

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/09/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Glen Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Glen Hill Rd Danbury, CT 06811	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, review of clinical records, facility policy and interviews for 2 of 2 residents reviewed for dignity (Resident # 41 and Resident # 71). The facility failed to ensure the residents were served lunch at the same time. The findings include:</p> <p>1. Resident # 71 diagnoses included Alzheimer's disease, dysphagia and type 2 diabetes mellitus.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 and was independent with eating.</p> <p>The Resident Care Plan (RCP) dated 4/10/25 identified potential nutritional risk as an area of concern. Interventions included: to provide a ground diet as ordered, encourage fluids, honor food preferences for meals, monitor intake of all meals and offer alternatives as needed, and report any declines and inability to self-feed.</p> <p>The physician's orders dated 6/1/25 directed to provide regular diet with ground texture, allow ice cream, soft breads, cakes, cookies and soft salad sandwiches upon requests, extra sauce, eat in view of staff. Allow regular food when brought in from home by family with supervision. Provided house supplement with breakfast, lunch and supper.</p> <p>Observations on 6/4/25 Resident #71 was sitting in the lounge area on Nature Way at 11:30AM waiting for lunch to be served. Resident #24 who usually eats in the main dining room was eating in the lounge area. Resident #24 received his/her tray at 11:45AM. Resident #71 along with Resident #41 sat at the dining table watching Resident #24 eat his/her meal. Resident # 71's meal was bought at 1:05PM (1 hour and 50 minutes after Resident #24).</p> <p>2. Resident #41's diagnoses included dementia, dysphagia and type 2 diabetes mellitus.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 as moderately cognitively impaired with a Brief Interview for Mental Status score of 9 and was independent with eating.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Resident Care Plan dated 4/30/25 identified nutritional risk as an area of concern. Interventions included supplements as ordered, fortified pudding with lunch and dinner, provide proper consistency of diet solids as ordered by speech therapy-may give pureed fruits, honor food preferences with no fish and eggs and offer alternative food choices as needed.</p> <p>The physician's orders dated 6/1/25 directed to provide ground texture with regular consistency, provide pureed fruit, no fish, no eggs, no carrots, no rice, no watermelon, allow bananas and regular snacks with no nuts or hard candy. Provide potatoes with gravy, provide cup of gravy with sauce on the side, reserve drinks for the end of the meal and magic cup with all three meals. Administer Lantus Solostar insulin 10 units subcutaneously (under the skin) once a day, Metformin 500 milligrams (mg) 2 tabs twice a day and blood sugar monitoring once a day in the morning.</p> <p>Observations on 6/4/25 Resident #41 was sitting in the lounge area on Nature Way at 12:00AM waiting for lunch to be served. Resident #24 who usually eats in the main dining room was eating in the lounge area. Resident #24 received his/her tray at 11:45AM. Resident #41 along with Resident #71 sat at the dining table watching Resident #24 eat his/her meal. Resident # 41 made a comment to Resident #24 stating I am going to eat your watermelon while you're gone. Resident # 41's meal was brought at 1:05PM (1 hour and 5 minutes after (Resident #24).</p> <p>Interview with the DNS on 6/4/25 at 2:00PM indicated that residents at the same table should be served their meal at the same time. The DNS indicated that the NA or nurse should have obtained the meals for the two residents in order for all three residents to have their meal at the same time.</p> <p>Interview with Nurse Aide ( NA #6) on 6/5/25 at 10:30AM indicated Resident #24 recently returned from the hospital and he/she normally eats in the main dining area but had been eating on the unit since his/her return. NA #6 stated that kitchen staff brought Resident #24's tray at 11:30 to the unit as this is the time the main dining room serves lunch. NA #6 indicated that all residents at a table should be served their meal at the same time and it was not normal practice for residents to watch others eat for that length of time. NA #6 stated she should have obtained Resident #71 and #41 a snack or went and got their trays. NA #6 indicated she let the kitchen staff know at 1:00PM that Residents #71 and #41 still did not have lunch at 1:00PM. NA #6 was informed that the trays were being brought to the unit and the trays arrived at 1:05PM.</p> <p>Review of Resident Rights policy directed, in part that all residents have the right to be treated with dignity and respect and to have a safe and homelike environment.</p> <p>Although requested, a facility policy on dining was not provided.</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, review of facility policy and interviews, the facility failed to ensure Grievance forms were readily available to residents, family members and visitors and the location of the forms. The facility failed to ensure the residents were made aware of the process for filing a grievance. The findings include:</p> <p>On 6/05/2025 at 9:58 AM a meeting with 12 residents who regularly attend the resident council meetings all agreed they were unaware of the grievance process and where the forms were located.</p> <p>An interview and observation on 6/05/25 at 10:38 AM with charge nurse RN #3 indicated the unit does not have any grievance forms.</p> <p>An observation and interview on 6/05/25 at 11:00 AM with Social Worker #1 while walking through the facility, identified no grievance forms located on the units only an empty folder in a file drawer. A policy regarding grievances and complaints was posted high above the State Ombudsman contact form and difficult for those in a wheelchair to see and read. The policy did not provide directions of how to obtain a form or who to contact. SW#1 indicated the policy would be lowered for ease of readability. SW#1 indicated she/he reviewed how to file a grievance with the residents but was unable to provide evidence of such.</p> <p>On 6/09/25 at 1:18 PM SW #1 indicated the posting on the bulletin boards were added and lowered for ease of access and grievance forms were placed in the lobby on a tabletop form holder for all to access if needed.</p> <p>A facility policy labeled Resident and Family Grievances with no date, indicated in part it was the policy of the facility to support each resident's and family's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal.</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, interviews and facility policy for 1 of 3 residents (Resident #25) reviewed for abuse, the facility failed to conduct a thorough investigation regarding an allegation of injury of unknown origin. The findings include:</p> <p>Resident #25's diagnoses included dementia, involuntary movements and age-related osteoarthritis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 as severely cognitively impaired and unable to participate in Brief Interview for Mental Status (BIMS) and noted totally dependent on staff for personal hygiene, transfers, toileting and bed mobility.</p> <p>The Resident Care Plan dated 1/25/24 identified Resident #25 as being dependent for activities of daily living as an area on concerns. Interventions included: to provide assist of 2 staff members for bed mobility, &amp;frac14; siderails to assist with bed mobility and positioning, provide cueing for safety and sequencing to maximize current level of functioning and monitor for fatigue and adjust ADL tasks accordingly.</p> <p>The physician's orders dated 2/1/25 directed to administer valium (muscle relaxer) 2 Milligrams(MG) two times a day via feeding tube for jerky movements, [NAME] Calcium 500 mg one tab once a day via feeding tube for fractures, Cholecalferol 1000 unit tab once a day via feeding tube for fractures, padded &amp;frac14; siderails used for positioning and enabler for turning, and splint to left arm every shift, remove daily when providing care.</p> <p>A Reportable Event submitted to the state agency indicated Resident #25 sustained an injury of unknown origin to his/her left thumb. At 7:00AM on 3/29/24 Resident #25 was noted with a slightly swollen red left thumb. The physician and responsible party were notified, and an order was obtained for an x-ray to Resident #25's left thumb at the facility. The x-ray to left thumb was completed at the facility at 9:20AM on 3/29/25 which revealed 1st left proximal phalanx fracture with mild displacement with soft tissue swelling. Resident #25 remained at the facility per responsible party request with stabilization utilizing a left thumb splint.</p> <p>The Director of Nursing Services (DNS) initiated an investigation on 3/29/25 to determine the possible cause of the fracture left thumb and rule out abuse. The statements obtained from nurse aides and licensed staff failed to identify the 2 nurse aides that provided care to Resident #25 on 3/28/25 on the 7-3 PM, 3-11 PM, and 11-7 AM shift. In addition, the statement obtained from Nurse Aide (NA #8) who provided care to Resident #25 on the 7-3 PM shift on 3/26/25 and 3/27/25 failed to identify who the 2nd staff member that helped with Resident #25's care. All the statements lacked any information regarding how care was provided to Resident #25 or if there was any unusual occurrence during care.</p> <p>A phone interview with Registered (RN #6) on 6/9/25 at 9:59AM identified she was the RN in the facility on 3/28/24 on the 3-11 PM shift. RN #6 indicated that she did not notice any injury to Resident #25's left thumb that evening. Additionally, RN #6 could not recall who provided care to Resident #25 on 3-11 PM shift on 3/28/25 or if 2 staff members helped Resident #25 per plan of care. RN #6 stated that she wrote a statement for the DNS but no one from the facility spoke to her directly regarding the investigation or requested any clarifications regarding her written statement.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview and review of the investigation with the DNS on 6/5/25 at 10:30AM identified she was unable to identify who provided care for the resident on 3/28/24. The DNS stated that she was responsible for conducting the investigation and ensuring the investigation was complete. Furthermore, the DNS stated that the investigation for abuse/injury of unknown origin was incomplete, and she was new at the time and just learning. The DNS stated that the investigation was lacking on the cause of injury.</p> <p>A review of Resident Care flowsheets on 6/5/25 identified that NA #9 provided care for Resident #25 on the 3-11 PM shift on 3/28/24 and NA #10 provided care for Resident #25 on the 11-7 AM shift.</p> <p>An attempt to contact NA #10 who is no longer an employee of the facility, on 6/6/25 at 10:30AM, was unsuccessful.</p> <p>An interview with NA # 9 on 6/6/25 at 2:00PM identified she worked on 3/28/24 on the 3-11 PM shift and worked on a split assignment but she could not recall if she provided care for Resident #25 that evening.</p> <p>A second interview with the DNS on 6/9/25 at 11:55AM identified she concluded that 2 people did not help Resident #25 on 3/28/25 because she had witnessed NA #8 providing care to Resident #25 alone on 3/29/24 in the morning. The DNS indicated that verbal and written education was immediately initiated on 3/29/24 with the nurse aides to ensure Resident #25 is in proper body alignment and the plan of care is followed for 2-person assistance.</p> <p>An interview with Advanced Practice Registered Nurse (APRN #1) on 6/9/25 at 12:15PM indicated Resident #25 fractured thumb was most likely pathological in nature. APRN #1 also indicated Resident #25 has jerky movements of his/her extremities which may have contributed to the injury to his/her thumb.</p> <p>A review of Resident #25's clinical record on 6/9/25 identified that APRN #1 had given Resident #25 a diagnosis of age-related osteoporosis with current pathological fracture on 4/2/24.</p> <p>An interview with the Medical Director on 6/11/25 at 9:00AM identified the diagnosis of pathological fracture for Resident #25 was incorrect and he would need to speak to APRN #1 regarding incorrect diagnosis. He stated that Resident #25 had an osteopenia fracture which can result from minor trauma. He indicated Resident #25 had previous fractures related to mild trauma due to osteopenia. In addition, Resident #25 has diagnosis of involuntary movements.</p> <p>A re-read of Resident #25's x-ray on 6/13/25 was conducted by a second radiologist from the same vendor. The x-ray results for Resident #25's left thumb revealed there was a fracture of the proximal phalanx, as reported. Diffuse bone demineralization is noted. There is no evidence that this is a pathological fracture.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility Abuse policy, directed, in part, notes the facility is to provide protection for the health, welfare and rights of all residents with written policies and procedures that prohibit and prevent abuse. A possible indicator of abuse is physical injury of a resident of an unknown source. An immediate investigation is warranted when there is suspicion of abuse. Identifying and interviewing all involved people, including alleged victims, alleged perpetrators, witnesses and others who might have knowledge, focusing on determining if abuse has occurred. Providing complete and thorough documentation of the investigation.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record reviews, facility policy and interviews for 1 of 3 residents (Resident #25) reviewed for abuse, the facility failed to ensure the plan of care for assistance of 2 staff members for all care provided was followed and for the only sampled resident ( Resident #46), the facility failed to develop a comprehensive plan of care to address the residents respiratory and sensory needs. The findings included:</p> <p>1.Resident #25's diagnoses included dementia, involuntary movements and age-related osteoarthritis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 as severely cognitively impaired and unable to participate in Brief Interview for Mental Status (BIMS) and was totally dependent on staff for personal hygiene, transfers, toileting and bed mobility.</p> <p>The Resident Care Plan dated 1/25/24 identified Resident #25 as being dependent for activities of daily living as an area on concerns. Interventions included: to provide assist of 2 staff members for bed mobility, &amp;frac14; siderails to assist with bed mobility and positioning, provide cueing for safety and sequencing to maximize current level of functioning and monitor for fatigue and adjust ADL tasks accordingly.</p> <p>The physician's orders dated 2/1/25 directed to administer valium (muscle relaxer) 2 milligrams (mg) two times a day via feeding tube for jerky movements, [NAME] Calcium 500 mg one tab once a day via feeding tube for fractures, Cholecalferol 1000 unit tab once a day via feeding tube for fractures, padded &amp;frac14; siderails used for positioning and enabler for turning, and splint to left arm every shift, remove for daily when providing care.</p> <p>A review of Resident #25's care card on 6/9/25 (directs NA to provide care) revealed Resident #25 required assistance of 2 staff for bed mobility.</p> <p>An interview with the DNS on 6/9/25 at 11:55AM identified she was investigating injury of unknown origin of a fractured left thumb to Resident #25 left hand. DNS indicated she was in the initial stages of her investigation. She proceeded to observe and assess Resident # 25's left thumb in the AM on 3/29/25. The DNS stated upon entering the room she witnessed NA #8 providing care to Resident #25 in bed without the assistance of another staff member per individualized plan of care. She further indicated based on this observation Resident #25 may have sustained the injury to his/her thumb prior because assistance of 2 staff members may not have been providing care. The DNS indicated that education was immediately initiated with NA #8 and the rest of NA staff regarding assistance of 2 staff members for care for Resident #25.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with NA #8 on 6/9/25 at 2:00PM identified NA #8 was providing care to Resident #25 in bed without the assistance of another staff member on 3/29/24. NA #8 indicated that she was the primary NA for Resident #25 during the day. She was aware that Resident #25 required the assistance of 2 staff members for care. She also stated that she thought she would be able to provide care to Resident #25 alone but realizes now that she should have obtained assistance by the plan of care plan. NA #8 indicated she was made aware in the AM of 3/29/25t Resident #25 had an injury to his/her thumb but still proceeded to provide care without assistance. NA #8 stated that the DNS observed her providing care on 3/29/25 to Resident #25 alone and she was immediately educated that Resident #25 required assistance of 2 staff members. NA #8 stated that assistance of 2 staff members was present on Resident #25's care card.</p> <p>A review of the Care Plan policy directed, in part, a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial needs is developed and maintained for each resident. The residents receive the services and/or items in the care plan to maintain the residents' well-being.</p> <p>Although a policy was requested related to resident care cards, the facility was unable to provide a policy.</p> <p>2. Resident #46's diagnoses included acute respiratory failure with hypoxia, pneumonia, unspecified organism and insomnia, unspecified.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was cognitively intact and independent for eating, touching assistance for oral hygiene and personal hygiene.</p> <p>a. Review of Resident #46 care plan did not include interventions to address the residents' respiratory care. The Resident care plan failed to identify any behaviors of refusal of care.</p> <p>An interview with the DNS and RN #1 on 6/5/25 at 11:22 AM indicated residents who are on oxygen should have a care plan. The DNS reported that all nursing staff are responsible for ensuring there is a care plan. RN#1 identified this was an oversight that the resident had no interventions for respiratory care.</p> <p>The facility policy labeled Care Plans Comprehensive Person-Centered, not dated, indicated in part; care plan interventions are chosen only after data gathering, proper sequencing of events and consideration of the relationship between the resident's problem areas and their causes. The policy further indicated that the care plan is ongoing and revised as information about the residents and their condition changes.</p> <p>b. Observation on 6/03/25 at 11:31 AM identified Resident #46 with hearing aids.</p> <p>Review of Resident #46 care plan failed to identify interventions for hearing aids.</p> <p>Interview with the DNS and RN #1 on 6/5/25 at 11:22 AM indicated the facility is responsible for the care/ maintenance of the hearing aid therefore a care plan would be implemented. DNS reported that the admission assessment did include the residents who have hearing aids.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record interview and facility policy and interviews for the only residents (Resident # 50) reviewed for bladder and bowel incontinence, the facility failed to ensure staff revised the care plan to reflect the current resident status. The findings include:</p> <p>Resident #50's diagnosis included overactive bladder, urge incontinence and Congestive Heart Failure (CHF).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] indicated in part Resident #50 was cognitively intact and required substantial assistance with toileting, used a wheelchair and had a functional limitation with range of motion of one lower extremity. The MDS further indicated Resident #50 was frequently incontinent of urine and always incontinent of bowel, no trial of a toileting program (scheduled toileting, prompted voiding or bladder training and no toileting program was being used to manage the bowel incontinence.</p> <p>The care plan initiated 4/3/2024 indicated Resident #50 was incontinent of bowel and bladder and was unable to cognitively or physically participate in a retraining program due to impaired mobility. Interventions included to assist with perineal care as needed, complete an incontinence assessment at intervals according to policy and procedure, monitor for signs of infection and skin redness and use multi-void disposable briefs. On 4/22/2025 an additional intervention was added to the care plan to check and change Resident #50 and to provide care as needed.</p> <p>A physician order dated 5/22/2024 directed to provide MiraLAX Powder 17 grams mixed in 4-8 ounces of fluid if no bowel movement in the past 72 hours.</p> <p>A physician order dated 7/23/2024 directed to provide Lasix (a diuretic) 60 mg tablet once daily for CHF.</p> <p>A Urology visit note dated 9/10/2024 indicated Resident #50 had a history of bladder cancer and advised timed toileting, limiting nighttime fluids and avoiding other irritants.</p> <p>The quarterly Bowel &amp; Bladder Program Screener dated 10/1/2024 was completed indicating Resident #50 was a Good Candidate for retraining.</p> <p>A physician order dated 12/2/2024 directed to provide MiraLAX Powder 17 grams by mouth for constipation and to hold for loose stools.</p> <p>The quarterly Bowel and Bladder Screener dated 1/1/2025 was completed and indicated Resident #50 was a good candidate for Schedule toileting (timed voiding).</p> <p>The quarterly Bowel and Bladder Screener dated 3/14/202 indicated Resident #50 was a Candidate for Schedule toileting (timed voiding).</p> <p>The urology visit note dated 3/25/2025 directed Resident # 50 to start Myrbetriq extended-release tablet (24 hour) one 50 mg tablet once daily for overactive bladder.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/09/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Glen Hill		STREET ADDRESS, CITY, STATE, ZIP CODE  1 Glen Hill Rd Danbury, CT 06811	

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The urologist also advised timed toileting, limiting nighttime fluids, avoiding caffeine and other irritants and warned the diuretic would likely exacerbate the frequency of urination and incontinence. Resident #50 started the Myrbetriq per physician's order on 3/27/2025.</p> <p>The quarterly MDS assessment dated [DATE] indicated Resident #50 was cognitively intact and always incontinent of bowel and bladder, required substantial assistance with toileting, dependent for transfer, used a wheelchair and had a functional limitation of range of motion of one lower extremity. The MDS further indicated Resident #50, had no trial of a toileting program (scheduled toileting, prompted voiding or bladder training) and no toileting program was being used to manage the bowel incontinence.</p> <p>The quarterly Bowel and Bladder Screener dated 5/14/2022 indicated Resident #50 was a Candidate for Scheduled toileting (timed voiding).</p> <p>On 6/9/2025 at 12:22 PM an interview and record review with the Director of Nursing Services (DNS) indicated Resident #50 had always been cognitively intact although the care plan initiated on 4/03/2024 indicated Resident #50 was unable to cognitively participate in a retraining program due to impaired mobility. The DNS further indicated Resident # 50 had bowel and bladder incontinence, Bowel and Bladder Incontinent Screens had all indicated Resident #50 was a candidate for retraining, the Urologist advised timed toileting on 2 consults and indicated she/he would have expected nursing staff to have informed the team of the results of the Bladder and Bowel Screens so Resident #50 could have trialed a toileting program using the bed pan and Resident #50 interviewed regarding his/her wishes and the care plan updated.</p> <p>The facility policy labeled Care Plans Comprehensive Person-Centered, not dated, indicated in part care plan interventions are chosen only after data gathering, proper sequencing of events and consideration of the relationship between the resident's problem areas and their causes. The policy further indicated the care plan is ongoing and revised as information about the residents and their condition changes as well as with significant change in condition, the desired outcome is not met, when readmitted to the facility from a hospital stay and at least quarterly in conjunction with the MDS.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, review of policy and staff interviews for 1 of 2 residents (Resident # 13) reviewed for ADL, the facility failed to ensure a resident received incontinence care promptly. The findings include:</p> <p>Resident #13 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease and heart disease.</p> <p>The admission MDS assessment dated [DATE] identified Resident #13 was cognitively intact, required partial/moderate assistance for toileting hygiene, and was frequently incontinent of the bladder.</p> <p>On 6/3/2025 at 1:49 PM, an interview with Resident #13 identified two weeks prior, the resident had to wait about 2 hours to get changed after an incontinence episode. Resident #13 indicated that although there were two male aides available, the resident preferred a female to help him/her with incontinence care. Resident #13 indicated she/he spoke to a female nurse and a female supervisor but was told to wait for the female aide to become available.</p> <p>On 6/4/2025 at 2:33 PM, an interview with NA #2 identified Resident #13 preferred females to provide toileting care. NA #2 indicated that if the resident were assigned a male aide, then an adjustment in the assignment would be made to accommodate the resident's preferences.</p> <p>On 6/5/2025 at 10:57 AM, an interview with NA# 3 identified on 5/23/2025, in the evening shift, he was assigned to take care of Resident #13. NA#13 indicated he answered the resident's call bell, and the resident requested to be changed. NA #3 indicated he offered to help Resident #13 get cleaned, but Resident #13 indicated she/he preferred a female for help with toileting. NA #13 indicated that he told Resident #13 that she/he would have to wait for the female aide on the floor (NA #4) to be free since she had to finish her assignment first and then notified LPN #1. NA #3 further indicated Resident #13 was eventually provided incontinence care by NA #4 about 1 hour or 1 hour and 15 minutes after the resident initially rang for help.</p> <p>On 6/5/2025 at 11:30 AM, an interview with LPN #1 identified on 5/23/2025, there were two male aides and one female aide working on the unit, and she indicated that she notified the nursing supervisor (RN #2) that the floor had several female residents that preferred a female aide and having two male aides would make the assignments challenging. LPN #1 indicated that she did not have an opportunity to offer toileting to Resident #13 because she was busy administering medications, helping another resident who was falling from their chair, answering phone calls, and speaking to providers. LPN #2 indicated that she informed Resident #13 that a female aide would be provided to help with their toileting care. LPN #2 also indicated there was another female nurse on the floor and that nurse was busy with her assignment and could not offer help. LPN #1 further indicated that NA #4 eventually provided incontinence care to Resident #13, and assignments were changed so that NA #4 would be Resident #13's NA for the rest of the shift. LPN #1 indicated Resident # 13 waited about an hour for care.</p> <p>An attempt to interview NA #4 and RN #2 was unsuccessful.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/2025 at 12:52 PM, an interview with the DNS indicated she was not aware Resident #13 had to wait an hour for care on 5/23/2025 and further indicated LPN #1 was hands-on and helped the NAs with resident care. The DNS indicated that she was aware Resident #13 preferred a female for toileting and has care planned the preference in the resident's medical record.</p> <p>A care plan revised on 5/29/2025 indicated that Resident #13 had functional performance limitations related to recent hospitalization and illness. Interventions included providing one-person physical assistance for personal hygiene and no male caregivers.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record interview and facility policy and interviews for the only residents (Resident # 50) reviewed for bladder and bowel incontinence, the facility failed to ensure attempts were made to restore the residents bladder. The findings include:</p> <p>Resident #50's diagnosis included overactive bladder, urge incontinence and Congestive Heart Failure (CHF).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] indicated in part Resident #50 was cognitively intact and required substantial assistance with toileting, used a wheelchair and had a functional limitation with range of motion of one lower extremity. The MDS further indicated Resident #50 was frequently incontinent of urine and always incontinent of bowel, no trial of a toileting program (scheduled toileting, prompted voiding or bladder training and no toileting program was being used to manage the bowel incontinence.</p> <p>The care plan initiated 4/3/2024 indicated Resident #50 was incontinent of bowel and bladder and was unable to cognitively or physically participate in a retraining program due to impaired mobility. Interventions included to assist with perineal care as needed, complete an incontinence assessment at intervals according to policy and procedure, monitor for signs of infection and skin redness and use multi-void disposable briefs. On 4/22/2025 an additional intervention was added to the care plan to check and change Resident #50 and to provide care as needed.</p> <p>A physician order dated 5/22/2024 directed to provide MiraLAX Powder 17 grams mixed in 4-8 ounces of fluid if no bowel movement in the past 72 hours.</p> <p>A physician order dated 7/23/2024 directed to provide Lasix (a diuretic) 60 mg tablet once daily for CHF.</p> <p>A Urology visit note dated 9/10/2024 indicated Resident #50 had a history of bladder cancer and advised timed toileting, limiting nighttime fluids and avoiding other irritants.</p> <p>The quarterly Bowel &amp; Bladder Program Screener dated 10/1/2024 was completed indicating Resident #50 was a Good Candidate for retraining.</p> <p>A physician order dated 12/2/2024 directed to provide MiraLAX Powder 17 grams by mouth for constipation and to hold for loose stools.</p> <p>The quarterly Bowel and Bladder Screener dated 1/1/2025 was completed and indicated Resident #50 was a good candidate for Schedule toileting (timed voiding).</p> <p>The quarterly Bowel and Bladder Screener dated 3/14/202 indicated Resident #50 was a Candidate for Schedule toileting (timed voiding).</p> <p>The urology visit note dated 3/25/2025 directed Resident # 50 to start Myrbetriq extended-release tablet (24 hour) one 50 mg tablet once daily for overactive bladder.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The urologist also advised timed toileting, limiting nighttime fluids, avoiding caffeine and other irritants and warned the diuretic would likely exacerbate the frequency of urination and incontinence. Resident #50 started the Myrbetriq per physician's order on 3/27/2025.</p> <p>The quarterly MDS assessment dated [DATE] indicated Resident #50 was cognitively intact and always incontinent of bowel and bladder, required substantial assistance with toileting, dependent for transfer, used a wheelchair and had a functional limitation of range of motion of one lower extremity. The MDS further indicated Resident #50, had no trial of a toileting program (scheduled toileting, prompted voiding or bladder training) and no toileting program was being used to manage the bowel incontinence.</p> <p>The quarterly Bowel and Bladder Screener dated 5/14/2022 indicated Resident #50 was a Candidate for Scheduled toileting (timed voiding).</p> <p>On 6/9/2025 at 12:22 PM an interview and record review with the Director of Nursing Services (DNS) indicated Resident # 50 had bowel and bladder incontinence, Bowel and Bladder Incontinent Screens had all indicated Resident #50 was a candidate for retraining, the Urologist advised timed toileting on 2 consults and indicated she/he would have expected nursing staff to have informed the team of the results of the Bladder and Bowel Screens so Resident #50 could have trialed a toileting program using the bed pan.</p> <p>The facility policy labeled Bowel and Bladder Policy indicated in part, a bowel and bladder assessment should be completed admission, readmission, quarterly and with any change in condition that may affect bowel and bladder continence. Assessment of a resident's appropriateness to participate in bowel and bladder continence maintenance include nursing staff therapy and physician services, the resident must possess the ability to comprehend educational efforts and follow through to identify the urge to void.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, observation, facility policy and interviews for the only sampled resident (Resident #46) reviewed for Respiratory care, the facility failed to ensure oxygen physician's order were current. The findings include:</p> <p>Resident #46's diagnoses included acute respiratory failure with hypoxia, pneumonia, unspecified organism and insomnia, unspecified.</p> <p>The admission Minimum Data Set assessment dated [DATE] identified Resident #46 was cognitively intact and independent for eating, touching assistance for oral hygiene and personal hygiene.</p> <p>Review of Resident #46 care plan did not include interventions for respiratory care. The Resident care plan did not identify any behaviors of refusal of care.</p> <p>A physician's order dated 5/16/25 directed, Oxygen at 1 Liter per minute via Nasal Cannula continuously.</p> <p>The nurse's note from 5/28/25 through 6/5/25 did not indicate any refusal of treatment.</p> <p>Observation on 6/03/25 at 11:31 AM of Resident # 46 being assisted back to his/her room identified no oxygen attached. Additional observation of the oxygen machine in residents' rooms identified no oxygen in use.</p> <p>Interview with Resident#46 indicated she has not received oxygen today. Person #1 indicated he/she was not sure why Resident #46 has oxygen in the room.</p> <p>Observation on 6/04/ 25 at 10:31AM of Resident #46 in the room with no oxygen on. Resident #46 identified although the oxygen machine is in the room she has not been on it for some time.</p> <p>Interview with LPN #1 on 6/4/25 at 10:33 AM indicated the resident was titrated off his/her oxygen last week and she/he is unsure why the physician's orders have not been updated. LPN #1 further indicated the nursing staff is responsible for ensuring physician's orders are accurate and given as ordered.</p> <p>The interview with DNS on 6/5/25 at 11:22 AM indicated if there are changes to resident's physicians ordered the expectation is that physician's orders are updated right away to reflect changes. The DNS could not explain why Resident #46 was not receiving oxygen as ordered or why the physician's orders were not updated to reflect current orders.</p> <p>After inquiry, a physician's order dated 6/4/25 directed Oxygen at 0-2 Liter per minute via Nasal Cannula as needed for oxygen saturation of less than 90.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations of kitchen, facility policy and interview, the facility failed to ensure food was served in safe and sanitary conditions. The findings include:</p> <p>An observation of the noon meal plating service in the kitchen on 6/6/25 at 11:40AM identified an open industrial garbage can with trash filled to the top; opened with no lid to cover the garbage can while food was being plated from the steam table. The garbage can was to the right of the steam table and 15 feet (ft.) away. The garbage can was opened by steam table for a half hour of the serving time of food from the steam table until 12:10PM.</p> <p>An interview with the Dietary Manager on 6/6/25 at 12:00PM identified the garbage can should have been covered and not in proximity to the steam table while food was being plated. The Dietary Manager further indicated that all kitchen staff is responsibility for ensuring garbage cans are removed and covered during meal service.</p> <p>After surveyor inquiry, the Dietary Manger had a dietary aide cover and move the garbage can from the serving area.</p> <p>A review of the Environment Policy directed, in part, all food preparation and food service areas will be maintained in safe and sanitary conditions. All trash containers will be covered in leak proof containers to prevent cross contamination.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #48) reviewed for foley catheters, the facility failed to ensure the foley catheter drainage bag was not touching the floor when in wheelchair. The findings included:</p> <p>Resident #48's diagnoses included congenital stricture of urethra, obstructive and reflex uropathy and urinary retention.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #48 was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 9 indicating the resident required moderate assistance for personal hygiene, dressing, transfers, utilizing a wheelchair for mobility and had an indwelling suprapubic urinary catheter (empties urine directly from the bladder from an opening in the abdomen).</p> <p>The Resident Care Plan dated 3/7/25 identified suprapubic catheter related to urinary retention as an area of concern. Interventions included: to change catheter per urology orders, check tubing for kinks every shift, position tubing and bag below the level of the bladder and away from entrance room door and change the indwelling catheter if exhibiting urinary drainage obstruction, signs and symptoms of infection and when the closed system is compromised.</p> <p>A physician's order dated 5/21/25 directed to change suprapubic tube monthly and as needed if occluded or leakage, empty suprapubic bag at least once a shift and enhance barrier precaution related to suprapubic catheter.</p> <p>Observations on 6/3/25 at 1:00PM identified the foley catheter drainage bag attached to the back of Resident #48's wheelchair (w/c) and was dragging on the floor when his/her wheelchair was being pushed from bedroom into the lounging area on the unit. On 6/4/25 at 10:05AM and 2:00PM, and 6/5/25 at 12:00PM, Resident #48's foley catheter drainage bag was attached to the back of his/her wheelchair. The foley drainage bag was not suspended and was touching the floor.</p> <p>Interview with RN #4, the Infection Control Preventionist on 6/6/25 at 10:56AM identified foley catheter drainage bags should be covered and not dragging or touching the floor. RN #4 was unsure if the policy on urinary catheters addresses foley catheter drainage bags touching the floor but indicated it was an infection control standard of practice. Furthermore, RN #4 indicated whoever provides care to a resident with a urinary catheter drainage bag is responsible for ensuring the drainage bag is not touching or dragging on the floor and the nurse should be periodically checking throughout the shift. RN #4 indicated after this concern was brought to her attention, she observed Resident #48's foley drainage bag touching the floor when he/she was in the wheelchair.</p> <p>After the surveyor inquiry, RN #4 made a referral to therapy regarding Resident #48's wheelchair. Therapy applied zip ties to back of wheelchair to ensure drainage bag is off the floor and RN #4 replaced the drainage bag with one that was short in length. In addition, RN #4 updated Resident #48's care plan with the above interventions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Catheter Care, Urinary policy, directed, in part, maintain clean technique when handling or manipulating the catheter, tubing or drainage bag. Be sure the catheter tubing and drainage bag are kept off the floor.</p>