STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, and facility policy for 12 of 20 residents, (Residents #3, 10, 13, 24, 32, 45, 49, 56, 80, 103, 104, and 105) whose clinical records lacked documentation that they had received their evening medications on 6/3/24 after the charge nurse left the facility and did not report off, the facility failed to ensure the resident representatives were notified, and for 1 of 2 residents (Resident #66) reviewed for non-pressure wounds, the facility failed to notify the physician or APRN/Family Nurse Practitioner (FNP-BC) when the resident's wound deteriorated on 10/7/24, and subsequently, 2 days later, when FNP-BC #1 did wound rounds on 10/9/24 and found the wound significantly deteriorated, the resident was sent to the hospital for treatment, and for 2 of 3 residents (Resident #4 and 9) reviewed for infection, the facility failed to ensure the resident representatives were notified when the residents had a change that required new medications related to covid-19, and for 1 of 3 residents (Resident #45) reviewed for hospitalization s, the facility failed to ensure that the physician was notified when the resident's blood sugars were outside the parameters. The findings include: 1. Resident #3 was admitted to the facility in July 2021 with diagnoses that included type 2 diabetes mellitus and depressive episodes. Review of the June 2024 monthly physician's orders directed to administer the following medications: Rivastigmine Tartrate 4.5 mg twice daily at 9:30 AM and 9:30 PM. Lantus Solution 100 unit/ml injection 17 units at bedtime (8:30 PM). Risperdal 0.5 mg at bedtime (9:30 PM). Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Lantus Solution due at 8:30 PM or Rivastigmine Tartrate and Risperdal due at 9:30 PM had been administered. 2. Resident #10 was admitted to the facility in November 2020 with diagnoses that included chronic pain syndrome, spinal stenosis, and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Baclofen 20mg three times daily at 9:30 AM, 5:30 PM, and 9:30 PM. Metoprolol Tartrate 50 mg twice daily at 9:30 AM and 6:30 PM. Meclizine HCL 50 mg twice daily at 6:00 AM and 6:00 PM. Tizanidine HCL 2 mg every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Baclofen due at 5:30 PM, Metoprolol due at 6:30 PM, Meclizine due at 6:00 PM, or Tizanidine due at 6:00 PM had been administered. 3. Resident #13 was admitted to the facility in November 2021 with a dementia diagnoses. Review of the June 2024 physician's orders directed to administer the following medications: Namenda 10 mg at bedtime at 8:30 PM. Trazadone HCL 50 mg at bedtime at 9:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Namenda due at 8:30 PM or Trazadone due at 9:30 PM had been administered. 4. Resident #24 was admitted to the facility in November 2021 with diagnoses that included COPD and Parkinson's Disease. Review of the June 2024 physician's orders directed to administer the following medications: Symbicort Inhalation Aerosol 80 - 4.5mcg/act twice daily at 8:30 AM and 5:30 PM. Sinemet 25 - 100 mg twice daily at 8:30 AM and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Symbicort due at 5:30 PM or Sinemet due at 5:30 PM had been administered. 5. Resident #32 was admitted to the facility in October 2021 with diagnoses that included BPH with lower urinary tract symptoms and type 2 diabetes mellitus. Review of the June 2024 physician's orders directed to administer the following medications: Finasteride 5 mg daily at 5:00 PM. Humalog Injection Solution (Insulin Lispro) 100 unit/ml inject per sliding scale before meals and at bedtime at 8:00 AM, 11:30 AM, 4:00 PM, and 9:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Finasteride due at 5:00 PM or Insulin Lispro due at 4:00 PM had been administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Resident #45 was admitted to the facility in December 2020 with diagnoses that included pulmonary embolism, hyperlipidemia, and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: Lipitor 40 mg daily at 5:00 PM. Senna 8.6mg at bedtime at 9:30 PM. Xalatan Ophthalmic Solution at bedtime at 9:30 PM. Carvedilol 3.125 mg every 12 hours at 8:30 AM and 8:30 PM. Eliquis 2.5 mg every 12 hours at 8:30 AM and 8:30 PM. Miralax 17 gm twice daily at 8:30 AM and 8:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Lipitor due at 5:00 PM, Senna due at 9:30 PM, Xalatan Solution due at 9:30 PM, Carvedilol due at 8:30 PM, Eliquis due at 8:30 PM, or Miralax due at 8:30 PM had been administered. 7. Resident #49 was admitted to the facility in January 2024 with diagnoses that included Charcot's Arthropathy and type 2 diabetes mellitus with foot ulcer. Review of the June 2024 physician's orders directed to administer the following medication: Keflex 4 mg four times daily at 1200 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Keflex due at 6:00 PM had been administered. 8. Resident #56 was admitted to the facility in September 2022 with diagnoses that included heart failure and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: Atorvastatin Calcium 20mg at bedtime at 8:30 PM. Calcium 600 mg 8in the evening at 8:00 PM. Doxazosin Mesylate 4 mg at bedtime at 8:30 PM. Entresto 97 - 103 mg every 12 hours at 8:30 AM and 8:30 PM. Hydrocortisone 10 mg twice daily at 8:30 AM and 8:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Atorvastatin Calcium due at 8:30 PM, Doxazosin Mesylate due at 8:30 PM, Entresto due at 8:30 PM, or Hydrocortisone due at 8:30 PM had been administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Resident #80 was admitted to the facility in December 2023 with diagnoses that included herpes viral infection, hyperlipidemia, and typed 2 diabetes mellitus. Review of the June 2024 physician's orders directed to administer the following medications: Crestor 5 mg daily at 5:00 PM. Acyclovir 400 mg every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Insulin Lispro per sliding scale before meals at 7:30 AM, 11:30 AM, and 4:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Crestor due at 5:00 PM, Acyclovir due at 6:00 PM, or the Insulin Lispro due at 4:30 PM had been administered. 10. Resident #103 was admitted to the facility in January 2024 with diagnoses that included orthostatic hypotension and repeated falls. Review of the June 2024 physician's orders directed to administer the following medication: Midodrine 10 mg before meals at 8:00 AM, 11:30 AM, and 4:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Midodrine due at 4:30 PM had been administered. 11. Resident #104 was admitted to the facility in December 2019 with diagnoses that included alcoholic cirrhosis and mild protein-calorie malnutrition. Review of the June 2024 physician's orders directed to administer the following medications: Spironolactone 50 mg twice daily at 8:30 AM and 5:30 PM. Ensure Plus three times daily at 9:30 AM, 1:30 PM, and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Spironolactone due at 5:30 PM or Ensure Plus due at 5:30 PM had been administered. 12. Resident #105 was admitted to the facility in December 2023 with diagnoses that included hypertension, hyperlipidemia, and BPH. Review of the June 2024 physician's orders directed to administer the following medications: Atorvastatin Calcium 40 mg daily at 5:00 PM. Finasteride 5 mg daily at 5:00 PM. Calcium Carbonate 600 mg twice daily at 8:30 AM and 5:30 PM. Furosemide 40 mg twice daily at 8:30 AM and 5:30 PM. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Carvedilol 6.25 mg twice daily at 8:30 AM and 5:30 PM. Pantoprazole Sodium 40 mg twice daily at 8:30 AM and 5:30 PM. Gabapentin 600 mg three times daily at 9:30 AM, 1:30 PM, and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Atorvastatin Calcium due at 5:00 PM, Finasteride due at 5:00 PM, Calcium Carbonate due at 5:30 PM, Carvedilol due at 5:30 PM, Pantoprazole due at 5:30 PM, or the Gabapentin due at 5:30 PM had been administered. Review of the reportable event forms dated 6/3/24 and the clinical records failed to reflect that the resident representatives for Residents #3, 10, 13, 24, 32, 45, 49, 56, 80, 103, 104, and 105 were made aware that the facility could not determine if the evening medications had been administered after the charge nurse left the facility during her shift. The Change of Condition Notification policy directs the facility to inform the resident, consult with the resident's health care provider, and if known notify the resident's legal representative or family member when there is: an incident involving the resident which may result in injury or requires medical treatment, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, and a decision to transfer or discharge the resident from the facility. 13. Resident #66 was readmitted to the facility in July 2024 with diagnoses that included uncontrolled type 2 diabetes, severe PVD, chronic kidney disease, history of right foot cellulitis with osteomyelitis, status post transmetatarsal amputation, and Charcot foot. A wound evaluation by Family Nurse Practitioner - Board Certified (FNP-BC #1) dated 9/11/24 identified the wound on the right plantar metatarsal head (first identified 8/14/24) was stable and measured 2.4cm by 2. 5cm by 0.2c with 50% new granulation tissue. Recommendations included to cleanse with normal saline, apply Calcium Alginate with silver to base of wound, and secure with ABD pad and rolled gauze daily and as needed. Review of the clinical record indicated that FNP-BC #1 evaluated the wound on 9/18/24 and 9/25/24 and the wound was stable with 100% granulation tissue. A wound evaluation by FNP-BC #1 dated 10/2/24 identified the wound was worsening, had a mild odor post cleansing, had 50% slough and moderate amount of serous drainage. Recommendations included a treatment change. Cleanse with Dakin's 1/4 strength, apply iodosorb, adaptic and Calcium Alginate with silver to base of wound, and secure with ABD pad and rolled gauze daily and as needed. Although the wound on the right plantar metatarsal head had worsened on 10/2/24 and required the treatment to be changed, review of the clinical record failed to reflect that an RN assessment of the wound had been done between 10/3/24 - 10/8/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound evaluation by FNP-BC #1 dated 10/9/24 identified the wound had deteriorated, was malodorous post cleansing, had 50% slough, periwound had severe maceration that measured 5.0cm by 12.0cm, erythema, warmth and a moderate amount of serous exudate. Further, the right leg had increased edema, and the resident appeared to have discomfort at the wound. Recommendation to send the resident to the hospital. Interview with LPN #9 on 10/23/24 at 3:54 PM identified she was the charge nurse for Resident #66 on Friday 10/5/24, Monday 10/7/24, Tuesday 10/8/24 and Wednesday 10/9/24. LPN #9 identified that when she worked on Friday 10/5/24, Resident #66's right plantar wound was at baseline, however, when she came in on Monday 10/7/24, after being off for the weekend, she noted that the wound had deteriorated, had increased drainage and a boggy and soggy area that was new. LPN #9 identified she reported the change in wound status to RN #8 and LPN #8 and brought them both into the resident's room and showed them the wound. LPN #9 indicated that RN #8 and LPN #8 changed the dressing to the resident's right plantar wound on 10/7/24 and again on 10/8/24. LPN #9 identified that on 10/9/24 FNP-BC #1 came in and identified the wound was worse and sent the resident to the hospital. Interview with RN #8 on 10/24/24 at 12:25 PM identified she was on orientation (hired as the wound nurse) and was being trained by LPN #8 on Monday 10/7/24 and Tuesday 10/8/24. RN #8 identified she and LPN #9 were notified by the charge nurse, LPN #9, on Monday 10/7/24 that Resident #66's wound was worse, and they went in and looked at the wound. RN #8 indicated the wound was slighted macerated, and wet and boggy. RN #8 told LPN #9 to call FNP-BC #1 and report the change. RN #8 indicated that she did not notify FNP-BC #1 or write a note regarding the worsening of the residents wound because she was on orientation and thought that LPN #9 had done it. RN #8 also thought that there was a new order to change the dressing to the right plantar wound twice daily because of the drainage, but after review of the record, RN #8 identified that there was no change to the frequency of the dressing change or documentation that the physician or FNP-BC #1 had been notified. After further review of the clinical record, RN #8 identified there was no documentation of an RN assessment of the wound on 10/7/24 or 10/8/24 after LPN #9 reported the wound had deteriorated. Interview with FNP-BC #1 on 10/23/24 at 2:41 PM identified the residents wound deteriorated significantly between 10/2/24 - 10/9/24. The wound was noted to have a large area of maceration, increased drainage and the resident's right leg was edematous. FNP-BC #1 indicated she was worried about the wound and spoke to the attending physician and to the resident. FNP-BC #1 identified she explained to Resident #66 that it was best for him/her to be evaluated in the hospital due to the deterioration. FNP-BC #1 identified she had not been notified of the change in the wound on 10/7/24 or 10/8/24 and observed the change when she came in on 10/9/24 to do weekly wound rounds. FNP-BC #1 identified she should have been notified of the change when it was identified and that had she been made aware of the change sooner, she could have increased the dressing change frequency to 2 or 3 times daily, get blood work or send the resident to the hospital for an evaluation. Although requested, an interview with LPN #8 was not obtained. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Change of Condition Notification policy directs the facility to inform the resident, consult with the resident's health care provider, and if known notify the resident's legal representative or family member when there is: an incident involving the resident which may result in injury or requires medical treatment, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, and a decision to transfer or discharge the resident from the facility. 14. Resident #4 was admitted to the facility in June 2021 with diagnoses that included multiple sclerosis, quadriplegia, and dysphagia. The annual MDS dated [DATE] identified Resident #4 had moderately impaired cognition, was always incontinent of bowel, utilized a urinary catheter for bladder and was fully dependent on staff to assist with eating, bathing, and toileting. The care plan dated 7/9/24 identified Resident #4 had impaired decision making. Interventions included to use task segmentation to support short term memory deficits and break tasks into one step at a time. Review of the facility Covid line list identified Resident #28 (Resident #4's roommate) began to have symptoms and subsequently tested positive for covid-19 on 10/18/24 Review of the clinical record identified the facility initiated Covid antigen testing on Resident #4 due to the covid-19 exposure on 10/19/24. During an initial tour of the facility on 10/21/24 beginning at 8:02 AM, observation identified Resident #4, and Resident #28 residing in the same room. A sign posted outside of residents' door identified Droplet/Contact Precautions. Interview with Person #2 on 10/21/24 at 10:26 AM identified he/she has had ongoing concerns and conveyed the concerns to the facility administration regarding the lack of notification when changes are noted in Resident #4 condition including treatments, hospitalization s, and procedures. Person #2 also identified that she was not aware of any covid-19 outbreaks at the facility and had not been notified of any outbreak issues with Covid at all during 2024. An APRN note dated 10/21/24 at 10:46 AM identified Resident #4 had exam finding that included a congested cough. The note further identified Resident #4 had close exposure to Covid 19 and was undergoing current testing. The note further identified Resident #4 had tested negative despite a cough, and that Robitussin as needed was ordered for 10 days. Review of the clinical record failed to identify any documentation related to notification to Person #2 regarding Resident #4 having exposure to Covid 19 due to an outbreak in the facility, that the exposure required testing, or that Resident #4 had developed a cough that required treatment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 10/20/24 identified Resident #9 was confirmed Covid-19 positive. Interventions directed to use transmission-based precautions, monitor oxygen saturation levels, notify and update physician and resident representative as needed. The APRN progress note written by APRN #2 dated 10/21/24 at 1:23 PM identified she was seeing Resident #9 today for Covid-19 infection. Resident #9 was had tested positive for Covid-19 over the weekend. Resident #9 reports sore throat resolved at this time but complains of nasal congestion and cough. Resident #9 has complaints of eye discomfort currently. Plan for new covid-19 infection to continue cough syrup as needed and continue acetaminophen as needed. Interview with the DNS on 10/23/24 at 8:18 AM indicated that her expectation was that either the supervisor or charge nurse can make the call to the resident representative that day to update on the new diagnosis of covid-19 and any new physician orders. The DNS indicated that the resident representative must be notified of any changes in condition such as a new diagnosis of covid-19, any new medications, or any medication changes right away and that notification must be documented in the clinical record. After clinical record review, the DNS indicated that there was not a progress note identifying that the resident representative was notified. Interview with LPN #1 on 10/23/24 at 8:41 AM indicated that on 10/20/24 Person #4 was visiting Resident #9 and brought to LPN #1's attention that Resident #9 was not feeling well and was tired. LPN #1 indicated that she had noted Resident #9's eyes were red and swollen and he/she was rubbing them. LPN #1 indicated there was a standing physician order to perform the covid-19 test. LPN #9 indicated that she decided to do the covid-19 test and it was positive, so she notified the RN supervisor via phone and called Person #4 via phone to inform Resident #9 had just tested positive for covid-19. LPN #1 indicated that she was not aware of the new physician order for cough syrup and did not call Person #4 to update him/her of the new physician order. Interview with Person #4 on 10/23/24 at 9:08 AM indicated that when he/she had visited Resident #9 on Sunday 10/20/24 he/she noticed Resident #9 was not feeling well and notified LPN #1. Person #4 indicated that LPN #1 had called him/her after the visit to informed him/her that Resident #9 had just tested positive with covid-19 and that the provider would be contacted. Person #1 indicated that no one called after that to inform him/her if the provider was contacted and had ordered any medications. Interview and clinical record review with the DNS on 10/23/24 failed to provide documentation that Person #4 was updated when the APRN wrote orders for the resident to receive cough syrup due to new onset covid-19. Review of the Change of Condition Notification identified the facility will inform the resident, residents' provider, and resident representative when there is a change of condition. The purpose is to ensure the residents change of condition or the start of a new medication was reported to the resident representative. The physician and resident representative notification must be documented in the electronic medical record. 46040 16. Resident #2 was admitted to the facility in March 2022 with diagnoses that included quadriplegia, aphasia, and weakness. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated 5/12/24 directed to administer Lovenox (an anticoagulant) injection 40 mg subcutaneously daily to prevent deep vein thrombosis. The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, was frequently incontinent of bowel, required a urinary catheter for bladder, and was dependent on staff to assist with eating, dressing, and transfers. The care plan dated 8/21/24 identified Resident #2 had a urinary catheter. Interventions included to monitor for blood and sediment. The care plan also identified Resident #2 required medication that increases the time it takes for the blood to clot. Interventions included to monitor for signs of bleeding in the urine, bowel movements, and bruising. A nurse's note dated 9/15/24 at 1:52 PM by LPN #7 identified that Resident #2 had an episode of genital bleeding with clots noted in his/her undergarment. The note identified Resident #2's urinary catheter was draining clear yellow fluid, and that Resident #2 was seen by the APRN and new orders for labs were placed. A change of condition follow up note dated 9/16/24 at 8:36 AM by LPN #6 identified Resident #2's urinary catheter was not draining after 2 attempts to flush. The note further identified 2 attempts to replace the catheter were also unsuccessful and that the ADNS was notified. Review of the clinical record failed to identify any documentation related notification to the physician or resident representative following the complications with Resident #2's urinary catheter and subsequent removal on 9/16/24. Interview with the ADNS on 10/24/24 at 11:45 AM identified she was aware that Resident #2 had the bleeding episode on 9/15/24, and issues with the urinary catheter on 9/16/24. The ADNS identified she was notified by LPN #6 that Resident #2's urinary catheter was removed and was unable to be replaced, and that Resident #2 was able to void freely. The ADNS identified that while she was aware of the prior bleeding episode and was notified by LPN #6 regarding the catheter issue, she did not make any notes or assess Resident #2 following the notification. The ADNS identified she believed there was communication with the APRN since a provider was in the facility daily but that she should have notified the APRN, completed an assessment on Resident #2, and ensured that Resident #2's resident representative was notified. The facility policy on change of condition directed that the facility would inform the resident, attending physician, and resident representative when there was a change of condition. The policy directed this included a need to alter treatment significantly (i.e a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment) and that the licensed nurse per state regulations would conduct a complete physical/mental evaluation and document the findings in the clinical record. The policy further directed that the licensed nurse would contact the attending physician and resident representative regarding the change of condition, repeated attempts would be made until successful, and all attempts would be documented with date and time. 17. Resident #45 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes, chronic kidney disease (Stage 4 severe) and morbid obesity. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS dated [DATE] identified Resident #45 had moderately impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing and dressing. The care plan dated 6/14/24 identified Resident #45 had a history of insulin dependent diabetes but no longer required medication. Interventions included to monitor for signs/symptoms of hyperglycemia, hypoglycemia, and administer insulin per MD order. Review of the clinical record identified Resident #45 was hospitalized from 7/3/24 - 7/9/24 due to abnormal lab values. A hospital W-10 report dated 7/9/24 identified Resident #45 had a diagnosis of acute kidney injury. The report also identified that while hospitalized , Resident #45 had elevated blood glucose levels and a hemoglobin A1C (a lab test that measures an average blood glucose level over a 3-month period) was high at 8.6 % (normal lab value 4.0-5.6%). Resident #45

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #43) reviewed for care planning, the facility failed to ensure resident care conferences were completed quarterly, that the resident was invited and attended, and the resident care plan was updated quarterly. The findings include: Resident #43 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and left non-dominant side, aphasia, cognitive communication disorder, and adjustment disorder with mixed disturbance of emotions and conduct. Interdisciplinary Care Planning Meeting document dated 2/19/24 failed to identify if Resident #43 had participated in the care plan process or attended the care plan meeting. Care Plan Meeting Attendees were Resident #43's representative and staff from MDS, social services, and dietary. Interdisciplinary Care Planning Meeting document dated 5/16/24 identified that Resident #43 did not attend the care plan meeting but was spoken to separately due to poor cognition. Care Plan Meeting Attendees were staff from MDS, social services, and dietary; a voicemail was left for the resident representative and the resident representative was updated upon a return call to the facility. Review of the current care plan identified the last care plan review completion date was 5/22/24. The admission MDS dated [DATE] identified Resident #43 had moderately impaired cognition, and it was very important for the resident to do things with groups of people. Interview with Resident #43 on 10/21/24 at 9:40 AM identified that while he/she receives excellent care by the facility staff, he/she does not feel well-informed and would like an update as to when he/she will be leaving the facility or if he/she will remain at the facility. Resident #43 indicated that he/she could not recall being involved in the quarterly care plan meetings, but he/she would like to participate. Interview and clinical record review with the Care Plan Meeting Scheduler (NA #3) on 10/23/24 at 11:15 AM failed to identify that a resident care plan meeting had been completed since 5/16/24. NA #3 indicated that Resident #43 had been in and out of the hospital a few times, and the care plan scheduling must have gotten confused. NA #3 indicated that in addition to sending a letter to Resident #43's representative, with a notification of the scheduled care plan meeting, a letter was also sent to Resident #43, in February and May. NA #3 identified that a care plan meeting would be scheduled on 11/1/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #3 on 10/23/24 at 11:33 AM identified that she meets with Resident #43 frequently, and she also attends his/her resident care plan meetings. SW #3 indicated that she is not responsible for scheduling or running the care plan meetings, Resident #43 has participated in some of the quarterly care plan meetings, as well as the resident representative via telephone. SW #3 further indicated that Resident #43 had been in and out of the hospital, and that may be the reason why the quarterly care plan meetings did not occur. Interview and clinical record review with the MDS Coordinator (LPN #10) on 10/13/24 at 11:42 AM failed to identify that the comprehensive care plan had been updated since May 2024, 5 months prior. LPN #10 indicated that the care plan should be updated quarterly and as needed; he typically updates the resident care plan when the MDS is scheduled. LPN #10 indicated that Resident #43's comprehensive care plan was most likely not updated in August because there was no MDS that needed to be completed; Resident #43 had been hospitalized and an Admission MDS was completed on 7/18/24. LPN #10 indicated that he did not complete the 7/18/24 admission MDS, and that the care plan should have been updated along with the admission MDS. LPN #10 further indicated that Resident #43 had a care plan meeting scheduled for 11/1/24, and the comprehensive care plan would be updated before then. Interview and clinical record review with the DNS on 10/24/24 at 1:06 PM identified that Resident #43's care plan meeting had not been done since 5/16/24 and that the comprehensive care plan was not updated when the last MDS was completed. The DNS identified that Resident #43 had been hospitalized a few times over the summer and was unsure if that was the reason that the care plan was not updated, and the care plan meeting did not occur. The DNS further identified that she would expect that all of the extended stay residents would meet with the interdisciplinary team, and if appropriate the responsible party, to review and update the comprehensive care plan, quarterly. The facility's Baseline/Comprehensive Person-Centered Care Plan policy directs the Comprehensive Person-Centered Care Plan (CPCCP) to be developed after the completion of the comprehensive assessment (MDS) and will be reviewed by an interdisciplinary team that includes the following representatives: the resident, the resident's family or legal representative, social services, nursing, dietary, therapeutic recreation, specialized rehabilitation, and health care provider. The policy further directs that the resident and/or representative have the right to participate in the development/implementation of the planning process, request meetings and have the right to request revisions to the plan of care. The CPCCP will be reviewed and revised as follows: quarterly following MDS completion, following a significant change in status, episodically, at the time of the hospital readmission to ensure the plan reflects resident's current status, and an annual MDS completion will require a full team meeting to ensure the CPCCP reflects the residence current status. The responsibility of the MDS/CPCCP coordinator is to schedule the resident's assessments and care plan meetings in accordance with regulation and resident/representative needs. Although requested, a resident care plan meeting policy was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 46040 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 20 of 20 residents (Residents #3, 10, 13, 24, 32, 39, 45, 49, 52, 56, 59, 67, 69, 70, 80, 103, 104, 105, 106, and 193), the facility failed to ensure medication administration was completed and documented, per the physician's order on 6/3/24 after the charge nurse left the facility and did not report off, and for 1 of 2 residents (Resident #2) reviewed for urinary catheters, the facility failed to ensure an RN assessment was completed following a change in condition, and for 1 of 3 residents (Resident #50) reviewed for falls, the facility failed to ensure that neurological checks were completed following an unwitnessed fall, and for 1 of 2 residents (Resident #9) reviewed for infection, the facility failed to ensure an RN assessment was completed after the resident had a change in condition, and for Resident #66 the facility failed to complete an RN assessment of a right plantar metatarsal foot wound, including documentation, on 10/7/24 and 10/8/24 when the wound was noted to be deteriorated, and for 1 of 3 residents (Resident #82) reviewed for falls, the facility failed to ensure neurological assessments and nursing assessments were completed per the facility policy following multiple falls, and for 1 of 2 residents (Resident #22) reviewed for skin conditions, the facility failed to ensure a resident, with chronic foot wounds, had his/her heels offloaded while in bed, per the physician's order and failed to ensure an RN assessment was completed upon a change in condition. The findings include: 1. Resident #3 was admitted to the facility in July 2021 with diagnoses that included type 2 diabetes mellitus and depressive episodes. Review of the June 2024 monthly physician's orders directed to administer the following medications: Rivastigmine Tartrate 4.5 mg twice daily at 9:30 AM and 9:30 PM. Lantus Solution 100 unit/ml injection 17 units at bedtime (8:30 PM). Risperdal 0.5 mg at bedtime (9:30 PM). Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Lantus Solution due at 8:30 PM or Rivastigmine Tartrate and Risperdal due at 9:30 PM had been administered. 2. Resident #10 was admitted to the facility in November 2020 with diagnoses that included chronic pain syndrome, spinal stenosis, and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: Baclofen 20mg three times daily at 9:30 AM, 5:30 PM, and 9:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Metoprolol Tartrate 50 mg twice daily at 9:30 AM and 6:30 PM. Meclizine HCL 50 mg twice daily at 6:00 AM and 6:00 PM. Tizanidine HCL 2 mg every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Baclofen due at 5:30 PM, Metoprolol due at 6:30 PM, Meclizine due at 6:00 PM, or Tizanidine due at 6:00 PM had been administered. 3. Resident #13 was admitted to the facility in November 2021 with a dementia diagnoses. Review of the June 2024 physician's orders directed to administer the following medications: Namenda 10 mg at bedtime at 8:30 PM. Trazadone HCL 50 mg at bedtime at 9:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Namenda due at 8:30 PM or Trazadone due at 9:30 PM had been administered. 4. Resident #24 was admitted to the facility in November 2021 with diagnoses that included COPD and Parkinson's Disease. Review of the June 2024 physician's orders directed to administer the following medications: Symbicort Inhalation Aerosol 80 - 4.5mcg/act twice daily at 8:30 AM and 5:30 PM. Sinemet 25 - 100 mg twice daily at 8:30 AM and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Symbicort due at 5:30 PM or Sinemet due at 5:30 PM had been administered. 5. Resident #32 was admitted to the facility in October 2021 with diagnoses that included BPH with lower urinary tract symptoms and type 2 diabetes mellitus. Review of the June 2024 physician's orders directed to administer the following medications: Finasteride 5 mg daily at 5:00 PM. Humalog Injection Solution (Insulin Lispro) 100 unit/ml inject per sliding scale before meals and at bedtime at 8:00 AM, 11:30 AM, 4:00 PM, and 9:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Finasteride due at 5:00 PM or Insulin Lispro due at 4:00 PM had been administered. 6. Resident #39 was admitted to the facility in February 2024 with diagnoses that included drug induced Parkinsonism, bipolar disorder, and hypotension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the June 2024 physician's orders directed to administer the following medications: Lyrica 75 mg three times daily at 8:30 AM, 2:30 PM, and 10:30 PM. Midodrine 5 mg three times daily at 8:30 AM, 2:30 PM, and 8:00 PM. Carbidopa-Levodopa 25-100 mg twice daily at 8:30 AM and 8:30 PM. Risperidone 0.25 mg twice daily at 8:30 AM and 8:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Lyrica due at 10:30 PM, Midodrine due at 8:00 PM, Carbidopa-Levodopa due at 8:30 PM, or Risperidone due at 8:30 PM had been administered. 7. Resident #45 was admitted to the facility in December 2020 with diagnoses that included pulmonary embolism, hyperlipidemia, and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: Lipitor 40 mg daily at 5:00 PM. Senna 8.6mg at bedtime at 9:30 PM. Xalatan Ophthalmic Solution at bedtime at 9:30 PM. Carvedilol 3.125 mg every 12 hours at 8:30 AM and 8:30 PM. Eliquis 2.5 mg every 12 hours at 8:30 AM and 8:30 PM. Miralax 17 gm twice daily at 8:30 AM and 8:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Lipitor due at 5:00 PM, Senna due at 9:30 PM, Xalatan Solution due at 9:30 PM, Carvedilol due at 8:30 PM, Eliquis due at 8:30 PM, or Miralax due at 8:30 PM had been administered. 8. Resident #49 was admitted to the facility in January 2024 with diagnoses that included Charcot's Arthropathy and type 2 diabetes mellitus with foot ulcer. Review of the June 2024 physician's orders directed to administer the following medication: Keflex 4 mg four times daily at 1200 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Keflex due at 6:00 PM had been administered. 9. Resident #52 was admitted to the facility in May of 2021 with diagnoses that included hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage and contractures to the left foot and hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the June 2024 physician's orders directed to administer the following medications: Calcium Carbonate - Vitamin D 500-200 mg twice daily at 9:00 AM and 5:00 PM. Carvedilol 25 mg twice daily at 9:00 AM and 5:00 PM. Tizanidine HCL 2 mg twice daily at 8:30 AM and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Calcium Carbonate - Vitamin D due at 5:00 PM, Carvedilol due at 5:00 PM, or Tizanidine HCL due at 5:30 PM had been administered. 10. Resident #56 was admitted to the facility in September 2022 with diagnoses that included heart failure and hypertension. Review of the June 2024 physician's orders directed to administer the following medications: Atorvastatin Calcium 20mg at bedtime at 8:30 PM. Calcium 600 mg in the evening at 8:00 PM. Doxazosin Mesylate 4 mg at bedtime at 8:30 PM. Entresto 97 - 103 mg every 12 hours at 8:30 AM and 8:30 PM. Hydrocortisone 10 mg twice daily at 8:30 AM and 8:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Atorvastatin Calcium due at 8:30 PM, Doxazosin Mesylate due at 8:30 PM, Entresto due at 8:30 PM, or Hydrocortisone due at 8:30 PM had been administered. 11. Resident #59 was admitted to the facility in September 2019 with diagnoses that included spinal stenosis and spinal fusion. Review of the June 2024 physician's orders directed to administer the following medications: Baclofen 5mg before meals and at bedtime at 6:30 AM, 11:30 AM, 4:00 PM, and 8:00 PM. Gabapentin 300 mg before meals and at bedtime at 6:30 AM, 11:30 AM, 4:00 PM, and 8:00 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Baclofen due at 8:00 PM or Gabapentin due at 8:00 PM had been administered. 12. Resident #67 was admitted to the facility in August 2021 with diagnoses that included chronic pain in the right and left shoulders and knees and difficulty walking. Review of the June 2024 physician's orders directed to administer the following medication: Meloxicam 7.5 mg twice daily at 8:30 AM and 5:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Meloxicam due at 5:30 PM had been administered. 13. Resident #69 was admitted to the facility in June 2022 with diagnoses that included CHF, COPD, atrial fibrillation, type 2 diabetes mellitus, and hyperlipidemia. Review of the June 2024 physician's orders directed to administer the following medications: Atorvastatin Calcium 20 mg daily at 5:00 PM. Senna 8.6 mg daily at 5:00 PM. Apixaban 2.5 mg twice daily at 8:30 AM and 5:30 PM. Carvedilol 25 mg twice daily at 8:30 AM and 5:30 PM. Metolazone 10 mg twice daily at 8:30 AM and 5:30 PM. Zovirax 400 mg twice daily at 8:30 AM and 5:30 PM. Insulin Lispro 100 unit/ml as per sliding scale three times daily at 8:30 AM, 12:30 PM, and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Atorvastatin Calcium due at 5:00 PM, Senna due at 5:00 PM, Apixaban due at 5:30 PM, Carvedilol due at 5:30 PM, Zovirax due at 5:30 PM, or the Insulin Lispro due at 5:30 PM had been administered. 14. Resident #70 was admitted to the facility in January 2022 with diagnoses that included dehiscence of amputation stump and type 2 diabetes mellitus. Review of the June 2024 physician's orders directed to administer the following medications: Expedite protein supplement twice daily at 9:30 AM and 6:30 PM. Metformin HCL 1000 mg twice daily at 9:30 AM and 6:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Expedite protein supplement due at 6:30 PM or Metformin due at 6:30 PM had been administered. 15. Resident #80 was admitted to the facility in December 2023 with diagnoses that included herpes viral infection, hyperlipidemia, and typed 2 diabetes mellitus. Review of the June 2024 physician's orders directed to administer the following medications: Crestor 5 mg daily at 5:00 PM. Acyclovir 400 mg every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Lispro per sliding scale before meals at 7:30 AM, 11:30 AM, and 4:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Crestor due at 5:00 PM, Acyclovir due at 6:00 PM, or the Insulin Lispro due at 4:30 PM had been administered. 16. Resident #103 was admitted to the facility in January 2024 with diagnoses that included orthostatic hypotension and repeated falls. Review of the June 2024 physician's orders directed to administer the following medication: Midodrine 10 mg before meals at 8:00 AM, 11:30 AM, and 4:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Midodrine due at 4:30 PM had been administered. 17. Resident #104 was admitted to the facility in December 2019 with diagnoses that included alcoholic cirrhosis and mild protein-calorie malnutrition. Review of the June 2024 physician's orders directed to administer the following medications: Spironolactone 50 mg twice daily at 8:30 AM and 5:30 PM. Ensure Plus three times daily at 9:30 AM, 1:30 PM, and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Spironolactone due at 5:30 PM or Ensure Plus due at 5:30 PM had been administered. 18. Resident #105 was admitted to the facility in December 2023 with diagnoses that included hypertension, hyperlipidemia, and BPH. Review of the June 2024 physician's orders directed to administer the following medications: Atorvastatin Calcium 40 mg daily at 5:00 PM. Finasteride 5 mg daily at 5:00 PM. Calcium Carbonate 600 mg twice daily at 8:30 AM and 5:30 PM. Furosemide 40 mg twice daily at 8:30 AM and 5:30 PM. Carvedilol 6.25 mg twice daily at 8:30 AM and 5:30 PM. Pantoprazole Sodium 40 mg twice daily at 8:30 AM and 5:30 PM. Gabapentin 600 mg three times daily at 9:30 AM, 1:30 PM, and 5:30 PM. Review of the June 2024 MAR failed to reflect documentation to show that on 6/3/24, the Atorvastatin Calcium due at 5:00 PM, Finasteride due at 5:00 PM, Calcium Carbonate due at 5:30 PM, Carvedilol due at 5:30 PM, Pantoprazole due at 5:30 PM, or the Gabapentin due at 5:30 PM had been administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 10/24/24 at 8:59 AM identified that based on the facility's investigation, LPN #3 notified LPN #6 that she was leaving and walked off her shift around 8:15 PM, on 6/3/24. LPN #6 immediately notified the Nursing Supervisor and after unsuccessful attempts to contact LPN #3, the Supervisor notified the DNS of the incident. The DNS indicated that multiple resident's medications had not been signed off as administered, from the 5:00 PM medication pass so she was unable to verify if the medications had been given. The medical APRN (APRN #1) was notified, each resident and their potential missed medications were reviewed, and orders to monitor Residents #3, 10, 13, 24, 32, 39, 45, 49, 52, 56, 59, 67, 69, 70, 80, 103, 104, 105, 106, and 193 were obtained. The DNS identified that she was unsuccessful in contacting LPN #3. The DNS further identified that it was her expectation that she would have signed off all the medications that were administered, and if she needed to leave, for whatever reason, she would expect the Nursing Supervisor to have been notified and a proper hand-off of both the cart keys and her assignment to another nurse. The DNS indicated that subsequent to this incident, LPN #3 was terminated. Interview with APRN #1 on 10/24/24 at 10:48 AM identified that she was notified immediately of the 6/3/24 incident and she reviewed each resident and missed medication with the nurse that evening. APRN #1 identified that there was nothing outstanding that would have caused harm as a result of potentially missing a dose of the medications. Appropriate monitoring was ordered for each individual based on their medical history and missed medication. APRN #1 indicated that she assessed Residents #3, 10, 13, 24, 32, 39, 45, 49, 52, 56, 59, 67, 69, 70, 80, 103, 104, 105, 106, and 193, the following morning. The facility's Medication Pass Policy directs medications are to be administered safely and timely, per the physician's orders and to remember the ten rights of a medication pass: right resident, right drug, right dose, right route, right time, right education, right to refuse, right documentation, right drug-drug interaction, and right evaluation. 21. Resident #2 was admitted to the facility in March 2022 with diagnoses that included quadriplegia, aphasia, and weakness. Thes physician's orders dated 5/12/24 directed Resident #2 required Lovenox (an anticoagulant) injection 40 mg daily to prevent deep vein thrombosis The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, was frequently incontinent of bowel, required a urinary catheter for bladder, and was dependent on staff to assist with eating, dressing, and transfers. The care plan dated 8/21/24 identified Resident #2 had a urinary catheter. Interventions included to monitor for blood and sediment. The care plan also identified Resident #2 required medication that increases the time it takes for blood to clot. Interventions included to monitor for signs of bleeding in the urine, bowel movements, and bruising. A nurse's note dated 9/15/24 at 1:52 PM by LPN #7 identified that Resident #2 had an episode of genital bleeding with clots noted in his/her undergarment. The note identified Resident #2's urinary catheter was draining clear yellow fluid, and that Resident #2 was seen by the APRN and new orders for labs were placed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A change of condition follow up note dated 9/16/24 at 8:36 AM by LPN #6 identified Resident #2's urinary catheter was not draining after 2 attempts to flush. The note further identified 2 attempts to replace the catheter were also unsuccessful and that the ADNS was notified. Review of the clinical record failed to identify any documentation related to a RN assessment following the issues with Resident #2's urinary catheter and subsequent removal on 9/16/24. Interview with the ADNS on 10/24/24 at 11:45 AM identified she was aware that Resident #2 had the bleeding episode on 9/15/24, and issues with the urinary catheter on 9/16/24. The ADNS identified she was notified by LPN #6 that Resident #2's urinary catheter was removed and was unable to be replaced, and that Resident #2 was able to void freely. The ADNS identified that while she was aware of the prior bleeding episode and was notified by LPN #6 regarding the catheter issue, she did not make any notes or assess Resident #2 following the notification. The ADNS identified she believed there was communication with the APRN since a provider was in the facility daily but that she should have notified the APRN, completed an assessment on Resident #2, and ensured that Resident #2's resident representative was notified. The facility policy on change of condition directed that the facility would inform the resident, attending physician, and resident representative when there was a change of condition. The policy directed this included a need to alter treatment significantly (i.e a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment) and that the licensed nurse per state regulations would conduct a complete physical/mental evaluation and document the findings in the clinical record. 22. Resident #50 was admitted to the facility on [DATE] with diagnoses that included dementia, dysphagia, and difficulty walking. The quarterly MDS dated [DATE] identified Resident # 50 had severely impaired cognition, was frequently incontinent of bowel and bladder, and required substantial assistance from staff with oral hygiene, toileting, and bathing. The MDS also identified Resident #50 had a history of recent falls. The care plan dated 2/28/24 identified Resident #50 had a history of falls. Interventions included an assist of 1 with transfers. A reportable event form dated 3/21/24 identified Resident #50 had an unwitnessed fall on that date. The report identified Resident #11 was found on the floor next to his/her bed at 4:18 PM. The report identified no injuries were observed. Review of the clinical record failed to identify any neurological monitoring or post fall monitoring of Resident #50 following the 3/21/24 fall. Interview with the DNS on 10/24/24 at 9:10 AM identified that prior to 7/25/24, neurological checks were completed on paper. The DNS identified after 7/25/24, the facility changed documentation from paper to electronic. The DNS identified that for any unwitnessed falls prior to 7/25/24, the nurse would have been expected to complete neurological checks per the paper flow sheet, assess the resident, and document in a progress note every shift for 72 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on Fall Management directed that neurological checks were to be documented on the neurological flow sheet for 72 hours in the following circumstances: if a resident reported a head strike. physical evidence that the resident hit head, and for an unwitnessed fall. The policy also directed that documentation for 72 hours should also be done for assessment of latent injury. The facility policy on Neurological Assessment/Evaluation directed that a licensed nurse would perform neurological evaluations whenever there was the possibility of a head injury, change in mentation, or an unwitnessed fall. The policy further directed that neuro-care flowsheets would be used for monitoring, and the flowsheet documentation included: vital signs, pupil reaction of both eyes, level of consciousness, motor function, speech, facial symmetry, and headache. The policy directed that neurological checks should be done every 15 minutes x 4; then 30 minutes x 4; then 2 hours x 4; then every shift for a total of 8 shifts. The policy also directed if the neurological check sheet was stopped before completion, the reason would be documented in the electronic record. 23. Resident #9 was admitted to the facility in July 2021with diagnoses that included dementia, renal insufficiency, depression, and heart failure. The quarterly MDS dated [DATE] identified Resident #9 had severely impaired cognition and required total assistance with personal hygiene, dressing, toileting, and transfers. Additionally, Resident #9 was taking antipsychotic, antidepressant, hypoglycemia, and diuretic medications daily. The care plan dated 10/15/24 identified Resident #9 had received the Covid-19 vaccine in September 2022. Interventions included to update the resident representative with any changes. The monthly physician orders for October 2024 (original date was 8/11/23) directed to obtain Rapid Antigen Covid-19 nasal swab testing as needed and record results as positive or negative documentative narrative in progress note as needed. The progress note written by LPN #1 on 10/20/2024 at 1:45 PM identified she noted Resident #9 with a cough, runny nose, and a temperature of 100.1. LPN #1 performed the Covid-19 test, and it was positive. Resident #9 was placed on transmission-based precautions. Review of the clinical record dated 10/20/24 failed to reflect an RN assessment of the resident after the positive covid-19 test and prior to notifying the APRN/MD. A physician's order dated 10/20/24 directed to give cough syrup 10 ml by mouth every 6 hours as needed for cough for 7 days. Additionally, to isolate for positive Covid-19 every shift for infection control measures for 10 days. Interview with DNS on 10/23/24 at 8:18 AM indicated that the charge nurse should notify the RN supervisor right away when there is a change in condition. The DNS indicated that she would expect the RN supervisor to physically do an assessment of Resident #9 and document the assessment in the clinical record. After clinical record review, the DNS indicated that there was no documentation of an RN assessment with the new diagnosis of covid-19 and she would have expected to see that documentation in the electronic clinical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with the DNS on 10/23/24, failed to provide documentation that reflected an RN assessment had been completed after Resident #9 tested positive for covid-19 on 10/20/24. Although attempted, an interview with RN #9 was not obtained. Review of the Change of Condition Policy identified to ensure a residents change in condition is evaluated and documented properly. Staff identify change in condition and notifies the licensed nurse. The licensed nurse per state regulations will conduct a complete physical/mental evaluation and document findings in the electronic medical record. 24. Resident #66 was readmitted to the facility in July 2024 with diagnoses that included uncontrolled type 2 diabetes, severe PVD, chronic kidney disease, history of right foot cellulitis with osteomyelitis and status post transmetatarsal amputation, and Charcot foot. A wound evaluation by Family Nurse Practitioner - Board Certified (FNP-BC #1) dated 9/11/24 identified the wound on the right plantar metatarsal head (first identified 8/14/24) was stable and measured 2.4cm by 2. 5cm by 0.2c with 50% new granulation tissue. Recommendations included to cleanse with normal saline, apply Calcium Alginate with silver to base of wound, and secure with ABD pad and rolled gauze daily and as needed. Review of the clinical record indicated that FNP-BC #1 evaluated the wound on 9/18/24 and 9/25/24 and the wound was stable with 100% granulation tissue. A wound evaluation by FNP-BC #1 dated 10/2/24 identified the wound was worsening, had a mild odor post cleansing, had 50% slough and moderate amount of serous drainage. Recommendations included a treatment change. Cleanse with Dakin's 1/4 strength, apply iodosorb, adaptic and Calcium Alginate with silver to base of wound, and secure with ABD pad and rolled gauze daily and as needed. Although the wound on the right plantar metatarsal head had worsened on 10/2/24 and required the treatment to be changed, review of the clinical record failed to reflect that an RN assessment of the wound had been done between 10/3/24 - 10/8/24. A wound evaluation by FNP-BC #1 dated 10/9/24 identified the wound had deteriorated, was malodorous post cleansing, had 50% slough, periwound had severe maceration that measured 5.0cm by 12.0cm, erythema, warmth and a moderate amount of serous exudate. Further, the right leg had increased edema, and the resident appeared to have discomfort at the wound. Recommendation to send the resident to the hospital. Interview with LPN #9 on 10/23/24 at 3:54 PM identified she was the charge nurse for Resident #66 on Friday 10/5/24, Monday 10/7/24, Tuesday 10/8/24 and Wednesday 10/9/24. LPN #9 identified that when she worked on Friday 10/5/24, Resident #66's right plantar wound was at baseline, however, when she came in on Monday 10/7/24, after being off for the weekend, she noted that the wound had deteriorated, had increased drainage and a boggy and soggy area that was new. LPN #9 identified she reported the change in wound status to RN #8 and LPN #8 and brought them both into the resident's room and showed them the wound. LPN #9 indicated that RN #8 and LPN #8 changed the dressing to the resident's right plantar wound on 10/7/24 and again on 10/8/24. LPN #9 identified that on 10/9/24 FNP-BC #1 came in and identified the wound was worse and sent the resident to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #8 on 10/24/24 at 12:25 PM identified she was on orientation (hired as the wound nurse) and was being trained by LPN #8 on Monday 10/7/24 and Tuesday 10/8/24. RN #8 identified she and LPN #9 were notified by the charge nurse, LPN #9, on Monday 10/7/24 that Resident #66's wound was worse, and they went in and looked at the wound. RN #8 indicated the wound was slighted macerated, and wet and boggy. RN #8 told LPN #9 to call FNP-BC #1 and report the change. RN #8 indicated that she did not notify FNP-BC #1 or write a note regarding the worsening of the residents wound because she was on orientation and thought that LPN #9 had done it. RN #8 also thought that there was a new order to change the dressing to the right plantar wound twice daily because of the drainage, but after review of the record, RN #8 identified that there was no change to the frequency of the dressing change or documentation that the physician or FNP-BC #1 had been notified. After further review of the clinical record, RN #8 identified there was no documentation of an RN assessment of the wound on 10/7/24 or 10/8/24 after LPN #9 reported the wound had deteriorated. Interview with FNP-BC #1 on 10/23/24 at 2:41 PM identified the residents wound deteriorated significantly between 10/2/24 - 10/9/24. The wound was noted to have a large area of maceration, increased drainage and the resident's right leg was edematous. FNP-BC #1 indicated she was worried about the wound and spoke to the attending physician and to the resident. FNP-BC #1 identified she explained to Resident #66 that it was best for him/her to be evaluated in the hospital due to the deterioration. FNP-BC #1 identified she had not been notified of the change in the wound on 10/7/24 or 10/8/24 and observed the change when she came in on 10/9/24 to do weekly wound rounds. FNP-BC #1 identified she should have been notified of the change when it was identified and that had she been made aware of the change sooner, she could have increased the dressing change frequency to 2 or 3 times daily, get blood work or send the resident to the hospital for an evaluation. Although requested, an interview with LPN #8 was not obtained. The Change of Condition Notification policy directs the facility to inform the resident, consult with the resident's health care provider, and if known notify the resident's legal representative or family member when there is: an incident involving the resident which may result in injury or requires medical treatment, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, and a decision to transfer or discharge the resident from the facility. 25. Resident #82 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, difficulty in walking, Parkinson's Disease, and displaced intertrochanteric fracture of the left femur. The care plan dated 6/17/24 [TRUNCATED]

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #11) reviewed for limited range of motion, the facility failed to ensure splints to treat contractures were applied as per the OT recommendations and physician's orders. The findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dysphagia, and weakness. A physician's order dated 5/12/24 directed to apply right palm guard during morning care and remove with evening care. A 7/10/24 OT evaluation assessment summary note identified Resident #11 had impaired range of motion to the right hand, and range of motion to the left hand was within functional limits. The note further identified that further OT services were not warranted as Resident #11 was at his/her functional baseline, and nursing staff was managing Resident #11 contracture impairments with a bilateral splint schedule and use of a right palm guard. A physician's order dated 7/11/24 directed to apply resting hand splints to the bilateral upper extremities at bedtime and removal with morning care. The quarterly MDS dated [DATE] identified Resident #11 had severely impaired cognition, was always incontinent of bowel and bladder and was fully dependent on staff assistance with transfers, bathing, and eating. The care plan dated 7/25/24 identified Resident #11 required a splint wear schedule. Interventions included to apply resting hand splints to the bilateral upper extremities at bedtime and removal with morning care. The care plan also identified Resident #11 required a right palm guard that was to be applied during morning care and removed with evening care. Interventions directed to perform skin checks with application and removal of the guard. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Person #1 on 10/21/24 at 10:08 AM identified Resident #11 required splints to his/her hands nightly. Person #1 identified he/she did not believe that the splints were being applied. Person #1 identified he/she was in the facility daily to visit Resident #11, and that the splints were always in the exact same position, on the top shelf of Resident #11's closet all the way against the right side. Person #1 identified that he/she checked the closet daily since the summer and that since that time, the splints had not ever appeared to have been moved or touched. Person #1 identified the splints were supposed to be applied to help Resident #11 from having further contracture to the right hand, and to prevent contracture to the left hand, and that because he/she believed the splints had not been applied as they were supposed to be, Resident #11's hands were getting worse, and that the left hand appeared to be contracted. Person #1 also identified that Resident #11 was supposed to have a right palm guard applied during the day because of the right hand contracture to prevent injury. Person #1 identified that while he/she had seen this applied in the past, it had been a couple of months since he/she had seen the guard on Resident #11, and he/she believed the facility may have lost it. Review of the October 2024 TAR identified Resident #11's splints were documented as applied at 8:00 PM on 10/22/24 by LPN #5. Further review of the October 2024 TAR identified that LPN #6 signed that the splints had been applied on 10/1, 10/12, 10,15, and 10/21/24. Review of the nurse aide care card for Resident #11 identified to apply resting hand splint to the bilateral upper extremities at bedtime and removal with morning care Observation on 10/23/24 at 6:49 AM identified Resident #11 did not have any splints applied. Resident #11 was observed sleeping in his/her bed with no splits or bracing applied to his/her hands. Interview and observations with LPN #6 on 10/23/24 at 6:52 AM LPN #6 identified that she had never seen Resident #11 were splints in the evening and had never applied splints to Resident #11. Observations identified that although Resident #11's splints were located in his/her closet on the top all the way to the right side, behind a disposable glove box, LPN #6 opened the closet, moved the glove box, lifted the splints, placed them back down in the same spot, and continued to look through the closet and indicated she was unable to locate Resident #11's splints. Interview with NA #1 on 10/23/24 at 6:55 AM identified she was not aware Resident #11 had orders to wear splints at night. NA #1 identified that she was not the regular aide assigned to Resident #11, but when she started her shift at 11:00 PM on 10/22/24, Resident #11 did not have any splints on his/her hands. Observation and interview with the ADNS on 10/23/24 at 6:58 AM identified that Resident #11's splints were located in the closet on the right side of the top shelf previously observed with LPN #6. The ADNS identified, after looking through several drawers, she was unable locate Resident #11's right palm guard and would have to check with the laundry staff to see if it may have been sent there by mistake. The ADNS identified that the resting splints for residents are usually kept in a drawer of the resident's dresser or nightstand but she was unsure why the splints had been placed in the closet. The ADNS identified she was also unsure if Resident #11 should have splints applied nightly and the right palm guard applied daily, and she would have to look into this. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with OTA #1 (Assistant Physical Therapy Director) on 10/23/24 at 7:54 AM identified that Resident #11 was supposed to have bilateral resting hand splints applied nightly and she was not aware that the splints were not being applied. OTA #1 identified that Resident #11 had several sessions of OT treatments and was currently only utilizing the splints overnight and the right palm guard daily due to contracture, but she would look into the matter as Resident #11 did require the splints to prevent further loss of ROM in his/her hands. OTA #1 also provided a document Hand Orthotic Wearing Schedule dated 6/11/24. Review of the documentation on the Hand Orthotic Wearing Schedule for Resident #11 identified that resting hand splints to the bilateral upper extremities were to be applied at bedtime and removed with morning care. The documentation also identified that the splints were to be stored in an orthotic mesh bag between uses. Observation and interview on 10/23/24 at 12:30 PM identified Person #1 was visiting Resident #11, who was positioned upright in his/her wheelchair. Resident #11 was observed to have a right palm guard in place, and the resting hand splints were observed on the top of Resident #11's nightstand. Person #1 identified he/she had never seen the splints out of the closet prior to 10/23/24 and identified the location he/she had previously always seen them as the location this surveyor observed with LPN #6 in Resident #11's closet. Person #1 also identified that the right hand guard had also not been applied in the last 2 months, and this was the first time he/she had seen it applied in a while. Person #1 also identified that the glove box in the closet had been moved, but every time he/she had checked the closet for the splints in the past, the glove box was also always in the same spot, sitting directly in front of the splints. Subsequent to surveyor inquiry, an OT evaluation assessment summary dated 10/24/24 identified Resident #11 would receive services 3 times weekly for 4 weeks to address right hand pain, address splint wearing schedule, and educate nursing staff on application and wear schedules for the resting hand splints and right hand guard per the established wearing schedules. The evaluation also identified Resident #11 had impaired range of motion to the right hand, and range of motion to the left hand was within functional limits. Although attempted, an interview with LPN #5 was not obtained. The policy on splinting directed that splints were used for contracture management or reduction, pain management, and to facilitate motor activity. The policy further directed that the nursing staff would be provided instructions on the wearing schedule, application and removal of splints, precautions, and when to contact the therapist, and that the therapist and interdisciplinary team would monitor for appropriate use and fit on a regular basis.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #50) reviewed for falls, the facility failed to ensure interventions were in place after a fall with major injury, and failed to ensure that 1:1 supervision was provided during meal time per the physician's order. The findings include: Resident #50 was admitted to the facility on [DATE] with diagnoses that included dementia, dysphagia, and difficulty walking. A physician's order dated 5/2/24 directed Resident #50 required 1:1 supervision with meals for safety and focus to task. The care plan dated 5/2/24 identified Resident #50 was at risk for aspiration due to oral dysphagia. Interventions included providing 1:1 supervision during meals to ensure completion of meals and use of safe swallow strategies. The care plan also identified Resident #50 had a history of falls. Interventions included to keep the call light within reach. The quarterly MDS dated [DATE] identified Resident #50 had severely impaired cognition, was frequently incontinent of bowel and bladder, and required supervision with eating. The MDS also identified Resident #50 was dependent on staff to assist with oral hygiene, toileting, and bathing. a. Review of the clinical record identified Resident #50 had an unwitnessed fall without injury on 7/17/24. A reportable event form dated 9/1/24 identified Resident #50 had a fall with major injury on that date. The report identified Resident #11 was found on the floor next to his/her bed at 7:20 AM after attempting to get up to the bathroom with discoloration and laceration next to the left eye and discoloration to the left elbow. Resident #50 was sent to the hospital for evaluation and found to have a supracondylar fracture to the left elbow and left zygoma fracture. The care plan updated 9/1/24 identified Resident #50 had a history of falls. Interventions included use of floor mats/perimeter mats. The nurse aide care card dated 10/21/24 identified Resident #50 was at high risk for falls. Observation on 10/23/24 at 7:05 AM identified Resident #50 sleeping in his/her bed with the room door open. During this observation there were no floor mats observed to be present on the floor. Interview with the ADNS immediately following this observation identified Resident #50 was supposed to have floor mats around his/her bed for safety. The ADNS identified she was not sure where the floormats went or why they were removed. The ADNS then located one floor mat that was folded and stored between a chair and dresser in Resident #50's room. The ADNS identified that she was unsure if there was a second floor mat and would have to look into this. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The nurse aide care card dated 10/21/24 identified Resident #50 required 1:1 supervision during meals to ensure completion of meals and use of safe swallow strategies. Observations on 10/23/24 beginning at 8:14 AM identified the following: At 8:14 AM, Resident #50 was observed to be sleeping, with a floor mat on either side of his/her bed. A bedside table with Resident #50's breakfast tray was observed in the room, located approximately 5 feet to the right side of Resident #50's bed, past the floor mat by approximately 3 feet. No staff were observed with Resident #50 or within eyesight of Resident #50's doorway at this time. At 8:24 AM, NA #1 was observed in Resident #50's room, attempting to wake Resident #50 and repositioned the bedside table to the end of Resident #50's bed. At 8:32 AM, Resident #50 was observed sleeping with the bedside table at the end of the bed and a constant observation was then started. At 8:33 AM, LPN #7 was observed entering Resident #50, waking Resident #50, positioning Resident #50's bedside table and setting up his/her breakfast tray, and then leaving the room at 8:35AM, at which point Resident #50 began to self-feed. At 8:38 AM LPN #7 returned to Resident #50's room, provided a straw, and then exited the room. From 8:39 AM - 8:47 AM Resident #50 was observed to feed him/herself alone. At 8:47 AM, NA #1 was observed entering Resident #50's room, asking if he/she needed anything, and exiting the room-a total time of 10 seconds. From 8:47 AM - 8:54 AM Resident #50 was observed self-feeding alone. At 8:54 AM, LPN #7 was observed entering Resident #50's room to administer medications. At 8:56 AM, LPN #7 exited Resident #50's room and Resident #50 resumed self-feeding. At 8:58 AM, Resident #50 was observed trying to push the bedside table toward the end of the bed and stopped self-feeding at this point. At 9:01 AM, LPN #7 and NA #1 entered Resident #50's room and NA #1 removed the meal tray. Interview with LPN #7 on 10/23/24 at 9:04 AM identified that Resident #50 required set up for meals, but did not require supervision and always feed him/herself. LPN #7 identified he was typically assigned to Resident #50's unit and had taken care of Resident #50 at least weekly for the last year. LPN #7 then reviewed the physician's orders at the request of this surveyor and identified that Resident #50 had an active order in place for 1:1 supervision with meals. LPN #7 identified that he was not aware Resident #50 had the order and that while he was aware speech therapy had been working with Resident #50 at the facility, he was not aware of any choking or aspiration issues. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SLP #1 on 10/23/24 at 10 AM identified that Resident #50 had current 1:1 supervision with meal orders in place for safety. SLP #1 identified Resident #50 had issues with remembering to chew and swallow his/her food and would hold food in his/her mouth, and that 1:1 supervision was needed to provide prompts to chew and swallow his/her food. SLP #1 identified she had been working with Resident #50 and that without cueing and redirection during meals, Resident #50 would hold food in his/her mouth due to impaired cognition, putting him/her at risk for aspiration. Interview with the DNS on 10/24/24 at 11:35 AM identified that Resident #50 did require 1:1 supervision with meals and that she had provided re-education to LPN #7 and all staff on the unit. The DNS also identified that Resident #50 did have a history of falls and that she was aware that the ADNS observed the issue regarding the floor mats in Resident #50's room, and that going forward staff were to ensure that the floor mats were in place. Although requested, the facility failed to provide any policies related to residents at aspiration risk and any documentation related to fall risk assessments for Resident #50. The facility policy on ADLs directed that staff were to provide assistance with ADLs based on person centered evaluation and the resident's care plan, and that activities that may require assistance included eating, swallowing, and feeding. The facility policy on fall prevention directed that residents at high risk for falls would have interventions initiated to prevent falls, that the risk factors for falls would be determined using the fall risk assessment, and risk factors included history of previous falls, dementia, confusion, and incontinence. The policy further directed interventions may include assessing environmental hazards (including the floor) and providing staff supervision with ADLs.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 42117 Based on review of the clinical record, facility documentation, and interviews for 2 of 5 residents (Resident #9 and 30) reviewed for unnecessary medications, the facility failed to ensure the physician or APRN signed and dated orders and wrote signed and dated progress notes. The findings include: 1. Resident #9 was admitted to the facility in July 2021with diagnoses that included dementia, heart failure, and diabetes. Review of the monthly physician's orders identified that from 1/1/24 through 9/31/24, 9 months, the physician nor APRN signed, or dated the orders. 2. Resident #30 was readmitted to the facility in January 2024 with diagnoses that included epilepsy, heart failure, and chronic obstructive pulmonary disease. Review of the monthly physician's orders identified that from 1/1/24 through 9/31/24, 9 months, the physician nor APRN signed, or dated the orders. Review of the clinical record identified from January 2024 - March 2024, 81 days, and from May 2024 - July 2024, 92 days, the physician/APRN failed to write, sign or date progress notes. Interview with the DNS on 10/24/24 at 7:30 AM identified the physician must sign the admission orders within 48 hours of admission and then see the resident, and sign, and date the interim and monthly orders every 30 days for the first 90 days. The DNS indicated that after 90 days, the APRN and physician can alternate every 60 days seeing, reviewing and signing the monthly and interim orders. The DNS indicated that the APRN and physician must sign the orders electronically. The DNS indicated that they do not print the orders out for the APRN or physician to sign and they would review, sign, and date the orders in the electronic medical record. Interview with Medical Director, (MD #1) on 10/24/24 at 9:58 AM indicated he was responsible to oversee the APRN's and physicians. MD #1 indicated that after the 90-day visit the resident's interim and monthly orders need to be reviewed, signed and dated by the APRN and physician alternating every 60 days. MD #1 indicated that the facility does not print out the admission or monthly orders for the APRN or physician to sign, they must be done in the electronic medical record. MD #1 indicated that prior to this surveyor inquiry he did not know how to sign off the orders in the electronic medical record. MD #1 indicated it has been since the facility has implemented the electronic medical record, over a year ago, that he and MD #2 are not signing orders. MD #1 indicated that after surveyor inquiry on 10/23/24, the facility showed him how to sign the orders and that day, at night into the morning of 10/24/24 he had gone through and signed off on all the current resident's admission, readmission, and monthly orders. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medical Director Policy identified he shall direct, coordinate and oversee medical care in the facility, including, but not limited to, supervising all medical professionals in the facility, in accordance with all applicable federal and state regulations. The medical director will oversee the implementation of systems to ensure that other licensed practitioners who perform physician delegated tasks act within the scope of practice and to ensure that staff are aware of practitioner notification requirements. Additionally, the medical director will coordinate and evaluate the medical care for the residents by reviewing residents' overall condition and program of care at each visit, including medications and treatments, documentation of progress notes with signatures, frequency of visits as required, signing and dating all orders, such as medications, admission orders, and readmission orders. The medical director will assure each attending physician visits assigned resident's scheduled intervals, completes required documentation, examines the resident, and discusses the Care Plan with unit nursing staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #9) reviewed for unnecessary medications, the facility failed to ensure pharmacy recommendations were responded to by the physician and/or APRN. The findings include: Resident #9 was admitted to the facility in July 2021 with diagnoses that included dementia, diabetes, and depression. The quarterly MDS dated [DATE] identified Resident #9 had severely impaired cognition. Resident #9 was receiving antipsychotic, antidepressant, and diuretic medications daily. The physician had documented that a GDR was contraindicated. The care plan dated November 2023 identified Resident #9 was on antipsychotic medications. Interventions included to monitor and document targeted behaviors. The monthly physician orders dated September 2023 directed to administer Risperdal 0.5mg at bedtime and Celexa 40 mg daily. a. Review of the clinical record failed to reflect a medication regimen review by the pharmacist for November and December 2023. Interview with the Corporate Clinical RN #5 on 10/23/24 at 10:39 AM and at 2:45 PM identified she was not able to find the pharmacy recommendations for November and December 2023. Interview with Pharmacist #2 on 10/24/24 at 9:29 AM indicated that on 11/15/23 pharmacy recommendations included the following. Resident #9 was receiving Risperidone 0.5 mg at bedtime without a recent attempt to taper. Please consider tape to 0.25mg at bedtime or document inability to do so. Pharmacist #2 indicated that the 12/11/23 pharmacy recommendations included the following. Resident #9 was receiving basal insulin with a sliding scale and coverage which was being used often. Please evaluate and consider increasing the dose of basal insulin to 17 units with eventual discontinuing of the sliding scale. Review of the clinical record failed to reflect that the physician responded to the pharmacy recommendations for November and December 2023 and no changes in the Risperdal or Insulin had been done. b. Review of the medication regimen review dated 2/12/24 again requested a taper of Risperidone. Resident #9 was currently taking Risperidone 0.5mg at bedtime for behaviors associated with dementia without a recent attempt to taper. Please consider a trial taper to 0.25 mg at bedtime, or document inability to do so. Review of the clinical record failed to reflect that the physician responded to the pharmacy recommendations for 2/12/24 and no changes in the Risperidone had been done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Review of the medication regimen review dated 6/20/24 identified Resident #9 was receiving routine fingerstick blood sugar monitoring. Please consider adding an order to notify MD if results are less than 60 and greater than 400. The pharmacy recommendation was signed by APRN #1 however, a physician's order was not written to notify the physician with the recommended parameters nor was a rationale for not changing the order. d. Review of the medication regimen review dated 7/15/24 identified Resident #9 was currently receiving Celexa 40 mg daily. Celexa is no longer recommended to be used at doses greater than 20 mg daily in people over [AGE] years old because it can cause dose dependent QT (heart waves) interval prolongation. Please evaluate and taper dose to 20 mg daily and monitor side effects. The pharmacy recommendation was signed by APRN #1 with a note for psychiatry to address, however, the order for Celexa was not changed. e. Review of the medication regimen review dated 9/30/24 identified this was a second request. Celexa in exceeding 20 mg per day, FDA warns Celexa is no longer recommended to be used at doses greater than 20 mg daily in people over [AGE] years old because it can cause dose dependent QT (heart waves) interval prolongation. Please evaluate and taper dose to 20 mg daily and monitor side effects. Review of the clinical record identified the pharmacy recommendation was not signed by the physician and had not been responded to. f. Review of the medication regimen review dated 10/22/24 identified the 9/30/24 recommendation hasn't been addressed for the Celexa in exceeding 20 mg per day. Please ensure the recommendation is addressed. Interview with Pharmacist #2 on 10/24/24 at 9:29 AM indicated that the provider should complete the monthly pharmacy recommendations within 7 to 14 days. Pharmacist #2 indicated that the provider APRN or MD must check off that they agree or disagree with the recommendation and sign and date the form. Pharmacist #2 indicate the form must remain in the resident's clinical record. Pharmacist #2 indicated that if the provider agrees with the recommendation the physician orders will be changed but it the provider disagrees with the recommendation the provider must write a progress note on the form or in the clinical record with a rational for not making the changes. Pharmacist #2 indicated that reviewing Pharmacist #1's notes that July's recommendation to decrease the Celexa was not addressed as of 10/22/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 10/24/24 at 8:33 AM indicate that she was responsible for the monthly pharmacy recommendations. The DNS indicated that she receives the recommendations from the pharmacy consultant each month via email and she prints them out and distributes them to the providers. The DNS indicated that the APRN's will put in their own physician orders for any changes that they will make. The DNS indicated that on rare occasions the APRN will sign off on the form and ask the supervisor to input the order change into the computer. The DNS indicated that once a pharmacy recommendation was completed, she would receive them, and she files them in her office by the month on the original. The DNS indicate that she does not file them in the resident's clinical records. The DNS indicated that the APRN must agree or disagree and if they disagree it is up to the provider to write a note. The DNS indicated that all pharmacy recommendations should be completed within a few days to a week by the APRN/MD's. Review of Resident #9's clinical record, the DNS indicated that the pharmacy recommendation on 2/12/24, 6/20/24, 7/15/24, and 9/30/24 were not completed by the providers. The DNS indicated that the pharmacy recommendation dated 7/15/24 and 9/30/24 were the same recommendation. Interview with MD #1 on 10/24/24 at 09:58 AM indicated that the pharmacy recommendations were divided by nursing, psych, and the APRN. MD #1 indicated that if any of them had any questions they would contact him. MD #1 indicated that the APRN should reply within a few days to the pharmacy recommendations by signing and dating the form and checking off if they agree or disagree with the recommendations. MD #1 indicated that if he was notified of the Celexa recommendation in July 2024 he would have given it to the psychiatric provider but if they did not respond to it, he would have reviewed all Resident #9's medications and if any other medications could affect the QT wave then he would have ordered an EKG. Interview with APRN #1 on 10/24/24 at 10:30 AM indicated that she does not recall signing the pharmacy recommendations but if it was brought to her attention, she almost always follows the pharmacy recommendations. APRN #1 indicated that if she was not going to follow a recommendation, she would write a progress note explaining why she did not follow it. APRN #1 indicated that she put in or discontinues the physician orders in the computer herself. Interview with psychiatric APRN #4 on 10/24/24 at 11:28 AM indicated that nursing will leave the pharmacy recommendations in her communication book, and she will address them when she comes into the facility. APRN #4 indicated when she receives a pharmacy recommendation, she will see the resident and review the resident's medication as a visit just for the pharmacy recommendation. APRN #4 indicated that she would write in her note reviewed pharmacy recommendation and stated whether she agreed or disagrees, and any changes that were made. Review of the clinical record, APRN #4 indicated that she did not receive the pharmacy recommendations on 11/15/23 or 2/12/24 for the decrease of the risperidone at bedtime, she would have reviewed the behaviors and if no behaviors she would have trialed the GDR at that time. Additionally, APRN #4 indicated that if she had received them, she would have written it in her notes. APRN #4 indicated that if she was aware that pharmacy on 7/15/24 had recommended decrease the Celexa from 40mg to 20 mg and she would have decreased it at that time. APRN #4 indicated that the new psychiatric APRN #3 was made aware of the pharmacy recommendation on 10/23/24 and did recommend decreasing the Celexa to 20 mg daily. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Monthly Drug Regimen Review Policy identified the consultant pharmacist shall review the medical record of each resident and perform a drug regimen review at least once each calendar month. The provider shall act upon the recommendations in a timely manner of 30 days or less. Shall document on the drug regimen review from whether he/she aggress or disagrees with the recommendations. The provider will document a clinical rationale if no changes are made. Regimen review recommendations along with prescriber responses shall be considered a permanent part of each resident's medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 46040 Based on observations, clinical record review, facility documentation, facility policy, and interviews, the facility failed to ensure that nursing staff maintained proper infection control techniques and appropriate hand hygiene procedures for residents who required transmission based and enhanced barrier precautions; and for one sampled resident reviewed for immunizations (Resident #2), the facility failed to ensure that a resident's immunity status was obtained following an identified infection control issue; and for 1 of 5 residents reviewed for transmission based precautions (Resident #344), the facility failed to ensure that a resident was cohorted based on infection prevention protocols, and failed to ensure appropriate transmission based precautions were implemented following admission to the facility and failed to handle soiled linen according to infection control standards and failed to monitor the temperature of the refrigerators that contained vaccinations. The findings include:. 1. Upon entrance to the facility on [DATE], the facility identified there was an active Covid 19 outbreak in the consisting of 2 residents. The facility also provided the following infection control documents: An undated TBP LIST (transmission-based precautions) and an undated EBP LIST (Enhanced Barrier Precautions). Review of the TBP list document identified a total of 8 resident including Resident #28 and Resident #343 as residents on transmission-based precautions. The list included only resident names and failed to identify the reason why TBP was required. Review of the EBP list document identified total of 24 residents who required EBP including Resident #103. The list included only resident names and failed to identify the reason why EBP was required. Subsequent to surveyor inquiry, the facility provided the document Covid List as of 10/21/24. The list identified a total of 4 residents, including Resident #28. The list failed to identify any additional information other than resident names. During an initial tour of the facility on 10/21/24 beginning at 8:02 AM, observations identified the following: A sign posted outside of Resident #28's door which identified STOP. Special Droplet/Contact Precautions. In addition to standard precautions, only essential personnel should enter this room. Everyone must (including visitors, doctors, and staff) clean hands when entering and leaving room, wear mask (fit tested n-95 or higher required when performing aerosol-generating procedures), wear eye protection (face shield or goggles), gown and gloves at the door. Keep door closed. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montowese Center for Health & Rehabilitation	163 Quinnipiac Avenue North Haven, CT 06473

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A sign posted outside of Resident #343's door which identified STOP. Contact Precautions. Everyone must clean their hands before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. A sign posted outside of Resident #103's room which identified STOP. Enhanced Barrier Precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: wear gloves and a gown before the following High- Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use (including urinary catheter), and wound care. Do not wear the same gown and gloves for the care of more than one person. Review of Resident #343's clinical record on 10/21/24 identified a physician's order that directed Resident #343 required contact precautions for Shingles for 10 days beginning on 10/18/24. Review of an updated Enhanced Barrier Precaution log dated 10/22/24 identified 39 total residents on the new list and identified Resident #103 required EBP related to a S/P tube with history of CAUTI'S (catheter associated urinary tract infections). Review of the updated Covid line list provided by the facility to the survey team on 10/23/24 identified a total of 10 positive residents on the list and included Resident #28. The list identified Resident #28 begin to have symptoms and subsequently tested positive on 10/18/24. Observations on 10/23/24 at 12:35 PM identified the following: NA #1 was observed assisting Resident #28 with his/her meal tray. Resident #28's door was fully open. NA #1 was observed wearing gloves and a disposable face mask. NA #1 did not have a gown or eye protection on. NA #1 finished assisting Resident #28, doffed her gloves prior to exiting Resident #28's room. NA #1 was not observed performing any hand hygiene after exiting Resident #28, which was observed to have a wall mounted hand sanitizer located directly outside the door. NA #1 then proceeded to walk down the hall and entered Resident #343's room. NA#1 entered the room for approximately 15-20 seconds, then exited the room. NA #1 was not observed donning or doffing gloves, gown, or performing hand hygiene before entering or upon leaving Resident #343's room. NA #1 was then observed entering Resident #103's room and failed to perform hand hygiene prior to entering the room. NA #1 was observed then assisting with Resident #103's meal tray, at which time Resident #103 requested his/her water pitcher be refilled. NA #1 was observed handling the water jug, removing the lid, and walking down the hall with the jug. NA #1 failed to perform hand hygiene prior to handling Resident #103's water pitcher. NA #1 then returned to the room with the water pitcher and used a wall mounted hand sanitizer upon exiting Resident #103's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #1 immediately following these observations identified she believed she performed hand hygiene between each resident interactions, however she was unable to identify when or which wall sanitizer she utilized. NA #1 identified after exiting Resident #28's room, she then walked across the hall, to a wall hand sanitizer located across from Resident #103's room, approximately 11 - 12 feet from Resident #28's room, and then entered Resident #343's room. NA #1 failed to identify when she sanitized between exiting Resident #343's room and entering Resident #103's room. NA #1 identified that she did not need to don full PPE when entering resident rooms to assist with meal trays. NA #1 identified she was aware the facility had an active Covid outbreak and reiterated she was only assisting with meal trays. Interview with the ADNS on 10/23/24 at 12:47 PM identified that NA #1 should have done full PPE and performed hand hygiene between residents. The ADNS identified she was aware the facility was in active Covid outbreak and that she would re-educate NA #1 regarding adhering to transmission-based precautions and hand hygiene to mitigate the spread of infections in the facility. Review of NA #1's clinical competencies and in servicing education identified she was educated by the facility on topics including hand hygiene, donning and doffing PPE, EBP, Covid 19, and respiratory protection 5/23 and 9/23, and most recently was in serviced on prevention of infection and completed competencies related to donning/doffing PPE and hand hygiene on 8/22/24. Interview with RN #1 (Director of Clinical Operations) and the DNS on 10/24/24 at 11:45 AM identified they were notified by the ADNS regarding NA #1 related to hand hygiene and PPE. RN #1 identified she had initiated mandatory in servicing for all clinical staff related to hand hygiene and PPE use. The facility policy on Precautions to Prevent Infection directed that standard precautions were intended to be applied for all patients in all healthcare settings regardless of suspected or confirmed presence of infectious agents. The policy directed standard precautions included hand hygiene and use of PPE depending on the anticipated exposure, and standard precautions intended to protect patients by ensuring healthcare personnel did not carry infectious agents to patients on their hands during patient care. The policy also directed that EBP fell between standard and contact precautions and would include adherence to standard precautions. The policy further directed for contact precautions, health care personnel caring for these patients should wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated surfaces with the patient's environment. The policy also directed that proper hand washing was a key preventative measure for preventing infections. The facility policy on Clinical guide for operations during Covid 19 Health Emergency directed that core principle of Covid 19 infection prevention included hand hygiene (use of an alcohol-based hand rub was preferred), face mask, and appropriate staff use of PPE. The policy further directed that staff who entered the room of a resident with confirmed Covid 19 infection should adhere to droplet and contact precautions. The facility policy on Empiric Transmission Based Precautions, directed that for residents with vesicular rash due to potential Varicella-zoster (shingles) pathogen, empiric precautions should include airborne and contact precautions, and contact precautions for localized zoster in an immunocompetent host. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #2 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, aphasia, and weakness. The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, was frequently incontinent of bowel, required a urinary catheter for bladder, and was dependent on staff to assist with eating, dressing, and transfers. The care plan dated 8/21/24 identified Resident #2 had difficulty making self-understood due to baseline aphasia. Interventions included to establish eye contact before communicating. Observations on 10/21/24 at 9:03 AM identified a Contact Precautions sign placed on the door entrance to Resident #2's room. A review of an undated facility provided TBP LIST (transmission-based precautions) provided to the survey team on 10/21/24 identified Resident #343 as a resident on the list, however the list did not provide any information related to the type of precautions in place or why. Review of Resident #343's clinical record on 10/21/24 identified a physician's order that directed Resident #343 required contact precautions for Shingles for 10 days beginning on 10/18/24. Review of Resident #2's (Resident #343's roommate) clinical record failed to identify any documentation related to varicella history or documented immunity. The clinical record also failed to identify any documentation that attempts were made to obtain this information. Interview with LPN #4 (Infection Preventionist) on 10/22/24 at 2:21 PM identified that Resident #343 was being treated for an active shingles outbreak, and that she did not determine Resident #2's varicella immunity status. LPN #4 identified that since Resident #2 was incontinent and unable to get out of bed independently she did not feel there would be an issue. Interview with RN #5 (Corporate Clinical Infection Preventionist) on 10/22/24 at 2:39 PM identified that since Resident #343 was diagnosed with shingles on 10/18/24, and Resident #2 had been rooming with him/her prior to that date, the facility would keep these residents together due to possible exposure. RN #5 identified contact precautions were implemented, and she was unsure if the facility had obtained Resident #2's varicella status and could not address this. Interview with MD #1 (Medical Director) on 10/24/24 at 11:05 AM identified that Resident #2 should not have been cohorted with Resident #343 unless there was confirmation of his/her varicella status. MD #1 identified that if Resident #2 had never had the varicella virus or the varicella vaccine, he/she would have been at risk to develop varicella, since shingles was caused by the same virus that caused varicella. MD #1 identified that this information should have been obtained by the nursing staff to determine any interventions that may have been needed for Resident #2. Review of the CDC clinical overview on Varicella (chickenpox) identified that Varicella was highly contagious and could be spread from person-to-person direct contact, inhalation of aerosols from vesicular fluid skin lesions from varicella zoster (shingles), and through possibly infected respiratory secretions that may also have aerosolized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC clinical overview on Shingles identified that people with active shingles lesions can spread Varicella zoster in those who have never had chickenpox or did not receive the varicella vaccine, and that active shingles lesions were infectious through direct contact and by breathing in virus particles from blisters until dried and scabbed over. The facility policy on Precautions to Prevent Infection directed that transmission-based precautions are for patients with known or suspected to be infected with infectious agents. The policy also directed those decisions regarding resident placement (shared or private) was individualized and included balancing infection risk and the presence of risk factors that increased the likelihood of transmission. The policy further directed that for residents on contact precautions, a single room was preferred and when a single room was not available, consultation with infection control personnel was recommended to assess various risks with other placement (cohorting, keeping the resident with an existing roommate). The policy directed that additionally, airborne precautions should be implemented to prevent transmission of agents that remain infectious over long distances when suspended in the air (e.g. Varicella virus), and when airborne precautions could not be implemented due to limited engineering resources, the facility should place the patient in a private room with the door closed. The facility policy on Empiric Transmission Based Precautions, directed that for residents with vesicular rash due to potential Varicella-zoster (shingles) pathogen, empiric precautions should include airborne and contact precautions, and contact precautions for localized zoster in an immunocompetent host. 3. Resident #344 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and end stage renal disease. The care plan dated 6/21/24 identified Resident #344 had COPD. Interventions included to monitor and report any signs/symptoms of respiratory infection including increased cough and wheezing. The 5 day PPS MDS dated [DATE] identified Resident #344 had moderately impaired cognition, was always incontinent of bowel, frequently incontinent of bladder and was dependent on staff to assist with dressing, bathing, and toileting. Upon entrance the facility on 10/21/24, the facility notified the survey team that Resident #344 had been transferred to the hospital for evaluation of altered level of consciousness. During an initial tour of the facility on 10/21/24 beginning at 8:02 AM, observations identified a Contact Precautions sign placed on the door entrance to Resident #45's room. During this observation, it was identified Resident #344 was Resident #45's roommate. Review of the clinical record failed to identify any diagnoses or orders related to contact precautions orders for Resident #45. Review of the clinical record on 10/22/24 identified Resident #344 had been readmitted to the facility to a private room. Further review of the clinical record identified that on 10/18/24, Resident #344 was readmitted to the facility following hospitalization from [DATE] - 10/18/24 with new diagnoses of Methicillin resistant staphylococcal aureus (MRSA) pneumonia and Clostridium Difficile (C. Diff) infection and was placed on contact precautions at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #4 (Infection Preventionist) on 10/22/24 at 2:21 PM identified that Resident #344 was readmitted to the facility on [DATE] with new diagnoses of MRSA pneumonia and C. Diff. LPN #4 identified that Resident #344 was readmitted to the facility during the evening shift and after she had left for the day, and she was not aware that she was admitted to a semi-private room. LPN #4 further identified she was notified on 10/19/24 of Resident #344's readmission and was notified no private rooms were available. LPN #4 identified that after speaking with Resident #344's representative who was agreeable with the plan, Resident #344 would remain in a semi-private room with Resident #45 until a private room was available. LPN #4 identified that since Resident #344 had diagnoses of MRSA and C-Diff, and Resident #45 required total care and did not utilize the shared bathroom, she did not think it would be an issue, although she was trying to get Resident #344 moved as soon as a private room opened due to previous episodes of confusion and she worried Resident #344 may enter Resident #45's area of the room. LPN #4 reiterated Resident #344 was admitted after her shift and she was not notified until 10/19/24, the following day. LPN #4 was unable to identify if Resident #45 had any prior history of colonized MRSA or C-Diff. LPN #4 also identified that Resident #344 was readmitted on [DATE] to a private room because one finally became available. Interview with RN #5 (Corporate Clinical Infection Preventionist) on 10/22/24 at 2:39 PM identified that while Resident #344 did have diagnoses of MRSA pneumonia and C-Diff, there were no issues with admission to a semiprivate room as Resident #45 required total care and did not use the same restroom. RN #5 identified contact precautions were sufficient and there were no issues related to cohorting of these residents despite Resident #344 having MRSA in the sputum. Review of the clinical record failed to identify any history of MRSA or C-Diff for Resident #45. Interview with the Director of Admissions on 10/23/24 at 2:48 PM identified she was responsible for admissions and readmissions to the facility and coordination of the bed boards along with the nursing staff. The Director of Admissions identified that the facility policy is when there is a resident being admitted or readmitted with a possible infection infection, she must discuss with the IP to determine if the admission is appropriate and what bed type should be used (private or semi-private) based on the diagnoses. The Director of Admissions identified that on 10/18/24, she was notified sometime during the day shift that Resident #344 was being discharged from the hospital and would be returning to the facility with the new diagnoses of MRSA pneumonia and C-Diff. The Director of Admissions identified that following this notification, she spoke in person with LPN #4, who was working at the time of the notification, and they had a discussion face to face regarding the new diagnoses and bed placement. The Director of Admissions identified that LPN #4 instructed her that as long as Resident #45 did not have any open skin areas it was appropriate to place Resident #344 in a semi-private room with him/her, as Resident #45 did not use a shared bathroom due to care needs. The Director of Admissions identified that she believed on 10/18/24 there were no private rooms available. Follow up interview with the Director of Admissions on 10/24/24 at 10:45 AM identified that if LPN #4 had notified her that Resident #344 had diagnoses that required a private room due to transmission-based precautions, she would have evaluated the facility bed board to make accommodations for readmission. The Director of Admissions identified that if accommodations for a private room could not be made, then the facility would not have been able to accept him/her for readmission. The Director of Admissions also identified that Resident #344 was readmitted to a private room on 10/21/24 due to that bed being the first available, and that the plan was to try to move him/her back to a semi-private room, but she had been busy and had not had time to inquire about this. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with MD #1 (Medical Director) on 10/24/24 at 11:05 AM identified that Resident #344 should not have been cohorted with Resident #45. MD #1 identified he was notified that Resident #45 was colonized with MRSA which would not impact cohorting if Resident #344 had a new MRSA diagnosis. MD #1 was unable to identify which staff member provided him this information. MD #1 identified that Resident #344 should have been placed in a private room, or with a resident who had confirmed MRSA colonization to ensure that there was no transmission of infection. MD #1 identified that since Resident #45 was bedbound and did not share a restroom, there was minimal chance for C-Diff infection between the two residents, however MRSA pneumonia could transfer between the two with droplets. MD #1 also identified that MRSA pneumonia would require droplet precautions in addition to contact precautions for anyone exposed who had not been colonized. The facility policy on Empiric Transmission Based Precautions, directed that for residents with negative HIV status or low risk of HIV infection who had respiratory infections related to possible pathogens including MRSA, the resident should be placed on Airborne plus Contact Precautions. The facility policy on Precautions to Prevent Infection directed that transmission-based precautions are for patients with known or suspected to be infected with infectious agents. The policy also directed those decisions regarding resident placement (shared or private) was individualized and included balancing infection risk and the presence of risk factors that increased the likelihood of transmission. The policy further directed that for residents on contact precautions, a single room was preferred and when a single room was not available, consultation with infection control personnel was recommended to assess various risks with other placement (cohorting, keeping the resident with an existing roommate). The policy directed that additionally, airborne precautions should be implemented to prevent transmission of agents that remain infectious over long distances when suspended in the air and when airborne precautions could not be implemented due to limited engineering resources, the facility should place the patient in a private room with the door closed. 4. Observation on 10/24/24 at 7:30AM identified an open bag of soiled laundry outside the door of room [ROOM NUMBER]. NA#4 took the bag of soiled laundry from the entrance of room [ROOM NUMBER] and walked across the hall to room [ROOM NUMBER]. NA #4 placed the bag of soiled linen in room [ROOM NUMBER] while she continued to remove soiled cups from various rooms on the unit. LPN #4 asked that NA#4 to retrieve the laundry from room [ROOM NUMBER] and bring it to the soiled utility room. NA #4 was identified in the corridor with the bagged soiled laundry wearing gloves. LPN #4 stated that gloves in the corridor were not appropriate, and LPN #4 further stated we have already trained on this, and now we will have to do it again. NA#4 indicated the laundry was found in room [ROOM NUMBER] from the previous shift and she was going to bring it to the soiled utility room as soon as she finished gathering the residual cups in the resident's room. LPN #4 identified it is her expectation that soiled laundry is placed in the soiled utility room as the nurse aide who provides care exits the room. 5. Review of the vaccination refrigerator temperature logs dated 8/1/24 - 10/24/24 at 12:00 PM identified 8 days in August and September 2024 temperatures were not recorded. Further, 9 days between 10/1/24 - 10/24/24 temperatures were not recorded. Temperatures ranged from 38 degrees to 44 degrees F. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #4 on 10/24/24 at 12:20PM identified she is the only one with a key to her office where the vaccination refrigerator was located and when she is out or on vacation no one else has a key to check temperatures. She further identified DNS #1 was aware of the limited access to her office and the vaccination refrigerator. Interview with DNS #1 and DNS #2 on 10/24/24 at 12:20 PM identified she was not aware there were limitations with accessibility to the refrigerated vaccines, the refrigeration logs or the Infection Preventionists office. DNS #1 identified it is her expectation that the vaccination refrigeration temperatures are recorded daily, and the vaccines be available for nursing for all shifts. The policy for Infection Prevention and Control dated 6/24 identified it's the policy of the facility to maintain an infection prevention and control program based on current nationally recognized evidence-based guidelines to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy states the Infection Control Preventionist is responsible for maintaining an active surveillance program. A policy for vaccination storage was not provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 43032 Based on review of facility documentation, facility policy and interview, the facility failed to designate an individual with the required training and certification to oversee the Infection Control Program. The findings include: Interview with LPN #4 on 10/21/24 identified she became the facility's Infection Control Nurse in February 2024. Interview with RN #4 (Staff Development Nurse) on 10/21/24 at 1:45 PM identified although she is the RN who has the responsibility to oversee the Infection Control program, her involvement and oversight of the Infection Control program is infrequent and the program is handled by LPN #4. RN #4 identified she became the back up for LPN #4 four months ago and has a certificate for Infection Prevention by OSHA, which focuses primarily on accidents such as the prevention of accidental needlesticks in a clinical setting. She stated she chose OSHA's training because it was the least expensive. Interview with RN #5 (Corporate Clinical Infection Control Nurse) on 10/23/24 at 9:30 AM identified she was not familiar with the OSHA certification for infection control in a nursing home. Interview with DNS #1 and DNS #2 on 10/24/24 at 12:20 PM identified after LPN #4 was hired she was supported by the Clinical Corporate Infection Control nurse who spent on average 2 days weekly in the facility. LPN #4 did not have inhouse support, and after the change in ownership, LPN #4 had the remote support of RN #5, the new Clinical Corporate Infection Control Nurse. DNS #1 identified that neither she, the ADNS or RN #4 have the specialized infection control certification. The policy for Infection Prevention & Control Program indicates the role for Administration is: Designate one or more individuals as the Infection Preventionist who is responsible for the implementation of infection control based on federal and state public health advisories, guidelines and rules. The infection preventionist will: Have primary professional training in nursing, medical technology, microbiology, epidemiology or another related field. Be qualified by education, training, experience or certification. Work at least part-time at the facility. Have completed specialized training in infection prevention and control, be an active member of the facility's quality assessment and assurance committee and reports to the committee on a regular basis.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation and interviews, the facility failed to ensure the 2-way call bell system was functioning. The findings include: Observation on 10/23/24 at multiple times throughout the day while accompanied by the Director of Maintenance and the BFSI identified the facility's 2-way communication system call bell failed to function properly. An interview with the Director of Maintenance on 10/23/24 at 7:13 AM indicated that he started 3 weeks ago at the facility and was aware that there was a problem with the 2-way call bell system for the residents. The Director of Maintenance indicated that there are rooms that the 2-way call bell system does not work. The Director of Maintenance indicated that the 2-way call bell system does not work in some rooms because the parts are no longer available, and he would have to replace the entire call bell system. The Director of Maintenance indicated the entire second floor 2-way call bell system does not work. The Director of Maintenance indicated the nursing staff can hear the resident at the desk as a muffled sound, but the resident cannot hear the nurses at all. The Director of Maintenance indicated that he was responsible to get quotes and give to corporate. Interview with the Director of Maintenance on 10/23/24 at 10:55 AM indicated that after surveyor inquiry maintenance and the Director of Housekeeping did an audit of the 2-way call bell system and on first floor and there were 2 beds, (104 door and 118 door) that the call bell system does not work at all, and on second floor for all beds the call light system is only one way. Director of Maintenance indicated that the residents could talk to the nurses, but some were muffled at the nurse's station, but the nursing staff cannot talk back to the residents. Interview with Director of Maintenance on 10/23/24 at 11:02 AM indicated he had spoken to the DNS and Admissions and the 2 beds where the call bell system does not work at all (room [ROOM NUMBER] D and 118 D) are currently empty and will not be filled through admissions until repaired. Interview with the Administrator on 10/23/24 at 1:00 PM indicated that she does not know what is wrong with the call bell system, except there was a problem identified at the end of August 2024. The Administrator indicated that she does not know how corporate wanted to handle the situation. The Administrator indicated there was not a policy regarding the call light system. Interview with the DNS on 10/23/24 at 1:05 PM indicated that the call bell system must be a 2-way system so when the residents use the call light to call the nurses the nurses can hear the resident, and the resident can hear the nurse. The DNS indicated that she was not aware that the second floor 2-way call bell system was not working.