STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075034	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolton Chronic & Convalescent Hospital Inc	400 Mill Plain Rd Fairfield, CT 06824

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 6 resident shared bathrooms on 1 of 4 nursing units, the facility failed to ensure personal care items were stored in a manner to maintain a clean, comfortable, and homelike environment, and for 1 resident (Resident #89), the facility failed to maintain safe and comfortable water temperatures in the residents bathroom. The findings include: 1. Observation on 4/1/25 at 11:33 AM and observation and interview with NA #5 on 4/7/25 at 4:15 PM and LPN #13 on 4/7/25 at 4:22 PM identified the following. room [ROOM NUMBER]'s shared bathroom contained four bedpans, all unlabeled and uncovered and wedged inside a metal rack located on the door side wall. room [ROOM NUMBER]'s shared bathroom contained two bedpans and one toilet hat, all unlabeled and uncovered and wedged inside a metal rack located on the door side wall. The bedpan and toilet hat at the top of the metal rack also had a black clothing garment rolled up on top of them. room [ROOM NUMBER]'s shared bathroom contained 3 bedpans, all unlabeled and uncovered and wedged inside a metal rack located on the door side wall. room [ROOM NUMBER]'s shared bathroom contained three urinals and one toilet hat, all unlabeled and uncovered and sitting inside a metal railing along the door side wall. The open side of the toilet was touching the wall. room [ROOM NUMBER]'s shared bathroom contained three bedpans, two were labeled and all were uncovered and wedged inside a metal rack located on the door side wall. Interview with NA #5 on 4/7/25 at 4:15 PM identified it was the nurse aides responsibility to label, cover, and store the resident's personal care items. NA #6 failed to indicate why the policy was not followed and was uncertain as to why the bed pans were inappropriately stored. Interview with LPN #13 on 4/7/25 at 4:22 PM identified it was nurse aides responsibility to label, cover and store the resident's personal care items. LPN #13 failed to indicate why the policy was not followed and was uncertain as to why the bed pans were inappropriately stored. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the IP Nurse (LPN #9) on 4/7/25 at 4:27 PM identified that resident's personal care items should be separated, labeled and covered per policy and that the nurse aide was responsible. LPN #9 was unable to indicate why the personal care items were inappropriately stored. Interview with the DNS on 4/8/25 at 10:12 AM identified all resident's personal care items should be labeled and covered with no duplicate items kept in the bathrooms. The DNS indicated the nursing staff was responsible to maintain items in that manner and that she would need to address it further with the staff on that unit. Subsequent to surveyor inquiry, an observation on 4/8/25 at 11:40 AM indicated the bathrooms of room [ROOM NUMBER], 5, 12, 16, 18 and 20 had all identified bedpans, urinals, and toilet hats bagged, labeled and appropriately stored in the bathrooms. Review of the facility policy, Disinfection of Bedpans and Urinals, undated, directed that each resident shall be assigned a bedpan or urinal for their exclusive use and the bedpan or urinal shall be labeled with the resident's name. 2. Resident #89's diagnosis included malignant neoplasm of the bladder and blindness. The quarterly MDS dated [DATE], identified Resident #89 had intact cognition, required partial to moderate assistance for eating, toileting hygiene, dressing, and was dependent on staff for all transfers. The care plan dated 1/23/25, identified Resident #89 had a self-care performance deficit related to limited physical mobility, and visual and hearing impairment. Interventions directed staff to anticipate the residents needs, assist with toileting, bed mobility and transferring. Observation on 3/31/25 at 11:26 AM identified the hot water temperature in Resident # 89's bathroom sink was 55°F. At 11:32 AM the hot water temp was 55°F. Interview with Maintenance Technician #5 stated he was not aware of the lack of hot water in Resident #89's room, but he would let the Maintenance Supervisor know. Observation on 4/1/2025 at 2:34 PM identified that the hot water temperature in Resident #89's bathroom sink was 56°F. Interview with Resident #89 on 4/3/3035 at 2:41 PM identified that he/she takes showers and at times receives a bed bath. Resident #89 stated that since the bathroom water was always cold, the staff have to bring in warm water from another room. Observation on 4/7/25 at 4:02 PM identified the hot water temperature in Resident #89's bathroom sink was 56°F. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Maintenance Supervisor #1 on 4/7/2025 at 4:02 PM identified there was a known problem with the hot water in Resident #89's bathroom but he indicated it had been fixed at some point last year. Maintenance Technician #6 entered the room, let the water run for 10 minutes and tested the hot water using his thermometer and determined it was 58°F. Maintentance Supervisor #1 stated he would look and see if he could repair the issue. At 4:29 PM Maintenance Supervisor #1 stated he had repaired the issue. The hot water temperature was retested and measured 119°F. The Maintenance Supervisor stated he had adjusted the mixing valve and reported there would not be an issue with the hot water moving forward. Observation and interview on 4/7/25 at 4:31 PM identified the hot water temperature in Resident #89's bathroom was 125.8°F, which exceeded acceptable guidelines. In a follow-up interview, Maintenance Supervisor #1 indicated that the issue had not actually been fixed and explained that the only way to get hot water in that room was by turning on the hot water at full strength in both the janitor's closet and the bathroom across the hall. The Maintenance Supervisor #1 identified he would call the plumber out that evening to properly address the problem. An interview with the Administrator on 4/8/2025 at 10:41 AM identified the Facility Administrator was aware of a historical problem with the hot water in Resident #89's room, noting that the water needed to run for approximately 15 minutes before becoming hot due to the room being serviced by a different line. The Administrator indicated he was not aware the water was running cold and identified this was a problem and stated once it was brought to his attention, he arranged for a plumber to come out to make the necessary repairs. Interview with the Administrator, Maintenance Supervisor #1, and Person #2 on 4/8/25 at 12:10 PM identified the hot water issue in Resident #89's room was caused by an improper connection made during the wing's renovation in 2008. Person #2 confirmed that the problem had existed since that time and stated it had not been fixed earlier because the facility never set up a time to repair it.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for 1 of 3 residents (Resident #26) reviewed for dignity, the facility failed to make prompt efforts to resolve the resident's grievances of care provided. The findings include: Resident #26's diagnoses included anxiety, congestive heart failure and irritable bowel syndrome. The admission MDS dated [DATE] identified Resident #26 was cognitively intact, and dependent on staff for transfers, bed mobility and toileting. The care plan dated 2/22/25 identified Resident #26 was alert and oriented. Interventions included monitoring for changes in behavior, mood, appetite and sleep pattern with changes reported to the physician, providing adequate time and encouragement to voice feelings, emotions, concerns and psychiatry consultations as needed. In an interview with Resident #26 on 3/31/25 at 11:48 PM the resident identified there were employees on the evening shift that have a mean tone when interacting with the resident and do things on their own. Resident #26 indicated that although he/she reported this to the nurse, nothing has changed. Resident #26 did not want to identify the staff members. Review of the grievance log dated 1/1/25 - 4/7/25 failed to identify any care concerns or grievances documented for Resident #26. Review of nurses notes dated 3/21/25, 3/24/25, 3/25/25, 3/26/25, 3/28/25, 3/29/25, 3/30/25, 4/1/25, 4/2/25, 4/3/25 and 4/4/25 identified Resident #26 had accusatory statements about staff and care given. Review of the current care plan on 4/7/25 failed to reflect that Resident #26 had accusatory behaviors with interventions to address such. Interview with the DNS 4/7/25 at 11:55 AM identified Resident #26 has reported in the past, complaints of caregivers talking to her/him in a poor manner. However, when it was followed up on by the supervisors, Resident #26's story changed, so no formal investigation was started, and nothing was ever put in writing. Interview with LPN #10 on 4/7/25 at 2:52 PM identified Resident #26 makes accusatory statements toward staff on a regular basis, but they were not factual due to his/her advanced age. LPN #10 could not identify what the accusations were, stating Resident #26 makes statements that he/she cannot recall, so as a precaution he/she has 2 caregivers for care. Interview with SW #1 on 4/7/25 at 2:49 PM identified that he was the facility Greivance Officer and the facility policy on grievances was to investigate any allegations within 24 hours and put interventions in place. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/7/25 at 3:16 PM identified the facility policy on accusations made by residents was to start an investigation initiated by the supervisor, see if there is a conflict with the care giver and then she would get a briefing. The DNS identified she was not aware of any investigations for Resident #26, but per the nurses notes she should have been. Follow up interview and record review with the DNS on 4/8/25 at 12:52 PM identified she had an investigation in her mailbox that she had not seen. The investigation dated 4/4/25 identified Resident #26 made a care concern allegation against evening shift nurse aides on 4/4/25 for being rude and not answering his/her call light in a timely fashion. The supervisor initiated an investigation, and the intervention was 2 caregivers at all times, with education provided to staff on respect, dignity and communication to with the charge nurse and supervisor. No grievance was filed, and the grievance officer was not notified. The DNS stated that this was the only investigation for Resident #26 that she was aware of, and no investigations were initiated for the allegations on 3/21/25, 3/24/25, 3/25/25, 3/26/25, 3/28/25, 3/29/25, 3/30/25, 4/1/25, 4/2/25, or 4/3/25. Interview and record review with SW #1 on 4/8/25 at 12:59 PM identified the nurses notes dated 3/21/25, 3/24/25, 3/25/25, 3/26/25, 3/28/25, 3/29/25, 3/30/25, 4/1/25, 4/2/25, 4/3/25 and 4/4/25, identified Resident #26 was making accusatory statements about staff and the care given, however he was not aware of any of them and indicated if he had been he would have followed up with Resident #26 to obtain more information, such as details on the staff member and then initiated education, SW #1 could not follow up at the time as Resident #26 was out of the building. Review of Patients Complaints/Grievances policy dated 7/24/2014 directed if a grievance is received by staff in person, by telephone or in writing, a report shall be originated by the staff receiving the grievance and then forward to the grievance officer for investigation and resolution. Each issue defined as a grievance shall be followed up with a written notice and a decision from the officer with a resolution within 7 days. Additionally, the Grievance officer is responsible for ensuring that all individuals adhere to the requirements of this policy, and any noncompliance is reported to the Administrator. Review of the Resident Behaviors and Accusations policy directed that all resident concerns and accusations will be taken seriously and investigated thoroughly, reported immediately to the Administrator or DNS with an internal investigation completed within 24 hours.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #45, 53 and 4) reviewed for abuse, the facility failed to report allegations of abuse to the Administrator, the State Agency and Police according to facility policy. The findings include: 1. Resident #45's diagnoses included cerebral palsy and adjustment disorder with anxiety. The quarterly MDS dated [DATE] identified Resident #45 had intact cognition, required the assistance of 2 via mechanical lift for transfers to the wheelchair, and was independent while in the wheelchair. a. Interview with Resident #45 on 3/31/25 at 11:50 AM identified that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair when exiting the dining room. Resident #45 stated that he/she in turn ran over Resident #53's feet three times with his/her wheelchair purposely. Resident #45 stated he/she sees Resident #53 in the hallway and Resident #53 is always looking in his/her (Resident #45's) room. The allegation of resident-to-resident abuse was reported by the surveyor to the DNS on 3/31/25 at 12:30 PM. The DNS indicated that she was not aware of any allegations of resident-to-resident abuse between Resident #45 and Resident #53. A review of Resident #45's care plan on 4/3/25 failed to reflect Resident #45's fear of Resident #53 or the alleged resident to resident allegation. b. Resident #53's diagnoses included Alzheimer's disease with agitation. The quarterly MDS dated [DATE] identified Resident #53 as being severely cognitively impaired and required a wheelchair for mobility. Physician's order for Resident #53 dated 3/5/25 directed to administer Trazadone (antidepressant) 50 mg every 6 hours as needed for anxiety. A review of Resident #53's nurse and social worker notes and care plan dated 2/1/25 through 4/3/25 failed to reflect the incident. Interview with Resident #53's representative on 4/1/25 indicated that he was not made aware that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair or that Resident #45 stated that he/she in turn ran over Resident #53's feet three times. Interview with LPN #6 on 4/2/25 at 10:50 AM, who was Resident #53's charge nurse during the 7:00 AM - 3:00 PM shift on 4/1/25 and 4/2/25 was unaware of any allegations made regarding Resident #45 and Resident #53. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/2/25 at 1:35 PM identified that the DNS reported the alleged allegation to the State Agency on 4/1/25 (a day after being notified) and had not reported the allegation to the police. The DNS indicated that the facility policy is to report alleged allegations to the State Agency immediately. The DNS indicated that she started the investigation first, which caused a delay in reporting and indicated that there was conflicting information regarding what occurred. The DNS also indicated that it is not normal practice to investigate first then report the allegation to the State Agency. The DNS indicated that the allegation happened a while ago, and SW #1 had addressed the issue. However, the first time the DNS was made aware of the alleged allegation was when it was reported to her by the surveyor on 3/31/25. The DNS identified the Social Worker had never made her aware of the incident. Interview with SW #1 on 4/3/25 at 10:22 AM identified that he was aware of the incident after it occurred as Resident #45 asked to speak to him. SW #1 indicated that Resident #45 never stated that Resident #53 grabbed his/her neck or that Resident #45 ran over Resident #53's feet. SW #1 stated that Resident #45 thinks that Resident #53 has pinpointed him/her but that Resident #53 has never been aggressive towards Resident #45 as far as he is aware. Resident #53 wheels independently by Resident #45's room frequently. Interview with PT #2 on 4/3/25 at 10:48 AM identified that Resident #45 had reported that he/she ran over Resident #53's feet purposely and that he/she is fearful of Resident #53. 2. Resident #4 diagnoses included dementia, depression and generalized anxiety disorder. Physician's order dated 3/3/25 directed to document behaviors once a shift and administer Citalopram 10 mg daily and Mirtazapine 30 mg daily for depression. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was independent with toileting, personal hygiene, and ambulation. Interview with Resident #4 on 3/31/25 at 11:30 AM identified that several weeks ago he/she believed that a nurse aide pushed him/her into the bathroom. Resident #4 was unable to identify the nurse aide by name but believed the nurse aide was white and worked during the day shift. Resident #4 stated that this nurse aide is around a lot and is mean and bossy. Resident #4 stated he/she does not want that nurse aide to care for him/her and that he/she had reported the incident to his/her resident representative when it occurred. The allegation was reported to the DNS on 3/31/25 at 12:30 PM by the surveyor. The DNS stated she was not aware of the allegation or concerns related to Resident #4 and it had not been reported. Interview with the Resident Representative on 4/2/25 at 10:25 AM identified that he/she was made aware of the allegation by Resident #4 but did not report the concern as he/she believed Resident #4 may have misinterpreted what occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #6 on 4/2/25 at 10:50 AM identified she was Resident #4's charge nurse on the day shift on 4/1/25 and 4/2/25 and she is Resident #4's primary nurse every other week. LPN #6 indicated that Resident #4 frequently mentions that a nurse aide is mean but the resident is unable to identify the nurse aide. LPN #6 indicated that Resident #4 is consistent in saying the nurse aide is mean and bossy, however, Resident #4 has never indicated to her that she was pushed by the nurse aide. LPN #6 identified that Resident #4 is confused and cannot always express his/her concerns clearly. LPN #6 identified that she has never reported to the administration Resident #4's concerns regarding a nurse aide being mean and bossy. Interview with RN #6 on 4/4/25 at 10:30 AM identified she was made aware by Resident #4 that a nurse aide pushed the resident. RN #6 identified she investigated the situation when it was reported to her. RN #6 identified that a nurse aide had pushed Resident #4 in the wheelchair to obtain a weight and Resident #4 did not want to be weighed and was upset because he/she was being pushed in the wheelchair onto the scale. RN #6 indicated she does not think she reported the incident to the DNS at the time it occurred, she did not think she obtained any written statements from staff and was unsure if she documented the incident in the nursing notes. Interview with the DNS on 4/2/25 at 1:35 PM indicated that after the allegation was reported to her for the first time on 3/31/25 at 12:30 PM she started the investigation which caused a delay in reporting the incident to the State Agency. The DNS indicated that RN #6 had investigated the situation when it occurred, however, the DNS was not aware of the incident involving Resident #4 because RN #6 did not report it. Review of the nurses and social worker notes and the care plan dated 2/1/25 through 4/3/25 failed to reflect documentation of the allegation. Review of the Resident/Patient Abuse policy revised 2/8/23 identified that any alleged or witnessed incident of abuse is to be immediately reported to the nursing supervisor. This report shall be promptly reported to the appropriate department heads and the administrator. The DNS or designated representative shall promptly notify the Police, DPH, the attending physician, the medical director and Administrator within 2 hours of notification of abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #45, 53 and 4) reviewed for abuse, the facility failed to immediately initiate a thorough investigation after allegations of abuse were either witnessed or reported, identify and remove the staff member involved, and report the results of the investigation to the administrator and to the State Agency within 5 working days of the incident. The findings include: 1. Resident #45's diagnoses included cerebral palsy and adjustment disorder with anxiety. The quarterly MDS dated [DATE] identified Resident #45 had intact cognition, required the assistance of 2 via mechanical lift for transfers to the wheelchair, and was independent while in the wheelchair. a. Interview with Resident #45 on 3/31/25 at 11:50 AM identified that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair when exiting the dining room. Resident #45 stated that he/she in turn ran over Resident #53's feet three times with his/her wheelchair purposely. Resident #45 stated he/she sees Resident #53 in the hallway and Resident #53 is always looking in his/her (Resident #45's) room. The allegation of resident-to-resident abuse was reported by the surveyor to the DNS on 3/31/25 at 12:30 PM. The DNS indicated that she was not aware of any allegations of resident-to-resident abuse between Resident #45 and Resident #53. A review of Resident #45's care plan on 4/3/25 failed to reflect Resident #45's fear of Resident #53 or the alleged resident to resident allegation. b. Resident #53's diagnoses included Alzheimer's disease with agitation. The quarterly MDS dated [DATE] identified Resident #53 as being severely cognitively impaired and required a wheelchair for mobility. Physician's order for Resident #53 dated 3/5/25 directed to administer Trazadone (antidepressant) 50 mg every 6 hours as needed for anxiety. A review of Resident #53's nurse and social worker notes and care plan dated 2/1/25 through 4/3/25 failed to reflect the incident. Interview with Resident #53's representative on 4/1/25 indicated that he was not made aware that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair or that Resident #45 stated that he/she in turn ran over Resident #53's feet three times. Interview with LPN #6 on 4/2/25 at 10:50 AM, who was Resident #53's charge nurse during the 7:00 AM - 3:00 PM shift on 4/1/25 and 4/2/25 was unaware of any allegations made regarding Resident #45 and Resident #53. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/2/25 at 1:35 PM identified that the DNS reported the alleged allegation to the State Agency on 4/1/25 (a day after being notified) and had not reported the allegation to the police. The DNS indicated that the facility policy is to report alleged allegations to the State Agency immediately. The DNS indicated that she started the investigation first, which caused a delay in reporting and indicated that there was conflicting information regarding what occurred. The DNS also indicated that it is not normal practice to investigate first then report the allegation to the State Agency. The DNS indicated that the allegation happened a while ago, and SW #1 had addressed the issue. However, the first time the DNS was made aware of the alleged allegation was when it was reported to her by the surveyor on 3/31/25. The DNS identified the Social Worker had never made her aware of the incident. Interview with SW #1 on 4/3/25 at 10:22 AM identified that he was aware of the incident after it occurred as Resident #45 asked to speak to him. SW #1 indicated that Resident #45 never stated that Resident #53 grabbed his/her neck or that Resident #45 ran over Resident #53's feet. SW #1 stated that Resident #45 thinks that Resident #53 has pinpointed him/her but that Resident #53 has never been aggressive towards Resident #45 as far as he is aware. Resident #53 wheels independently by Resident #45's room frequently. Interview with PT #2 on 4/3/25 at 10:48 AM identified that Resident #45 had reported that he/she ran over Resident #53's feet purposely and that he/she is fearful of Resident #53. Although PT #2 was aware of the incident, according to the DPH reportable events portal, the incident took place on 3/24/25, was not reported to DPH until 4/1/25, and the investigation summary was not submitted until 4/11/25. Review of the Resident/Patient Abuse policy revised 2/8/23, directed following the initial report of suspected or alleged abuse, the involved department supervisor(s)/department head(s) shall immediately initiate an investigation of the incident, this investigation shall include, but not limited to, interviewing of the resident and or family members and interviewing of all involved staff. 2. Resident #4 diagnoses included dementia, depression and generalized anxiety disorder. Physician's order dated 3/3/25 directed to document behaviors once a shift and administer Citalopram 10 mg daily and Mirtazapine 30 mg daily for depression. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was independent with toileting, personal hygiene, and ambulation. Interview with Resident #4 on 3/31/25 at 11:30 AM identified that several weeks ago he/she believed that a nurse aide pushed him/her into the bathroom. Resident #4 was unable to identify the nurse aide by name but believed the nurse aide was white and worked during the day shift. Resident #4 stated that this nurse aide is around a lot and is mean and bossy. Resident #4 stated he/she does not want that nurse aide to care for him/her and that he/she had reported the incident to his/her resident representative when it occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegation was reported to the DNS on 3/31/25 at 12:30 PM by the surveyor. The DNS stated she was not aware of the allegation or concerns related to Resident #4 and it had not been reported. Interview with the Resident Representative on 4/2/25 at 10:25 AM identified that he/she was made aware of the allegation by Resident #4 but did not report the concern as he/she believed Resident #4 may have misinterpreted what occurred. Interview with LPN #6 on 4/2/25 at 10:50 AM identified she was Resident #4's charge nurse on the day shift on 4/1/25 and 4/2/25 and she is Resident #4's primary nurse every other week. LPN #6 indicated that Resident #4 frequently mentions that a nurse aide is mean but the resident is unable to identify the nurse aide. LPN #6 indicated that Resident #4 is consistent in saying the nurse aide is mean and bossy, however, Resident #4 has never indicated to her that she was pushed by the nurse aide. LPN #6 identified that Resident #4 is confused and cannot always express his/her concerns clearly. LPN #6 identified that she has never reported to the administration Resident #4's concerns regarding a nurse aide being mean and bossy. Interview with RN #6 on 4/4/25 at 10:30 AM identified she was made aware by Resident #4 that a nurse aide pushed the resident. RN #6 identified she investigated the situation when it was reported to her. RN #6 identified that a nurse aide had pushed Resident #4 in the wheelchair to obtain a weight and Resident #4 did not want to be weighed and was upset because he/she was being pushed in the wheelchair onto the scale. RN #6 indicated she does not think she reported the incident to the DNS at the time it occurred, she did not think she obtained any written statements from staff and was unsure if she documented the incident in the nursing notes. Interview with the DNS on 4/2/25 at 1:35 PM indicated that after the allegation was reported to her for the first time on 3/31/25 at 12:30 PM she started the investigation which caused a delay in reporting the incident to the State Agency. The DNS indicated that RN #6 had investigated the situation when it occurred, however, the DNS was not aware of the incident involving Resident #4 because RN #6 did not report it. Review of the nurses and social worker notes and the care plan dated 2/1/25 through 4/3/25 failed to reflect documentation of the allegation. Although the resident reported the incident to RN #6 when it happened, RN #6 did not report the incident to the DNS or Administrator, the staff member was not identified or removed, and an investigation was not initiated. According to the DPH reportable events portal, the incident took place at the end of February 2025, was not reported to DPH until 4/1/25, and the investigation summary was not submitted until 4/11/25. Further, when requested, a statement obtained from RN #6, who was the supervisor on the day of the allegation, was undated and there was no statement from the alleged nurse aide involved. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident/Patient Abuse policy revised 2/8/23 identified all incidents or events that constitute alleged, suspected or actual abuse will be thoroughly investigated, initially by the nursing supervisor to whom it was reported and a complete investigation by the department head. Following the initial report of alleged or suspected abuse, the involved department head shall immediately initiate an investigation of the incident that shall include, but not limited to interviewing of the resident and/or family, and interviewing all staff involved. As a first step, the employee shall be removed from the assignment and interviewed independently. The immediate and initial first response is suspension from duty pending final investigation outcome.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 residents (Resident #46) reviewed for bowel and bladder incontinence, the facility failed to develop a comprehensive care plan for a resident with incontinence and for 1 of 2 residents (Resident #418) reviewed for tube feeding, the facility failed to develop a comprehensive care plan that identified the resident was to receive nothing by mouth (NPO). The findings include: 1. Resident #46's diagnoses included Parkinson's disease, bipolar disorder, and major depressive disorder. The annual MDS dated [DATE] identified Resident #46 had intact cognition, required substantial/maximal assistance with bed mobility and transfers and was dependent with toileting. The MDS also indicated Resident #46 used a walker and wheelchair as mobility devices and was frequently incontinent of bladder and always continent of bowel. The MDS further indicated a toileting program trial had not been attempted with the resident since urinary incontinence was noted in this facility. The care plan dated 4/3/25 identified Resident #46 had limited physical mobility and decreased strength and endurance with impaired balance. Interventions included to anticipate and meet the residents needs and respond promptly to all requests for assistance with encouragement to fully participate with each interaction. The RCP failed to identify Resident #46's bladder and bowel incontinence. The NA flow sheet for Urinary Continence dated 3/9/25 to 4/6/25 identified Resident #46 had 12 recorded episodes of urinary continence and 98 recorded episodes of urinary incontinence (a 30 day look back). The NA flow sheet for Bowel Movements dated from 3/9/25 to 4/6/25 identified Resident #46 had 24 episodes of bowel continence and 6 episodes of bowel incontinence (a 30 day look back). Review of the written nurse aide assignment for Resident #46 indicated the resident was incontinent of bladder with mixed incontinence of bowel. Observation and interview with Resident #46 on 4/2/25 at 10:15 AM identified he/she was seated in the wheelchair and wearing an adult incontinence brief. Resident #46 indicated he/she experienced dribbling incontinence of urine overnight but otherwise was aware of when he/she had to urinate or move bowels. Resident #46 identified that due to his/her need for staff assistance in the bathroom to transfer to and from the toilet and because he/she had to wait for help from staff during the day, he/she had to wear an adult incontinence brief all the time. Resident #46 indicated if he/she was put on a toileting program, he/she may not need to wear an adult incontinence brief during the day, but the staff have not addressed his/her incontinence, and such a program had not been offered to her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the registered nurse supervisor (RN #3) on 4/7/25 at 12:35 PM identified an assessment for incontinence should have been completed for Resident #46 either on admission or with a change in his/her continence status. RN #3 indicated that based on the assessment a care plan should have been developed, and the resident should have been put on a toileting program. RN #3 identified the care plan nurse (RN #4) and charge nurse would have been responsible to develop and update the care plan for Resident #46 and she was unable to indicate why that was not done. Interview and review of the clinical record with the DNS on 4/8/25 at 11:50 AM identified she was unable to locate a completed bladder and bowel assessment for Resident #46 within the resident's entire medical record. The DNS indicated that she would have expected the assessment to be completed quarterly for a resident exhibiting a change in their continence, such as with Resident #46. The DNS further identified that had the assessment been completed for Resident #46, he/she would have had a toileting program customized for him/her and the care plan would have been developed to promote continence. The DNS indicated both measures could have helped the resident to maintain his/her continence, however, it was not done. The DNS further identified she would need to address the adding of incontinence to Resident #46's care plan with the care plan nurse (RN #4). Although attempted, an interview with the care plan nurse (RN #4) was not obtained. Review of the Continence Improvement Program policy, undated, directed the residents identified as participants in this program would have incontinence or a new onset of incontinence and a thorough assessment would be completed. The policy directed that once a determination was made as to the type of incontinence the resident exhibited a care plan and toileting program would be initiated. The policy further directed that ongoing reviews of the implemented program would be conducted when care planning was done, and it would be noted in the care planning summary. Review of the Care Plan policy, undated, directed a comprehensive care plan would be developed and updated as needed and would include assessments related to the resident's medical condition, functional abilities, and rehabilitation goals. The policy further directed regular assessments will be performed to monitor changes in the resident's condition and to adjust the care plan accordingly. 2. Resident #418's diagnoses included dysphagia (difficulty swallowing), gastrostomy status and pneumonitis due to inhalation of food and vomit. A physician's order dated 3/24/25 directed NPO (nothing by mouth), tube feeding for diet with NPO texture and NPO consistency. A nutrition evaluation dated 3/24/25 identified Resident #418's diet order was NPO with tube feeding of Jevity 1.2 at 70 ml per hour for 22 hours/day. The nutrition evaluation further indicated Resident #418's eating ability was NPO with a tube feeding for total nutrition related to a diagnosis of severe dysphagia. The admission MDS dated [DATE] identified Resident #418 was severely cognitively impaired and was dependent with bed mobility, toileting, and transfers. The MDS further indicated Resident #418 had difficulty with swallowing and a feeding tube. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 4/2/25 identified Resident #418 had a swallowing problem and required a tube feeding related to a diagnosis of dysphagia. Interventions included that all staff would be informed of the resident's special dietary and safety needs, monitor the resident for difficulty swallowing (holding or pocketing food in mouth) and to provide a bland diet and sippy cup for liquids. The care plan indicated to follow physician's orders for current feeding. The care plan failed to identify Resident #418 was NPO. Review of the NA assignment sheet for Resident #418 on 4/3/25 failed to indicate the resident's NPO status. Interview, observation, and review of facility documents with LPN #3 on 4/3/25 at 12:50 PM identified Resident #418 was not listed as being NPO on the written NA assignment and that is what the NA's referred to for care specific information on residents. LPN #3 indicated that NPO should have been listed on the written NA assignment for Resident #418, otherwise the NA may not have known the resident was to have nothing by mouth. LPN #3 identified the admitting nurse should have told the unit clerk to put the NPO status on the written NA assignment since the NA's only use the computer for charting and not to reference care specific information. Interview with NA #3 on 4/3/25 at 4:15 PM identified she was unable to find in the computer that Resident #418 was NPO. NA #3 indicated that the written NA assignment should have had Resident #418's NPO status listed because the NA's refer to their written assignment for care specific information and only use the computer for charting purposes. Interview and review of facility documents with the DNS on 4/3/25 at 4:55 PM identified the NA would know Resident #418 was NPO because it would be written on the NA assignment. Review of the written NA assignment with the DNS failed to indicate Resident #418 was NPO. The DNS identified she would have expected the residents NPO status to be indicated on the assignment which should have been updated by the nursing staff, and written in by hand, if necessary, until the unit clerk was able to type it in. The DNS indicated the NAs still relied on paper because the facility was not fully computerized yet. Subsequent to surveyor inquiry, review of the written NA assignment sheet for Resident #418 on 4/7/25 indicated the resident's NPO status had been updated. An additional interview and review of the clinical record with the DNS on 4/8/25 at 11:50 AM identified NPO was not indicated on Resident #418's care plan. Although the DNS identified RN #4 created the original care plan for Resident #418, it would be the charge nurse's responsibility to further review, customize and tailor it to the resident's needs. The DNS indicated Resident #418's care plan should not have interventions listed for a bland diet or a sippy cup (since the resident was NPO) and that she would have the care plan corrected and updated. The DNS further identified that since both the care plan and the written NA assignment failed to indicate Resident #418 was NPO, the NA's may not have known because it would have been the responsibility of the nurse to verbally inform the NA's. Although attempted, an interview with the care plan registered nurse (RN #4) was not obtained. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, NPO Status Policy, undated, directed the facility was committed to accurately communicating and documenting NPO status orders to all relevant staff and that NAs would be informed of the NPO status through their assignment sheets which would clearly indicate the resident's NPO status and any specific instructions. Review of the facility policy, Care Plan, undated, directed a comprehensive care plan would be developed and updated as needed and would include assessments related to the resident's medical condition, functional abilities, and nutritional needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 5 residents (Resident #39, 42 and 49) reviewed as part of the medication storage task, the facility failed to ensure a licensed nurse documented the administration of controlled pain medications, including the level of pain and the effectiveness of the medication consistent with professional standards. As part of the medication storage task the facility failed to ensure controlled medications for pain and anxiety were available and were not borrowed from another resident's supply consistent with professional standards, and for 1 resident (Resident #25) the facility failed to ensure medications were administered according to accepted professional standards. The findings include: 1. Resident #39 had diagnoses that included unilateral hernia and wedge compression fracture of the vertebra. The admission MDS dated [DATE] identified Resident #39 was severely cognitively impaired required partial to moderate one person assist with bed mobility and transfers and was receiving medications to treat pain within the preceding 5 days and was not currently in pain. The care plan dated 1/6/25 identified Resident #39 was at risk for pain related to decreased mobility and chronic back pain. Interventions included the administration of pain medication as ordered, assess pain scale twice a shift and evaluating effectiveness of pain medications. Physician's order dated 3/18/25 directed to administer Oxycodone HCL 2.5 mg. Give 0.5 tablet, (narcotic/controlled drug) every 4 hours as needed for severe pain and conduct pain assessments twice a shift using a scale as follows. Zero indicating no pain, 1 - 3 indicating mild pain, 4 - 6 indicting moderate pain, and 7 - 10 indicting severe pain. a. Pain assessment dated [DATE] identified Resident #39 reported a pain level of zero at 1:00 PM. The controlled substance disposition record dated 3/18/25 identified LPN #16 administered Oxycodone 2. 5mg to Resident #39 at 3:15 PM. The MAR dated 3/18/25 failed to reflect that LPN #16 administered Oxycodone 2.5 mg to Resident #39 at 3:15 PM, or its effectiveness. Review of the nurse's notes for 3/18/25 failed to reflect complaints of pain, the administration of Oxycodone 2. 5 mg at 3:15 PM or its effectiveness. b. Pain assessment dated [DATE] identified Resident #39 reported a pain level of 6 at 11:00 PM. The controlled substance disposition record dated 3/18/25 identified LPN #16 administered Oxycodone 2. 5mg to Resident #39 at 11:00 PM. The MAR dated 3/18/25 failed to reflect that LPN #16 administered Oxycodone 2.5 mg to Resident #39 at 11:00 PM, or its effectiveness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse's notes for 3/18/25 failed to reflect complaints of pain, the administration of Oxycodone 2. 5 mg at 11:00 PM or its effectiveness. c. Pain assessment dated [DATE] identified Resident #39 reported a pain level of zero at 1:00 PM. The controlled substance disposition record dated 3/20/25 identified LPN #16 administered Oxycodone 2. 5mg to Resident #39 at 4:00 PM. The MAR dated 3/20/25 failed to reflect that LPN #16 administered Oxycodone 2.5 mg to Resident #39 at 4:00 PM, or its effectiveness. Review of the nurse's notes for 3/20/25 failed to reflect complaints of pain, the administration of Oxycodone 2. 5 mg at 4:00 PM or its effectiveness. d. Pain assessment dated [DATE] identified Resident #39 reported a pain level of zero at 9:00 PM. The controlled substance disposition record dated 3/20/25 identified LPN #16 administered Oxycodone 2. 5mg to Resident #39 at 9:00 PM. The MAR dated 3/20/25 failed to reflect that LPN #16 administered Oxycodone 2.5 mg to Resident #39 at 9:00 PM, or its effectiveness. Review of the nurse's notes for 3/20/25 failed to reflect complaints of pain, the administration of Oxycodone 2. 5 mg at 9:00 PM or its effectiveness. Interview and review of the clinical record with LPN #16 on 4/2/25 at 3:10 PM identified she was the assigned nurse responsible for medication administration during the 3:00 PM to 11:00 PM shift on 3/18/25 and 3/20/25. LPN #16 identified that when administering an as needed (PRN) medication, she would routinely sign out the medication on the MAR and a nurse's note would automatically generate in the progress note section of the electronic medical record (EMR) indicating the PRN medication was administered. The EMR system would later prompt to enter the resident's response/effectiveness of the medication following the administration. LPN #16 indicated that omitting the documentation of the administration of the Oxycodone 2.5mg on the MAR and its effectiveness was an oversight. LPN #16 further identified there were occasions during the shift where she recognized the need to complete documentation in the MAR, intended to do so, but unintentionally failed to do so. Interview with RN #7 on 4/2/25 at 3:41 PM identified she was a nursing supervisor who worked the 11:00 PM to 7:00 AM shift and conducted controlled drug audits twice monthly. RN #7 identified she did not routinely cross refence a signed out controlled drug with the MAR to identify discrepancies as part of her audits but would expect that any medication signed out by licensed staff from the controlled substance disposition record to also be documented as administered on the MAR. Interview and review of the clinical record with the DNS on 4/3/25 at 10:34 AM identified she would expect licensed staff to document on the MAR the administration of medications at when signing out the controlled substance disposition record. In doing so, the EMR system populates the administration of the medication in the nurse progress notes and later prompts documentation of the effectiveness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the American Nurses Association (2021) Nursing: Scope and Standards of Practice (4th edition) outlines professional standards emphasizes the importance of accurate and timely documentation of controlled medication as a core component of nursing practice. 2. Resident 42 had diagnoses that included intervertebral disc degeneration and osteoarthritis. The quarterly MDS dated [DATE] identified Resident #42 had intact cognition, was independent with bed mobility and transfers and mobilized independently with the wheelchair. The care plan dated 12/16/24 identified Resident #42 had osteoarthritis and chronic pain related to compression fractures of the sacrum. Interventions included administering pain medication according to physician's orders and assessing the effectiveness. Physician's order dated 12/19/24 directed to administer Tramadol 50mg (narcotic controlled drug/substance) every 6 hours as needed for moderate to severe pain, and conduct pain assessments twice a shift using a scale as follows. Zero indicating no pain, 1 - 3 indicating mild pain, 4 - 6 indicting moderate pain, and 7 - 10 indicting severe pain. a. A pain assessment dated [DATE] identified Resident #42 reported a pain level of zero at 9:00 PM. The controlled substance disposition record dated 12/27/24 identified LPN #16 administered Tramadol 50mg to Resident #42 at 9:45 PM. The MAR dated 12/27/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #42 at 9:45 PM, or its effectiveness. Review of the nurse's notes for 12/27/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 9:45 PM or its effectiveness. b. A pain assessment dated [DATE] identified Resident #42 reported a pain level of zero at 9:00 PM. The controlled substance disposition record dated 12/30/24 identified LPN #16 administered Tramadol 50mg to Resident #42 at 10:00 PM. The MAR dated 12/30/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #42 at 10:00 PM, or its effectiveness. Review of nurse's notes for 12/30/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 10:00 PM or its effectiveness. c. A pain assessment dated [DATE] identified Resident #42 reported a pain level of zero at 9:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The controlled substance disposition record dated 12/31/24 identified LPN #16 administered Tramadol 50mg to Resident #42 at 9:00 PM. The MAR dated 12/31/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #42 at 9:00 PM, or its effectiveness. Review of nurse's note for 12/31/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 9:00 PM or its effectiveness. d. A pain assessment dated [DATE] identified Resident #42 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 1/10/25 identified LPN #16 administered Tramadol 50mg to Resident #42 at 5:00 PM. The MAR dated 1/10/25 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #42 at 5:00 PM or its effectiveness. Review of nurse's notes for 1/10/25 failed to reflect complaints of pain, the administration of Tramadol 50mg at 5:00 PM or its effectiveness. Interview and review of the clinical record with LPN #16 on 4/2/25 at 3:10 PM identified she was the assigned nurse responsible for medication administration during the 3:00 PM to 11:00 PM shift on 12/27/24, 12/30/24, 12/31/24 and 1/10/25. LPN #16 identified that when administering an as needed (PRN) medication, she would routinely sign out the medication on the MAR and a nurse's note would automatically generate in the progress note section of the electronic medical record (EMR) indicating the PRN medication was administered. The EMR system would later prompt to enter the resident's response/effectiveness of the medication following the administration. LPN #16 indicated that omitting the documentation of the administration of the Tramadol 50mg on the MAR and its effectiveness was an oversight. LPN #16 further identified there were occasions during the shift where she recognized the need to complete documentation in the MAR, intended to do so, but unintentionally failed to do so. Interview with RN #7 on 4/2/25 at 3:41 PM identified she was a nursing supervisor who worked the 11:00 PM to 7:00 AM shift and conducted controlled drug audits twice monthly. RN #7 identified she did not routinely cross refence a signed out controlled drug with the MAR to identify discrepancies as part of her audits but would expect that any medication signed out by licensed staff from the controlled substance disposition record to also be documented as administered on the MAR. Interview and review of the clinical record with the DNS on 4/3/25 at 10:34 AM identified she would expect licensed staff to document on the MAR the administration of medications at when signing out the controlled substance disposition record. In doing so, the EMR system populates the administration of the medication in the nurse progress notes and later prompts documentation of the effectiveness. According to the American Nurses Association (2021) Nursing: Scope and Standards of Practice (4th edition) outlines professional standards emphasizes the importance of accurate and timely documentation of controlled medication as a core component of nursing practice. (continued on next page)

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	075034	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolton Chronic & Convalescent Hospital Inc	400 Mill Plain Rd Fairfield, CT 06824

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #99 had diagnosis that included osteoarthritis of the right shoulder and intervertebral disc degeneration of the lumbar region. The annual MDS dated [DATE] identified Resident #99 had moderately impaired cognition, required one person assist with bed mobility, two person for transfers, had reported pain in the preceding five days and received opioid pain medication. The care plan dated 7/22/24 identified Resident #99 was at risk for pain related to osteoarthritis and chronic back pain. Interventions included assessing pain using pain scale, administer pain medications according to physician orders and evaluate effectiveness. Physician's order dated 8/11/24 directed to administer Tramadol 50mg (narcotic controlled drug/substance) every 6 hours as needed for moderate pain, and conduct pain assessments twice a shift using a scale as follows. Zero indicating no pain, 1 - 3 indicating mild pain, 4 - 6 indicting moderate pain, and 7 - 10 indicting severe pain. a. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 9/25/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:30 PM. The MAR dated 9/25/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:30 PM, or its effectiveness. Review of the nurse's notes for 9/25/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:30 PM or its effectiveness. b. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 9/27/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. The MAR dated 9/27/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 9/27/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. c. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 9/29/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR dated 9/29/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM, or its effectiveness. Review of the nurse's notes for 9/29/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 7:00 PM or its effectiveness. d. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/1/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM. The MAR dated 10/1/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM, or its effectiveness. Review of the nurse's notes for 10/1/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 7:00 PM or its effectiveness. e. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/3/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. The MAR dated 10/3/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 10/3/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. f. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/4/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. The MAR dated 10/4/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 10/4/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. g. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/8/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 8:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR dated 10/8/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 8:00 PM, or its effectiveness. Review of the nurse's notes for 10/8/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 8:00 PM or its effectiveness. h. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 9:00 PM. The controlled substance disposition record dated 10/9/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 9:00 PM. The MAR dated 10/9/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 9:00 PM, or its effectiveness. Review of the nurse's notes for 10/9/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 9:00 PM or its effectiveness. i. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/11/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. The MAR dated 10/11/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 10/11/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. j. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/12/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM. The MAR dated 10/12/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM, or its effectiveness. Review of the nurse's notes for 10/12/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 7:00 PM or its effectiveness. k. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/13/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR dated 10/13/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 10/13/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. l. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/15/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM. The MAR dated 10/15/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 6:00 PM, or its effectiveness. Review of the nurse's notes for 10/15/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 6:00 PM or its effectiveness. m. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/16/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 5:00 PM. The MAR dated 10/16/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 5:00 PM, or its effectiveness. Review of the nurse's notes for 10/16/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 5:00 PM or its effectiveness. n. A pain assessment dated [DATE] identified Resident #99 reported a pain level of zero at 5:00 PM. The controlled substance disposition record dated 10/17/24 identified LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM. The MAR dated 10/17/24 failed to reflect that LPN #16 administered Tramadol 50mg to Resident #99 at 7:00 PM, or its effectiveness. Review of the nurse's notes for 10/17/24 failed to reflect complaints of pain, the administration of Tramadol 50mg at 7:00 PM or its effectiveness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the clinical record with LPN #16 on 4/2/25 at 3:10 PM identified she was the assigned nurse responsible for medication administration during the 3:00 PM to 11:00 PM shift on 9/25/24, 9/27/24, 9/29/24, 10/1/24, 10/3/24, 104/24, 10/8/24, 10/9/24, 10/11/24, 10/12/24, 10/13/24, 10/15/24, 10/16/24 and 10/17/24. LPN #16 identified that when administering an as needed (PRN) medication, she would routinely sign out the medication on the MAR and a nurse's note would automatically generate in the progress note section of the electronic medical record (EMR) indicating the PRN medication was administered. The EMR system would later prompt to enter the resident's response/effectiveness of the medication following the administration. LPN #16 indicated that omitting the documentation of the administration of the Tramadol 50mg on the MAR and its effectiveness was an oversight. LPN #16 further identified there were occasions during the shift where she recognized the need to complete documentation in the MAR, intended to do so, but unintentionally failed to do so. Interview with RN #7 on 4/2/25 at 3:41 PM identified she was a nursing supervisor who worked the 11:00 PM to 7:00 AM shift and conducted controlled drug audits twice monthly. RN #7 identified she did not routinely cross refence a signed out controlled drug with the MAR to identify discrepancies as part of her audits but would expect that any medication signed out by licensed staff from the controlled substance disposition record to also be documented as administered on the MAR. Interview and review of the clinical record with the DNS on 4/3/25 at 10:34 AM identified she would expect licensed staff to document on the MAR the administration of medications at when signing out the controlled substance disposition record. In doing so, the EMR system populates the administration of the medication in the nurse progress notes and later prompts documentation of the effectiveness. According to the American Nurses Association (2021) Nursing: Scope and Standards of Practice (4th edition) outlines professional standards emphasizes the importance of accurate and timely documentation of controlled medication as a core component of nursing practice. 4. A review of the facility Controlled Substance Disposition Records on 3/31/25 at 10:30 AM identified the following: a. Review of a Controlled Substance Disposition Record for Resident #218 identified on 3/25/25 at 7:30 PM (1) tablet of Lorazepam 0.5 mg was removed noting it was borrowed for Resident #69. b. Review of a Controlled Substance Disposition Record for Resident #468 identified on 3/22/25 at 4:30 PM (1) tablet Oxycodone 5mg 0.5 mg tab was removed noting it was borrowed for Resident #470. c. Review of a Controlled Substance Disposition Record for Resident #57 identified on 3/25/25 at 9:00 PM (2) Lorazepam 1 mg tablets were removed noting they was borrowed for (unidentifiable entry). d. Review of a Controlled Substance Disposition Record for Resident #29 identified on 11/26/24 at 11:30 AM (1) tablet of Tramadol 50 mg was removed noting it was borrowed for Resident #474. e. Review of a Controlled Substance Disposition Record for Resident #39 identified on 3/16/25 at 11:45 AM (1) tablet of Oxycodone 5mg was removed noting it was borrowed for (unidentifiable entry). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LPN #2 on 3/31/25 at 12:24 PM identified if a medication was needed right away, the nursing supervisor has obtained the medication from another residents supply. An interview with RN #2 on 3/1/25 at 1:01PM identified there have been occasions in the past where the nursing supervisor had obtained pain medication from another residents supply for a resident reporting pain. An interview and facility documentation review with RN #3 on 4/1/25 at 10:40 AM identified she was the regularly assigned nursing supervisor for the 7:00 AM to 3:00 PM shift. RN #3 identified if a medication was needed and unavailable, the facility could access an after-hours (Pyxis) cart to obtain the medication, or the physician could be notified to request an alternative medication. RN #3 further identified on some occasions medications were borrowed from other resident's supply when unavailable. While RN #4 indicated physician's orders were obtained in those other instances, RN #4 was unable to provide documentation that physician's orders had been obtained for Resident #218, 468, 57, 2 and 39. An interview with the DNS on 4/02/25 at 1:00 PM identified that she was aware that on occasion, controlled medications were borrowed from other residents, recognizing this as poor practice. The DNS identified nursing staff were required to be preregistered to access the after-hours Pyxis system, which necessitated the presence of two nurses to remove controlled medication. However, not all shifts had nursing staff authorized to enter Pyxis system, thereby limiting access. The DNS identified limited access to the Pyxis system and late day admissions as root causes leading to the borrowing of medications from other residents. The DNS further identified this was mentioned by the pharmacy consultant as well. An interview with Person #8 on 4/3/25 at 2:04 PM identified she was the Pharmacy Consultant for the facility and routinely conducts medication storage room inspections. Person #8 identified she did note controlled medications were being borrowed and spoke to the DNS about this practice. Person #8 indicated that first doses should not be obtained for use from other residents. A review of the facility policy for Automated Medication Dispensing Systems directs only authorized nursing personnel approved by the DNS and with specialized training may have access to the Automated Medication Dispensing System. 5. Resident #25's diagnoses include chronic kidney disease with hydronephrosis, neoplastic disease unspecified, and weakness/failure to thrive. Review of a self-administration of medication form dated 7/30/20 identified Resident #25 did not wish to self-administer medications. A quarterly MDS dated [DATE] identified Resident #25 had intact cognition and required set-up assistance for eating and oral hygiene. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 3/18/25 identified Resident #25 had an activities of daily living (ADL) self-care deficit and limited mobility with interventions that included breaking down all tasks into sub-tasks for completion, provide rest periods as needed, and provide one-step directions, provide cueing as needed, monitor understanding and repeat as needed (prn). Observation on 4/1/25 at 10:30 AM and 4/3/25 at 9:30 AM identified Resident #25 was out of bed, seated in a recliner chair, with a small clear plastic medication cup on the tray table in front of the resident containing 4 pills. (Resident #25 identified the pills were a multivitamin with minerals, Lasix (a diuretic), Potassium, and Vitamin D). There were no licensed staff with Resident #25 or in the vicinity of Resident #25's room. Interview with Resident #25 at that time identified the pills were his/her morning medication that was left by the nurse (LPN #11) with instructions for the resident to take after he/she finished eating breakfast. Resident #25 further indicated nurses frequently leave medication for him/her to take without supervision. Interview with LPN #11 on 4/3/25 at 11:15 AM identified Resident #25 was alert/oriented and she had left Resident #25's medications in a cup with the resident and proceeded to administer another resident's medications in another room because the resident stated he/she was not ready to take the pills during breakfast. Additionally, LPN #11 stated she returned to Resident #25's room to ensure the resident had taken the pills. Additionally, LPN #11 stated she was aware she was not supposed to leave medication in front of the resident, but the resident requested her to leave the medication. Furthermore, LPN #11 stated a physician order can be obtained to leave medication with residents but could not confirm an order was present for medication to be left at the bedside. Interview with the DNS on 4/11/25 at 9:45 AM indicated that nurses may not leave medications unattended at the bedside for residents to self-administer as that is unacceptable practice. The General Dose Preparation and Medication Administration policy dated 12/1/2007 indicated facility staff should not leave medications or chemicals unattended, and staff must observe the resident's consumption of the medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 residents (Resident #74, 79 and 27), reviewed for Activities of Daily Living (ADL's), for Resident #74 and 79 the facility failed to maintain the residents' fingernails and for Resident #27, the facility failed to answer the residents calls for help in a timely manner after he/she had been incontinent. The findings include: 1. Resident #74's diagnoses included unspecified dementia-unspecified severity with agitation, chronic obstructive pulmonary disease, and metabolic encephalopathy. The monthly physician orders dated 1/29/25 directed skin and nail assessments weekly on shower days and document findings. The quarterly MDS dated [DATE] identified Resident #74 was moderately cognitively impaired and was fully dependent on staff for personal hygiene. The care plan dated 3/21/25 indicated Resident #74 had an ADL self-care deficit and limited physical mobility related to activity intolerance, metabolic encephalopathy and musculoskeletal impairment. Interventions included to monitor/document/report to MD any changes and reasons for self-care deficit. Review of the March 2025 TAR identified skin and nail assessment were administered weekly on shower days. Observations on 3/31/25 at 10:00 AM, 4/01/25 at 11:00 AM and 4/2/25 at 11:45 AM identified Resident #74's fingernails were very long with dark debris under the fingernails. Interview with Resident #74 on 3/31/25 at 10:00 AM indicated a family member will sometimes paint his/her fingernails because he/she does not wish to pay the salon for this service. The resident stated her/his preference is to keep the fingernails trimmed because sometimes food gets under the fingernails when they are longer. Interview with NA #8 on 4/3/25 at 9:15 AM indicated it is the nurse aides responsibility to cut and file resident's fingernails. Interview with LPN #5 on 4/3/25 at 9:15 AM indicated NA's do fingernail care on shower days or whenever necessary. Interview with the DNS on 4/7/25 at 12:20 PM identified it is the NA's responsibility to do fingernail care on shower days, at least once per week or in between. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/8/25 at 10:05 AM indicated she was not aware of any directive from the family that fingernail care would only be performed by family or that staff should not be doing nail care for Resident #74. Further, the DNS stated if nails are long and in need of attention, the expectation is that staff will perform nail care weekly on shower day. Subsequent interview with LPN #5 on 4/11/25 at 11:10 AM indicated she was not aware of any communication from Resident #74 or his/her family members that staff should not do fingernail care. Undated Bath-Shower and Bath-Bed policies indicated fingernails are to be cleansed and thoroughly dried and nail care to be performed if necessary. 2. Resident #79's diagnoses included Alzheimer's disease with early onset, essential hypertension and generalized anxiety disorder. The monthly physician order dated 1/10/25 directed skin and nail assessments weekly on shower days and document findings. The quarterly MDS dated [DATE] identified Resident #79 was moderately cognitively impaired and required partial/moderate assistance with showers, personal and toileting hygiene. The care plan dated 2/3/25 identified Resident #79 had an ADL self-care performance deficit and limited physical mobility related to activity intolerance, fatigue, impaired balance and limited mobility. Interventions included to monitor/document/report to MD changes or reasons for self-care deficit. A nurses note dated 3/25/25 at 1:16 PM identified Resident #79's skin was intact in relation to ordered skin and nail assessment on shower day. Observation on 3/31/25 at 10:30 AM identified Resident #79's nails were observed to be dirty and long. Resident #79 identified during that observation, he/she has asked the nurse aide to cut his/her nails, but no one has cut them. Observation on 4/3/25 at 10:47 AM identified Resident #79's fingernails were long and in need of trimming. Interview with LPN #5 on 4/3/25 at 9:15 AM indicated NA's do fingernail care on shower days or whenever necessary. Interview with NA #8 on 4/3/25 at 9:55 AM indicated it is NA's responsibility to trim and file resident's fingernails. NA #8 reported fingernails can be trimmed and filed at any time. NA #8 reported nurses are responsible for trimming fingernails for residents with diabetes. Interview with the DNS on 4/7/25 at 12:20 PM identified fingernail care is performed by the NA on shower days or any time. The DNS stated if a resident's nails are long and in need of attention, the expectation is the staff will perform nail care weekly on shower day. Review of the undated Bathing policy indicated fingernails are to be cleansed and thoroughly dried and nail care to be performed when necessary. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #27's diagnosis included cerebellar ataxia, epilepsy, functional quadriplegia, and a feeding tube in place. The quarterly MDS dated [DATE] identified Resident #27 had no cognitive impairment, was dependent on staff for toileting, personal hygiene, bed mobility, and all transfers. The MDS identified that Resident #27 had impairment on both sides of the upper and lower extremities and was always incontinent of urine and frequently incontinent of bowel movements. The care plan dated 2/4/25 identified Resident #27 was incontinent of bladder. Interventions directed staff to change briefs at least every 2 - 3 hours and as needed. Constant observation on 4/2/25 at 11:21 AM - 12:21 PM identified the following. Resident #27 was in his/her room, in bed calling out for help. The door to the resident's room was closed and the call light above the door was illuminated. Upon entering the room, the resident stated he/she had a bowel movement and needed to be changed. The resident stated he/she had been calling for approximately 30 minutes. At 11:23 AM the resident pushed the call bell again and a staff member responded through the intercom and asked what the resident needed. The resident stated he/she had gone to the bathroom and needed to be changed. When the resident began to explain that he/she had been calling already for 30 minutes, the staff member hung up the intercom and an overhead page for assistance was heard. Between 11:23 AM and 12:21 PM while in the room, Resident #27 was observed to ring the call bell eight times. On three occasions, staff answered through the intercom but disconnected without speaking to Resident #27 or paging for assistance to the resident's room. Other times there was no answer. At 12:13 PM, staff told Resident #27 through the intercom he/she would need to wait because lunch trays were being passed out. At 12:21 PM, an hour later, NA #7 entered the room. The resident told NA #7 that he/she had been calling since 10:30 AM and NA #7 responded that they were busy and the facility was short-staffed. The resident again explained he/she had had a bowel movement and needed help, but NA #7 repeated that others needed help too and the resident would need to wait. NA #7 proceeded to provide incontinent care to the resident at that time who was observed to have a wet diaper. Interview with the Unit Secretary #7 on 4/2/25 at 12:31 PM identified that residents typically request assistance by using the call bell or approaching the front desk. Unit Secretary #7 identified that Resident #27 had requested help multiple times but Unit Secretary #7 did not take further action outside of overhead paging requesting assistance to the resident's room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN # 1 on 4/2/25 at 12:31 PM identified that typically if a resident needed bathroom assistance and the NA was too busy to help, another staff member would be expected to help. LPN #1 explained that the nurse aide indicated that she had already provided care for the resident, and she was not aware that no one entered the room to provide incontinent care. The LPN added that she would have expected someone to check on Resident #27, especially since there were several aides working that day. LPN #1stated, that should have never happened. Interview with NA #7 on 4/3/25 at 12:21 PM identified that she was in another resident's room and was unable to respond to the request for assistance. NA #7 stated that she did tell the nurse that she could not help, however, NA #7 could not identify who she told. LPN #15 indicated she had not been told NA #7 was unable to provide assistance to Resident #27. Review of the Incontinence/Perineal Policy that was in effect, directed incontinent care to be provided at least every 2 - 3 hours to keep Residents clean and dry.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #27) reviewed for dignity, the facility failed to provide activities of interest. The findings include: Resident #27's diagnosis included cerebellar ataxia, epilepsy, mild anxiety and depression. The quarterly MDS dated [DATE] identified Resident #27 had no cognitive impairment, was dependent on staff for toileting, hygiene, bed mobility, and all transfers, and required a wheelchair for ambulation. The care plan dated 2/4/25 identified Resident #27 was at risk for alterations in his/her psychosocial well-being. Resident #27 enjoyed bingo, reading, music, game shows, and pet therapy. Interventions instructed staff to offer Resident #27 activities such as reading materials, puzzles, cards, music, and ensure weekly transportation to a chosen activity. Additionally, Resident #27 was to be provided with an activity calendar and offered items from the activity cart three times per week. Nurse Aide Assignment Card dated 4/2/25 identified Resident #27 liked to attend bingo. Observation on 3/31/25 at 1:23 PM identified Resident #27 was lying in bed awake in a dark room. Observation on 4/1/25 at 11:45 AM identified Resident #27 lying in bed watching TV. Interview with Resident #27 on 4/2/25 at 11:27 AM identified that she liked to play bingo but had not attended in a long time. Interview with the Director of Recreation on 4/3/25 at 3:43 PM identified that Resident #27 used to attend bingo but had not been to the activity in a while because the resident was often not dressed and ready in time for bingo. Interview with Recreational Therapist #1 on 4/3/2025 at 3:46 PM identified she did not typically offer any activities to Resident #27 because the door was usually closed, and she did not want to disturb Resident #27. Recreation Therapist #1 was aware the resident enjoyed bingo but indicated he/she had not attended in some time. Recreational Therapist #1 had previously asked the nurse aides to get the resident out of bed and have him/her ready for bingo, but the resident continued to not be ready when the activity began. Recreational Therapist #1 identified he/she did not escalate the issue and could not recall the last time Resident #27 participated in bingo. Aside from a blessing visit on 3/13/25, Recreational Therapist #1 could not identify the last 1:1 interaction with the resident but mentioned she would occasionally stop into Resident #27's room to say hello and to see if he/she needed anything. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 4/8/25 at 10:55 AM identified that the Recreational Department generally notified nursing of scheduled events for the day, and nursing was responsible for ensuring the resident was out of bed and ready to attend. LPN #5 recalled that, in the past, Resident #27 sometimes refused to get up in time to be dressed and ready to attend bingo. Additionally, there were times the resident declined to attend the activity altogether. LPN #5 was unable to provide documentation in the clinical record indicating Resident #27 refused to get up for bingo. Interview with Director of Recreation on 4/8/25 at 11:27 AM identified that while it is acceptable for a resident to choose not to attend an activity, if a resident wished to attend but wasn't ready in time, the recreation therapist should have followed up with nursing. The Director of Recreation also emphasized that a 1:1 visit should involve engaging the resident in activities, such as reading or other interactive tasks, and the visit should be documented. Review of facility documentation dated 1/1/25 to 4/8/25 identified Resident #27 had not participated or refused to participate in bingo. Review of the Therapeutic Recreation Policy directed that Therapeutic Recreation offers meaningful activities that support each resident's social emotional and physical needs. The program aims to promote well-being, encourage socialization and help residents maintain or improve their abilities.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation review of the clinical record, facility documentation, facility policy and interview for 1 of 5 residents (Resident #83) reviewed for pressure ulcers, the facility failed to correctly set and monitor an air mattress for a resident with a pressure ulcer. The findings include: Resident #83's diagnoses included a pressure ulcer to the left buttocks, Alzheimer's disease, and dementia. The admission MDS dated [DATE] identified that Resident #83 was severely cognitively impaired and required substantial/maximal assistance with bed mobility and was dependent with toileting and transfers. Additionally, the MDS identified Resident #83 required a pressure reducing device for his/her bed. The care plan dated 1/16/25 identified a potential for pressure ulcer development related to decreased mobility. Interventions included an air mattress with direction to check the air mattress every shift for proper functioning and inflation and to set the air mattress at 280. A physician's order dated 3/19/25 directed an air mattress on Resident #83's bed and to check for proper inflation and functioning every shift with the dial set at 280 every shift. A physician's order dated 3/28/25 directed to clean Resident #83's new stage 2 pressure ulcer on the left buttocks with normal saline followed by calcium alginate and zinc oxide daily for 7 days and then re-evaluate. Observation on 4/2/25 at 10:08 AM identified Resident #84 was in bed and on his/her back. The air mattress was operating, and the dial was set at 160. Observation, interview and review of the clinical record with LPN #8 on 4/2/25 at 11:50 AM identified Resident #84 was in bed on his/her back. The air mattress was operating, and the dial was set at 160. LPN #8 indicated that although she had signed the TAR that she had checked the air mattress, she did not know what the air mattress dial was ordered to be set at. LPN #8 proceeded to the nurse's station to check the physician's order and then returned to the resident's room and reset the air mattress dial from 160 to 280. LPN #8 identified that she had made a mistake and should have checked the air mattress setting and adjusted it to the correct setting before signing the TAR. LPN #8 further indicated she should have followed the physician's order and kept a better eye on the mattress setting. Interview with the IP nurse LPN #9 on 4/2/25 12:10 PM identified she had first observed Resident #83's pressure ulcer on 3/28/25 and initiated the treatment order. LPN #9 indicated Resident #83's air mattress should have been correctly set and monitored by the nurse every shift. Although LPN #9 was unable to indicate why the air mattress had been set at 160 for Resident #83, she indicated the nursing staff should have checked the mattress and kept it at the correct setting of 280 on all shifts. LPN #9 indicated that having the incorrect setting on Resident #83's air mattress could have affected the resident's wound development and healing and she would need to provide further education to the nursing staff. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 4/3/25 at 4:40 PM identified Resident #83's air mattress should have been correctly set and monitored by the nurse every shift. The DNS indicated the nurse had to sign off on the TAR and should have made sure the air mattress was kept at the correct setting of 280 on all shifts. The DNS identified she needed to reinforce with the nursing staff their responsibility to have Resident #83's air mattress at the correct setting because the incorrect setting on the air mattress could have affected the resident's wound development and healing. Review of the facility policy, Pressure Ulcer Prevention Protocol, undated, directed pressure relief mattresses were to be monitored for proper function every shift. Review of the facility policy, Proactive Protekt Aire Mattress Overlay Policy, undated, directed the device would be implemented for residents at risk for or currently experiencing pressure injuries and physician orders would be obtained prior to use. The policy further directed nursing staff would monitor placement and proper function of the device at least once per shift.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #46) reviewed for bowel and bladder incontinence, the facility failed to provide appropriate treatment and services to restore bowel and bladder continence to the extend possible. The findings include: Resident #46's diagnoses included Parkinson's disease, bipolar disorder, and major depressive disorder. The annual MDS dated [DATE] identified Resident #46 had intact cognition, required substantial/maximal assistance with bed mobility and transfers and was dependent with toileting. The MDS also indicated Resident #46 used a walker and wheelchair as mobility devices and was frequently incontinent of bladder and always continent of bowel. The MDS further indicated a toileting program trial had not been attempted with the resident since urinary incontinence was noted in this facility. The care plan dated 4/3/25 identified Resident #46 had limited physical mobility and decreased strength and endurance with impaired balance. Interventions included to anticipate and meet the residents needs and respond promptly to all requests for assistance with encouragement to fully participate with each interaction. The RCP failed to identify Resident #46's bladder and bowel incontinence. The NA flow sheet for Urinary Continence dated 3/9/25 to 4/6/25 identified Resident #46 had 12 recorded episodes of urinary continence and 98 recorded episodes of urinary incontinence (a 30 day look back). The NA flow sheet for Bowel Movements dated from 3/9/25 to 4/6/25 identified Resident #46 had 24 episodes of bowel continence and 6 episodes of bowel incontinence (a 30 day look back). Review of the written nurse aide assignment for Resident #46 indicated the resident was incontinent of bladder with mixed incontinence of bowel. Observation and interview with Resident #46 on 4/2/25 at 10:15 AM identified he/she was seated in the wheelchair and wearing an adult incontinence brief. Resident #46 indicated he/she experienced dribbling incontinence of urine overnight but otherwise was aware of when he/she had to urinate or move bowels. Resident #46 identified that due to his/her need for staff assistance in the bathroom to transfer to and from the toilet and because he/she had to wait for help from staff during the day, he/she had to wear an adult incontinence brief all the time. Resident #46 indicated if he/she was put on a toileting program, he/she may not need to wear an adult incontinence brief during the day, but the staff have not addressed his/her incontinence, and such a program had not been offered to her. Interview and review of the clinical record with the registered nurse supervisor (RN #3) on 4/7/25 at 12:35 PM identified an assessment for incontinence should have been completed for Resident #46 either on admission or with a change in his/her continence status. RN #3 indicated that based on the assessment a care plan should have been developed, and the resident should have been put on a toileting program. RN #3 identified the care plan nurse (RN #4) and charge nurse would have been responsible to develop and update the care plan for Resident #46 and she was unable to indicate why that was not done. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 4/8/25 at 11:50 AM identified she was unable to locate a completed bladder and bowel assessment for Resident #46 within the resident's entire medical record. The DNS indicated that she would have expected the assessment to be completed quarterly for a resident exhibiting a change in their continence, such as with Resident #46. The DNS further identified that had the assessment been completed for Resident #46, he/she would have had a toileting program customized for him/her and the care plan would have been developed to promote continence. The DNS indicated both measures could have helped the resident to maintain his/her continence, however, it was not done. The DNS further identified she would need to address the adding of incontinence to Resident #46's care plan with the care plan nurse (RN #4). Although attempted, an interview with the care plan nurse (RN #4) was not obtained. Review of the Continence Improvement Program policy, undated, directed the residents identified as participants in this program would have incontinence or a new onset of incontinence and a thorough assessment would be completed. The policy directed that once a determination was made as to the type of incontinence the resident exhibited a care plan and toileting program would be initiated. The policy further directed that ongoing reviews of the implemented program would be conducted when care planning was done, and it would be noted in the care planning summary. Review of the Care Plan policy, undated, directed a comprehensive care plan would be developed and updated as needed and would include assessments related to the resident's medical condition, functional abilities, and rehabilitation goals. The policy further directed regular assessments will be performed to monitor changes in the resident's condition and to adjust the care plan accordingly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #27) reviewed for enteral nutrition and who received nutrition via gastrotomy tube (g tube), the facility failed to provide appropriate care to prevent complications. The findings include: Resident #27's diagnosis included cerebellar ataxia, COPD, severe malnutrition, and g tube placement. The quarterly MDS dated [DATE] identified Resident #27 had no cognitive impairment, was dependent on staff for toileting hygiene, transfers, and bed mobility and received nutrition through a feeding tube (g tube). The care plan dated 2/4/25 identified Resident #27 was totally dependent on tube feeding for all of nutritional needs. Interventions included to elevate the head of the bed 45 degrees during and for 30 minutes after tube feedings and to monitor for aspiration. A physician's order dated 3/4/25 directed to administer Jevity 1.5 tube feeding formula at 40cc/hour for 20 hours and to monitor for aspiration. The Nurse Aide Care Card dated 4/2/25 indicated Resident #27 was receiving tube feedings. Observation on 4/2/25 at 12:23 PM identified the resident lying on his/her back in bed and the tube feed was connected and infusing as ordered at 40cc/hour. NA #7 entered the room to provide incontinent care and began lowering the head of the bed to a flat position with the feeding infusing. This surveyor stopped NA #7. NA #7 indicated at that time, the head of the bed should not be lowered while the tube feed is running, my mistake. NA #7 raised the head of the bed back to a 45 degree angle and left the room to notify the nurse. NA #7 explained that she was from the agency and had not received a facility orientation, stating, you just come in blind. Interview with LPN #1 on 4/2/25 at 12:31 PM identified that the tube feed should have been paused or turned off prior to Resident #27 being placed in a flat position and she would have expected NA #7 to be aware of this and to pause the tube feed. LPN #1 explained that during orientation for agency staff, they are given a tour of the unit and informed about which residents are on tube feedings and the type of care each resident requires. LPN #1 acknowledged that she did not specifically instruct the NA #7 to pause the tube feedings and added, maybe I should have. Interview with DNS on 4/3/25 at 5:36 PM identified that basic nurse aide competencies are assumed for agency nurse's aides, as the agency is responsible for sending qualified and competent staff. The DNS explained that while agency staff were expected to follow the facility's policies and procedures, it was the agency's responsibility to conduct background checks and verify assessments and competencies. The facility did not provide formal training for agency staff; instead, nurses would have given a detailed report to each nurse aide, outlining resident-specific priorities and care needs. Review of the Aspiration Policy directed residents with tube feeding should have the head of bed up 30 - 45 degrees at all times. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry the Nurse Aide Assignment Card reflected staff to turn tube feeding off prior to laying Resident #27 flat.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 4 of 4 residents (Residents #110, 368, 25, 39) reviewed for respiratory care, the facility failed to determine the frequency with which oxygen and nebulizer tubing should be changed and implement such, and failed to administer oxygen according to the physician's order. The findings include: 1. Resident # 110's diagnoses included acute respiratory failure, hypoxia and centrilobular emphysema. The admission MDS dated [DATE] identified Resident #110 had intact cognition, required partial/moderate assistance from staff for transfers and changing position in bed and was on continuous oxygen therapy. The care plan dated 2/11/25 identified Resident #110 had emphysema, COPD, and interstitial lung disease. Interventions included providing oxygen, incentive spirometer, checking pulse oximetry as ordered and as needed. The physician's order dated 4/1/25 directed to administer oxygen at 2 to 3 liters per minute via nasal canula as needed to maintain a pulse oximetry greater than 92%, as needed every shift. Observation on 4/1/25 at 9:21 AM identified Resident #110 was in bed with oxygen at 1.5 liters per minute via nasal canula. Further, the oxygen tubing was without the benefit of a label/date as to when it was changed. Observation and interview with LPN # 7 on 4/1/25 at 10:27 AM identified that it is facility policy for the oxygen company to come out weekly and change oxygen tubing. Additionally, LPN #7 identified Resident #110 should be on 2 - 3 liters of oxygen per the physician's order, and she checks the pulse oximetry in the morning and at noon. Observation of the oxygen settings for Resident #110's concentrator with LPN #7 identified it was set to 1.5 liters (ball of the gauge was on 1.5. LPN #7 changed the gauge setting to 2.5 liters. Interview and order review with APRN #2 on 4/2/25 at 3:10 PM identified she would expect Resident #110 to be on 2 or 3 liters of oxygen as needed at all times, and to keep his/her pulse oximetry at 92% or above since he/she she had respiratory failure. APRN #2 identified a setting of 1.5 liters would not be appropriate since Resident #110 does not have a titration order. 2. Resident #368 diagnoses included acute respiratory failure with hypoxia, congestive heart failure (CHF) and pneumonia. The admission MDS dated [DATE] identified Resident #368 was cognitively intact and required partial/moderate assistance for transfers and toilet use. Additionally, it identified Resident #368 was on continuous oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 3/27/25 identified Resident #368 had an altered respiratory status and difficulty breathing. Interventions included providing oxygen, incentive spirometry, and checking pulse oximetry as ordered and as needed. The physician's order dated 3/19/25 directed to provide humidified oxygen at 2 liters per minute via nasal cannula continuously every shift, titrate to keep saturation above 92%. Observation on 3/31/25 at 11:20 AM identified Resident #368 was sitting in his/her recliner chair wearing oxygen at 1.5 liters via nasal canula. The oxygen tubing was without the benefit of a label/date as to when it was changed. Interview with LPN #4 on 4/1/25 at 10:06 AM identified the oxygen tubing should be labeled and dated by the oxygen company vendor weekly. Further, LPN #4 identified Resident #368 had an oxygen titration order, with a pulse oximetry of 96% on 1.5 liters of oxygen. Interview with the DNS on 4/2/25 at 10:02 AM identified the oxygen company vendor is responsible to change and label oxygen tubing weekly. Interview with the Oxygen Vendor on 4/7/25 at 11:05 AM identified the company is responsible for servicing the oxygen machines and comes out every 90 days or more frequently if there is an issue (which may include delivering oxygen tubing supplies). However, the facility is responsible for the changing and labeling of the tubing on a weekly basis. Follow up interview and oxygen vendor contract review with the DNS on 4/7/25 at 3:12 PM failed to identify that the oxygen vendor was responsible for changing or labeling the oxygen tubing in the facility. Review of the Oxygen policy dated 9/2023 directed in part its commitment to providing safe, and effective administration, monitoring and storage of oxygen therapy for residents in compliance with state and federal regulations. 3. Resident #25's diagnoses include chronic kidney disease, hydronephrosis and embolism. The monthly physician's orders dated 3/9/25 directed Resident #25 is to have oxygen at 2 liters per minute via nasal cannula for comfort as needed. The quarterly MDS dated [DATE] identified Resident #25 had no cognitive impairment, required set-up assistance for eating and oral hygiene and supervision/touching assistance for toileting hygiene and personal hygiene. The care plan dated 3/18/25 failed to reflect a focus or intervention relative to the administration and management of oxygen administered via nasal cannula. Observations on 3/31/25 at 10:05 AM and 4/01/25 at 9:50 AM identified Resident #25 was wearing a nasal cannula attached to the oxygen condenser; however, the oxygen tubing was not labeled with a date of the last change. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Oxygen Vendor on 4/7/25 at 11:05 AM identified the vendor swaps out the machines every 90 days, unless there is a problem identified, and they are called to come earlier to replace the equipment. Further, the Oxygen Vendor indicated the facility is specifically responsible for changing the oxygen supplies (nasal cannula, oxygen tubing and masks) and the vendor only maintains the machines to deliver respiratory care. Interview with the DNS on 4/7/25 at 3:12 PM identified he/she believed the oxygen vendor was responsible for changing the respiratory supplies weekly. However, in the DNS interview, the oxygen vendor contract was reviewed and tubing changing and labeling was not identified in the contract as provided by the oxygen vendor. The oxygen policy reviewed failed to reflect how often the oxygen tubing should be changed ad who was responsible for that task. 4. Resident #39's diagnoses include chronic obstructive pulmonary disease, centrilobular emphysema and ventricular fibrillation. The quarterly MDS dated [DATE] identified Resident #39 had severe cognitive impairment and was fully dependent on staff for all activities of daily living. The care plan dated 4/4/25 identified Resident #39 had congestive heart failure and interventions included administering oxygen as ordered by MD and check pulse oximetry as ordered and PRN. Physician's orders dated 3/25/25 directed to administer DuoNeb via nebulizer as scheduled and PRN. Physician's orders dated 4/2/25 directed oxygen to keep oxygen saturation above 92%. A nurses note dated 3/29/25 at 11:42 PM identified an oxygen saturation of 95% on 02 via nasal canula. A nurses note dated 4/3/25 at 3:23 PM identified an oxygen saturation of 94% on 02 at 2 liters, scheduled neb treatment. Observations on 3/31/25 at 10:10 AM and 4/1/25 at 9:55 AM identified the nebulizer and oxygen tubing were not labeled with a date of the last change. Interview with the DNS on 4/7/25 at 3:12 PM identified he/she believed the oxygen vendor was responsible for changing the respiratory supplies weekly. However, in the DNS interview, the oxygen vendor contract was reviewed and tubing changing and labeling was not identified in the contract as provided by the oxygen vendor. The oxygen policy reviewed failed to reflect how often the oxygen tubing should be changed ad who was responsible for that task.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review facility documentation, facility policy and interviews and as part of the medication storage task the facility failed to have medications available to meet the needs of each resident. The findings include: A review of the facility Controlled Substance Disposition Records on 3/31/25 at 10:30 AM identified the following: a. Review of a Controlled Substance Disposition Record for Resident #218 identified on 3/25/25 at 7:30 PM (1) tablet of Lorazepam 0.5 mg was removed noting it was borrowed for Resident #69. b. Review of a Controlled Substance Disposition Record for Resident #468 identified on 3/22/25 at 4:30 PM (1) tablet Oxycodone 5mg 0.5 mg tab was removed noting it was borrowed for Resident #470. c. Review of a Controlled Substance Disposition Record for Resident #57 identified on 3/25/25 at 9:00 PM (2) Lorazepam 1 mg tablets were removed noting they was borrowed for (unidentifiable entry). d. Review of a Controlled Substance Disposition Record for Resident #29 identified on 11/26/24 at 11:30 AM (1) tablet of Tramadol 50 mg was removed noting it was borrowed for Resident #474. e. Review of a Controlled Substance Disposition Record for Resident #39 identified on 3/16/25 at 11:45 AM (1) tablet of Oxycodone 5mg was removed noting it was borrowed for (unidentifiable entry). An interview with LPN #2 on 3/31/25 at 12:24 PM identified if a medication was needed right away, the nursing supervisor has obtained the medication from another residents supply. An interview with RN #2 on 3/1/25 at 1:01PM identified there have been occasions in the past where the nursing supervisor had obtained pain medication from another residents supply for a resident reporting pain. An interview and facility documentation review with RN #3 on 4/1/25 at 10:40 AM identified she was the regularly assigned nursing supervisor for the 7:00 AM to 3:00 PM shift. RN #3 identified if a medication was needed and unavailable, the facility could access an after-hours (Pyxis) cart to obtain the medication, or the physician could be notified to request an alternative medication. RN #3 further identified on some occasions medications were borrowed from other resident's supply when unavailable. While RN #4 indicated physician's orders were obtained in those other instances, RN #4 was unable to provide documentation that physician's orders had been obtained for Resident #218, 468, 57, 2 and 39. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 4/02/25 at 1:00 PM identified that she was aware that on occasion, controlled medications were borrowed from other residents, recognizing this as poor practice. The DNS identified nursing staff were required to be preregistered to access the after-hours Pyxis system, which necessitated the presence of two nurses to remove controlled medication. However, not all shifts had nursing staff authorized to enter Pyxis system, thereby limiting access. The DNS identified limited access to the Pyxis system and late day admissions as root causes leading to the borrowing of medications from other residents. The DNS further identified this was mentioned by the pharmacy consultant as well. An interview with Person #8 on 4/3/25 at 2:04 PM identified she was the Pharmacy Consultant for the facility and routinely conducts medication storage room inspections. Person #8 identified she did note controlled medications were being borrowed and spoke to the DNS about this practice. Person #8 indicated that first doses should not be obtained for use from other residents. A review of the facility policy for Automated Medication Dispensing Systems directs only authorized nursing personnel approved by the DNS and with specialized training may have access to the Automated Medication Dispensing System.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #420) reviewed for a significant medication error, the facility failed to ensure the correct dose of a controlled pain medication was administered per the physician's order. The findings include: Resident #420's diagnoses included displaced fracture of the left leg, spiral fracture of the left tibia and chronic pain. A physician's order dated 1/23/25 directed to administer Morphine Sulfate Oral Solution 10mg/5ml, give 2.5 ml by mouth every 4 hours as needed for moderate pain x 10 days. A pain evaluation and management record dated 1/23/25 identified Resident #418 had severe pain in his/her left leg and upper extremity and was being followed up by pain management. Review of the State of Connecticut Department of Public Health Reportable Events form dated 1/24/25 identified an unintentional overdose of Morphine Sulfate Oral Solution had occurred with Resident #418 at 10:00 AM. The form indicated that no adverse effects were noted, and the resident remained stable. A physician's order dated 1/24/25 at 12:30 PM directed to hold Morphine Sulfate Oral Solution 10mg/5ml by mouth until 6:00 PM this evening (1/24/25 at 6:00 PM) A nurse's note, written by the DNS dated 1/24/25 at 5:59 PM identified a medication error involving the administration of Morphine Sulfate Oral Solution had occurred at 10:14 AM. Resident #420 had been administered a 50mg dose of the medication instead of the 5mg dose that had been ordered (100mg/5ml solution was administered instead of the 10mg/5ml solution that was ordered). The resident, DNS, APRN and MD were all notified of the error, and the resident was ordered to be closely monitored with the Morphine Sulfate Oral Solution order put on hold for re-administration until 6:00 PM on 1/24/25. Resident #420 had exhibited no apparent adverse reactions at the time of the evaluation. A nurse's note dated 1/24/25 at 6:08 PM identified Resident #420 had been administered Morphine Sulfate Oral Solution 10mg/5ml, 2.5 ml by mouth as needed for moderate pain. The admission MDS dated [DATE] identified Resident #420 was cognitively intact and was dependent with bed mobility, toileting, and transfers. The MDS indicated Resident #420 frequently experienced pain and received scheduled and as needed pain medications. The care plan dated 2/3/25 identified an alteration in musculoskeletal status related to displaced spiral fracture of the shaft of the left tibia. Interventions included to administer analgesics as ordered by the physician and monitor and document for side effects and effectiveness. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documents with the RN supervisor (RN #3) on 4/7/25 at 12:25 PM identified she did not have the Morphine Sulfate Oral Solution 100mg/5ml stored in the Omnicell because the bar code was not working, and she was unable to store the medication in the Omnicell. RN #3 identified the pharmacy, and the DNS were aware and while she awaited intervention by the pharmacy, she had the Morphine Sulfate stored in a locked cabinet in the nursing supervisor's office. RN #3 indicated on the morning of 1/24/25 she was contacted by LPN #8 who stated Resident #420's Morphine Sulfate Oral Solution had not yet arrived from the pharmacy and the resident was in a lot of pain. RN #3 identified that had the medication been in the Omnicell, that would have required two nurse witnesses, but since the medication was in the locked cabinet in the supervisor's office, she alone removed the Morphine Sulfate Oral Solution 100mg/5ml and brought it to LPN #8. RN #3 indicated that she should have compared Resident #420's physician's order to the medication before dispensing the Morphine Sulfate 100mg/5ml solution to LPN #8 but had made a mistake. RN #3 further identified that she was busy that day and when LPN #8 asked for the Morphine Sulfate Oral Solution she gave her what was in the locked cabinet and never checked the order in the computer. Interview with the DNS on 4/7/25 at 1:00 PM identified she was immediately notified of the medication error with the Morphine Sulfate Oral Solution on 1/24/25 and completed an assessment of Resident #420 after the incident. The DNS indicated that she was aware that the Morphine Sulfate Oral Solution 100mg/5ml was being kept in a locked cabinet in the supervisor's office and she identified she had emailed the pharmacy and informed them of the issue with the Omnicell/barcode. The DNS identified that if the Morphine Sulfate Oral Solution was secured in the Omnicell, it would have required 2 licensed nurses to remove the medication from the device. The DNS indicated that although RN #3 should have compared the Morphine Sulfate Oral Solution with Resident #420's physician's order before dispensing the medication to LPN #8, RN #3 did not, and LPN #8 assumed it was the correct medication and administered the incorrect dose to the resident. Per the DNS, when LPN #8 realized her medication administration error, she notified RN #3 and the DNS. The DNS identified that Resident #420 had no apparent ill effects after the medication error and both RN #3 and LPN #8 were disciplined and re-education was completed with the facility's licensed nursing staff after the incident. Although requested, the DNS was unable to provide her email to the pharmacy regarding the Omnicell/barcode issue. Interview with LPN #8 on 4/8/25 at 11:30 AM identified that although she read the medication order for Resident #420 from her computer when she called RN #3 to request the Morphine Sulfate Oral Solution on the morning of 1/24/25, she did not check the label on the Morphine Sulfate Oral Solution 100mg/5ml with the physician's order prior to administering the medication to Resident #420. LPN #8 identified after she administered the medication to Resident #420, she looked at the Morphine Sulfate oral solution box and realized she had made a mistake and administered the wrong concentration and dosage to the resident. LPN #8 indicated she immediately notified RN #3 and the DNS of her medication administration error and went and checked on Resident #420 and informed the resident about the error. LPN #8 further identified this was a serious error because she failed to complete the necessary checks before administering a controlled substance. Review of the facility policy, Medication Related Errors, dated 12/1/07, directed an example of an administration error would include when a facility administers to the resident a medication dose by the correct route but in a different dosage than was specified by the original order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, General Dose Preparation and Medication Administration, dated 12/1/07, directed the facility should take all measures required by facility policy and applicable law including using a 3 way check to compare the medication to the medication administration record (MAR) and to the prescription label. In addition, prior to administration of medication facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, and confirm that the MAR reflects the most recent medication order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy and interviews, the facility failed to ensure food was stored, prepared and served in safe, sanitary conditions in the main kitchen and one of the kitchenettes. The findings include:: During observations of meal service on 4/2/25 at 11:30 AM with the Director of Food Services, the following was identified: 1. a. Dietary aide #1 (DA) and DA #2 were working on the tray line plating condiments, fruit and beverages without the benefit of wearing beard restraints. Interview with the Director of Food Service at the time of observation identified beard restraints should be worn when plating food on trays and indicated that all staff are aware of the policy regarding beard restraints and that DA #1 and DA #2 forgot to put them on when they started to plate the trays with food items. After the surveyor inquiry, the Dietary Supervisor provided DA #1 and DA #2 beard restraints which were applied prior to resuming plating food. b. DA #3 was observed cooking 8 pieces of fish fillets on the stove grill directly next to an open, uncovered, full industrial size garbage can. After the surveyor inquiry, the Director of Food Services had DA #3 remove the fish from the grill and the garbage can was covered and removed from the area next to the stove. The Director of Food Services indicated that food should not be prepared next to an open garbage can and DA #3 must not have seen the full garbage can when she started preparing the fish. 2. a. Observations of dry storage area 4/2/25 at 12:30 PM identified the following items, opened and undated. There were 4 opened bags of [NAME] pasta undated and a large bag of rice. A large bag of twist pasta that was ½ full, a large bag of shell pasta that was ¾ full, a large bag of orzo pasta that was ½ full, a large bag of spaghetti that was ¼ full and a large bag of rice that was ½ full. The Director of Food Services indicated that these dry food items should have been labeled with the date opened by the dietary worker that opened the food items. The Director of Food Services directed a DA to discard the pastas and rice. b. Observations of the refrigerator and freezer storage areas on 4/2/25 at 1:00 PM identified a bag of 7 frozen breaded fish fillets opened with no date, a bag of fresh broccoli with a ¼ remaining in the bag opened with no date, and a quart of orange juice with ¼ used with no date. The Director of Food Services indicated that all the opened items should have been labelled with the date opened. All the unlabeled food items were discarded by the Director of Food Services. c. Observation of the 2 ice cream freezers identified no thermometers. A review of the temperature log for the ice cream freezers identified a temperature of 5 degrees documented for 4/2/25. An interview with the Director of Food Services at the time of observation indicated that he was not sure why there were no thermometers in place and that he was certain there were thermometers there previously. He indicated that he had documented the freezer temperatures for 4/2/25 but was unable to explain how he obtained the temperature readings without thermometers in place. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Facial Hair Restraint policy dated 1/25/2018 directed, in part, facial hair more than two days growth and hanging must wear hair guard/beard restraint. A review of Labelling and Dating of Food Items policy directed, in part, open food items or prepared food items will be appropriately labeled displaying food items and name, date prepared/opened and discarded according to the expiration date on the original package or within 7 days for the standard disposal rule. A review of Temperatures on Refrigerator/Freezers policy directed, in part, all refrigerators/freezers will have a temperature log to check AM & PM temperatures, and all units will contain a thermostat for monitoring. 3. Observation on 3/31/25 at 10:00 AM, in the main dining room located on the west wing in the attached kitchenette identified the following. Inside the refrigerator/freezer combo unit was soiled with dried spilled liquids, crumbles of food products and was malodorous. The unit contained a thermometer placed in the door of both the refrigerator and freezer. A temperature log was not found and there was a bucket of carpet cleaner chemical on top of the unit. The refrigerator contained 5 single serving milk cartons in the door with expiration dates of 3/15/25, a quart of eggnog expired on 2/3/25, 2 half gallon serving pitchers without the benefit of a label or date and a Poland Springs 12 oz plastic bottle containing a dark liquid, 50% filled, unlabeled. In one of two drawers, a Styrofoam bowl with a clear plastic cover, not labeled or dated with extensive green material visible on the underside of the plastic cover. The second of two drawers contained a black plastic container with a clear plastic cover containing an unknown liquid, also not labeled with content or use by dates. Inside the refrigerator was a disposable plate with two cupcakes covered with plastic wrap and a resident name written in marker, without a date. The outside of the refrigerator and freezer was soiled around the handles and along the edge of the doors with brown matter. The front vent cover was off and to the side of the refrigerator on the floor. The microwave in the room was soiled on the inside with food debris on the sides and turntable and the outside was soiled with fingerprints, food debris, and dust buildup. There was a mixed salad on the opposite counter in a Styrofoam bowl covered in plastic wrap, not dated or labeled. To the right of the sink was a commercial coffee maker unplugged and with old coffee grounds spilled and other dried spillage and debris in and around the outside of the unit. The tile floor contained numerous stains and debris littered throughout. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/7/25 at 12:20 PM indicated the main dining room had been closed for a period of time due to an outbreak in the facility. The dates of the closure were from 12/3/2024 - 12/18/24. The DNS reported the dining room was not closed for any other time period and indicated the kitchen team was responsible for maintaining the kitchenette, including stocking the room, discarding expired items, cleaning the room and contents. Interview with the Dietary Services Director and Dietary Supervisor, together on 4/3/25 at 3:00 PM, indicated the dietary aides are responsible for maintaining the kitchenette in a clean and neat manner and checking and recording temperatures in accordance with professional standards of food safety and facility policy. The Dietary Services Director and Dietary Supervisor both indicated in the interview the temperature monitoring was stopped when the dining room was closed due to an outbreak and further indicated, it was just recently re-opened. Interview indicated the temperatures had been monitored up until the dining room was closed. However, when the logs were requested for viewing, both individuals stated they had not been monitoring temperatures for the refrigerator/freezer unit as previously indicated. The Dietary Services Director indicated resident food brought in from outside was not to be stored in this refrigerator and should be stored in the nourishment room. Further, the Dietary Supervisor reported that the kitchen does not stock this refrigerator, however, the items in the refrigerator were noted to have come from the kitchen. The Dietary Services Director indicated the coffee maker was not utilized and was broken and should be discarded. After surveyor interviews, the refrigerator was emptied and wiped down on the inside, however, some soiled areas in the doors and drawers remained. A sign was placed on the outside of the refrigerator/freezer indicating resident food was not to be stored in this unit. Further, a thermometer monitoring sheet was placed on the refrigerator door. The outside of the refrigerator/freezer, microwave and counters were not cleaned, and the coffee maker remained in place unplugged and soiled. Review of the undated Food and Nutrition Services Policy for Labelling and Dating of Food Items indicated all food items from an accredited vendor will be properly labeled and dated with an expiration date, including open items. Review of the undated Food/Nutrition Policy on Temperatures on Refrigerators/Freezers identified all refrigerators/freezers will have a temperature log to check AM & PM temperatures. All fridge temps must read between 32 - 40 degrees Fahrenheit and all freezer temps will read between -20-0 degrees Fahrenheit.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of facility documentation and staff interview the facility failed to submit accurate PBJ staffing data on 2/26/24, 2/27/24, 2/28/24, and 2/29/24. The findings include: The PBJ 2nd quarter report for January 1, 2024, through March 31, 2024, triggered no licensed nurses 24 hours a day. Interview with the Administrator on 4/8/25 at 3:55 PM identified that he was not aware of what happened and why the report indicated a lack of nursing staff. The Administrator explained that the DNS usually takes care of the scheduling. Interview with DNS on 4/8/25 at 3:57 PM identified that while Person #3 was responsible for inputting PBJ data, she was not aware of why the report triggered no licensed staff 24 hours a day on 2/26/24, 2/27/24, 2/28/24, and 2/29/24. Subsequent to the interview, the DNS provided the schedules that confirmed licensed nursing staff were available on all shifts for the days in question. Attempt to interview Person #3 was unsuccessful. Review facility mandatory submission of staffing based on payroll data information directed, in part, the facility must submit complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.

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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** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 3 of 10 residents (Resident #27, 83 and 93) reviewed for infection control and including transmission based precautions, the facility failed to ensure staff wore required PPE, failed to ensure staff performed hand hygiene with each glove change and prior to exiting the room, failed to ensure staff discard PPE prior to exiting the room, and failed to post the correct transmission based precaution signage outside the residents room. For 2 of 5 residents (Resident #63 and 83), reviewed for pressure ulcers, the facility failed to perform hand hygiene when required during a dressing change. Further, observation identified a staff member failed to handle soiled linen according to accepted infection control standards. The findings include: 1. Resident #27's diagnoses included cerebellar ataxia, epilepsy, failure to thrive with a Gastronomy-tube (g tube) in place. The quarterly MDS dated [DATE] identified Resident #27 had no cognitive impairment was dependent on staff for toileting, personal hygiene, bed mobility, and all transfers, had impairment on both sides of the upper and lower extremities, was always incontinent of urine and frequently incontinent of bowel. The care plan dated 2/4/25 identified Resident #27 was incontinent of bladder. Interventions included to change briefs every 2 - 3 hours and as needed. In addition, Enhanced Barrier Precautions (EBP) were required for Resident #27 because he/she had an indwelling medical device (g tube) in place. Observation on 3/31/25 at 1:23 PM identified an EBP sign was affixed to the door of Resident #27's room directing staff to wear gloves and a gown for high contact resident care including dressing, bathing, changing linen, device care and wound care. An isolation precaution cart stocked with gloves and gowns was provided outside of Resident #27's room. Observation on 4/2/25 at12:21 PM identified NA #7 entered Resident #27's and began to provide incontinent care to Resident #27 without the benefit of an isolation gown. Interview with NA #7 on 4/2/25 identified an EBP sign was posted on Resident #27's door and supplies were available just outside the resident's room. NA #7 said she should have a gown and gloves on and that she did not put on the appropriate PPE because she was just overwhelmed. Subsequently, NA #7 put on a gown and gloves. The Nurse Aide Assignment Card dated 4/2/25 identified Resident #27 was on Enhanced Barrier Precautions and required staff to wear a gown and gloves for high contact care. (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 Enhanced Barrier Precautions policy directed, in part, that EBP are recommended for residents with indwelling medical devices or wounds who do not otherwise meet criteria for Contact Precautions, even though they do not have a history of having a multi-drug resistance colonization or infection. 2. Resident 63's diagnoses included dementia, osteoarthritis, and a history of venous thrombosis. The quarterly MDS dated [DATE] identified Resident #63 had both short and long-term memory loss and was severely impaired at making decisions. Resident #63 was dependent on staff for care for turning/repositioning, bed mobility, and toileting/tub transfers. The care plan dated 2/21/25 identified Resident #63 was at risk for the development of pressure ulcers related to decreased mobility. Interventions included providing treatment and medications as ordered, following policies and protocols for the prevention of skin breakdown, and repositioning the resident every 2 hours. A physician's order dated 4/2/25 directed staff to clean the left heel with normal saline and apply calcium alginate, followed by the application of an ABD pad (abdominal pad - a highly absorbent multi-layered medical dressing). Observation of wound care and interview with RN #1 on 4/7/25 at 10:56 AM, identified an Enhanced Barrier Precaution (EBP) sign affixed to the wall just outside of Resident #63's room. Prior to entering the room, RN #1 performed hand hygiene and donned an isolation gown. RN #1 opened all the necessary packaging on the tray table next to Resident #63. RN #1 then applied gloves without the benefit of hand hygiene and removed the old dressing. RN #1 performed the wound care treatment per the physician's order and then wrapped the wound with gauze. RN #1 removed her gloves, signed and dated the dressing, and then reapplied gloves without the benefit of hand hygiene. RN #1 gathered all the trash and changed the trash bag and changed gloves again without the benefit of hand hygiene and reapplied the resident's foot boot. RN #1 removed her PPE and performed hand hygiene. Interview with RN #1 identified hand hygiene should have been performed before and after each glove change. Interview with Infection Preventionist, LPN #9 on 4/7/25 12:10 PM, identified that hand hygiene would be expected before and after glove use. Review of the Standard Precaution Policy directed, in part, that staff were to wash their hands immediately after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. 3. Resident #83's diagnoses included a pressure ulcer to the left buttocks, Alzheimer's disease, and dementia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission MDS dated [DATE] identified that Resident #83 was severely cognitively impaired and required substantial/maximal assistance with bed mobility and was dependent with toileting and transfers. Additionally, the MDS identified Resident #83 required a pressure reducing device for his/her bed. The care plan dated 1/16/25 identified a potential for pressure ulcer development related to decreased mobility. Interventions included to monitor and assess pressure ulcers for signs and symptoms of complications and provide dressing changes and treatments as ordered. A physician's order dated 3/28/25 directed to cleanse the new stage 2 pressure ulcer on the left buttocks with normal saline followed by calcium alginate and zinc oxide applied to the area once daily for 7 days and then re-evaluate. Observation of pressure ulcer treatment change by LPN #8 with the assistance of NA #6 on 4/2/25 at 11:50 AM identified Resident #83 was in bed in the supine position. After LPN #8 obtained dressing supplies from the treatment cart and entered the resident's room, she applied gloves without the benefit of hand hygiene. NA #6 rolled the resident onto his/her right side. LPN #8 prepared the dressing supplies on a clean field, then removed her gloves, and applied a new pair without the benefit of hand hygiene. LPN #8 opened Resident #83's brief, removed the dressing dated 4/1/25 and provided the resident with peri care. LPN #8 removed her gloves and applied a new pair without the benefit of hand hygiene. LPN #8 performed the treatment per the physician's order, removed her gloves, and left the room without the benefit of hand hygiene. NA #6 stayed with Resident #83 to assist with morning care. Interview with LPN #8 on 4/2/25 at 11:57 AM identified it was facility policy to perform hand hygiene before putting gloves on, when changing gloves and when removing gloves. LPN #8 indicated she was nervous and forgot to perform hand hygiene during Resident #83's dressing change and she proceeded back into the bathroom and washed her hands. Interview with IP nurse LPN #9 on 4/2/25 at 12:10PM identified she had first observed Resident #83's pressure ulcer on 3/28/25 and initiated the treatment order. LPN #9 indicated that during the wound treatment it would have been her expectation that the nurse would have completed hand hygiene prior to applying gloves, when gloves were removed and before leaving the resident's room. LPN #9 identified that although LPN #9 may have been nervous when completing the wound treatment, she should have still followed appropriate infection control practices. Interview with the DNS on 4/3/25 at 4:40 PM identified that while LPN #8 was conducting the wound treatment she should have performed hand hygiene upon entry into Resident #83's room, when her gloves were removed and before leaving the resident's room. The DNS indicated it was the policy of the facility that nursing staff complete appropriate hand hygiene and that LPN #8 must have forgotten. The DNS identified she would need to review appropriate infection control practices with LPN #8. Review of facility policy, Clean Dressing Procedure, dated 4/2011, directed to wash or sanitize hands when entering the resident's room, after removing/applying gloves and before exiting the resident's room. Review of facility policy, Standard Precautions, undated, directed to wash hands immediately after gloves are removed to avoid transfer of microorganisms to other patients or environments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and contact precaution sign review with LPN #1 on 4/02/25 at 12:43 PM identified the policy on PPE removal was to do so after contact with the resident, outside of the room, which was why the trash bin was located outside the room, stating she washed her hands when she got to the nurse's station. Review of the contact precaution signage posted directed that gown and gloves were discarded prior to exiting the room, and hand hygiene to be performed when leaving the room. Observation of Resident #93's room with LPN #1 on 4/2/25 at 12:45 PM identified NA #1 applying a clothing protector onto Resident #93 inside the room, without the benefit of wearing PPE or the benefit of hand hygiene when leaving the room per the contact precaution signage posted. Interview with NA #1 on 4/2/25 at 12:47 PM identified the facility policy is to wear a gown and gloves when in a contact precaution room, followed by hand hygiene prior to exiting the room, however she did not think to do so. Review of the Contact Precautions policy directed in part specified patients with known or suspected microorganisms that can be transmitted with direct, or indirect (touching of the environment) contact will be placed in a private room. Handwashing will be performed prior to entry and exit of the room, additionally gowns and gloves will be applied prior to room entry with removal prior to leaving the patient's environment. Review of the Enhanced Barrier Protection policy directed in part the use of gown and gloves for high-contact resident care activities is indicated when contact precautions do not otherwise apply, in residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for resident with MDRO infection or colonization. The Isolation Gown policy directed in part that precaution gowns limit the spread of infection, and to discard the gown in the trash container and wash hands prior to leaving the room. Review of the Placing a Resident on Precautions policy directed in part that residents with a known infection will be placed on precautions per Center for Disease Control (CDC) guidelines (the CDC recommends implementing contact precautions, including isolating patients with suspected or confirmed C. diff, using PPE like gowns and gloves, and thoroughly cleaning and disinfecting patient rooms). 5. An observation of NA #4 on 4/8/25 at 9:45 AM identified she was in the hall with visibly soiled linen in her right hand and visibly soiled brief in the left hand (both had visible brown staining and were wet). NA #4 lifted the soiled linen and garbage container using the back of each gloved hand and placed the soiled items in the containers. NA #4 was then observed to remove her gloves, discard them in the garbage container and then open the cover of the clean linen cart to obtain a clean linen and incontinent pad without first performing hand hygiene. The task was interrupted. An interview with NA #4 on 4/8/25 at 9:45 AM identified she should have performed hand hygiene before handling clean linen. An interview with the DNS on 4/8/25 at 3:11 PM identified NA #4 should have handled the soiled material with one gloved hand leaving a free ungloved hand to open and close doors and containers. Hand hygiene should have been performed following discarding soiled linen/garbage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy for hand hygiene directed hand hygiene should be performed during times that include when handling used linen and potentially contaminated excretions, etc.

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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. Based on review of facility documentation, facility policy and interviews, the facility failed to hire a qualified Infection Preventionist, that had specialized training in infection prevention and according to the facility policy. The findings include: Interview with the DNS on 4/2/25 at 10:50 AM identified she had an Infection Prevention certificate in (Healthcare Setting) and oversaw the Infection Prevention and Control Nurse (IP), who was an LPN and in the process of obtaining specialized IP training. Interview with the Infection Prevention Nurse (IP) on 4/2/25 at 10:52 AM identified she assumed the role of Infection Prevention and Control Nurse on 11/24/24, over 4 months ago, and started the Infection Control training in March of 2025. Follow up interview with the Infection Prevention Nurse on 4/8/25 at 11:52 AM identified she was aware of the mandatory infection prevention training but delayed getting the training because she was under the impression that she needed to attend the mandatory education in person. Additionally, she identified that due to the nature of the position things got busy, so she started the online training through Center for Medicare Services (CMS) and CDC Train. Review of the specialized training certificates on 4/8/25 at 11:55 AM identified online training through CMS COVID-19 Training for Nursing Home Management was completed on 3/26/25. Additionally, the infection control training modules offered through CDC Train Nursing Home Infection Preventionist Training identified 5 completed modules dated 3/27/25 and 3/28/25 (the training consisted of 23 modules and submodules). A review of the facility Infection Preventionist Nurse job description identified the individual was accountable for decreasing the incidence and transmission of infectious disease between patients, staff, visitors and the community. Through strategic planning, leadership, and consultation, lead a robust team in identification and implementation of infection prevention goals and objectives throughout the facility. Additionally, education, qualifications and credentials specified possessing a current CT license as an RN, 2 years of professional nursing experience in the long-term care setting was required and a minimum of 3 years in nursing administration, or a comparable management position with ICN training and APIC interaction.