM with the Director of Food Service identified a reach-in refrigerator that contained a half-filled opened jug of salsa med chunk that did not have a date opened or a discard date, and a manufacture's expiration date of [DATE]. There was also an opened container of extra strong Dijon mustard with white wine that was a quarter filled and had a broken lid. The mustard did not have a date open, a discard date and was unable to locate a manufacturer's expiration date. Interview with the Director of Food Service on [DATE] at 10:36 AM identified food items are labeled with the date the product arrives at the facility and staff are responsible for labelling the food items with the date the item was opened and the date the item needs to be discarded. The Director provides a guide used in the facility's in-service regarding food storage and retention guide identified when a Salsa was opened, it is good for one month. Observation on [DATE] at 10:40 AM with the Director of Food Service of the Produce Refrigerator identified a half bag of Parmesan cheese with no open and discard date, or expiration date. Observation on [DATE] at 10:45 AM with the Director of Food Service of the Walk-in Freezer identified: A tray containing small individual cups of citrus nourishment with a label identifying an open date of [DATE] and an expiration date of [DATE]. A tray containing small containers of chickpeas with a label identifying an open date of [DATE] and an expiration date of [DATE]. A flat dough-like item wrapped in saran wrap with no open date, no expiration or discard date or what the food item was. Interview with Dietary Aide #1 on [DATE] at 10:45 AM identified some of the nourishments are made by the dietary staff. She identified it was the responsibility of the dietary aide assigned to the area to label food items when opened, to prepare nourishments, and to check for outdated/expired foods and discard daily. However, she indicated that she did not work on the days the items were to be discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Food Service on [DATE] at 10:45 AM identified the food items should have been labeled with an open and discarded date as well as discard items in the fridge. He identifies that the items would be discarded at the end of the day and staff are aware of their responsibilities as they are given an assignment sheet to complete. Review of the AM job assignment sheet which included positions, staff name and responsibility was provided by the Director which identified stock cleaning/ Tues was responsible for label and store delivery starting with refrigerator items, then freezer, then dry goods and rotate product using FIFO (first in and first out). Also, the nourish/serve station staff were responsible for prepare nourishment per tally, clean and organize nourishment area and function room. Observation on [DATE] at 10:50 AM with the Director of Food Service of the dry food storage area identified: 1. An opened half-filled package of biscuit mix with no open and discard date. 2. An opened half-filled bag of corn flakes with no open and discard date. 3. An opened half-filled bag of cheerios with no open and discard date. 4. An opened bag of rotini noodles with no open and discard date. 5. Three opened bags of bread with no open and discard date. Interview with the Director of Food Service on [DATE] at 10:50 AM identified items should have been labeled with an open and discard/expiration date. He identified that staff are responsible for labeling food items with the date the item was opened and the date the item to be discarded/expired. Observation on [DATE] at 11:00 AM with the Director of Food Service of the kitchen area near the prep station area identified: An opened bottle of Molasses with no open and discard date, and a manufacture's best buy date of [DATE]. An opened container of red wine with no lid with a label identifying an open date of [DATE] and an expiration/discard date of [DATE] generated by the facility. An opened bottle of soy sauce with a label identifying an open date of [DATE] and an expiration/discard date of [DATE] generated by the facility. An opened bottle of kitchen gravy with a label identifying an open date of [DATE] and an expiration/discard date of [DATE] 24 generated by the facility. Interview with the Director of Food Service on [DATE] at 11:00 AM identified the cooks labeling the items incorrectly and the cooks were responsible for checking and discarding expired items based on the food storage and retention guide that was discussed at their in-service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Food Service on [DATE] at 11:00 AM identified the cooks were incorrectly labeling the items and the cooks are responsible for checking and discarding expired items. Interview with [NAME] #1 on [DATE] at 1:00 PM identified she labeled the food items with the pre-printed stickers provided which had an expiration date of 7days. She identified that the managers are aware of the dates on the pre-printed stickers are 7 days and not all items when opened are expired in 7 days. She further identified that not all items are expired on the manufacture's date, as when items are opened the expiration or used by dates changed depending on the item. [NAME] #1 further identified the supervisor and the director were responsible for checking the items in the kitchen area for expiration and the cooks were responsible for labeling items when opened and checking the storage areas for expiration dates. Observation with the Director of Food Service on [DATE] at 11:10 AM identified the dining room staging kitchen which was off the main kitchen which serviced the first-floor dining room containing a bag belonging to an employee on the bottom shelf of the refrigerator. Immediately the kitchen staff, whose bag belongs to quickly removed the bag from the refrigerator. Interview with the Director of Food Service on [DATE] at 11:10 AM identified the bag found in the refrigerator as belonging to a kitchen staff, as she removed the bag. He then identified that staff were not allowed to store personal items such as lunch bags in the refrigerator on the resident's unit, and staff are aware they have a designated area to store their lunch and other items. Observation of the dining room staging kitchen on [DATE] at 10:30 AM identified the dining room staging kitchen which was off the main kitchen which serviced the first-floor dining room a black bag belonging to an employee on the bottom shelf of the refrigerator. Immediately the kitchen staff, whose bag belongs to, quickly removed the bag from the refrigerator. Observation with the Director of Food Service on [DATE] at 11:37 AM identified the refrigerator in the 4th floor kitchenette designated for residents to store food items brought from the outside containing a lunch bag belonging to an employee. The refrigerator had a label which indicated that this refrigerator is for residential personal items only and staff fridge is located in the employee dining room. Interview with the Director of Food Service on [DATE] at 11:37 AM identified the bag found in the refrigerator as belonging to a nursing staff. He then identified that staff were not allowed to store personal items such as lunch bags in the refrigerator on the resident's unit, and staff are aware they have a designated area to store their lunch and other items. He further identified that the kitchen staff would clean the fridge in the AM and remove any items that do not belong in the fridge. Interview with the Director of Food Service on [DATE] at 12:36 PM identified it was the policy and practice of the facility to check expiration dates daily and discard expired foods. Review of Food Storage: Cold Foods policy identified all foods will be stored wrapped in covered containers, labeled and dated, and arranged in a manner that prevents cross contamination. Review of the Food Storage: Dry Goods policy identified storage areas will be neat, arranged for easy identification, and date marked as appropriate. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Receiving policy identified all foods will be stored in a manner that ensures appropriate and timely utilization based on the principles of first in - first out (FIFO) inventory management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46117 Based on observations, review of the clinical records, facility policies, facility documentation and interviews, the facility lacked effective administration to maintain the highest practicable physical, mental and psychosocial well-being of the residents. The findings include: The Administrator failed to ensure the residents had safe, homelike environment and the room temperature were kept at comfortable and safe levels and failed to endure the water management plan was followed to prevent and mitigate the growth of Legionella species in the water and failed to ensure the positive Legionella test result were reported to the state survey agency.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, review of clinical records, review of facility documentation, review of facility policy/procedures, and interviews, the facility failed to ensure the water management plan was followed to prevent and mitigate the growth of Legionella species in the water and failed to ensure the positive Legionella test results were reported to the state survey agency. These failures resulted in the finding of Immediate Jeopardy and the facility failed to appropriately track and place Residents #50, #76 and #94 on Enhanced Barrier Precautions (EBP). The findings include: 1. A tour of the facility and review of facility documentation on [DATE] identified the facility consisted of 5 floors; resident floors consisted of the third floor with a census of 73, the fourth floor with a census of 43 and the fifth floor with a census of 49 for a total census of 165. The second floor was a former resident floor but was not in use and did not have any residents residing on the floor. The facility's water management plan identified the facility contracted with two outside water management companies. The first water Contractor (WC#1) is responsible for the hyperchlorination system (a water treatment method that increases the chlorine level in water), and the second water contractor (WC #2) is responsible for planning, developing, and mitigating the growth of Legionella in the facility's water supply. The request for the water management committee meeting documentation for the period of [DATE] through [DATE] identified the committee only met once during that time period ([DATE]). Review of committee meeting documentation prior to the requested time period identified the meetings were conducted on a monthly basis, and the committee was comprised of the Director of Maintenance, the Administrator and respective managers. The purpose of the water management committee meetings were to discuss the safety of the water supply used for cooking, drinking, cleaning, and bathing. The facility water was tested for Legionella species and other bacteria using an outside independent service (WC #2). The facility's in-house process to keep the water safe included the routine task of running the water, flushing the toilet, and checking water temperatures. The facility's last water safety committee meeting minutes dated [DATE] identified routine tasks performed to maintain the water safety included: the eye wash stations should be flushed (running the water for approximately 5 to 10 minutes) once a week, the hot water temperatures should be checked once a week and placed in a log, the water should be flushed once a month in areas where the water is not in use (faucets, showers, eye wash stations, etc.) and the results placed in a log. The minutes further identified the water contractor (WC #1) treated the water with chlorine once per month, water sampling testing completed once per month, and the ice machine and kitchen would be inspected once per month. On [DATE] at 1:45 PM, a request was made to the Director of Maintenance to provide all Legionella testing from [DATE] to February 2025 and all documentation related to the facility's water management maintenance records such as water flushes, temperature logs, the monthly water inspection results and all the related information identified in the water safety committee meeting minutes. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's water sampling test results collected from [DATE] to [DATE] noted the following: Water samples collected on [DATE] at 10:00 AM identified 8 testing locations on the 2nd floor, and the faucets had a final result of equal to 43 Colony Forming Units per milliliters (CFU/ml) which identified positive Legionella species (not Legionella pneumophila) in the water. Water samples collected on [DATE] at 8:00 AM identified 8 testing locations on the 2nd floor, and the faucets had a final result of equal to 90.5 CFU/ml which identified positive Legionella species (not Legionella pneumophila) in the water. Water samples collected on [DATE] at 8:00 AM identified 8 testing locations on the 2nd floor, and the faucets had a final result of equal to 134.5 CFU/ml which identified positive Legionella species (not Legionella pneumophila) in the water. Water samples collected on [DATE] at 8:00 AM identified 8 testing locations on the 2nd floor, and the faucets had a final result of equal to 147.5 CFU/ml which identified positive Legionella species (not Legionella pneumophila) in the water. Water samples collected on [DATE] at 9:00 AM identified 8 testing locations on the 2nd floor, and the faucets had a final result of equal to 500 CFU/ml which identified positive Legionella species (not Legionella pneumophila) in the water. The water management plan identified that when Legionella species is found in the water, the following interpretive testing guidance should be considered: When the positive Legionella test sites detect less than (<)1 CFU/ml, the facility will maintain their environmental assessment and Legionella monitoring. When the positive Legionella test sites detect greater than (>) or equal to 1 CFU/ml, the facility will review the water sample collection, handling, and testing for faucets that are not frequently used, the facility will confirm the water system (chlorination) was currently operating, review the record of its water management plan, review the water characteristics and any incoming water changes, immediately institute a short term control measure in accordance with the direction of the qualified professional (contracted water management providers) and notify the local health department, and the state Department of Public Health (DPH). The guidance further identified that the water system should be re-tested no sooner than 48 hours and no later than 7 days after a disinfection to determine the efficacy of the treatment, and if the re-tested water indicates a greater than or equal to 1, the facility would repeat the short-term measures, and additional measure should be reviewed. When the positive legionella test sites detect greater than or equal to 10 CFU/ml, the facility will immediately institute a short-term control measure in accordance with the direction of a qualified professional and will immediately notify the local health department and the state health department (DPH). Additionally, the water system should not be used for potable water until the facility is cleared by the local health department and DPH. The facility's water management plan identified that when a positive Legionella water sample is identified, the following the short-term control measures should be taken: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. The use of potable water will be restricted and bottled water will be utilized. 2. The faucet aerators removed (a device to prevent unnecessary water splashes that could result in the spread of the bacteria), soaked in a bleach solution for 30 minutes and left off until otherwise directed. 3. The removal and replacement of shower heads and lines throughout the facility that are in use and assess the need for point of use filters that are in accordance with the Environmental Protection Agency (EPA). 4. Flush each affected area faucet immediately for 5 to 10 minutes (hot and cold tap water). 5. Notify the Medical Director and state survey agency. 6. Perform clinical surveillance on residents for any respiratory signs and symptoms. 7. Consider the need to notify the residents, families, and staff. Further review of the water management plan identified the facility was unable to provide any water maintenance records and/or documentation that was discussed in their last safety water committee meeting dated [DATE]. In addition, the last monthly water sample testing was completed in the month of [DATE] and no further water sampling testing had been completed. Interview with the Director of Maintenance on [DATE] at 1:20 PM identified he had no knowledge of the facility's water management plan to prevent and/or mitigate the growth of Legionella in the water. He identified that he did not flush or perform any water maintenance, nor had he conducted and/or participated in water safety committee meetings since he started his position in [DATE]. He further identified that he was unaware that the water sampling completed in [DATE] indicated the potable water system was positive for Legionella species. He indicated that WC #1 comes monthly to treat the water with chlorine, and he had assumed that WC #1 was responsible for the facility's water management and for ensuring the water was safe to use. In addition, he identified that he had the water management plan binder in his office but was unaware of the details of the water management plan and/or the need to conduct routine water maintenance. Interview with WC #1 on [DATE] at 2:00 PM identified that he has provided a hyperchlorination treatment to the water on a monthly basis to mitigate the growth of Legionella bacteria in the water. He further identified that the hyperchlorination of the water was part of the facility's comprehensive water management plan; however, the facility's maintenance staff are responsible for providing additional water maintenance to effectively manage and prevent the Legionella species growth in the water. In addition, he identified that he had last provided service to the facility on [DATE], but he could not provide any documentation to confirm the service provided. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with WC #2 on [DATE] at 9:45 AM identified he was responsible for the planning, development, and mitigation of the growth of Legionella species when detected in the water. He identified that the facility opted to do its own water sampling tests and are responsible for notifying him of any positive Legionella species in order for him to offer his guidance in mitigating the growth of Legionella species in the water. He further identified that any water sampling final result of greater than (>) 1 CFU/ml would be considered positive of Legionella in the water and the facility would need to follow the steps indicated in their water management plan. Additionally, he identified that he was not notified of the water sampling test results of positive Legionella species in the water from [DATE] to [DATE]. He noted that water filters once installed on a faucet are good for 90 days only. He also identified that the facility maintenance staff are responsible for providing the routine water maintenance indicated in the water management plan. In addition, he identified that he ceased his services in [DATE]. Observation in the kitchen on [DATE] from 11:30 AM to 11:45 AM identified a sink located near the ice machine that had a Nephros water filter in place with a manufacturer's expiration date of [DATE] and the ice machine also had a Nephros water filter in place that had a manufacturer's expiration date of [DATE]. The dietary staff identified that the ice machine was used to service the entire facility. A tour of shower rooms on [DATE] from 1:30 PM to 2:00 PM identified the following: The D wing (3rd floor) had a shower faucet with a Nephros water filter that had a manufacturer's expiration date of [DATE]; however, there was no date identifying when the filter was installed, which is necessary because the filters are only good for three months once installed regardless of the expiration date noted on the filter. The A wing (3rd floor) had a shower faucet with no water filter installed. The C wing's (4th floor) shower room had a shower head with a Nephros water filter with a manufacturer's expiration date of [DATE] and a second shower head with a Nephros water filter with a manufacturer's expiration date of [DATE]. Both water filters failed to have a date when the filters were installed. The C wing's (5th floor) shower room had a shower head with a Nephros water filter with a manufacturer's expiration date of [DATE] and a second shower head in the same shower room with a Nephros water filter that was missing the expiration date and neither water filter contained a date when they were installed. Interview with the Administrator in the presence of the DNS on [DATE] at 2:05 PM identified that she began working as the Administrator in [DATE]. The Administrator identified that the facility had a water management plan in place and had a contract with two water management companies to manage the facility's water supply. She also identified that she had seen the water contractor in the facility but was unaware of the details of the visit. In addition, the Administrator identified that she assumed that the maintenance staff and the water contractor were working to ensure the safety of the water supply system. Additionally, she identified that she participated in a corporate meeting, but she could not recall whether the facility's water management plan was discussed. She further identified that she was unaware of the positive Legionella species in the facility's water supply. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the DNS in the presence of the Administrator on [DATE] at 2:15 PM identified that she started as the DNS in [DATE]. She identified that she was unaware of Legionella species in the water, but had she been aware, she would have educated the nursing staff to monitor the residents for respiratory symptoms. Interview with the Resource Operator for Genesis (RO #1) via telephone in the presence of the Administrator and the DNS on [DATE] at 3:34 PM identified RO #1 was the Senior Administrator (corporate staff) who oversees the facility. She identified that she was aware that the facility had a history of positive Legionella species in the water, but she was unaware that the facility had a positive Legionella species in the water on [DATE]. She indicated that the Maintenance Director and the Administrator receives the results of the water sampling tests and are responsible for reviewing the test results to ensure that the Legionella is within acceptable parameters. She further identified, she would expect the Maintenance Director and Administrator to reach out to the water contractor when necessary. Additionally, RO #1 identified that the current administration would not be aware of the [DATE] water sample result and noted that she had received the water sample test results completed in [DATE] in [DATE]. She further identified; she was aware at the time that the water was positive for Legionella species; however, she identified that she assumed that the previous Administrator and Maintenance Director had reached out to the water contractor to provide guidance in mitigating the Legionella in the water. She could not provide a reason why there was no water sampling testing conducted after [DATE] or why she as the person overseeing the facility had not ensured that the positive Legionella was addressed. Interview with the Medical Director on [DATE] at 2:13 PM identified that he was made aware of the positive Legionella on [DATE] and noted that he participated in the formation of the immediate plan of correction. He further noted that he remembered that the building had a positive Legionella test result a long time ago and had installed filters on the showers, but he denied knowing about the positive Legionella results in August of 2024. Interview with the Infection Preventionist (IP) on [DATE] at 10:30 AM identified that she started working at the facility in [DATE]. She further conveyed that as the IP she would expect to be notified of any Positive Legionella test results. Additionally, she noted that when positive Legionella is identified, her role would be to monitor the residents for any signs or symptoms of Legionella related illnesses. The facility failed to implement and/or follow the procedures indicated in their water management plan to mitigate the growth of Legionella when it was detected and placed all residents at risk for Legionnaire disease. These failures resulted in the finding of Immediate Jeopardy. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Immediate Jeopardy template was provided to the Administrator and DNS on [DATE] at 4:14 PM. The facility provided an Immediate Jeopardy removal plan that was accepted on [DATE] at 7:05 PM. The plan included the following measures: staff in all departments to be educated on the water management contingency plan, bottled water for consumption, residents who required showers provided/offered non-rinse foam cleanser, cleanse spray, and disposable wipes, all sinks tagged with signage indicating to not use until water testing completed, based on the water contractor's recommendations, the facility will audit and change all expired Nephro filters and thereafter change them every 90 days for the shower filter and every six months for the ice machine. It further identified that the facility had placed an order for 4 Nephro filters, 11 shower wand filters and 225 sink filters through the water contractor and noted that once the water filters were installed the water would be able to be used. Further, the plan noted that all residents would be assessed for changes in condition and any changes in respiratory status and findings would be reported to the Medical Director. The plan further identified that a message had been sent to the families notifying them of the situation. Further review of the Immediate Jeopardy removal plan with the Administrator on [DATE] at 10:30 AM identified the facility had ordered an additional 500 gallons of water for consumption; however, the facility had not ordered the required water filters as identified in the plan per recommendations of WC #2 as outlined in the removal plan. Subsequent to surveyor inquiry, the Administrator presented documentation that she ordered an initial 20 water filters that were to be shipped overnight to the facility on [DATE] at 12:05 PM. The survey team validated the implementation of the removal plan through observations, staff interviews and review of staff training. Interview with WC #2 on [DATE] at 1:10 PM identified that he collected water samples on [DATE] and sent them out to be tested but the results take at least fourteen days. He further identified that he checked the residual chlorination in the water and noted that the level was zero, which indicated a lack of chlorine that could help to mitigate the growth of Legionella species. The Water Management Plan policy identified that the facility complies with all federal requirements for the purpose of reducing the risk of growth and the spread of Legionella and other opportunistic pathogens in the water system. 2. Resident #50's with diagnoses included cerebral infarction, hemiplegia affecting right dominant side, aphasia following cerebral infarction, and dysphagia following cerebral infarction. The admission MDS dated [DATE] identified Resident #50 had intact cognition, eating was not attempted due to medical conditions and had an enteral feeding tube. The care plan dated [DATE] identified Resident #50 had an enteral feeding tube to meet resident nutritional needs. Care plan interventions directed to check for patency and placement daily, monitor for nausea and vomiting, aspiration precautions, enteral feeding changes per physician order, and head of bed elevated at least 45 degree. The physician's order dated [DATE] directed to administer Nepro 1.8 via enteral feeding at 50 cubic centimeters (cc) per hour for 16 hours. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on [DATE] at 2:30 PM identified Resident #50 was laying in bed with the head of the bed elevated at approximately 45 degree and noted with infusing Nepro 1.8 via enteral feeding at 50 cc/hr. There was no EBP signage posted outside the door and no Personal Protective Equipment (PPE) was available outside the resident room. Resident #76's with diagnoses included multiple sclerosis, fibromyalgia, and neuromuscular dysfunction of the bladder. The quarterly MDS dated [DATE] identified Resident #76 had intact cognition, dependent with toileting, and had an indwelling urinary catheter. The care plan dated [DATE] identified Resident #76 had urinary foley catheter related to neurogenic bladder and multiple sclerosis. Care plan interventions directed to change indwelling catheter monthly, monitor for sign and symptoms of infection, and urinary catheter care every shift. The current physician's order directed to perform foley catheter care every shift and as needed. Observation on [DATE] at 10:15 AM identified Resident #76 laying in bed, a foley catheter with the urine collection bag was hooked to the bed frame. There was no EBP signage outside the door and no Personal Protective Equipment (PPE) was noted outside the resident's room. Resident #94's with diagnoses included chronic respiratory failure, anoxic brain damage, functional quadriplegia, gastrostomy status, and tracheostomy. The quarterly MDS dated [DATE] identified Resident #94 had severe cognitive impairment, had an enteral feeding tube and a tracheostomy in place. The care plan date [DATE] identified Resident #94 at risk for dehydration related to the use of enteral feeding. Care plan interventions directed to administer tube feeding per physician's order, monitor input and output per facility protocol, and monitor for signs and symptoms of dehydration. The current physician's order directed to administer Jevity 1.5 calories via enteral feeding continuously at 55 cc/hr and to provide tracheostomy care every shift. Observation on [DATE] at 10:45 AM identified Resident #94 laying in bed with the head of the bed elevated at approximately 45 degree with Jevity infusing via enteral feeding at 55 cc/hr. There was no EBP signage outside the door and no Personal Protective Equipment (PPE) was available outside the resident room. Intermittent observations of Residents #50, #76, and #94 room door from [DATE] to [DATE] failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as bathing, showering, device care or care of a urinary catheter, enteral feeding, and tracheostomy. Interview with NA #6 and LPN #6 on [DATE] at 12:15 PM identified that staff knows when a resident is on any precautions based on the posted signage outside of the resident's room which also states the type of PPE to worn and when to wear the PPE. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation and interview with the Infection Preventionist (RN #2) on [DATE] at 1:00 PM failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as dressing, bathing, showering, device care for care of a urinary catheter, enteral feeding, and tracheostomy for Resident #50, #76, and #94. She identified that all residents who had external medical device such as urinary catheter, enteral feeding, and tracheostomy will be placed on EBP and staff should be wearing proper PPE such as gloves and gown when providing a direct contact with the resident. She identified that a signage should have been placed on the door and PPE outside the resident room. Review of the Enhanced Barrier Precautions EBP) policy identified that EBP will be used in addition to standard precautions when contact precautions does not apply to reduce the risk of transmission of microorganisms by direct and/or indirect contact. The EBP also indicates that any residents who had chronic wounds and/or use of medical device will be placed on EBP if the criteria for contact precaution was not met.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on review of the clinical records, review of facility documentation, facility policy, and interviews for three of five sampled residents (Resident #60, Resident # 98, and Resident #149) reviewed for immunizations, the facility failed to ensure that the influenza and/or pneumococcal vaccine was offered. The findings include: Resident #60 was admitted to the facility on [DATE] with diagnosis that included seizures, hydrocephalus and depression. The quarterly MDS assessment dated [DATE] identified Resident #60 had intact cognition. The assessment further identified that Resident #60 influenza vaccination was not up to date. Review of Resident #60's immunization consents and records with Infection Preventionist (RN #2) on 2/25/25 at 1:15 PM failed to identify that the influenza vaccine was offered and/or administered to the resident. Resident #98's was admitted to the facility on [DATE] with diagnosis that included Parkinson, bipolar disorder, and depression. The quarterly MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment. The assessment further identified that Resident #98 influenza and pneumococcal vaccination was not up to date. Review of Resident #98's immunization consents and records with Infection Preventionist (RN #2) on 2/25/25 at 1:15 PM failed to identify that the influenza and pneumococcal vaccines were offered and/or administered to the resident. Resident #149's was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia, bipolar disorder, and intellectual disabilities. The admission MDS assessment dated [DATE] identified Resident #149 had severe cognitive impairment. The assessment further identified that Resident #149 pneumococcal vaccination was not up to date. Review of Resident #149's immunization consents and records with Infection Preventionist (RN #2) on 2/25/25 at 1:15 PM failed to identify that the pneumococcal vaccine was offered and/or administered to the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Infection Preventionist (RN#2) on 2/27/25 at 11:30 AM identified that she just started her position as Infection Preventionist at the facility on January 2025. She identified that all residents admitted to the facility would be offered the influenza and/or pneumococcal vaccines upon admission. She identified that the admission nurse would obtain the influenza and/or pneumococcal consent from the resident and/or responsible party on admission. She also identified that she would review the resident immunization records to ensure the influenza and/or pneumococcal vaccines were up to date. She identified that Resident #60 influenza vaccine was not offered, Resident #98 influenza and pneumococcal vaccine were not offered, and Resident #149 pneumococcal vaccine was also not offered. She could not provide a reason why Resident #60, Resident #90, and Resident #149 influenza and/or pneumococcal vaccines were not offered. Subsequent to surveyor inquiry, Resident #60's influenza vaccine consent was obtained and administered on 2/26/25, Resident #98 influenza and pneumococcal vaccine consents were obtained on 2/26/25 and Resident #98 influenza vaccine was administered on 2/26/25 while the pneumococcal vaccine was administered on 2/28/25, and Resident #149 pneumococcal vaccine consent was obtained and administered on 2/26/25. Review of Influenza Immunization identified all residents would be offered influenza vaccines every year unless medically contraindicated to prevent the spread of influenza and its complications to all residents. Review of Pneumococcal Vaccine identified that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia infections. The policy also identified that all residents would be assessed for eligibility to receive the pneumococcal vaccine series when indicated within 30 days of admission to the facility unless medically contraindicated or the resident had completed the current recommendation of the vaccine series.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on review of the clinical records, review of facility documentation, facility policy, and interviews for two of five residents (Resident #98 and Resident #149) reviewed for immunizations, the facility failed to ensure that the COVID-19 vaccination was offered and/or assessed to resident. The finding include: Resident #98 was admitted to the facility on [DATE] with diagnosis that included Parkinson, bipolar disorder, and depression. The quarterly MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment. The assessment further identified that Resident #98 COVID-19 vaccination was not up to date. Review of Resident #98's immunization consents and records with Infection Preventionist (RN #2) on 2/25/25 at 1:15 PM failed to identify that COVID-19 booster vaccine was offered to the resident. Resident #149 was admitted to the facility on [DATE] with diagnosis that included paranoid schizophrenia, bipolar disorder, and intellectual disabilities. The admission MDS assessment dated [DATE] identified Resident #149 had severe cognitive impairment. The assessment further identified that Resident #149 COVID-19 vaccination was not up to date. Review of Resident #149's immunization consents and records with Infection Preventionist (RN #2) on 2/25/25 at 1:15 PM failed to identify that the COVID-19 booster vaccine was offered to the resident. Interview with the Infection Preventionist (RN#2) on 2/27/25 at 11:30 AM identified that she just started her position as Infection Preventionist at the facility on January 2025. She identified that all residents at the facility would be offered the COVID-19 booster vaccines when eligible and not medically contraindicated to the residents. She also identified that she would review the resident immunization record to ensure the resident COVID-19 vaccines were up to date. She identified that Resident #98 and Resident #149 COVID-19 booster vaccines was not offered. She could not provide any reason why the COVID-19 booster vaccines was not offered to Resident #98 and Resident #149. Subsequent to surveyor inquiry, Resident #98 COVID-19 vaccine consent was obtained and administered on 2/26/25, and Resident #149 COVID-19 vaccine consent was obtained and administered on 2/26/25. Review of COVID-19 Vaccination policy identified that the facility would vaccinate its residents against certain preventable disease such as COVID-19 disease. Each resident would be offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident had already been immunized.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075001	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Center	6448 Main Street Trumbull, CT 06611

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 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 47900 Based on observations and interviews, the facility failed to ensure kitchen equipment was maintained in a safe and functional manner. The findings include: An observation during a tour of the kitchen on 2/20/25 from 10:36 AM to 11:15 AM with the Director of Food Service identified that the pot washer was not functioning, and the door of the food warmer was unable to close and was held closed by a door stopper. Interview with the Director of Food Service on 2/20/25 at 11:15 AM identified the pot washer had been broken for months and the food warmer door was not closing properly because of the gasket around the door for months. He added that he had notified the Administrator and the Maintenance Director. Interview with the Director of Food Service on 2/28/25 at 11:26 AM identified the equipment has been in need of repair for almost a year and noted that they utilize the 3-bay sink to wash the pots then put them through the dishwasher. In addition, the they have been utilizing a door stopper or a cart to keep the door of the food warmer closed. Interview with the Director of Maintenance on 3/3/25 at 10:05 AM identified the kitchen needs repairs such as gaskets for the refrigerators, the warmer gasket needs to be replaced, and the broken pot washer. The Director of Maintenance identified he started working at the facility in November of 2024 and had tried to fix various broken items and leaks in the building and became overwhelmed. He further identified that he became aware of the broken items in the kitchen about two weeks ago and was trying to get a company to come out to the facility to fix the issues; however, due to the facility's outstanding debts to vendors, often times the companies will not come out to the facility without some payment by the facility. Interview with the Administrator on 3/3/25 at 11:27 AM identified that when broken equipment is reported, the maintenance department is responsible for assessing the issue to identify whether it can be fixed by them or if it requires an outside vendor to resolve the issue. She further identified that she was not aware of the broken pot washer or warmer as she had just started working at the facility in November of 2024. The Administer noted that based on the type of repairs needed it requires corporate approval. Interview with Dietary Aide #2 on 3/3/25 at 12:30 PM identified that the warmer door does not stay closed, and she uses a cart or door stopper to keep the door closed to maintain the temperature. Review of the Equipment policy identified all food service equipment will be clean, sanitary, and in proper working order.