STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075047	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hewitt Health & Rehabilitation Center, Inc	45 Maltby Street Shelton, CT 06484

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 4 of 32 residents (Resident #31, Resident #94, Resident #214 and Resident #315) reviewed for Advance Directives, the facility failed to follow facility policy for completion of resident's choices for advance directives. The findings include: 1. Resident #31's diagnoses included paranoid schizophrenia, malignant neoplasm of the kidney, and lymphedema. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 was cognitively intact and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated [DATE] identified Resident #31 required staff assistance with his/her activities of daily living. Interventions included Advance Directives per resident/representative and per physician orders and please ensure Resident #31 was accompanied to medical appointments as necessary. Review of Resident #31's clinical record on [DATE] at 9:47 AM failed to identify a Medical Interventions Consent Form (which identified Advanced Directives) was included and signed by the resident/responsible party. A physician order in effect on [DATE] (original order dated [DATE]) directed the administration of Cardiopulmonary Resuscitation (CPR) as Resident #31's code status. Although requested, a current Medical Interventions Consent Form filled out with Resident #31's choices for administration of life support systems and medical interventions was not provided. 2. Resident #94's diagnoses included dementia, adjustment disorder with mixed anxiety and depressed mood, and chronic kidney disease. The Resident Care Plan (RCP) dated [DATE] identified Resident #94 required staff assistance with his/her activities of daily living. Interventions included Advance Directives per resident/representative and per physician orders and assist with feeding as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #94 was moderately cognitively impaired and was independent with eating, bed mobility and transfers. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #94's clinical record on [DATE] at 11:03 AM failed to identify a Medical Interventions Consent Form (which identified Advanced Directives) was included and signed by the resident/responsible party. A physician order dated [DATE] (original order dated [DATE]) directed administration of Cardiopulmonary Resuscitation (CPR) as Resident #94's code status. Although requested, a current Medical Interventions Consent Form completed with Resident #94's choices for administration of life support systems and medical interventions was not provided. Interview with Social Worker (SW) #1 on [DATE] at 3:00 PM identified she did not routinely review the Advance Directives with residents upon admission for those residents with resident representatives. SW #1 identified that the Advance Directives were reviewed on admission by the nursing supervisor who would reach out to the resident representative by phone and leave a message requesting a call back to review the Advance Directives. 3. Resident #214's diagnoses included paranoid schizophrenia, diabetes, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #214 was severely cognitively impaired, used a walker, and was independent with eating, bed mobility, and transfers. The Resident Care Plan (RCP) dated [DATE] identified Resident #214 required assistance/supervision with his/her activities of daily living: bathing, dressing, transfers, toileting, ambulation, eating/drinking and mobility. Interventions included Advance Directives per resident/representative and per physician orders. A Medical Interventions Consent Form (which identified Advanced Directives) dated [DATE] identified per the resident's representative via telephone conference, the choices for administration of life support systems and medical interventions for Resident #214 were: Do not resuscitate (DNR)/Do not intubate (DNI), do not administer artificial means of nutrition, intravenous fluids, hospitalization. The form further identified Resident #214 was comfort measures only (CMO). Review of physician orders identified while Resident #214 was hospitalized for a psychiatric admission under a Psychiatric Express Clinic (PEC) (emergency psychiatric care) on [DATE], all physician orders including Advance Directives were discontinued. Review of physician orders in the clinical record failed to identify a physician order for Advance Directives from [DATE] through [DATE] (upon Resident #214's re-admission). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DNS) on [DATE] at 12:55 PM identified the nursing supervisor was responsible for obtaining the Advance Directives on the Medical Interventions Consent Form and entering the physician order into the electronic medical record (EMR). The DNS identified if the resident representative did not come to the facility on admission/re-admission of the resident, the nursing supervisor would reach out to the resident representative by phone and the Medical Interventions Consent Form would be flagged in the chart if no response was received. The DNS identified that audits and chart reviews were completed on charts for admissions/re-admissions to ensure that the Medical Interventions Consent Form and the physician order in the electronic record match. The DNS could not identify the reason Resident #31's, Resident #94's Medical Interventions Consent Form was not in the chart, or the reason Resident #214 did not have re-admission Advanced Directive physician orders. Subsequent to surveyor inquiry, an Advance Practice Registered Nurse (APRN) order dated [DATE] directed Resident #214's Advance Directives: Do not resuscitate (DNR)/Do not intubate (DNI)/Do not hospitalize (DNH)/No artificial nutrition or hydration/Comfort measures only (CMO). Interview with Licensed Practical Nurse (LPN) #2 on [DATE] at 10:30 AM identified if there was not physician orders for Advance Directives in the electronic medical record (EMR) she would refer to the Medical Interventions Consent Form in the resident's paper chart. LPN #2 identified she preferred to check the chart to verify the Advance Directives, but that if there were no physician orders for Advance Directives in the EMR it was policy to administer Cardiopulmonary Resuscitation. 4. Resident #315 was admitted to the facility on [DATE] with diagnoses that included sepsis, congestive heart failure, and endocarditis. An admission nursing assessment dated [DATE] identified Resident #315 was cognitively intact and required a 2 person assist for transfers. Also identified that Resident #315 required assistance with dressing, bathing, eating and oral hygiene. The Resident Care Plan dated [DATE] identified Resident #315 required assistance with activities of daily living. Interventions included to provide advance directives as per physician orders, assist with mouth/dental care, and assist with feeding as needed. Physician orders dated [DATE] directed that Resident #315 had a code status of do not resuscitate (DNR). An interview on [DATE] at 2:36 PM with Licensed Practical Nurse (LPN) #10 identified that Resident #315 code was a DNR and the order was obtained on [DATE], 8 days after admission on [DATE]. Also, identifying that a code status should be completed upon admission by the admitting nurse, that any resident without a code status would be provided with cardiopulmonary resuscitation (CPR) and that there was no physician order regarding code status for 8 days. An interview on [DATE] at 10:26 AM with the Director of Nursing (DNS) identified that Resident #315's code status was obtained on [DATE] (8 days after admission) and would be classified as a full code and given CPR. Further, identifying that a code status was to be in place 24 to 48 hours after admission and if a resident could not sign, a verbal consent could be obtained with the responsible party with 2 registered nurses acting as witnesses. The DNS was unsure of the reason there was a delay in obtaining a code status for Resident #315. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Advance Directives policy directed, in part, licensed nursing staff and/or the resident's attending physician would review advance directives with the capable resident or the responsible party. The policy identified the advance directive consent form would be signed and dated by the person who reviewed the advance directives with the resident or responsible party and a physician's order would be obtained related to the resident's advance directives and refusal of treatment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #1, Resident #53, Resident #78 and Resident #85) reviewed for nutrition, the facility failed to notify the resident representative (Resident #1, Resident #53 and Resident #78) and failed to notify the physician (Resident #85) of a weight loss. The findings include: 1. Resident #1's diagnoses included dementia, depression, and anemia. Review of the face sheet in the clinical record identified Resident #1 was not responsible for him/herself and a family member was the resident representative. The Resident Care Plan (RCP) dated 11/7/24 identified Resident #1 had the potential for a nutritional decline related to multiple medical diagnoses and the need for an altered consistency diet. Interventions included to provide fortified foods as ordered, provide supplements as ordered, and offer different foods and fluids. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, weighed 131 pounds (lbs.), had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. The MDS further identified Resident #1 was independent with eating, required supervision or touching assistance with bed mobility, and was independent with transfers. Review of the Weights and Vitals Summary identified Resident #1 weighed 130.5 pounds (lbs.) on 11/18/24, weighed 123.8 lbs. on 11/21/24 (a 6.7 lb./5.13% loss in 3 days), weighed 127.6 lbs. on 12/11/24 and 1/16/25. On 2/12/25, Resident #1 weighed 113.0 lbs. (a 14.6 lb./11.4% loss in 27 days and/or a 17.5 lb./13.4% loss in 3 months). A Dietician progress note dated 2/21/25 at 8:02 AM identified Resident #1 had a 13.3 lbs. (10%) weight loss in 1 month from 1/16/25 (127.6 lbs.) through 2/20/25 (114.3 lbs.). The note further identified Resident #1's weights had previously been stable for the past year within a range of 128 lbs. to 136 lbs. A Dietician progress note dated 4/8/25 at 2:53 PM identified Resident #1 had a 16.7 lbs. (12.8%) weight loss in 6 months from 10/2/24 (130.5 lbs.) through 4/6/25 (113.8 lbs.). Review of nursing notes in the electronic medical record (EMR) from 2/1/25 through 5/16/25 failed to identify documentation that the resident representative was notified of Resident #1's significant weight loss. 2. Resident #53's diagnosis included Parkinson's disease, dementia, and depression. Review of the face sheet in the clinical record identified Resident #53 was not responsible for him/herself and a family member was the resident representative. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #53 was severely cognitively impaired, required moderate assistance for eating, and personal hygiene. Also, identified Resident #53 required maximal assistance for transfers, toileting, and was dependent for bathing. Further, identified Resident #53 had a weight loss of 5% in the last month or loss of 10% or more in the last 6 months. Review of the Weight and Vitals Summary identified that Resident #53 on 10/1/24 weighed 108.9 pounds (lbs), on 11/2/24 weighed 107.9 lbs., on 12/2/24 weighed 101.8 lbs. (a 6.1 lb./5.6 loss in 1 month), on 1/7/25 weighed 107.3 lbs., on 2/8/25 weighed 103.4 lbs., on 3/2/25 weighed 97.3 lbs. (a 6.1 lb./5.8% loss) with a steady decrease in weight noted until 5/1/25 when Resident #53 weighed 93.6 lbs. (a 14.3 lb./13.2% loss in 6 months/from 11/2/24 to 5/1/25. A Dietician progress note dated 3/14/25 identified that Resident #53 triggered for a 6 lb. weight loss which equaled 5.9% in 30 days and a 10 lbs weight loss which equals 9.3% in 60 days. A Dietician progress note dated 5/2/25 identified that Resident #53 triggered for a 9 lb. weight loss which equaled 9.5% in 3 months. The Resident Care Plan (RCP) dated 5/2/25 identified weight loss with interventions directed weigh Resident #53 as ordered, provide supplements as ordered, and provide diet as ordered. A Dietician progress note dated 5/16/25 identified that Resident #53 triggered for a 8.2 lb. weight loss which equaled 8.4% in 2 months. An interview on 5/19/25 at 9:52 AM with Licensed Practical Nurse (LPN) #10 identified that Resident #53 has had a significant weight loss over the past 6 months of 13.25 % and that the family was not notified. Further, identifying that the nurse was responsible for notifying the responsible party of a significant weight loss. 3. Resident #78's diagnoses included early onset Alzheimer's disease, diabetes, and epilepsy. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was severely cognitively impaired, weighed 127 pounds (lbs.), had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. The MDS further identified Resident #78 was independent with eating, required substantial/maximal assistance with personal hygiene, and required partial/moderate assistance with bed mobility and chair/bed transfers. The Resident Care Plan (RCP) dated 2/6/25 identified Resident #78 had the potential for a nutritional decline related to medications, multiple medical diagnoses, and poor appetite. Interventions included offering to set up meals, provide diet as ordered, and obtain weights as ordered. Review of the Weights and Vitals Summary identified Resident #78 weighed 130.5 lbs. on 11/13/24 and 11/18/24, weighed 126.9 lbs. on 12/1/24, weighed 125.8 lbs. on 4/6/25, weighed 118.8 lbs. on 5/2/25 and weighed 117.2 on 5/9/25 (a 13.3 lb./10.1% loss in less than 6 months). A Dietician progress note dated 4/4/25 at 11:33 AM identified Resident #78 had been re-admitted from the hospital on 3/28/25 and the monthly/re-admission weight was pending. The note further identified Resident #78's weight had been stable with a range between 127 lbs. to 130 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Dietician progress note dated 4/11/25 at 9:07 AM identified Resident #78 had a 8.4 lbs. (6.6%) weight loss in 16 days from 3/23/25 (127.9 lbs.) through 4/9/25 (119.5 lbs.). The note identified the weight loss was following Resident #78's hospitalization and identified Resident #78's weights would be changed to weekly weights. Review of nursing notes in the electronic medical record (EMR) dated 4/1/25 through 4/30/25 failed to identify documentation that the resident's representative was notified of Resident #78's significant weight loss. Review of nursing notes in the electronic medical record (EMR) from 2/13/25 through 5/19/25 failed to identify documentation that the resident representative for Resident #44 was notified of Resident #44's weight loss. Review of the Weights and Vitals Summary dated 5/19/25 identified Resident #44 had a severe weight loss of 7.68% in 1 month from 2/13/25 through 3/11/25, and a severe weight loss of 15.4% in 6 months from 10/1/24 through 4/6/25. Interview with the Dietician on 5/16/25 at 11:30 AM identified it was the responsibility of the nurses to update the family/responsible party of a resident's weight loss, and that weight losses were discussed at the weekly risk meetings. Interview with Director of Nursing Services (DNS) on 5/16/25 at 12:05 PM identified it was the responsibility of the nurses to notify the family/responsible party of a resident's weight loss. DNS identified the nurses receive an alert triggered within the EMR when they entered the resident's weight into the computer which alerted them to a weight loss. DNS identified the nurse was then expected to call the family/responsible party to notify of the weight loss. Interview with Licensed Practical Nurse (LPN) #7 on 5/19/25 at 9:50 AM identified weights were obtained by the nurse aides and then entered into the EMR by the nurse. LPN #7 identified when weights were entered into the EMR through the weight tab she would see an alert/flag of a percentage of weight loss if it reached a reportable level. LPN #7 identified if a weight was flagged for weight loss she would obtain a re-weight to verify the weight. LPN #7 identified it was the responsibility of the nurse to report a weight loss to the family/responsible party and that it would be documented in a progress note by the nurse that the family/responsible party had been notified. LPN #7 identified that she only wrote a nursing note regarding a resident's weight loss after she had notified the family/responsible party, and if she didn't write a progress note, then she didn't update the family/resident representative. LPN #7 further identified that she looked for the triggered alert when she entered resident's weights in order to identify a weight loss. 4. Resident #85's diagnosis included congestive heart failure, pleural effusion, and cardiomyopathy. The Resident Care Plan (RCP) dated 2/3/25 identified Resident #85 was at risk for cardiac issues with interventions to obtain weight as ordered/per policy, watch for signs/symptoms associated with cardio-respiratory issues and report to the physician, and diet as ordered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician orders dated 2/7/25 are directed to weigh Resident #85 daily in the morning (am), and to call the physician for a gain of 3 pounds (lbs) or more in 24 hours and 5 lbs in 1 week. Also, Resident #85 orders dated 2/8/25 directed congestive heart failure protocols assessments on Monday, Wednesday, and Friday. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #85 was cognitively intact, independent for eating, toileting, showering, dressing, and transfers. Review of the daily weights identified that Resident #85 weighed 382.3 pounds (lbs.) on 1/31/25 and weighed 386 lbs. on 2/1/25 (a 3.7 lb. weight gain in 1 day). Additionally, Resident #85 weighed 377.6 lbs. on 2/28/25 and weighed 382.0 lbs. on 3/1/25 (a 4.4 lb. weight gain in 1 day). An interview on 5/15/25 at 2:41 PM with Licensed Practical Nurse (LPN) #10 identified that Resident #85 was to be weighed daily, if a weight gain of 3 lbs or more in 24 hours or 5 pounds in 1 week the physician was to be notified, she could not provide documentation that the physician was notified of the weight gain. An interview on 5/19/25 at 10:30 AM with the DNS identified that Resident #85 had protocols in place to call the physician for a gain of 3 pounds in 24 hours and 5 lbs. in 1 week, that congestive heart failure (CHF) protocols were in place for Resident #85 which provide directions to notify the physician. Also, identified if the resident gains 3 lbs or more he/she could be experiencing fluid overload, heart failure, or respiratory failure and that would be the fault of the facility for not notifying the physician of the weight gain. An interview on 5/19/25 at 12:19 PM with Advance Practice Registered Nurse (APRN) #3 identified that she was covering for the APRN that wrote the initial order for notification of weight parameters and her expectation for a resident who was on CHF protocols was to be notified of a weight gain of 3 lbs in 24 hours or 5 lbs in 1 week and would expect a reweight to be completed. Also identified that a full assessment of the resident would be completed to rule out any issues, to rule out shortness of breath, and edema. Review of the facility weight monitoring policy identified accurate and timely measurements of weight changes in all residents was an important tool in assessing the resident's nutritional status. Also, identified charge nurses should review the weight and compare to the previous weights to determine a 5% weight loss change in 30 days or 10% weight loss in 180 days. Further, identified significant weight changes to be reported to the physician and family. Review of the facility heart failure clinical protocol identified the physician will review and make recommendations for relevant aspects of the nursing care plan for obtaining weights and when to report findings to the physician.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 of 3 residents (Resident #264) reviewed for abuse, the facility failed to ensure a medication was administered as indicated by the physician's order which resulted in Resident #264 receiving a psychotropic medication. The findings include: Resident #264's diagnoses included autistic disorder, developmental disorder, and unspecified convulsions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #264 was severely cognitively impaired and required partial/moderate assistance with bed mobility and was dependent with toileting and transfers. The MDS assessment indicated Resident #264 received antipsychotic, antianxiety, antidepressant and anticonvulsant medications. The Resident Care Plan dated 5/7/25 identified a seizure disorder with interventions that included to administer medications as ordered. A physician's order dated 5/7/25 directed Lorazepam (a psychotropic medication) 1 mg by mouth every 24 hours as needed for seizures. A nursing note written by Licensed Practical Nurse (LPN) #7 and dated 5/9/25 at 7:47 AM identified Resident #264 was agitated throughout the night and Lorazepam was given which was effective (physician orders directed to administer for seizures). Review of the Medication Administration Record (MAR) for Resident #264 on 5/9/25 indicated Lorazepam 1 mg oral tablet was administered at 3:42 AM by LPN #7 and the dose was effective. Interview with LPN #7 on 5/16/25 at 8:36 AM identified that although Resident #264's Lorazepam order was indicated to be administered for seizures, she administered Resident #264's Lorazepam on 5/9/25 because the resident was agitated and not sleeping. LPN #7 indicated because Resident #264 had not had a seizure, she asked the nursing supervisor (RN #4) if she could administer the medication for agitation and she was told by RN #4 to go ahead and give it. LPN #7 identified she documented her administration of the Lorazepam on the MAR for 5/9/25 under the order which was indicated for seizures because a new order indicated for agitation was not obtained from the physician by RN #4. LPN #7 further indicated that she now realized she should not have administered Lorazepam to Resident #264 if it was not ordered for agitation and she had made a mistake. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the nursing supervisor (RN #4) on 5/16/25 at 9:09 AM identified she was notified on 5/9/25 by LPN #7 that Resident #264 was agitated and not sleeping and although the Lorazepam order was only indicated for seizures, she gave permission to LPN #7 to administer the medication to the resident. RN #4 indicated that she was aware that Resident #264 had not had a seizure on 5/9/25 and although she tried to reach the physician for a new order, the physician did not call back. RN #4 was unable to recall which physician she tried to contact but she did not obtain a new order for Resident #264's Lorazepam to indicate administration for agitation or insomnia. RN #4 identified she realized she should not have authorized the administration of Lorazepam to the resident if it was only indicated for seizures. Interview and review of the clinical record with the DNS on 5/16/25 at 2:35 PM identified Resident #264's Lorazepam should have only been administered as indicated for seizures and it should not have been administered for agitation or insomnia. The DNS indicated that RN #4 should not have authorized the administration of the medication without contacting the provider for a new order and if RN #4 was unable to reach the provider the medication should not have been administered to the resident. The DNS identified that although Resident #264 had not had a seizure on 5/9/25, LPN #7 documented her administration of the Lorazepam on the order indicated for seizures because a new order indicated for agitation was never obtained. The DNS stated she would need to provide further education to LPN #7 and RN #4 regarding this incident. Review of facility policy, Medication Administration, undated, directed all medications shall be administered safely and accurately in accordance with physician's orders and facility protocols and all medications must be administered only with a valid physician's order.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #18) reviewed for abuse, the facility failed to report an injury of unknown origin to the State Agency (SA) timely. The findings include: Resident #18's diagnoses included dementia, anemia, and non-thrombocytopenic purpura. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was severely cognitively impaired and was dependent for transfers, toileting, and bed mobility. The Resident Care Plan dated 4/15/25 identified skin issues and skin breakdown related to venous ulcers and skin tears. Interventions included to inspect skin when providing care and gentle handling during all care. Observation on 5/12/25 at 12:30 PM identified Resident #18 was in bed and his/her right upper extremity, which was partially outside of the bed covers, had a large area of light purple colored bruising to the top of the hand and wrist area. The skin of the exposed area of the resident's right upper extremity appeared to be intact. The nursing supervisor (RN #6) progress note dated 5/12/25 at 4:45 PM identified Resident #18 had a change in condition with a skin tear to his/her right forearm and discoloration of the extremity from mid-hand to elbow with swelling in the wrist area noted. The APRN was made aware, and a wound treatment and x-ray were ordered. A Reportable Event form signed as filed on 5/12/25, identified Resident #18 had an area of discoloration and swelling noted to the right wrist. The form indicated the physician and family were notified and an investigation was not initiated. A nursing progress note dated 5/13/25 at 12:23 PM identified an x-ray of the right forearm had been ordered by the APRN for Resident #18, secondary to a hematoma. Nursing progress notes dated 5/13/25 at 1:15 PM and 5/13/25 at 7:16 PM identified the bruising to Resident #18's right hand had increased and become more swollen. Interview and record review with the DNS on 5/14/25 at 3:05 PM identified that Resident #18 had sustained a skin tear with a large area of bruising and swelling to his/her right upper extremity which was first observed on 5/12/25. The DNS indicated that although Resident #18's injury was considered an injury of unknown source, she had not reported the resident's injury to the SA because it was still being investigated. The DNS identified it would have been her responsibility to report Resident #18's injury to the SA timely. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another interview with the DNS on 5/16/25 at 2:40 PM identified that although an investigation of Resident #18's injury of unknown source (from 5/12/25) was being conducted, she had still not reported the injury to the SA. The DNS indicated she had not reported the injury because it was still being investigated and she was overwhelmed with work this week. The DNS further identified that she was aware that Resident #18's injury of unknown source was not reported timely to the SA (within 24 hours) and that it would have been her responsibility to have reported the injury timely. Subsequent to surveyor inquiry, on 5/19/25, the DNS reported Resident #18's injury of unknown origin (from 5/12/25) to the SA. Attempts to contact the nursing supervisor (RN #6) were unsuccessful. Review of the facility policy, Injuries of Unknown Origin, undated, directed an injury of unknown origin is an injury where the source is not observed or cannot be explained by resident or staff. The policy further directed all injuries of unknown source will be promptly reported in accordance with federal and state regulations and within the required time frame.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **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 of 4 residents (Resident #44) reviewed for pressure injury, and for 1 of 4 residents (Resident #78) reviewed for nutrition, the facility failed to complete a significant change in status (SCSA) Minimum Data Set (MDS) assessment for a resident with a decline in 2 or more areas. The findings include: 1. Resident #44's diagnoses included dementia, pressure ulcer of sacral region (Stage 3), and anxiety. The Resident Care Plan (RCP) dated 11/1/24 identified Resident #44 was at risk for skin breakdown due to decreased mobility, incontinence, and poor nutrition. Interventions included to offer and/or encourage Resident #44 to reposition as needed and provide incontinent care as needed. The RCP further identified Resident #44 had the potential for nutritional decline related to pain and Resident #44 did not like to eat breakfast per his/her choice. Interventions included encourage Resident #44 to eat as much of his/her meal independently and assist if needed with completing his/her meal, and providing snacks as ordered. a. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was moderately cognitively impaired, had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months, and was at risk for developing pressure ulcers. The MDS further identified Resident #44 was independent with eating, required partial/moderate assistance with bed mobility, and supervision or touching assistance for transfers. A note written by Social Worker #1 on 1/14/25 at 8:26 AM identified Resident #44 had been admitted to hospice care on 1/14/25. A nursing note written by Licensed Practical Nurse (LPN) #9 on 1/19/25 at 3:21 PM identified Resident #44 had a newly identified open area to the coccyx measuring 2.5 centimeters (cm) (length) by 1.0 cm (width). A wound progress note written by Advanced Practice Registered Nurse (APRN) #4 on 1/22/25 at 9:28 PM identified Resident #44 was seen for consultation for evaluation and management of his/her Stage 2 coccyx pressure ulcer which measured 2.0 cm (length) by 2.0 cm (width) by 0.1 cm (depth). A note written by Social Worker #1 on 1/23/25 at 12:18 PM identified Resident #44's family had reconsidered the enrollment of Resident #44 in hospice services. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was cognitively intact, weighed 154 lbs., had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. The MDS assessment identified Resident #44 had 1 unhealed Stage 2 pressure ulcer that was not present on admission/reentry. The MDS assessment identified Resident #44 required partial/moderate assistance with eating, substantial/maximal assistance with bed mobility, and was dependent for transfers. The MDS assessment further identified Resident #44 received physical therapy services starting on 1/24/25, received occupational therapy services starting on 1/27/25, and received speech therapy services starting on 1/28/25. A decline in at least 3 functional mobility areas plus a new pressure ulcer were identified when compared with the previous quarterly MDS assessment and a significant change MDS had not been completed. b. A nutritional note written by the Dietician and dated 2/21/25 at 8:49 AM identified Resident #44 had a 9.8 lbs. (6.4%) weight loss in 1 month from 1/13/25 (154.4 lbs.) through 2/13/25 (144.6 lbs.). The note further identified Resident #44's weight loss was 20.7 lbs. (13%) after a reweight on 2/20/25 (133.7 lbs.). A nutritional note written by the Dietician and dated 3/14/25 at 8:29 AM identified Resident #44 had an 11.1 lbs. (7.7%) weight loss in 1 month from 2/13/25 (144.6 lbs.) through 3/11/25 (133.5 lbs.). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was moderately cognitively impaired, weighed 131 lbs., had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. The MDS assessment identified Resident #44 had 1 unhealed Stage 3 pressure ulcer that was not present on admission/reentry. The MDS assessment identified Resident #44 required setup or clean-up assistance with eating and required substantial/maximal assistance with bed mobility and transfers. A sustained decline in at least 3 functional mobility areas plus a weight loss with worsening of a pressure ulcer were identified when compared with the previous 2 quarterly MDS assessments and a significant change MDS had not been completed. 2. Resident #78's diagnoses included early onset Alzheimer's disease, diabetes, and epilepsy. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was severely cognitively impaired, had no weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. The MDS further identified Resident #78 was independent with eating, required partial/moderate assistance with upper body dressing and lower body dressing, and required partial/moderate assistance with toilet transfers. The Resident Care Plan (RCP) dated 2/6/25 identified Resident #78 had the potential for nutritional decline related to medications, multiple medical diagnoses, and poor appetite. Interventions included to provide the diet as ordered and obtain weights as ordered. The RCP further identified Resident #78 required staff assistance with his/her activities of daily living (ADLs). Interventions included to assist with feeding as needed and Resident #78 fluctuated in his/her ability to perform ADLS due to his/her diagnoses/cognitive status which required assistance as needed. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	An Advanced Practice Registered Nurse (APRN) progress note written by APRN #1 on 3/28/25 at 3:43 PM identified Resident #78 was seen for a post-hospitalization visit. The note identified Resident #78 had been hospitalized from [DATE] through 3/28/25 with altered mental status, delirium, toxic encephalopathy, mild dehydration, and suspected urinary tract infection (UTI). The note further identified Resident #78 was newly dependent on staff with ADLs and he/she required assistance with eating and transfers. A nutritional note written by the Dietician on 4/11/25 at 9:07 AM identified Resident #78 had a 8.4 lbs. (6.6%) weight loss in 16 days from 3/23/25 (127.9 lbs.) through 4/9/25 (119.5 lbs.). The note identified the weight loss was following Resident #78's hospitalization, Resident #78's appetite was less since his/her hospitalization and Resident #78 required more assistance for meals sometimes Resident #78 even needing to be fed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 was severely cognitively impaired, weighed 118 lbs., had weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. The MDS assessment identified Resident #78 required supervision or touching assistance with eating, substantial/maximal assistance with upper body dressing and lower body dressing, and toilet transfers. A decline in 4 functional mobility areas plus weight loss were identified when compared with the previous annual MDS assessment and a significant change MDS had not been completed. Interview with the Director of Nursing Services (DNS) on 5/16/25 at 12:05 PM identified weekly risk meetings were attended by the DNS, RN #3, LPN #6, Social Worker #1, Dietician, and Administrator. Interview and clinical record review with LPN #6 on 5/19/25 at 11:05 AM identified that she had just learned subsequent to surveyor inquiry, in an earlier interview with a surveyor, that criteria for completing a SCSA MDS assessment included weight loss and 1 change in ADLs. LPN #6 identified that she had previously understood that a significant change required a decline in 2 ADLs or a resident going on hospice or having a gastrostomy tube placed. LPN #6 identified resident weight losses were reviewed at the weekly risk meetings, and she attended the weekly risk meetings. LPN #6 identified she was unaware Resident #44 and Resident #78 experienced weight loss, and indicated the Dietician had not informed her of the weight loss. LPN #6 identified that although she attended the risk meetings, she looked to see if weight loss was coded by Dietician in Section K of the MDS. LPN #6 identified there was a 14-day window for completing a SCSA MDS assessment after identifying a significant change, but that she hadn't previously been aware that weight loss plus one additional area of decline would qualify as a significant change. LPN #6 identified for Resident #44 and Resident #78 she needed to reevaluate after learning of additional criteria for a significant change. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual which contained instructions the facility must follow when submitting MDS assessments directed, in part a significant change was a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff, impacts more than 1 area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. The manual directed an SCSA is appropriate if there are either two or more areas of decline and when a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interview for one of one resident (Resident #80) reviewed for timeliness of care planning, the facility failed to conduct a quarterly care conference. The findings include: Resident #80 diagnosis included diabetes, anxiety, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #80 was cognitively intact and was independent for eating, transferring, showering, dressing, and toileting. The Resident Care Plan (RCP) dated 1/3/25 identified that Resident #80 was at risk for changes in mood related to the diagnosis of anxiety, and depression with interventions directed to encourage Resident #80 to converse and express his/her feelings, attend group activities, and offer to discuss feelings on being placed at the facility. The Resident Care Conference (RCC) note dated 4/1/25 at 1:44 PM identified that Resident #80 was out of the building on leave of absence and that the meeting was postponed. An interview on 5/14/25 at 12:41 PM with Licensed Practical Nurse (LPN) #6 identified that there was not a RCC meeting for the month of April 2025 for Resident #80 and that it was postponed because the resident was out of the building. Also, identified that a care plan meeting should take place every 92 days or if there was a significant change. Further, identifying the RCC was not rescheduled from the April 2025 postponed meeting. An interview on 5/19/25 at 10:41 AM with the Director of Nursing (DNS) identified that a RCC should be held quarterly with the Resident, and the one scheduled for April 2025 was canceled and not rescheduled as it was an oversight. Although a policy on RCC meeting was requested, one was not provided. Subsequent to this surveyor's inquiry a RCC meeting had been scheduled for 5/19/25.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 of 4 residents (Resident #44) reviewed for pressure injury, and 1 of 3 residents (Resident #264) reviewed for falls, the facility failed to ensure completion of an Registered Nurse (RN) assessment after a resident fell (Resident #44) and the identification of a new pressure ulcer (Resident #264). The findings include: 1. Resident #44's diagnoses included dementia, fibromyalgia, and anxiety. The Resident Care Plan (RCP) dated 11/1/24 identified Resident #44 was at risk for skin breakdown due to decreased mobility, incontinence, poor nutrition and poor circulation. Interventions included offer and/or encourage Resident #44 to reposition as needed, provide incontinent care as needed, and check Resident #44's skin weekly with scheduled bath/shower. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was moderately cognitively impaired and was at risk for developing pressure ulcers. The MDS further identified Resident #44 was independent with eating, required partial/moderate assistance with bed mobility, and supervision or touching assistance for transfers. A nursing note written by Licensed Practical Nurse (LPN) #9 on 1/19/25 at 3:21 PM identified Resident #44 had a newly identified open area to the coccyx measuring 2.5 centimeters (cm) by 1.0 cm. The note identified the wound was cleansed with Normal Saline and covered with a dry clean dressing. The note further identified the nursing supervisor was notified and she would obtain a treatment order but failed to identify a subsequent Registered Nurse (RN) assessment of the coccyx open area. Review of the Nursing Daily Attendance Report dated 1/19/25 identified LPN #9 worked the 7:00 AM to 3:00 PM shift that day, and Registered Nurse (RN) #7 was the nursing supervisor for the 7:00 AM to 3:00 PM shift. Interview with the Director of Nursing Services (DNS) on 5/19/25 at 1:05 PM identified there should be an RN assessment documented in the electronic medical record (EMR) following report of a new pressure ulcer, and all new pressure ulcers require completion of an accident and injury (A&I) report. The DNS further identified RN #7 was no longer employed by the facility. Interview with RN #7 on 5/20/25 at 10:51 AM identified she was the nursing supervisor working 1/19/25 during the 7:00 AM to 3:00 PM shift. RN #7 identified she could not recall being informed of a new pressure ulcer for Resident #44 on 1/19/25. RN #7 identified that when notified of a new wound she would fill out a wound tracker, notify the family, and obtain orders from the Advanced Practice Registered Nurse (APRN). RN #7 further identified she did not recall this event, and if there wasn't any documentation from her in the EMR related to this event it was likely LPN #9 forgot to notify her even though LPN #9 documented in her note that she did update RN #7. Attempts to contact LPN #9 were unsuccessful. Review of the Change in Resident Condition/Family/MD Notification policy directed, in part, when there is a significant change in the condition of a resident's physical status an RN assessment will be conducted. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #264's diagnoses included fracture of the left femur, autistic disorder, and unspecified convulsions. The admission Minimum Data Set assessment dated [DATE] identified Resident #264 was severely cognitively impaired and required partial/moderate assistance with bed mobility and was dependent with toileting and transfers. The Resident Care Plan dated 5/7/25 identified a fall risk with multiple risk factors and a seizure disorder. Interventions included to transfer the resident per the physician's orders and to maintain safety in the environment. A nursing note written by Licensed Practical Nurse (LPN) #8 and dated 4/21/25 at 10:58 PM identified Resident #264 was found on the floor and the resident's family member reported the resident had slid off the recliner and onto the floor. The nursing note indicated that 4 staff with a gait belt assisted Resident #264 off the floor and into bed. Review of the facility schedule for 4/21/25 indicated RN #6 was the nursing supervisor for the 3:00 PM-11:00 PM shift. Interview with LPN #8 on 5/19/25 at 10:03 AM identified she was the charge nurse for Resident #264 on 4/21/25 for the 3:00 PM-11:00 PM shift. LPN #8 indicated the resident's family member notified her that Resident #264 was on the floor around 10:00 PM and when LPN #8 entered the room, the resident was found sitting on the floor. LPN #8 identified that it took her and 3 other staff to assist the resident off the floor and back into bed. LPN #8 indicated she never informed RN #6 about Resident #264's fall because it was the end of her shift, and she could not find RN #6. Additionally, LPN #8 identified she had made a mistake, did not follow facility policy, should have informed RN #6 of the fall and made sure Resident #264 was assessed after the incident. Interview and review of the clinical record with the DNS on 5/19/25 at 11:00 AM identified she was aware LPN #8 did not inform RN#6 about Resident #264's fall on 4/21/25 and because of that a post fall RN assessment of the resident was never done. The DNS indicated LPN #8 should have informed RN #6 about the incident and made sure the resident was assessed by RN #6 before the resident was assisted off the floor. The DNS stated she did not know why LPN #8 did not inform RN #6 of the fall and LPN#8 was later issued a disciplinary write up by the DNS for not following the facility's policy and protocols. The DNS identified that Resident #264 was not assessed until the following day (4/22/25) by the Advanced Practice Registered Nurse (APRN). Attempts to contact the RN Supervisor (RN #6) were unsuccessful. Review of the facility policy, Falls: Minimizing Risk of Injury, undated, directed after a resident falls, a RN assessment occurs and when the resident is deemed safe by the supervisor to remain in the facility the resident will be transferred off the floor to appropriate seating per the plan of care. Review of the facility policy, Change in Resident Condition/Family/MD Notification, undated, directed in the event of an accident involving the resident, a RN assessment will be conducted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observations, review of the clinical record, facility documentation, facility policy and interviews, for the only sampled resident (Resident #21) reviewed for activities of daily living, the facility failed to maintain clean and trimmed fingernails. The findings include: Resident #21's diagnoses included hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke) affecting the right dominant side, dementia, and end stage renal disease. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #21 was severely cognitively impaired and dependent with transfers, toileting and personal hygiene. The Resident Care Plan (RCP) dated 3/11/25, identified Resident #21 had a history of a stroke with hemiparesis (partial paralysis or weakness of the right side) and needed assistance with activities of daily living (ADL's). Interventions included to anticipate and meet the residents needs and to provide daily skin care and hygiene. Review of the nurse aide (NA) care card for Resident #21 identified he/she was to be showered on the Thursday, 3:00 PM-11:00 PM shift and the resident required total assistance with bathing and to keep his/her nails trimmed and clean. Interview and observation with LPN #1 on 5/13/25 at 11:24 AM identified Resident #21's right hand was contracted and his/her fingernails on both hands were lengthy and unclean with a dark brown substance underneath them. A lengthy thumb nail on the resident's right hand was pressing into the side of his/her 4th finger of the same hand. LPN #1 indicated that, although the nurse aides (NA) were responsible to provide nail hygiene, the facility did not always have enough staff to take care of the resident's fingernails. LPN #1 further identified that nail care should have been completed during the resident's weekly shower, and she was unsure why it was not done. LPN #1 proceeded to assist Resident #21 with opening his right hand and the skin of the inside of the resident's hand appeared dry and intact. Observation on 5/15/25 at 12:55 PM identified the fingernails of Resident #21's bilateral hands remained lengthy and unclean with a dark brown substance underneath them. The resident's right hand was noted to be resting in the resident's lap with the fingers open (hand was not contracted). Interview with NA #3 on 1:00 PM on 5/15/25 at 1:00 PM identified nail trimming and cleaning was to be done on weekly on shower day and Resident #21 was scheduled on the Thursday, 3:00 PM to 11:00 PM shift. NA #3 indicated that although she saw the resident's fingernails were long and dirty and had told the nurse about it 2 weeks ago, she became busy and was unable to take care of it on her shift. NA #3 further identified that because Resident #21's nails remained lengthy and unclean with a dark brown substance underneath and since the resident has never refused to have his nails trimmed or cleaned, she would try to take care of them today. Subsequent to surveyor inquiry, on 5/16/25 at 9:45 AM Resident #21 was seated in the wheelchair in the hallway and his fingernails on both hands were trimmed and clean. When asked about his/her fingernails, Resident #21 responded by smiling and nodding his head up and down (resident non-verbal). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with NA #4 on 5/16/25 at 10:40 AM identified that she was assigned Resident #21 on 3:00 PM to 11:00 PM shift on Thursday, 5/8/25 but did not recall giving the resident a shower and did not provide the resident nail hygiene. NA #4 indicated that she does not provide nail hygiene on her shift because it is done by the NA on the morning shift. NA #4 identified that although she took care of the resident almost every day and continued to notice (after 5/8/25) that Resident #21's fingernails on both hands remained lengthy and unclean with a dark brown substance underneath, she was too busy and told the nurse she would have to take care of them another time. Interview with the DNS on 5/16/25 at 2:40 PM identified the policy on nail hygiene was that it was provided for residents as needed and with daily ADL care by the NA. The DNS indicated nail hygiene should have been completed by the NA for Resident #21 when his/her nails were observed to be lengthy and/or unclean, and she would have expected the NA's to have paid special attention to ensure the resident's fingernails were not pressing into his/her right-hand contracture. The DNS, although unsure why nail hygiene had not been provided for Resident #21, indicated she would need to further address the issue with the nursing staff. Interview with the Director of Rehab on 5/16/25 at 2:55 PM identified Resident #21 was admitted to the facility after experiencing a stroke with hemiplegia on his/her right side and the resident was unable to tolerate a splint or orthotic for the right upper extremity. The Director of Rehab indicated Resident #21 did not have functional use of his/her right hand and would be unable to trim or clean his/her own nails. The Director of Rehab identified she had made the nursing staff aware of the need to keep Resident #21's nails shorter due to the right-hand contracture and the risk of skin breakdown and the resident should have had his/her fingernails trimmed and cleaned on a regular basis. The Director of Rehab further indicated she was not made aware of the resident had ever refused to have his/her nails trimmed and cleaned. Review of the facility policy, AM Care/ADL's, undated, directed to provide individualized assistance, nursing staff would assist with AM care for each resident daily and fingernail care including trimming of nails if needed was to be provided.

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Hewitt Health & Rehabilitation Center, Inc	45 Maltby Street Shelton, CT 06484

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 1 of 2 residents (Resident #85) reviewed for edema, the facility failed to weigh the resident per physician orders. The findings include: Resident #85's diagnosis included congestive heart failure, pleural effusion, and cardiomyopathy. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #85 had intact cognition, and was independent with eating, oral hygiene, toileting, upper/lower body dressing and personal hygiene. Additionally, the MDS identified Resident #85 had no significant weight loss and had a diagnoses of heart failure. A physician order dated 12/1/24 directed for Resident #85 to be weighed daily. Review of the weight record from 12/1/24 to 5/15/25 identified a daily weight was not obtained 38 times out of 166 occasions. The Resident Care Plan dated 2/3/25 identified Resident #85 was at risk for cardiac issues with interventions weight as ordered/per policy, watch for signs/symptoms associated with cardio-respiratory issues and report to the physician, and diet as ordered. An interview on 5/15/25 at 2:41 PM with Licensed Practical Nurse (LPN) #10 identified that Resident #85 was to be weighed daily and that Resident #85 was not weighed daily. Further, identifying that she was responsible for making sure the resident was weighed according to the physician orders. An interview on 5/19/25 at 10:30 AM with the Director of Nursing (DNS) identified that Resident #85 was a daily weight and that the resident was not weighed daily according to the weight record. Also, identifying that the nurse was responsible for obtaining the daily weight and for the documentation of the weight. Review of the facility weight monitoring policy identified that residents will be weighed weekly for 4 weeks on admission and readmission then monthly, unless otherwise indicated by the physician's order.

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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 observations, interviews, record and policy reviews for 1 of 3 residents (Resident #106) sampled for pressure injuries, the facility failed to provide treatment for a wound per physician's order and failed to transcribe wound orders accurately. The findings included: Resident #106's diagnoses included a stage 3 pressure ulcer of the sacral region, muscle weakness and osteomyelitis of vertebral, sacral and sacrococcygeal region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #106 was cognitively intact, and required substantial/maximal assistance for dressing, toileting and changing position in bed. Additionally, the MDS identified Resident #106 had a Stage 3 pressure ulcer defined as full thickness loss, with subcutaneous fat visible but bone, tendon or muscle was not exposed. Slough was present but did not obscure the depth of tissue loss, may include undermining and tunnelling. The Resident Care Plan dated 3/12/25 identified Resident #106 had a pressure ulcer or potential for pressure ulcer development related to immobility. Interventions included administering treatment as ordered and following facility policies/protocols for the prevention/treatment of skin breakdown. The physician's order dated 4/23/25 directed to cleanse the sacrum stage 3 wound with ¼ strength Dakin's solution (an antiseptic), apply prep to peri wound area-let dry, then apply calcium alginate with silver (an antiseptic dressing that absorbs wound drainage) followed by dry clean dressing daily and as needed. a.Observation of the wound treatment on 5/15/25 at 11:46 AM identified LPN # 5 apply gloves then a gown without the benefit of hand hygiene. Nurse Aid (NA) #2 assisted with Resident #106's positioning in bed by standing on the residents' left side while LPN #5 was on the right. While Resident #106 was lying on his/her left side, LPN #5 applied the Dakins solution to gauze that was placed in a medicine cup and set it aside. She then removed the dressing dated 5/14/25 that was on Resident #106's sacral wound and removed the dressing packed inside the wound, disposing of both in the trash receptacle. LPN #5 then removed her right glove, without the benefit of removing her left glove, reached her right hand under her gown and pulled out a clean glove that she then applied to her right hand without the benefit of hand hygiene or removal of the left glove. She cleaned the sacral wound with the Dakins saturated gauze, dried the area and then used skin prep around the wound. LPN #5 then removed both gloves and applied clean gloves without the benefit of hand hygiene, opened the collagen matrix dressing (a dressing that promotes a moist wound environment), at which point the surveyor intervened and called the Infection Preventionist Nurse for clarification. Interview with LPN #5 on 5/15/25 at 11:56 AM identified she was going to use the collagen matrix dressing because it was in her treatment cart, even though the physician's order directed for a calcium alginate with silver dressing, stating the dressings were the same thing. Interview with the Infection Prevention Nurse (IPN) on 5/15/25 at 12:01 PM identified the collagen matrix dressing LPN #5 was ready to apply was not an appropriate substitute for the calcium alginate with silver dressing that was ordered by the physician, and that the facility did not use those two dressings interchangeably. LPN #5 then proceeded to clarify with the IPN nurse if the collagen matrix dressing could be used for Resident #106, to which he responded no. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the wound treatment on 5/15/25 at 12:05 PM by the IPN identified appropriate application of PPE, hand hygiene and completion of wound treatment per physician's order (calcium alginate with silver dressing followed by a dry clean dressing). b.Review of the wound report from 4/23/25 identified the wound APRN recommended Resident #106's stage 3 sacrum wound to be cleaned with ¼ strength Dakin's solution (an antiseptic), apply skin prep to the peri wound area-let dry, then apply calcium alginate with silver (an antiseptic dressing that absorbs wound drainage), followed by dry clean dressing twice a day and as needed (the order was transcribed as once a day for dressing frequency). Interview and record review with IPN on 5/15/25 at 12:11 PM identified that he accompanied the wound APRN on weekly rounds, she made recommendations, and they were transcribed by him. A review of the 4/23/25 APRN wound note identified Resident #106's Treatment Recommendations were to cleanse with 0. 125% Dakin's solution (1/4 strength), apply calcium alginate with silver to base of the wound, secure with a dry clean dressing and change twice a day and as needed for soiling, saturation, or accidental removal. The IPN identified the order was incorrectly transcribed as once a day. Subsequent to surveyor inquiry the order was changed to reflect the wound APRN recommendations of changing Resident # 106's sacral wound dressing frequency to twice a day. Review of the Physician's Orders Policy directed in part the purpose was to ensure physician's orders are complete and accurate. Review of the Treatment Process directed in part to cleanse the wound according to the physician's order-assess/evaluate/measure appearance as appropriate and apply the new dressing per physician's order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 residents (Resident #6, Resident #98, and Resident #110) reviewed for smoking, the facility failed to ensure timely completion of smoking assessments, to secure smoking materials per the resident plan of care (Resident #6), and failed to provide supervision to a resident smoking (Resident #6) per the smoking assessment. The findings include: 1. Resident #6's diagnoses included end stage heart failure, asthma, and acquired absence of the left leg. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was cognitively intact and was independent with toileting, bed mobility, and transfers. The MDS indicated Resident #6 used a motorized wheelchair and was not ambulatory. Additionally, the sections of the MDS identifying tobacco use was not completed. An admission smoking assessment dated [DATE] at 10:01 PM identified Resident #6 wanted to smoke but did not have the potential to violate the smoking policy. The assessment indicated Resident #6 required supervision with smoking and the resident was going outside with another resident that smoked. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was cognitively intact and was independent with toileting, bed mobility, and transfers. The MDS indicated Resident #6 used a motorized wheelchair and was not ambulatory. A physician's order dated 5/1/25 directed Resident #6 may go on a leave of absence and to medical appointments independently and with medications. The orders directed the resident may be up in his/her power custom wheelchair as tolerated and was non-ambulatory but independent with all transfers and indoor and outdoor mobility. An admission smoking assessment dated [DATE] at 9:54 AM identified Resident #6 was a current smoker who wanted to smoke but did not have the potential to violate the smoking policy. The assessment indicated Resident #6 required supervision with smoking. The Resident Care Plan (RCP) dated 5/7/25 identified Resident #6 was an active and independent smoker who agreed to not smoke on facility property (as the facility was a non-smoking facility) and to not have any smoking materials in his/her possession. Interventions included to provide the resident with a copy of the facility's smoking policy and the resident would return his/her lighter, matches and cigarettes to the nursing staff when he/she was finished smoking. An observation on 5/13/25 at 8:45 AM identified Resident #6 was outside in a wheelchair on the sidewalk bordering the building of the facility and he/she was smoking a cigarette unsupervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/13/25 at 11:45 AM with Resident #6 within his/her room, indicated that although he/she was made aware this was a non-smoking facility when admitted , the facility was aware he/she was smoking outside, and he/she did not keep smoking materials on his/her person and had given them to the nursing staff. Resident #6 then proceeded to display a black cigarette lighter which was kept in the right-hand pocket of his/her sweatshirt. Resident #6 indicated he/she was not smoking on facility property and that to obtain smoking materials he/she independently went to a local store in the power wheelchair. Interview with the Administrator on 5/13/25 at 11:55 AM identified she was aware Resident #6 was smoking outside of the facility and the resident was supposed to give the nurse her smoking materials to secure in the medication cart. The Administrator was informed that Resident #6 displayed having a black cigarette lighter on her person. The Administrator indicated the resident should not have a lighter in her possession and she would go and speak to the resident and confiscate the lighter and any other smoking materials found with the resident. A nursing note dated 5/13/25 at 1:43 PM identified Resident #6 was smoking on a leave of absence and the DNS later met with the resident and reviewed the prohibited smoking items policy. The resident stated she purchased the items and forgot to give them to the nurse. The nursing note indicated the prohibited items were taken and stored in the medication cart. Subsequent to surveyor inquiry, a smoking assessment dated [DATE] at 9:47 AM identified Resident #6 was a current smoker and wanted to smoke but did not have the potential to violate the smoking policy. The assessment indicated the resident was able to smoke independently. Subsequent to surveyor inquiry, the RCP was updated on 5/13/25 to reflect a prohibited items violation had occurred with Resident #6 and interventions included a room and package search with the residents consent to determine the presence of any prohibited items and to try to determine the cause of the violation. Interview with LPN #5 on 5/14/25 at 1:00 PM identified she was the charge nurse for Resident #6 and she was aware the resident went outside multiple times a day to smoke cigarettes. LPN #5 indicated she was not responsible for Resident #6's smoking materials and was not sure where they were stored. LPN #5 identified she did not have or handle smoking materials for Resident #6 and believed that the resident's smoking materials were kept at the front desk and given to the resident when he/she went out to smoke. An observation on 5/14/25 at 1:05 PM identified Resident #6 was outside in a wheelchair on the facility sidewalk, which was adjacent to the side of the building, and the resident was smoking a cigarette. Interview with the front desk secretary on 5/14/25 at 1:09 PM identified the facility was a non-smoking facility and he does not have or keep resident's smoking materials at the front desk. The front desk secretary was aware that Resident #6 would sign out of the facility and go outside to smoke cigarettes multiple times per day, but he believed the resident kept smoking materials on his/her person and the resident purchased them in the community. The front desk secretary indicated he was not responsible for resident's smoking materials and was not sure who was. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another interview on 5/14/25 at 2:20 PM with Resident #6, seated in the wheelchair and back in his/her room, indicated he/she was smoking outside earlier, and he/she had given the nurse his/her smoking materials which were secured in the medication cart. Resident #6 indicated he/she did not have smoking materials in his/her possession or in his/her room. Another interview with LPN #5 on 5/14/25 at 2:22 PM indicated that although she had observed Resident #6 leaving the unit multiple times today and the resident had returned smelling like cigarette smoke, she did not have Resident #6's smoking materials in the medication cart and did not know where they were kept. LPN #5 indicated Resident #6 had not asked her for nor had she provided the resident with his/her smoking materials that day. Interview and review of the clinical record with the DNS on 5/14/25 at 2:30 PM identified the charge nurse was responsible to secure Resident #6's smoking materials and the resident should not be smoking on the sidewalks on or around the facility, as those were considered facility property. The DNS was informed LPN #5 did not have Resident #6's smoking materials in the medication cart and had indicated it was the front desk that kept them however, the front desk secretary did not have the smoking materials either, so the resident likely still had smoking materials on his/her person. The DNS indicated she would speak to the resident and complete a room search now. Additionally, the DNS identified that she or the nursing staff were responsible to complete resident smoking assessments on admission and on a quarterly basis. Review of the clinical record indicated Resident #6's smoking assessments were completed only on 5/22/24 and 5/1/25 and both indicated the resident required supervision with smoking (smoking assessments were not completed in August 2024, December 2024, and March 2025). The DNS indicated she was unsure why smoking assessments were not completed quarterly as required, and the most recent smoking assessment she completed for the resident on 5/13/25, determined the resident was independent with smoking. The DNS identified that Resident #6 had been observed outside of the facility and on facility property smoking cigarettes unsupervised prior to 5/13/25. An observation made on 5/15/25 at 12:40 PM identified Resident #6 was outside in a wheelchair smoking a cigarette at the back side of the building at the end of the facility's rear entrance driveway. 2. Resident #98's diagnosis included diabetes, falls, and osteoarthritis. Resident #98 was admitted to the facility in November 2023. The Resident Care Plan (RCP) dated 11/22/23 identified that prior to admission Resident #98 was an active smoker, resident was told the facility was smoke free, and he/she agreed while at the facility not to have any smoking materials on his/her possession. Interventions directed to provide Resident #98 with smoking cessation material if requested, provide a copy of the facility's smoking policy, and off to obtain a physician order for nicotine patch, gum, or lozenges. A smoking assessment was not completed on admission in November 2023, and only one smoking assessment was completed on 3/8/24 which identified Resident #98 was able to smoke independently, had a history of smoking, had the potential to violate the smoking policy, and had a desire to continue to smoke. Further, identified that Resident #98 declined to provide the nurse with his/her lighter. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #98 was cognitively intact, used tobacco and was independent for transfers, dressing and toileting. Also, identified was Resident #98 required set up for eating and showering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders dated 10/24/24 identified that Resident #98 directed independent with a leave of absence from the facility. 3. Resident #110's diagnosis included substance abuse, acute kidney failure, and acute respiratory failure. Resident #110 was admitted to the facility in April 2025. The admission Minimum Data Set assessment dated [DATE] identified Resident #110 had intact cognition, was independent for eating, supervision assistance for toileting, showering, and transfers. Also, identified Resident #110 required moderate assistance for personal hygiene. Further, identifying Resident #110 used tobacco. The Resident Care Plan dated 5/1/25 identified Resident #110 was actively smoking, aware the facility was smoke free, and agreed to not have any smoking materials in his/her possession. Interventions directed to offer to obtain a physician order for nicotine patch, gum or lozenges, provide the resident with the facility's smoking policy, and provide the resident with smoking cessation materials if requested. An observation made on 5/13/25 at 8:45 AM of Resident #6 and Resident #98 with smoking materials outside on the sidewalk of the facility (each had a cigarette and they shared a lighter). Review of the Smoking assessment dated [DATE] (29 days after admission to the facility) at 9:46 AM identified that Resident #110 was a current smoker and was able to smoke independently. A nursing note dated 5/13/25 at 10:12 AM identified that the resident was a current smoker, policy was reviewed, and a smoking assessment was completed. Also, identifying that Resident #110 had an order for independent leave of absence from the facility. An interview on 5/14/25 at 9:50 AM with Resident #110 identified that he/she smoked, did not have any smoking materials in his/her possession, the facility asked upon admission if he/she was a smoker and the facility was aware. Also, Resident #110 identified that he/she had smoked since being admitted to the facility An interview on 5/14/25 at 12:57 PM with the Director of Nursing (DNS) identified that she was unaware that Resident #110 was a smoker and that a smoking evaluation was not completed upon admission to the facility. The DNS also identified that the MDS identified Resident #110 was a smoker and evaluation should have been completed at admission. Further, identifying the facility was a non-smoking facility but if the facility was made aware that a resident chooses to smoke order would be obtained for independent leave of absence. An interview on 5/14/25 at 10:05 AM with Licensed Practical Nurse (LPN) #10 identified that Resident #98 was a smoker, she does not hold Resident #10's smoking materials, that a smoking assessment was to be completed upon admission and the resident was told it was a nonsmoking facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 5/14/25 at 1:03 PM with the DNS identified that she was not aware that Resident #98 was a smoker although he/she had a Resident Care Plan for smoking, and Resident #98's annual MDS identified Resident #98 as a smoker. Also, identified that Resident #98 last smoking evaluation was completed on 3/8/24 and a smoking evaluation was to be completed every quarter or with a significant change in condition. An observation made 5/15/25 at 12:40 PM Resident #98 and Resident #6 observed smoking on back side of building at the end of the facility driveway. An interview on 5/15/25 at 2:33 PM with LPN #10 identified that she does not hold smoking materials for any residents and the Assistant Director of Nursing Service had the smoking materials. Subsequent to this surveyor's inquiry the facility performed a smoking assessment for Resident #110. Review of the facility policy, Smoking, dated 10/1/24, directed that except for facilities that are designated to allow smoking, all other company facilities were non-smoking and only residents who reside in a smoking facility may participate in a supervised smoking program. The policy directs that a smoking assessment is to be completed on admission and with any change or violation of the smoking policy. The policy further directs that residents who obtain smoking materials while on a leave of absence will be instructed to provide materials to staff upon returning to the facility. Review of the facility's policy (from the admission packet), Smoking, undated, directed the facility is a smoke free environment for all employees, residents and visitors and all smoking will be prohibited anywhere on grounds, including parking areas, access roads, and in vehicles parked on the property.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews and review of the Payroll Based Journal (PBJ) submissions, the facility failed to provide the appropriate number of weekend staff for Quarter 1 and Quarter 2 of Fiscal Year (FY) 2024 (October 1, 2023 through March 31, 2024). The findings include: PBJ submissions for Quarter 1 and Quarter 2 of FY 2024 (October 1, 2023 through March 31, 2024). indicated the facility had triggered for excessively low weekend staffing. An interview with the Scheduler on 5/16/25 at 9:36 AM identified she was not responsible for submitting staffing reports to PBJ and was not aware that the facility had triggered for low weekend staffing for Quarters 1 and 2 of FY 2024. The Scheduler indicated weekend staffing during that time was a challenge due to nursing staff calling out for their schedule shifts, retainment of staff, and agency staff calling out before scheduled shifts. The Scheduler identified more staff have been hired, retainment of staff is better, and they rarely need to call agency staff to help with covering scheduled shifts. Interview with the HR coordinator at 05/16/25 09:54 AM identified that she was responsible for submitting staff data to the PBJ, but she was not employed at the facility during Quarters 1 and 2 of FY 2024 when low weekend staffing was triggered. An interview with the [NAME] President (VP) of Clinical Operations on 5/16/25 at 10:04 AM identified that he was aware the facility triggered for during Quarter 1 and Quarter 2 of FY 2024. The VP of Clinical Operations indicated that in response to the low weekend staffing, the facility offered various shifts, per diem shifts, weekend only part-time shifts, offered bonuses, and held hiring events. The interview identified that after the various recruitment efforts, weekend staffing has greatly improved. Review of the Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Reporting Long Term Care Facility Policy Manual, dated June 2022, directed Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information. Additionally, it identified that facilities that do not meet requirements will be considered noncompliant and subject to enforcement actions by CMS.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **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 1 of 3 residents (Resident #25) reviewed for medication administration, the facility failed to administer medications per the physician's order resulting in a medication error rate greater than 5%. The findings include: Resident #25's diagnoses included dementia, atrial fibrillation and history of venous thrombus and embolism (blood clot). The annual Minimum Data Set assessment dated [DATE] identified Resident #25 was severely cognitively impaired and required substantial/maximal assistance with bed mobility and toileting and was dependent with transfers. The Resident Care Plan dated 3/6/25 identified constipation and a history of deep vein thrombosis (blood clot). Interventions included to administer medications as ordered and initiate bowel regimen as per the physician's orders. A physician's order dated 5/1/25 directed to administer Aspirin EC 81mg by mouth one time a day for atrial fibrillation and Miralax powder 17 gram/scoop by mouth two times daily for constipation. Observation of medication administration on 5/15/25 at 8:11 AM with Licensed Practical Nurse (LPN) #5 identified she had prepared and dispensed all ordered and scheduled oral medications for 9:00 AM for Resident #25. Prior to administration of medications to the resident, LPN #5 confirmed there were 9 pills in the medication cup as follows: 1. Amlodipine 5mg, 1 tablet 2. Atorvastatin 40mg, 1 tablet 3. Gabapentin 100mg, 1 tablet 4. Gerikot 8.6mg, 2 tablets 5. Quetiapine 50mg, 1 tablet 6. Quetiapine 25mg, 1 tablet 7. Acetaminophen 500mg, 1 tablet 8. Tradjenta 5mg, 1 tablet Medication reconciliation for Resident #25 identified LPN #5 failed to dispense and administer Aspirin EC 81mg by mouth and Miralax 17gm by mouth with the 9:00 AM medication administration observation. (continued on next page)

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Hewitt Health & Rehabilitation Center, Inc	45 Maltby Street Shelton, CT 06484

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for 5/15/25 for Resident #25 identified Aspirin EC 81mg and Miralax powder 17 gram/scoop were signed as administered by LPN #5 at 9:00 AM. Interview with LPN #5 on 5/15/25 at 10:35 AM identified that although she had signed for the Aspirin EC 81mg and Miralax 17 gram/scoop on Resident #25's MAR for 5/15/25 at 9:00 AM, she did not administer either medication to the resident. LPN #5 indicated she was nervous and forgot to dispense and administer the Aspirin EC and Miralax to the resident and would need to notify the nursing supervisor to obtain a new order from the physician to administer the medications now. Interview with the Registered Nurse Supervisor (RN #2) on 5/15/25 at 10:45 AM identified LPN #5 was responsible to administer all Resident #25's medications as ordered. RN #2 indicated LPN #5 should not have signed for medications in the MAR that she did not administer, but she was likely nervous. RN #2 identified she would contact Resident #25's physician and would speak to LPN #5 further. Interview with the Director of Nursing Services (DNS) on 5/15/25 at 10:50 AM identified LPN #5 was responsible to administer all Resident #25's medications as ordered. The DNS indicated LPN #5 should not have signed for medications in the MAR that she did not administer and if she was not administering a medication, she should have identified a reason in the MAR. The DNS indicated LPN #5 was likely nervous and she would provide further education to LPN #5. Review of the facility policy, Medication Administration, undated, directed all medications shall be administered safely and accurately in accordance with physician orders, facility protocols, and applicable state and federal regulations. The medication error rate was 7.14% based on the medication administration observation task.

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, facility documentation, and review of facility policy for 1 of 2 medication storage rooms, the facility failed to maintain proper refrigerator temperatures for medication storage. The findings include: Observation of Unit 1C medication storage room with the ADNS and LPN #10 on 5/19/25 at 11:25 AM identified that the medication refrigerator was documented on the temperature logs to be out of range on 5/1/25, 5/2/25, 5/3/25, 5/5/25, 5/6/25, 5/8/25, 5/9/25, 5/10/25 5/12/25, 5/14/25, 5/15/25 5/16/25, and 5/17/25. The refrigerator temperature log identified ranges should be between 36 degrees Fahrenheit (F) through 46 degrees F and were documented between 28 degrees F and 32 degrees F. The refrigerator contained 2 vials of Lispro 100units/ml, 2 Lispro Kwik pens 100units/ml, 1 Lantus Solostar pen 100units/ml, 3 Insulin Glargine pens, 1 Ozempic pen, 67 Bisacodyl 10 mg suppositories, 4 Acetaminophen 650mg suppositories,1 bottle of Brimonidine Tartrate ophthalmic solution, 1 Vancomycin Iso-osmotic 1gm/200mls, and 1 0.9% Sodium Chloride 100mls. An interview with LPN #10 on 5/19/2025 at 11:30 AM identified that it is the responsibility of the 11:00 PM - 7:00 AM nurse to document the refrigerator temperature on the monitoring log. Additionally, the interview identified that she was not aware of the out-of-range temperatures and that if she found the refrigerator to be out of range, she would notify the nurse supervisor. An interview and facility documentation review with the DNS on 5/19/2025 at 11:33 AM identified that the medication refrigerator in Unit 1C medication storage room was documented as being out of range and that she was not aware. The DNS indicated she would expect to be notified of out-of-range medication temperatures. Additionally, the interview identified that maintenance should have been notified to troubleshoot the out-of-range findings and that it was the responsibility of the 11:00 PM to 7:00 AM nurse supervisor to record the refrigerator temperatures. An interview and facility documentation review with the Maintenance Director at on 5/19/2025 at 11:52 AM identified that he was not made aware of the out-of-range temperature findings for the medication refrigerator in the medication storage room on Unit 1C. Additionally, he identified if he was made aware that he would trouble shoot the refrigerator and if the issue was not corrected, he would reach out to the vendor for them to come on site and repair. An interview with the Pharmacist on 5/19/2025 at 12:21 PM identified that the medications located in the Unit 1C medication refrigerator were still effective and had not been compromised with the out-of-range temperatures. An interview with the 11:00 PM to 7:00 AM Nurse Supervisor, RN #4 on 5/19/2025 at 12:52 PM identified that the policy for monitoring refrigerator temperatures indicated refrigeration temperatures to be in range between 30 degrees F and 42 degrees F. Additionally, RN #4 indicated that if she noticed temperatures to be out of range, she would notify maintenance to assess the equipment. Although requested from the DNS, temperature logs for the Unit 1C medication refrigerator from 5/1/2024 through 4/30/2025, were not provided. (continued on next page)

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the refrigerator and freezer temperature logs policy, dated 8/2018, identified that temperatures for refrigerators should be between 38 degrees F and 40 degrees F. Additionally, it indicated in the event the temperatures do not meet these requirements to notify maintenance and the supervisor on duty.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation(s), review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #18) reviewed for skin condition (non-pressure), and for 1 of 4 residents (Resident #106) reviewed for pressure injury, the facility failed to ensure proper personal protective equipment (PPE) were donned (placed on) during wound care for a resident on enhanced barrier precautions (EBP) and the facility failed to ensure proper hand hygiene was performed during wound care. The findings include: 1. Resident #18's diagnoses included dementia, anemia, and non-thrombocytopenic purpura. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was severely cognitively impaired and was dependent for transfers, toileting, and bed mobility. Additionally, the MDS identified Resident #18 had venous/arterial ulcers and skin tears. The Resident Care Plan dated 4/15/25 identified venous ulcers and a skin tear to the lower extremities and EBP related to wounds. Interventions included donning of gown and gloves when providing wound treatment. The physician orders dated 5/12/25 directed to cleanse the right arm, right shin and left thigh skin tears with normal saline, apply xeroform and wrap with kerlix gauze daily. The orders further directed to cleanse the left lower leg venous ulcer daily with normal saline, apply iodosorb followed by adaptic and apply a dry clean dressing daily. Observation of Resident #18's room on 5/13/24 at 10:30 AM identified EBP signage was posted on the door frame which directed staff must wear gloves and a gown for wound care. A cart containing disposable isolation gowns and other PPE was located outside of Resident #18's room. Interview, observation, and review of facility documentation with LPN #1 on 5/13/25 at 10:50AM identified she provided Resident #18 wound care without the benefit of an isolation gown. LPN #1 acknowledged she did not don an isolation gown when she provided Resident #18's wound care and indicated she did not know she needed to. Review of the EBP signage (posted outside of Resident #18's room) with LPN #1 directed an isolation gown and gloves are to be worn during wound care. LPN #1 stated although the EBP signage was posted outside of Resident #18's room and she had been provided training on EBP, she didn't know she had to don an isolation gown during wound care. Interview with the DNS on 5/15/25 at 10:05 AM identified that for resident's on EBP, nursing staff should don an isolation gown and gloves when providing wound care. The DNS indicated that she (together with the staff development nurse) has conducted ongoing education with all the nursing staff regarding EBP and LPN #1 should have known what PPE was required and should have donned an isolation gown when providing Resident #18's wound care. The DNS identified she would need to provide further education to LPN #1. Review of the facility policy, Enhanced Barrier Precautions, undated, directed targeted gown and glove use during high contact resident care activities, such as wound care. The policy further directed staff will don PPE (gown and gloves) before providing high contact care to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #106's diagnoses included stage 3 pressure ulcer of the sacral region, muscle weakness, and osteomyelitis of vertebral, sacral and sacrococcygeal region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #106 was cognitively intact, and required substantial/maximal assistance for dressing, toileting and changing position in bed. Additionally, the MDS identified Resident #106 had a Stage 3 pressure ulcer defined as full thickness loss, with subcutaneous fat visible but bone, tendon or muscle was not exposed. Slough was present but did not obscure the depth of tissue loss, may include undermining and tunnelling The Resident Care Plan dated 3/12/25 identified Resident #106 had a pressure ulcer or potential for pressure ulcer development related to immobility. Interventions included administering treatment as ordered and following facility policies/protocols for the prevention/treatment of skin breakdown. The physician's order dated 4/23/25 directed to cleanse the sacrum stage 3 wound with ¼ strength Dakin's solution (an antiseptic), apply skin prep to the peri wound area-let dry, then apply calcium alginate with silver (an antiseptic dressing that absorbs wound drainage) followed by dry clean dressing daily and as needed. Observation of Resident #106's room on 5/15/25 at 11:41 AM identified Enhanced Barrier Precautions signage posted outside the door identifying that everyone was to clean their hands prior to entering, and after leaving the room. Additionally, the sign directed that gloves and gowns were applied for high contact activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, assisting with toileting, device care, and wound care. Observation of Nurse Aide (NA) 2 on 5/15/25 at 11:42 AM identified her outside Resident #106's room applying a gown then gloves (per the signage posted for enhanced barrier precaution), without the benefit of hand hygiene prior to entering the room. Observation of the wound treatment on 5/15/25 at 11:46 AM identified LPN # 5 apply gloves then a gown (per the signage posted for enhanced barrier precaution), without the benefit of hand hygiene. NA # 2 assisted with Resident #106's positioning in bed by standing on the residents' left side while LPN #5 was on the right. With Resident #106 lying on her left side, LPN #5 applied the Dakins solution to sterile dressing that was placed in a medicine cup, she set it aside, then removed the dressing dated 5/14/25 that was covering the sacral wound and disposed of it in the trash receptacle, then removed the dressing packed inside the wound and disposed of it in the trash receptacle as well. LPN # 5 then removed her right glove, without the benefit of removing her left glove, reached her right hand under her gown and pulled out a clean glove that she then applied to her right hand without the benefit of hand hygiene or removal of the left glove. She cleaned the sacral wound with the Dakins saturated gauze, dried the area and then used skin prep around the wound. LPN #5 then removed both gloves and applied clean gloves without the benefit of hand hygiene, opened the collagen matrix dressing (a dressing that promotes a moist wound environment, which is the opposite of the intent of the dressing the physician ordered), at which point the surveyor intervened. Interview with LPN #5 on 5/15/25 at 11:56 AM identified it was facility policy to perform hand hygiene when going in and out of a resident's room and after performing care. Additionally, she identified the facility policy on glove use was to change gloves between residents. LPN # 5 could not identify if hand hygiene should be performed between glove changes or prior to applying personal protective equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA # 2 on 5/15/25 at 11:56 AM identified it was facility policy to perform hand hygiene before and after resident care, as well as prior to applying PPE. She could not identify a reason why she did not perform hand hygiene prior to applying the gown and gloves. Interview with the Infection Prevention Nurse on 5/15/25 at 12:01 PM identified that it was facility policy to perform hand hygiene prior to applying PPE and between glove changes, as well as after removal of PPE. Review of the Enhanced Barrier Precautions policy directed in part that staff will perform hand hygiene and apply PPE prior to high contact activities (which included wound care). Review of the Hand Hygiene policy directed in part that healthcare workers should perform hand hygiene to disrupt the transmission of microorganisms and should be performed before and after resident care, and after handling contaminated items. Review of the Treatment Process directed in part to perform hand hygiene, then apply clean gloves prior to starting the treatment, and perform hand hygiene between removing soiled gloves and applying clean ones.