STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075063	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avery Nursing Home/Noble Building	705 New Britain Ave Hartford, CT 06106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident #127) reviewed for advance directives, the facility failed to ensure there was a physician's order indicating the resident's wishes related to cardiopulmonary code status, hospitalization, and intravenous fluids. The findings include: Resident #127's diagnoses included dementia, hypertension, and muscle weakness. The annual MDS assessment dated [DATE] identified Resident #127 had severely impaired cognition and required maximal assistance with toileting hygiene, bathing dressing, personal hygiene and bed mobility. The care plan dated [DATE] identified Resident #127 had advance directives to be honored by staff per resident/family election of full code status with interventions that included CPR (Cardiopulmonary Resuscitation). A review of the clinical record identified an Advance Directive Consent Form that was signed by Resident #127's responsible party and the physician/APRN on [DATE] that identified the election of a code status of CPR/full code, hydration by intravenous fluids, nutrition by feeding tube, hospitalization to prolong life, antibiotic therapy and no to comfort measures. Review of physician's orders for the period of [DATE], through [DATE], failed to identify an order that addressed the elected choices identified on the Advance Directive Consent Form to have the status of CPR and/or the choice to accept hydration by intravenous fluids, feeding tube, nutrition by feeding tube, hospitalization to prolong life, antibiotic therapy and no to comfort measures. Interview with LPN #7 on [DATE] at 1:59 PM identified that if Resident #127 had a life-threatening emergency where the decision to administer CPR or withhold CPR, he indicated that there were several places to locate this information such as the banner on the computer screen in the electronic medical record system, the physician's order, the advance directive section of the paper chart and in the electronic medical records. However, he identified that the resident's code status should always be in the physician's orders which is written based on the Advance Directive Consent form. After reviewing the physician's orders with LPN #7, he noted that there were no orders addressing the resident's code status in the current physician's orders. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing (ADNS) on [DATE] at 2:10 PM identified that a physician's order should be in place to address the resident's selected code status. The ADNS further identified code status is obtained on admission after which a physician's order is obtained. She added that if the order is written in the physician's order in the physical chart it should be noted by the nurse and entered into the electronic medical record. Interview with the DNS on [DATE] at 3:00 PM identified the code status can be found in four different places such as the face sheet, consent, physical chart and physician orders, and the information should all match. She added it was the nursing supervisor's responsibility to obtain the order and input the order in the computer. She further identified that a physician's order should be in place directing the resident's elected code status. Review of the Advance Directives policy and procedures identified when a resident/patent is being admitted to the facility, a copy of the Withdrawing and Withholding Treatment and Your Rights to Make health Care Decisions will be given to them on or prior to admission. The policy and procedure further identified the responsibility of explaining Advance Directives will belong to a licensed nurse and the physician will write appropriate orders to indicate code status and this must be verified by nursing when reviewing the orders on admission.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, review of facility policy/procedure, review of facility documentation and interviews for thee sampled residents (Residents #34, #38 and #158) residing on a secured unit, the facility failed to assess, care plan, demonstrate that the secured unit was the least restrictive setting, and obtain consents for residents who were selected to reside on the secured unit. The findings include: Observations on all days of the survey: 5/12/25, 5/13/25, 5/14/15, 5/15/25, 5/16/25 and 5/19/25 identified the secured unit was identified as Station 2 and noted that all doors that could be used to exit the unit required a code to be punched in to a key pad located on the wall by the egress doors. Resident #34 was admitted to the facility in 2018 with diagnoses that include schizophrenia, osteoarthritis, bipolar disorder, major depressive disorder, agoraphobia with panic disorder. In 2020 the diagnoses of dementia and anxiety were added. The quarterly MDS assessment dated [DATE] identified Resident #34 had moderately impaired cognition, did not utilize alarms or physical restraints, did not exhibit hallucinations, delusions, physical or verbal behavioral symptoms directed toward self or others, did not wander or reject care and was dependent with a 1 person assist for transfers and mobility. The physician's orders dated 4/21/25 directed psychiatric/mental health evaluation as needed, check patient every 2 hours on 3-11 and 11-7am shift for safety purposes, monitor mental status changes and if there is a change in condition send to the emergency department, monitor target behaviors of angry outbursts, kicking, and screaming at the end of each shift, monitor how often the behavior occurs and the response to redirection. The physician's orders did not identify that Resident #34 resided on a secured unit. The care plan dated 3/4/25 identified Resident #34 was involved in a verbal altercation with another resident; care plan interventions included redirect resident away to prevent harm, provide psychiatric consult, medicate as ordered, encourage resident to verbalize feelings, divert with activities to redirect attention away from agitation/anxiety, attempt to identify sources of agitation/anxiety and help to resolve where appropriate. The care plan further identified the Resident #34 had a mental disorder and interventions identified reinforce existing coping skills, monitor mood and r5eport any changes to the physician and/or APRN. Further review of the care plan did not identify that Resident #34 resided on a secured unit. The psychiatric provider's notes dated 2/6/25, 2/27/25, and 4/10/25 identified Resident #34 was not a danger to self or others, had no reports of manic behaviors and resided on a secure dementia unit. The notes did address the resident's residence on a secured unit. The physician's progress note dated 3/4/25 identified Resident #34 was stable and had no complaints. The note did not address the resident's placement on a secured unit or that the approach for placement was the least restrictive setting. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/13/25 at 10:06 AM identified Resident#34 in his/her room which is located on the secured unit. Interview on 5/16/25 at 9:30 AM identified Resident #34 identified the inability to ambulate independently and indicated the need for help and the use of a walker. Resident #34 further identified his/her preference to stay in bed and indicated his/her unhappiness with living in the facility but indicated the inability to go home. Resident #38 was admitted to the facility in March 2024 with diagnoses that included Alzheimer's dementia, schizoaffective disorder bipolar type, chronic diastolic heart failure and generalized muscle weakness. The annual MDS assessment dated [DATE] identified Resident #38 had moderately impaired cognition was independent with position changes and ambulation, did not exhibit wandering behavior, but exhibited rejection of care 1 to 3 times in the last 7 days. The care plan dated 4/1/25 identified Resident #38 was at risk for wandering with interventions that included check wander-guard for placement each shift, elopement assessments to be completed on admission, quarterly, and as needed, and in the event an exit alarm is activated, staff should take special care to be sure that only one resident has triggered the alarm and return resident to unit. The physician's orders dated 4/21/25 directed psychiatric/mental health evaluations, and annual chart assessments for elopement. The orders did not address the resident residing on a secured unit. The psychiatric note dated 1/7/25 identified Resident #38 was alert, forgetful but overall organized, had no behavioral concerns and resided in a long-term care setting in a locked dementia unit but failed to identify criteria met for placement or that this was the least restrictive setting. The elopement and wandering assessment dated [DATE] identified Resident #38 was not at risk for elopement. Social services progress note dated 3/26/25 identified Resident #38 had one incident of rejection of care with no other behavioral concerns. Observation on 5/16/25 at 10:00 AM identified Resident #38 standing in the doorway to his/her room watching other residents in the hallway. Resident #38 resides on the secured unit. Resident #158 was admitted to the facility in April 2024 with diagnoses that included Lewy Body dementia, and mild neurocognitive disorder without behavioral disturbance. The annual MDS assessment dated [DATE] identified Resident #158 had severely impaired cognition, and did not exhibit wandering behaviors. Where is the resident's physical ability. The care plan dated 4/15/25 identified Resident #158 was at risk for wandering/elopement with an approach to assess for room change to secure unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order report dated 4/21/25 directed Resident #158 was independent with ambulation. The physician's note dated 1/21/25 identified Resident #158 had very early dementia with depression and anxiety stable and poor prognosis. The physician's notes did not identify the need or assessment for placement on a secured unit. Elopement and wandering assessment dated [DATE] identified Resident #158 was not at risk for elopement. Social services note dated 2/10/25 at 11:56 AM identified Resident #158 had slight difficulty focusing at times with no new behaviors that quarter. The note indicated Resident #158 was adjusting well on station 2 although it did not identify the unit is a secured unit. The psychiatric note dated 2/18/25 identified Resident #158 had a chronic illness requiring continued care, with symptoms of delusions, paranoia, and restlessness. The note indicated Resident #158 was not currently a danger to self/others, had advancing dementia with the need for 24-hour supervision and assistance. The note did not mention that resident's placement on a secured unit. Further review of psychiatric notes dated 3/20/25 and 4/1/24 failed to address Resident #158's residence on the secured unit and/or if the secured unit was the least restrictive setting. The elopement and wandering assessment dated [DATE] identified Resident #158 was not at risk for elopement. Social service note dated 5/6/25 at 12:42 PM identified Resident #158 had no behavioral changes or instances of wandering over the quarter. Interview on 5/12/25 at 9:21 AM with Resident #158 identified the awareness of not being able to leave the unit. Interview on 5/13/25 at 3:00 PM with the DNS identified the facility did not have criteria for placement in the secured unit. The DNS indicated the unit is a long-term care unit and was not a dementia unit. She further identified the unit was open to anyone who wanders so they can roam the unit freely and be safe on the unit; however, it should not be considered a dementia or behavioral unit. The DNS reiterated the unit was a long-term unit and was not aware of any parameters for placement regarding secured units. Interview on 5/16/25 at 12:12 PM with the ADNS, identified that she, along with the Administrator, DNS, Admissions staff and Social Worker discuss the residents and decide who would be appropriate for admission to the secured unit. The ADNS indicated that the secured unit is appropriate for a resident who has issues with elopement or someone with a diagnosis of Alzheimer's or dementia. Additionally, behaviors are also a reason for placement on the unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/19/25 at 2:40 PM with the Medical Director identified the secured unit was primarily dementia specific for residents who are more advanced and have a greater chance of wandering. The Medical Director indicated that making the decision for placement was a nursing task and placement was meant for safety or if a resident was a higher risk in a non-secured unit related to wandering. The Medical Director identified there was not a checklist or criteria for placement of residents on the secured unit. The Medical Director further identified that simply because he didn't identify the residents who belonged on the unit, doesn't mean he disagrees with the placement. The Medical Director indicated he was not aware of the regulatory guidance and documentation requirements for secured unit placement. Review of the facility assessment failed to identify a secured unit in the facility and failed to identify criteria for placement on the unit. Although requested the facility was unable to provide placement consents, assessments for placement or demonstration that the placement was the least restrictive approach for housing for the residents residing on the unit.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for five of five sampled residents (Resident #30; #62 #128 #151 and #159) reviewed for resident assessment, the facility failed to ensure the residents Minimum Date Set (MDS) Assessments were transmitted to CMS (Centers for Medicare & Medicaid Services) within 14 days of the MDS completion date and/or the care plan completion date. The findings include: Resident #30 had a quarterly MDS assessment dated [DATE] with a completion date of 4/16/25 (the assessment should be transmitted within 14 days of the completion date). The assessment was required to be submitted by 4/30/25. The facility's transmittal record identified the assessment was transmitted on 5/7/25, which made it seven days late. Resident #62 had a quarterly MDS assessment dated [DATE] with a completion date of 4/9/25 (the assessment should be transmitted within 14 days of the completion date). The assessment was required to be submitted by 4/23/25. The facility's transmittal record identified the assessment was transmitted on 5/7/25, which made it fourteen days late. Resident #128 had a quarterly MDS assessment dated [DATE] with a completion date of 4/10/25 (the assessment should be transmitted within 14 days of the completion date). The assessment was required to be submitted by 4/14/25. The facility's transmittal record identified the assessment was transmitted on 5/7/25, which made it thirteen days late. Resident #151 had a quarterly MDS assessment dated [DATE] with a completion date of 4/14/25 (the assessment should be transmitted within 14 days of the completion date). The assessment was required to be submitted by 4/28/25. The facility's transmittal record identified the assessment was transmitted on 5/7/25, which made it nine days late. Resident #159 had an annual MDS assessment dated [DATE] with a completion date of 4/16/25 (the assessment should be transmitted within 14 days of the completion date). The assessment was required to be submitted by 4/30/25. The facility's transmittal record identified the assessment was transmitted on 5/7/25, which made it seven days late. Interview on 5/16/25 at 4:48 PM with LPN #1 (Noble unit manager, MDS Coordinator) identified has been the MDS Coordinator for two years. LPN #1 was unable to provide an explanation or answer as to why the assessments were submitted late for Residents #30, #62, #128, #151, and #159. She noted that the facility hired a company to help with MDS's and sometimes they have sent reports to the facility, indicating that the MDS assessments were submitted, then the facility finds out later that a couple were not submitted as indicated. LPN #1 identified that it may be some type of glitch with the system. The facility's electronic medical record (EMR) system compiles a list of when MDS assessments are due and noted the assessments should be submitted within 14 days of the MDS completion date. Review of the Resident Assessment Instrument Manual (RAI) identified; comprehensive assessments must be submitted within 14 days of the care plan completion date. All other MDS assessments, including those for significant change in status or quarterly assessments, must be submitted with 14 days of the MDS completion date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident #427) who was a new admission, the facility failed to ensure an interdisciplinary care plan meeting was held and failed to develop the comprehensive care plan. The findings include: Resident #427 was admitted to the facility on [DATE] with diagnoses that included heart failure, peripheral vascular disease and gout. The baseline care plan dated 4/14/25 identified the following care plan focused areas: nutritional status, return to community referral and psychosocial well-being along with approaches for each identified area. The admission MDS assessment dated [DATE] identified Resident #427 was cognitively intact, dependent on staff for toileting hygiene, required moderate assistance with personal hygiene, upper body dressing, bed mobility and bathing, was occasionally incontinent of bladder and always continent of bowel. The assessment further identified that the following triggered areas would be included in the care plan: activities of daily living functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dehydration/fluid maintenance, and pressure ulcer. Additionally, the completion date of the assessment was noted as 4/24/25. Review of the clinical record failed to identify that an interdisciplinary care plan meeting was held with the resident and review of the baseline care plan dated 4/14/25 failed to identify that all of the triggered areas that the assessment identified would proceed to the care plan were included on the care plan. The interdisciplinary care plan meeting should have taken place by May 1, 2025. This meeting should have resulted in the completion of the comprehensive care plan. Interview with the Unit Manager (RN #5) on 5/16/25 at 10:35 AM identified Resident #427 had a baseline care plan in place which was only good for 21 days. He further identified that the comprehensive care plan should have been developed and implemented within 21 day of the resident's admission date and acknowledged that the care plan was over two weeks late at this point in time. RN #5 identified that he was responsible for completing the comprehensive care plan and was unable to give a reason why it was not completed. He further noted that all of the triggered areas that were identified as being care planned for on the MDS should be included on the comprehensive care plan. The care plan should have included the triggered areas of activities of daily living, rehabilitation potential, urinary incontinence, falls, dehydration and fluid maintenance and pressure ulcers; none of which was included on the care plan. Review of the Resident Care Plan policy identified that a comprehensive care plan shall be developed for all residents utilizing an interdisciplinary approach within 21 days of admission. Based on review of the clinical record, review of facility policy/procedures and interviews for 1 of 4 sampled residents (Resident #10) reviewed for accidents, the facilit failed to ensure the care plan was reviewed and revised to reflect the resident's ADL status. The findings included: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10 was admitted to the facility in March 2023 with diagnoses that included heart failure, unspecified osteoarthritis, left hand contracture, muscle weakness and hemiplegia and hemiparesis following cerebral infarction affecting unspecified site. The Quarterly MDS dated [DATE] identified Resident #10 had intact cognition, had impairment on one side to the upper extremity, required extensive assistance with bed-mobility, and transfers requiring 2 person assistance and indicated Resident #10 weighed 213 lbs. The Care plan dated 10/31/23 identified the resident had an alteration in self care deficit r/t depression and dementia with interventions for extensive assist of one with personal hygeine, bathing, and indicated Resident #10 transferred independently with walker, walked independently with walker on unit. This was the only mention of transfers/mobility until the care plan identified a fall on 12/19/23 due to decreased mobility and Fall risk Assessment with score of 7 or greater with interventions or an approach that the patient will be wheeled backwards when crossing thresholds for safety. The physician's orders dated 9/8/23 directed a weekly shower once a day on Tues. The physcian's orders did not direct a transfer status until 2/15/24 which directed Resident#10 was a hoyer lift with 2 person assist. Occupational Therapy Assistant notes dated 4/17/23 identified Resident #10 was dependent with bathing tasks and could participate in light grooming supine with verbal direction and some physical assistance due to hand contracture. Occupational therapy plan of care notes dated 12/7/23 identified Resident #10 was dependent for bed mobility, transfers and ADLs and utilized a hoyer lift for transfers. Physical Therapy progress notes dated 11/14/23 identified Resident #10 was dependent, 100% assist for transition from supine to sitting position and vice versa, and dependent, requires 100% assistance by one or more persons to transfer. Treatment administration histoy dated 12/1/23 through 12/31/23 identified transfers with a hoyer lidt a dn 2-person assist 3 times daily after 12/6/23 (after Resident#10 returned from a hospital stay) and were completed throguhout the month. Interview on 5/16/25 at 12:12 PM with ADNS identified the supervisors who do the admission or the unit managers are responsible for oversight of the care plans. Interview on 5/19/25 at 3:30 PM with RN#5 who identified that the care plan for Res #10 was incorrect and he did not know who entered the care plan. RN#5 indicated it did not reflect the resident status as the resident was a hoyer lift, had a deficit and did not self ambulate. RN#5 identified it was the responsibility of the unit manager to make sure the plan of care was updated and accurately reflected the resident status. The facility policy for development of the resident care plan identified the unit urse manager or the MDS coordinator will assume responsibility for coordinating and attesting to the completion of the comprehensive assessment and care plan. Resident #114 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pressure Ulcer/Injury Based on review of the clinical record, review of facility policy/procedures, and interviews for 1 of 3 sampled residents (Resident #114) reviewed for pressure injuries, the facility failed to ensure the care plan was reviewed and revised to reflect the resident status when the resident developed skin/pressure issues. Resident #114 diagnoses included Sacral pressure ulcer stage 3, pressure ulcer of left heel unstageable, Parkinson's disease with dyskinesia with fluctuations. The Quarterly MDS dated [DATE] identified Resident#114 had severely impaired cognition, and required partial/moderate assistance with rolling left and right, sit to lying, lying to sitting on side of bed and sit to stand. The MDS indicated Resident #114 was not at risk for developing pressure ulcers and didn't have any pressure ulcers/injuries. The care plan dated 12/01/24 identified Resident #114 was an assist of 2 with transfers via hoyer, hoyer for toileting and required assist with ADLs with interventions of consults as scheduled and rehab as ordered. The care plan indicated Resident #114 was at risk for impaired skin integrity , decreased mobility, incontinence, and decreased sensory perception with interventions to include a pressure redistribution device on bed and in wheelchair, assist with turning and repositioning every 2-3 hours per protocol, monitor skin integrity with AM and PM care and bathing and report any changes in skin condition to charge nurse. Physician's orders dated 11/7/2024 directed Resident #114 was an assist of one with rolling walker for transfers, mobility and toileting, and assist of one for upper/lower body dressing and washing. Nursing progress note dated 12/01/2024 at 3:33 PM identified Resident #114 was noted to have an excoriated area to the coccyx and added treatment of calmoseptine twice daily and indicated the APRN and supervisor had been notified. Nursing progress note dated 12/20/2024 at 8:59 PM identified Resident #114 had a noted open area to sacral 0.5 x 0.5 cm. The note indicated the on-call APRN updated and Supervisor notified. The note directed administration of calmoseptine cream to promote healing and protect the skin and indicated the concern was written in the APRN book for further assessment in the morning. Wound MD progress note dated 2/12/2025 identified Resident #114 was seen by the wound doctor for a wound to the left heel and a wound to the sacrum. The note indicated the treatment for the wound to the sacrum was changed to Calcium alginate and indicated this was the first time the sacrum wound was seen by the wound doctor and was identified as a stage 3 pressure wound (identified as Site 2) and measured 2.0. 8x0.3 cm with moderate serous exudate. The note directed of off-load wound and reposition per facility protocol and turn side to side in bed every 1-2 hours if [NAME] and ordered a group 2 mattress. Interview on 5/19/25 at 2:10 PM with RN#5, unit manager, identified the unit managers are responsible to review the care plans to make sure they reflect the resident's status. RN#5 indicated that when a resident has a status change, such as a new wound, the care plan should reflect the current ADLs and presentation of the resident. RN#5 identified the skin status for Resident #114 could have been updated when the excoriation changed to an open pressure area. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry 5/15/25, wound areas 12/2/24 excoriation to sacral area, 12/5/24 left heel black area, 2/3/25 left heel open, scant drainage and 2/10/25 sacral wound noted were added to the care plan. The facility policy for baselin/comprehensice person centered care plans identified the care plan will be reviewed and revised quarterly, following a significant change and as the plan of care changes. ****NOTES***** F689 The facility failed to ensure Resident #74 was free from accidents/hazards. F657 The facility failed to ensure the care plan was reviewed and revised to reflect the resident's ADL status. 05/13/25 09:44 AM Resident had a reported incident from the facility regarding a fall from the wheelchair. The resident did not mention this at all. 05/13/25 12:42 PM discussion with resident fell from the shower chair. The resident stated that there was one aide who was pushing her through the hallway from the shower room and there used to be a metal threshhold in the doorway because there was carpet and she couldn't get the chair to go over that and I slid off of the chair and fell and hit my head. They sent me right to the hospital and they told me everything was okay. I still have some pain in the back of my head and sometimes in my neck. But, now they rub my neck with something to make it feel better. They don't like you to be in pain. Resident #10 was admitted to the facility 3/31/23 with diagnoses that included heart failure, unspecified osteoarthritis, left hand contracture, muscle weakness and hemiplegia and hemiparesis following cerebral infarction affecting unspecified site. The physician's orders dated 2/15/24 directed the resident be a hoyer lift with 2 person assist. The Care plan dated identified the resident had a fall on 12/19/23 due to decreased mobility and Fall risk Assessment with score of 7 or greater with interventions or an approach that the patient will be wheeled backwards when crossing thresholds for safety. The start date for this intervention was 12/19/23 The Quarterly MDS dated [DATE] identified Resident #10 had intact cognition, had impairment on one side to the upper extremity, required extensive assistance with bed-mobility, and transfers (requiring 2 person assistance) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note dated 12/12/23 at 10:47 PM identified Approx 6:45pm CNA was transporting from shower room to her room via transport/shower chair. CNA stated she was going thru double doors and going over a raised area on the floor when resident slid out of the chair. Resident stated she hit the back of her head, but was unsure whether her head hit the floor or the chair. Full body audit was done. No swelling, no bumps, or redness to back of head noted at time of assessment. No apparent injuries and/or bruises . ROM to all extremities WNL. Resident denies pain and/or discomfort. On call [NAME] APRN was notified and updated including resident is on heparin. Daughter [NAME] was notified. [NAME] APRN stated it is worst to hit the back of head then it is to hit the front of head and internal bleeding can be present when back of head is hit. [NAME] APRN stated to call daughter back and inform her of this information. Also, [NAME] APRN instructed this writer to inform daughter if she does not want resident to go to hospital, she would have to come in tomorrow morning and sign a Do Not Transfer to Hospital form. This writer called daughter [NAME] back and updated her on the information received from B. [NAME] APRN, daughter [NAME] replied send to hospital and that her daughter (resident's grand daughter was coming to visit). Also, information from B. [NAME] was relayed to resident, resident was told her daughter [NAME] C. wants her sent to hospital and resident agreed with daughter's decision. Approx 7:30pm resident left building to Hartford Hospital via ambulance escorted by two EMT's. BP 180/90 P 70 T 97.6 RR 18 POX 99% RA. Supervisor updated. Review of the reportable events report dated 12/14/23 identified the fall occured in the hallway at 6:45 PM. The resident was A&Ox 3CNA ([NAME]) was pushing the shower chair through the double door when the resident slid out of the chair and hit the back of her head. A full body audit was completed and RN [NAME] stated no apparent injuries and/or bruises and denied pain. 05/14/25 03:14 PM Vivette [NAME] cna 37 yrs. shower chair. They have a regular shower chair which has a seatbelt. We are not allowed to use the seatbelt because it is a restraint. There is a bariatric chair that does not have a seat belt, and there is a reclined chair that we use for residents who are not able to sit up or residents who have had a stroke or can't move easily on their own .we are able to hoyer them into the shower chair and then back to bed. Unsure if it is on the resident care card or the care plan. 05/14/25 03:20 PM christian [NAME] Resident was in noble in 2023. Uncertain how it is decided which shower chair the residents should use. I am wondering if therapy assesses for that. 05/14/25 03:30 PM TC to cna [NAME] and # [PHONE NUMBER] and not taking calls/OOS?? 05/14/25 03:30 PM TC to [NAME] RN [PHONE NUMBER] and the mailbox is full. 05/16/25 08:35 AM [NAME] (COTA) Assistant Director of Rehab Dont normally provide education regarding the shower chairs unless there is a problem related to use. Looking back into the computer they use Nethealth and in 2023 they used cassamba. Logins weren't working because of a name change. Will print assessments from admission through the fall and anything that was done in response to the fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/16/25 09:50 AM [NAME] CNA we used two people to hoyer her out of the bed .I used the shower chair with the leg lifts I rollled her into the shower successfully and then when rolling her back to her room I was alone. We did have inservice after that incident (there is now 2 people to move people in the shower chair) We had carpet at the time and there was a threshhold and the two front wheels got stuck on the threshhold. The two back wheels went up and she began falling out of the chair. I did catch her head and made it safe while she was slipping. She did not hit her head and we should have used two people to move the resident but I just forgot about it. 05/16/25 10:07 AM [NAME] RN Staff Development 1.5 yrs .The facility does not do training on use of the shower chairs. There is not any training unless there is an incident. They go to school .and after orientation we monitor them closely to see how they do it. They usually bring the shower chair to the resident's room. and they roll the resident in the hallway to the shower and to the room there is only one staff required to transport in the shower chair. 05/16/25 11:45 AM [NAME] cna (5yrs) .we follow the assignment .if a resident is a hoyer lift they are an assist of two and when transportting to and from the shower in the chair it bis also two people. this has always been like that. F686 The facility failed to ensure the resident received care consistent with professional standards of practice or received necessary treatment and services to promote the healing of a pressure ulcer. F710 the facility failed to ensure a resident was evaluated and assessed by the physician related to the resident's skin status. F657 The facility failed to ensure the care plan was reviewed and revised when the resident developed skin/pressure issues. 05/12/25 02:36 PM Stage 3 on the Sacrum that is facility acquired. Resident # 114 05/16/25 11:42 AM Observation of wound care with mirian [NAME] lpn and [NAME] cna (5 yrs) 05/12/25 02:40 PM Loss of over 11% in 6 weeks. (Jan/[DATE]) 05/13/25 12:39 PM Observation of resident laying in bed with pillow supporting the left arm. resident does not rouse when spoken to. 05/15/25 10:50 AM 05/16/25 8:50 AM 05/16/25 11:50 AM Observation of lpn setting up wound care items uses a towel as base .sodium chloride solution .wound dressing with silver, Gloves Removed old dressing (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves used ns and gauze to clean wound bed and removed old packing Gloves skin prep gloves silver dressing to wound bed f/b calcium alginate and covered with DCD. moved/boosted resident and got new gloves. took off ppe washed hands. Resident #114 was admitted to the facility 10/11/23 with diagnoses included Sacral pressure ulcer stage 3, pressure ulcer of left heel unstageable, Parkinson's disease with dyskenesia with fluctuations. The Quarterly MDS dated [DATE] identified Resident#114 had severely impaired cognition, 05/19/25 10:54 AM [NAME] RN 3 yrs - took over as wound nurse in July 2024. It looks like the first time we saw her for the sacrum was 2/13/25. If any areas come up in morning report or if staff sees something, they will come and tell me or the unit managers. When an area becomes open there should have been a notification to have the wound doctor see the resident. 05/19/25 11:33 AM Interview with APRN [NAME] who identified the first time she saw the resident was in January 22, 25. If I am seeing the resident for a specified complaint then I keep my notes succinct. I work mon, wed, and fri and when i finish something then i thin the book. If it was an excoriation then they need an order. 05/19/25 11:46 AM LM for [NAME] did weekly skin checks through [DATE] and made progress note regarding APRN notification. 05/19/25 11:48 AM I usually report it to the supervisor and put it in the APRN book and they are supposed to follow up. I need an order from some one to put a dressing or something more than a routine thing. i dont remember if i texted christian (manager) but i am pretty sure I notified the supervisor but i remember the open areas i remember the aide notified me there was an open area. I sent a text w/picture [DATE] @7:53pm I am pretty sure it was [NAME]. [NAME] Kirzon FNP 12/01/2024 03:33 PM (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Daily Note: Resident noted with excoriated area to coccyx Treatment calmoseptine BID. POA [NAME] updated. APRN updated and Supervisor. 12/09/2024 01:00 PM Date:12/09/2024 06:00 PM Encounter ID:11904284928003 Reason: Weakness Parkinson's Type: SNF Follow Up Location: [NAME] Heights Provider: [NAME] Kirzon, FNP NO MENTION OF THE SACRUM/COCCYX 12/20/2024 08:59 PM Resident is alert and verbal noted with open area to sacral 0.5 x 0.5 cm. On call APRN updated and Supervisor notified. Administered calmoseptine cream to promote healing and protect the skin , resident is laying on the side to relive pressure to the area, Concern written on APRN book for further assessment in the morning. All needs met at this time. Date:01/22/2025 04:30 PM Encounter ID:11904284928005 Type: Acute Visit Location: [NAME] Heights Provider: [NAME], FNP NO wound observations associated with visit 1st visit by this APRN Date:02/03/2025 02:30 PM Encounter ID:11904284928004 Reason: Dti To Left Heel Type: Acute Visit Location: [NAME] Heights Provider: [NAME], FNP (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Only wound reviewed was the wound to left heel Date:02/05/2025 02:45 PM Encounter ID:11904284928006 Reason: Acute Visit Type: SNF Follow Up Location: [NAME] Heights Provider: [NAME], FNP Only wound mentioned is ongoing treatment to the heel. 02/06/2025 11:52 AM Pt seen by the [NAME] Wound MD, Dr. Al-Arshani, per request of nursing for an area on her L heel. Area assessed and treatment ordered for Santyl and DCD QD. Call placed to [NAME] and consent obtained for Dr. Al-Arshani to mechanically debride the area as needed. Treatment completed per orders and tolerated well. Consult uploaded to chart. 02/13/2025 04:49 PM Pt seen by the [NAME] Wound MD, Dr. Al-Arshani, per request of nursing for an area on her L heel and sacrum. Areas assessed and treatment changed to Calcium Alginate for her sacrum and Medi-honey for her L heel and QD. Treatment completed per orders and tolerated well. Consult uploaded to chart. 02/20/2025 04:51 PM Pt seen by the [NAME] Wound MD, Dr. Al-Arshani, per request of nursing for an area on her L heel and sacrum. Areas assessed and treatment changed to Calcium Alginate for her sacrum and Medi-honey for her L heel and QD. Treatment completed per orders and tolerated well. Consult uploaded to chart. 02/26/2025 05:02 AM [Recorded as Late Entry on 02/27/2025 05:02 AM] Pt seen by the [NAME] Wound MD, Dr. Al-Arshani, per request of nursing for an area on her L heel and sacrum. Areas assessed and treatment changed to Dakins wet to moist for her sacrum and Medi-honey for her L heel and QD. Treatment completed per orders and tolerated well. Consult uploaded to chart. 03/05/2025 02:17 PM WOUND ROUNDS PROGRESS NOTE: wound culture recommended to Sacral area. Start Augmentin 500mg/125mg, PO every 12 hours x 7 days, after culture obtained. Then continue same treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/19/25 12:44 PM TC to Dr. Al .I would not have knowledge of the wound until it was brought to my attention. I don't know what was occuring with the resident, whether they were in or out or had some other issues will return call this afternoon. 05/19/25 02:07 PM Christian [NAME] Nurse unit manager since 2023. Usually the supervisors are the 3-11 pm. I have to go see it. I would really like to see it if I am going to document on it. I assess and measure, write a nursing note, contact the doctor/APRN (usually call or put on the communication book if it is not emergent) and the wound team so the resident is seen weekly. The staging would be the doctor, I would do the measurement and any drainage, etc and document and notify the infection control nurse and if it can't wait then intervene until seen by the wound team. How often should the area be reassessed. If I put calmoseptine then the person who does the treatment should be evaluating. The nurse said she put it in the book, she would have seen it if it was in the book. 05/19/25 02:19 PM [NAME] RN supervisor 3-11pm when they call or text me, I go and check what the nurse needs. She was already in Station 3 at that time. I will check the phone, but I always send it to the APRN and put a treatment until they are seen the next day. I told them to put it in the APRN book or send it to the unit manager. I don't recall if I

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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 observation, review of the clinical records, review of facility policy/procedures and interviews for one of four sampled residents (Resident #149) reviewed for accidents, the facility failed to ensure medications were administered according to professional standards. The findings include: Resident #149's diagnoses included muscle weakness, primary open angle glaucoma bilateral, hypertensive heart and chronic kidney disease with heart failure and chronic kidney disease. The quarterly MDS assessment dated [DATE] identified Resident #149 was cognitively intact, had no behaviors, was independent with eating, was dependent for toileting, utilized a wheelchair for mobility, and received anticoagulant, antiplatelet, and hypoglycemic medications. The care plan dated 5/9/25 identified Resident #149 was at risk for pain related to limited mobility with interventions that included administer medications as ordered. The physician's order dated 5/1/25 directed Amlodipine 5mg 1 tablet every morning, Aspirin delayed release 81mg 1 tab every morning, Ferrous Sulfate 325mg 1 tab every morning, Flecainide 50mg 1 tablet to be administered every hours, multivitamin 1 tab every morning, Pioglitazone 30mg 1 tablet once a day, Metformin 1000mg 1 tab once a day, Metoprolol Succinate 50mg extended release once daily, Gabapentin 100mg 2 tablets once daily, Pataday once daily relief eye drops 0.2% 1 drop to each eye once a morning, Vitamin B-12 500mcg 1 tablet once daily. Observation on 5/12/25 at 11:15 AM identified Resident #149 in his/her room with a clear plastic medication cup containing four pills in it, administering the medication to himself/herself. Interview with Resident #149 at 11:15 AM identified that the nurse always leaves them for her to take when he/she is ready. Interview on 5/12/25 at 11:30 AM with RN#3 identified she leaves the medications often at Resident #149's bedside due to the fact the resident is not usually ready for them until sometime in the afternoon. She further identified that she should observe the resident take the medication and acknowledged that the resident does not have a self-administration order. Interview on 5/16/25 at 8:38 AM with the Nurse Manager (RN #5) identified medications for Resident#149 should not have been left at the bedside, and that when a nurse administers medication they should watch the resident swallow the medication to ensure it was administered appropriately. She further noted that even though Resident #149 was alert and oriented she did not have a self-medication order and therefore should not be administering the medication. Review of the medication administration record (MAR) for the 5/12/25 identified RN #3 had signed off the medications, but the resident had not taken the medication and RN #3 had not observed Resident #149 administer the medication. The facility did not provide a medication administration policy, although it was requested. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Self Administration of Medications by Resident policy identified that a resident may self-administer medications if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents.

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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 review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #26) reviewed for skin conditions, the facility failed to administer a treatment/medication as ordered. The findings include: Resident #26's diagnoses included heredity syndrome of bilateral lacrimal glands, dry eye disorder, and malignant melanoma of right upper eyelid. The quarterly MDS assessment dated [DATE] identified Resident #26 was cognitively intact, had no behaviors, required substantial/maximal assist with toileting, and was independent with eating. The care plan dated 4/24/25 identified Resident #26 was at risk for impaired skin integrity related to right upper eye lid malignant melanoma with interventions that included treatments as ordered with monitoring per protocol and as needed, and extremities to be assessed by the licensed staff daily on the 3pm -11pm shift. The physician's orders dated 5/1/25 directed Artificial Tears 1%, 1 drop to each eye twice daily; 8AM-11AM; 4 PM- 7PM. The orders further directed to cleanse the right shin and right calf with normal saline gently, pat dry, apply Adaptec (wound dressing) to the open areas followed by Hydrofera Blue (antibacterial wound dressing), cover with ABD gauze pad including top of foot and lightly wrap with kerlix. Interview with Resident #26 on 5/12/25 at 10:15 AM identified that on the second shift on 5/11/25 he/she did not receive his/her artificial tears or his/her treatment to the right leg. Resident #26 identified that he/she rang the call bell and when the call was answered someone said they would be back, and they never returned. After 11:00 PM when the third shift started Resident #26 rang the call bell again and told the third shift nurse that the eye drops and treatment had not been administered, and the third shift nurse completed the treatment for him/her. The Grievance/Complaint report dated 5/12/25 identified Resident #26 filed a complaint regarding not receiving the dressing change and eye drops as ordered on 5/11/25 and noted the 11PM-7AM nurse appeared frustrated that care was not performed on the prior shift. Review of the MAR for the month of May 2025 identified LPN #4 who worked the 3PM-11PM shift on 5/12/25 signed the MAR indicting that she had administered the eye drops and the treatment to the leg wounds. An interview with LPN #4 was attempted; however, LPN #4 did not return the phone call. Interview with the DNS on 5/14/25 at 12:25PM identified she was aware of Resident #26 not receiving care on 5/11/25 and processed the incident as a medication error. She further noted that LPN #4 was an agency nurse, and she had contacted the agency and requested LPN #4 not return to the facility (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 on 5/14/25 at 1:53 PM identified Resident #26 complained of not receiving the artificial tears and the treatment to the leg on 5/12/25 when he arrived on third shift. He identified that the dressing on the right leg reflected the date and time of the previous day, so he knew it had not been changed. He further identified that he completed the treatment to the left leg, but had not administered the eye drops because he was not made aware they had not been administered. Although a policy for medication administration was requested one was provided. The clean dry non-sterile dressing change policy directed dressing changes as ordered by the physician shall be performed by a licensed nurse.

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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 observation, review of the clinical record, review of facility policy/procedures, and interviews for two of three sampled residents (Residents #114 & #128) reviewed for pressure ulcers, the facility failed to ensure the necessary proper documentation of a pressure injury consistent with professional standards and failed to provide the necessary treatment and services to promote the healing of a pressure ulcer. The findings included: 1. Resident #114 has a diagnosis of Parkinson's disease. The significant change MDS assessment dated [DATE] identified Resident#114 had intact cognition, did not have behaviors, did not have range of motion impairments, required set up assistance with eating, required partial to moderate assistance with toileting hygiene, required substantial to maximal assistance with rolling to the left or right while in bed, did not ambulate, was at risk for the development of pressure ulcers but did not have any pressure ulcers. The assessment further identified that the resident weighed 155 pounds and had not experienced any weight loss within the past six months. The care plan dated 12/1/24 identified Resident #114 required the assistance of two staff members for transfers via Hoyer (mechanical lift) with an intervention for rehabilitation as ordered. The care plan further identified the risk for impaired skin integrity, due to decreased mobility, incontinence, and decreased sensory perception with interventions to include pressure redistribution devices on bed and wheelchair, assist with turning and repositioning every 2-3 hours per protocol, monitor skin integrity with morning care, evening care, bathing and report any changes in skin condition to charge nurse. Review of the treatment administration record (TAR) for the month of December/2024 directed to cleanse the coccyx with normal saline, pat dry, apply Calmoseptine twice per day. The nurse's note dated 12/1/24 at 3:33 PM identified Resident #114 was noted to have an excoriated area to the coccyx. The note further identified that the APRN was notified and an order to apply Calmoseptine (a multi-purpose moisture a barrier that protects and helps heal skin irritations) twice daily was obtained. The initial acquired wound report dated 12/20/24 completed by RN#9 identified Resident #114 had a Stage II pressure area to the sacral area that measured 0.5 cm in length by 0.5 cm in width. The area was further noted to have a small amount of drainage and mild pain. The nurse's note dated 12/20/24 at 8:59 PM identified the open area to the sacral area. The note further identified that the on-call APRN and nursing supervisor were notified. The note directed the administration of Calmoseptine cream to promote healing and protect the skin and indicated the concern was written in the APRN book for further assessment in the morning. Review of the TAR for the month of January/2025 identified a treatment order that directed to cleanse the coccyx (excoriation) with normal saline, pat dry and apply Calmoseptine twice daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	APRN #1's progress note dated 1/22/25 at 4:30 PM identified Resident #114 was seen. The note did not address the wound to the coccyx. APRN#1's progress note dated 2/3/2025 at 2:30 PM identified Resident #114 was seen for a DTI to the left heel. The only wound reviewed or mentioned in the note was the wound to the left heel. APRN progress note dated 2/5/2025 at 2:45 PM identified Resident #114 was seen for a follow up visit. The note mentioned ongoing treatment to the heel but failed to mention anything regarding the sacrum/coccyx. The wound Physician's progress note dated 2/5/2025 identified Resident #114 was seen for assessment of the left heel. The note did not address a wound to the coccyx/sacrum area. Review of the TAR for the month of February/2025 identified the treatment with the Calmoseptine was administered until a new order was implemented on 2/12/25. Facility wound tracking forms dated 12/27/24, 1/2/25, 1/9/25, 1/16/25, 1/23/25, 1/30/25 and 2/3/25 all identified a left heel wound but failed to identify a sacrum/coccyx wound inclusive of wound assessments. The wound Physician's progress note dated 2/12/25 identified Resident #114 was seen for the wound to the sacrum, and noted the treatment to the sacrum was changed to Calcium Alginate. The note further identified that this was the wound Physician's first time assessing the sacral/coccyx wound. Additionally, the wound was assessed to be a stage 3 pressure wound (a full-thickness skin loss injury that extends into the subcutaneous tissue, exposing fat) measuring 2.0 cm in length by 0.8 cm in width by 0.3 cm in depth with moderate serious exudate. The note further identified to turn side to side in bed every 1 to 2 hours and to order a group two mattress (a powered pressure reducing mattress used to treat pressure ulcers) if able. A physician's order dated 2/12/25 directed: clean the coccyx area with normal saline, dry, apply Calcium Alginate and cover with a dry clean dressing once daily. Review of the clinical record identified that the stage 2 pressure ulcer to the coccyx/sacrum was first identified on 12/20/24, but there was no weekly monitoring/assessment (inclusive of appearance, size, drainage) in place until the pressure ulcer was identified as a stage 3 on 2/12/25. The wound physician's progress note dated 2/19/25 identified the sacral/coccyx wound was unstageable (a full thickness tissue loss where the base of the wound is covered by a layer of dead tissue making it difficult to determine the actual depth and stage of the injury) due to necrosis, the measurements were noted as 4 cm by 4cm by 0.3cm. The treatment was changed from Calcium Alginate to Santyl with gauze island and a bordered dressing once daily. The wound physician's progress note dated 2/26/25 identified that a surgical excisional debridement was completed on the sacral/coccyx wound and the measurements were noted as 3.5cm by 4.0 cm by 0.4 cm with moderate serous exudate. The wound physician's progress note dated 3/5/25 identified a recommendation to culture the sacral/coccyx wound and to start Augmentin (antibiotic) 500mg/125mg by mouth every twelve hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/13/25 at 12:39 PM identified Resident #114 laying turned slightly to the right side in bed with pillow supporting the left arm. Resident #114 did not move or respond when spoken to. Observation on 5/16/25 at 11:50 AM identified the treatment to wound was completed as ordered. A nurse aide assisted with positioning the resident during the wound care. Interview on 5/19/25 at 10:54 AM with the Wound Nurse (RN #6) identified that the first notification made to the wound team concerning the sacral/coccyx wound was 2/13/25. RN#6 could not identify how she was notified of the wound but indicated that If a wound is mentioned in morning report or if staff sees something, she or the unit managers are supposed to be notified. RN#6 further identified that when an area is identified the resident should be seen by the wound physician. Interview on 5/19/25 at 11:33 AM with APRN#1 identified that the first time she saw the resident was in January of 2025. APRN#1 indicated she was not notified of a wound or excoriation. APRN#1 also indicated that she does not keep the communication pages of the APRN communication book and when she sees a resident for a communicated problem, she discards the paper that the communication is written on once she addresses the concern and therefore, was not able to provide any communication regarding Resident #114 from the APRN communication book. Interview on 5/19/25 at 11:48 AM with RN#9 identified that when a new skin condition is found on a resident it is usually reported to the nursing supervisor and put in the APRN's book so they can follow up. RN#9 checked her phone history and indicated that a text message to the RN supervisor (RN #8) notifying her of the open area along with a picture of the area had been sent she sent on 12/20/24 at 7:53 PM. Interview on 5/19/25 at 12:44 PM with the wound Physician (MD #2) identified that he provides a contracted service and the facility has the responsibility to request that he assess a resident's wounds. Interview on 5/19/25 at 2:07 PM with the Unit Manager (RN #5) identified that when a wound is reported, the nursing supervisor should go and assess the wound and document the assessment findings, the physician/APRN should also be notified via phone call or put in the communication book. The wound physician should also be notified of the wound so that the resident could be seen weekly by the wound physician. RN#5 further identified that the staging would be done by the physician and there should be an interim treatment put in place right away. Interview on 5/19/25 at 2:19 PM with RN #8 identified that was the nursing supervisor that worked on the 3pm-11pm shift on 12/20/24. RN #8 identified that she told the staff to notify the APRN via communication in the APRN book. She did not confirm receiving a text concerning Resident #114's pressure wound. Interview on 5/19/25 at 3:32 PM with RN#5 identified that he had not initially assessed the sacral/coccyx wound but noted that when he did see the wound, he observed a hole. He noted that he felt they missed something regarding the treatment and assessment of the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/19/25 at 5:15 PM with MD#2 identified he was first notified of Resident #114's sacral wound on 2/12/25 and staged it as a stage 3. MD#2 indicated that based on this staging, it should have been referred to the wound team sooner, but that is at the discretion of the facility provider and staff. MD#2 indicated that usually when wounds are open and cannot be managed by a simple skin treatment, they are referred to the wound nurse, who adds it to his schedule of patients to be seen. MD#2 identified he was not able to speak of the wound prior to his assessment, but indicated it was classified as pressure. Review of the facility policy for wound care documentation identified the documentation of wound appearance will be accomplished on a regular basis to identify initial condition of the affected area followed by weekly progress of wound healing and indicated that all residents will be assessed by the charge nurse for risk of skin breakdown using the Braden Scale on admission, readmission, major change in condition and quarterly thereafter. The policy identified that once identified, all wounds will be observed daily and progress or lack thereof documented weekly. Failure of the wound to demonstrate improvement/healing within 2-3 weeks requires reassessment of the treatment plan and referrals for lack of improvement will be initially referred to the nurse manager of the unit and then to the wound assessment team or APRN. The policy specifically outlines documentation to include: a. Site/location b. Stage (for pressure ulcers only) Wound healing is to be described by changes in the wound appearance and size, not by reverse/down staging. c. Size, including length, width and depth measured in centimeters. The length is listed first and identifies the measurement of the wound that is head to toe. The width is second and identifies the measurement of the wound that is side to side. Depth is third and identifies the deepest area of the wound bed. d. Appearance of the wound bed. Describes the tissue present in the wound bed. When there is a combination of tissue types they should be identified by the percentage present. The facility policy for treating and reporting wound acquired in the facility identified that an incident/accident report shall be completed for each wound that occurs in the facility and forwarded to the Director of nursing as soon as completed and that pressure areas shall be treated according to treatment protocols. The policy indicated that the nurse will document the acquired wound on the Initial acquired wound report, completing each section, signing and dating the form and immediately delivering it to the unit manager's office. On off shifts, the nurse will notify the nursing supervisor as well as place the completed form in the unit manager's office. 2. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #128's diagnoses included pressure ulcer of the sacral region, vitamin B12 deficiency, hyperkalemia, and iron deficiency anemia. The significant change MDS assessment dated [DATE] identified Resident #128 was moderately cognitively impaired, had no behaviors, required substantial to maximal assistance with bed mobility, transfers, and dressings, was dependent on staff for personal hygiene. The assessment further identified the Resident utilized a walker and wheelchair for mobility, and was at risk for the development of pressure ulcers but did not currently have any pressure ulcers. The care plan dated 10/16/24 identified Resident #128 was at risk for skin breakdown related to decreased mobility with interventions that included low air loss mattress, treatments as order by doctor, and incontinent care every two hours and as needed. The nurse's note dated 12/4/24 at 2:36 PM identified Resident #128 was seen by the wound physician for two new stage 3 pressure wounds, one located on the left heel, and one located on the genitalia; new orders were placed. The dietary note dated 12/6/24 at 9:48 AM identified Resident #128 had increased nutritional needs due to the new pressure wound and a recommendation was made for 30ml of protein supplement to be given twice daily to promote wound healing. The dietary note dated 1/2/25 at 10:50 AM identified Resident #128 had increased nutritional needs due to the ongoing pressure wound and a second recommendation was made for 30ml of protein supplement to be given twice daily to promote wound healing. The physician's order dated 1/2/25 directed liquid protein fortifier 1gram/6ml 30ml twice daily. The order was discontinued on 1/5/25. The physician's order dated 1/8/25 directed liquid protein fortifier 1 gram/6ml 30ml twice daily. Interview on 5/19/25 at 12:10 PM with the Dietician identified that she made the original recommendation on 12/6/24, but it was not implemented until the second time she made the recommendation on 1/2/25. She further identified that recommendations were placed in the APRN's book for review and then nursing would enter the order into the electronic medical record (EMR). She noted that this process changed at some point but could not identify when it changed. Additionally, she identified that the current process is that you hand the recommendation to the unit supervisor and then they follow up with the APRN/physician. Interview on 5/19/25 at 12:45 PM with the Unit Manager (RN #5) identified that the current process is the dietician hands a recommendation to the unit manager and the unit manager obtains the order from the APRN or physician and enters the order into the EMR. RN #5 further identified that if she is not working the recommendation is left in the APRN book. The APRN book typically does not have notes in it regarding dietary as it would be a paper that would be signed and then placed in the chart. RN #5 did not know what happened with the original recommendation and why it was not followed up on and noted that if it had been given to him he would have followed up on it. Review of Resident #128's clinical record (physical chart) on 5/19/25 at 12:50 PM failed identify signed dietary recommendation from 12/6/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the APRN book on 5/19/25 at 12:55 PM did not contain and reference to the dietary recommendation from 12/6/25. A request was made for a policy that addressed how dietary recommendations are processed but a policy was not provided. Review of the Pressure Ulcer Policy treatment protocols directed the dietician will assess the nutritional status of the patient and recommend nutritional supplementation when appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of four sampled residents (Resident #10) reviewed for accidents, the facility failed to ensure Resident #10 was free from accidents when transported in a shower chair. The findings included: Resident #10 was admitted to the facility in March 2023 with diagnoses that included heart failure, unspecified osteoarthritis, left hand contracture, muscle weakness and hemiplegia and hemiparesis following cerebral infarction. The quarterly MDS assessment dated [DATE] identified Resident #10 had intact cognition, had impairment on one side to the upper extremity, required extensive assistance with bed-mobility, and transfers and had a weight of 213 pounds (lbs.). The care plan dated 10/31/23 identified Resident #10 had a self-care deficit with interventions that included: extensive assist of one with personal hygiene, and bathing, independent with transfers with a walker, and ambulates independently with walker on unit. Occupational therapy note dated 12/7/23 identified Resident #10 was dependent for bed mobility, transfers and activities of daily living (ADL) and utilized a Hoyer lift (mechanical lift) for transfers. The physical therapy progress note dated 11/14/23 identified Resident #10 was dependent and required total assistance for transitions from supine to sitting position, it also identified total assistance of one or more persons was required for transfers. A nurse's note dated 12/12/23 at 10:47 PM identified that at approximately 6:45pm Resident #10 was being transported from the shower room via shower chair and when pushed over a raised area on the floor (door threshold), the resident sustained a fall from the shower chair. The note further identified that Resident #10 identified he/she hit the back of his/her head but was unable to say if it was hit on the floor or the back of the shower chair. An assessment at the time identified no swelling, bumps or redness to the back of the head. The note identified there were no apparent injuries, and range of motion to all extremities were within normal limits. Resident #10 denied pain and was sent to the acute care hospital for evaluation. Following the accident, an intervention was added to the care plan on 12/13/25 that instructed that for safety purposes, Resident #10 should be wheeled backwards when crossing thresholds. Interview on 5/13/25 at 12:42 PM with Resident #10 identified NA #6 was pushing him/her in the shower chair shower when the chair hit a threshold in the hallway and he/she fell from the chair and hit his/her head on something. Resident #10 further noted that he/she was sent to the hospital and was told everything was okay but noted that he/she had a persistent pain in the back of the head and sometimes in the neck. Resident #10 indicated, NA#6 was very upset and apologized. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/13/25 at 3:04 PM with the DNS identified the transport to and from the shower is included in the shower policy but could not identify what the requirement for staff is when using the reclining bariatric chair. Additionally, the DNS indicated the threshold on that unit had been replaced since the accident. Interview on 5/14/25 at 3:14 PM with NA#7 identified she worked at the facility for 37 years and indicated the facility utilized three different shower chairs: a regular shower chair with a seatbelt, a bariatric chair that does not have a seat belt, and a reclined chair used for residents who are not able to sit up or residents who have had a stroke or can't move easily on their own. NA#7 further identified that residents that require a Hoyer lift for transfers are transferred to the shower chair and transported to and from the shower room in the shower chair. NA#7 identified a Hoyer transfer requires 2 people and that sometimes the shower chairs are easier with 2 people but could not say with certainty that the shower chairs require 2 staff for transport. Interview on 5/14/25 at 3:20 PM with the Unit Manager (RN #5) identified he was uncertain how it is decided which shower chair the residents should use and indicated he was unsure if therapy assessed for shower chair use. Interview on 5/16/25 at 7:46 AM with NA#1 who has worked at the facility for 22 years, identified that all NA's receive training on shower chair use and that they had to sit in them to be moved so they would understand how it felt to the residents. NA#1 could not identify if any of the shower chairs required 2 staff to maneuver and indicated that she had worked on night shift for a long time and had not given showers in a long while. Interview on 5/16/25 at 8:35 AM with the Assistant Director of Rehabilitation (OT #1) identified therapy did not normally provide any education regarding shower chairs unless there was an identified problem related to use. OT #1 identified that he/she would print the assessments from admission through the fall and anything that was done in response to the fall. Interview on 5/16/25 at 9:50 AM with NA#6 identified she used the reclining shower chair to move Resident #10 to and from the shower room. NA#6 indicated that when rolling Resident #10 back to the room, the shower chair got caught on the threshold of the hallway where there used to be a rug and the back wheels went up and Resident #10 began falling out of the chair. NA#6 identified that after the incident the facility conducted an in-service and instructed that two people are required to move the reclining shower chair. The two back wheels went up and Resident #10 began falling out of the chair. NA#6 indicated that at the time of the incident, two people were required to move the shower chair but noted she had forgotten and moved Resident #10 by herself. Interview on 5/16/25 at 10:07 AM with the Staff Development Nurse (RN #7) identified that the facility does not do training on use of the shower chairs unless there is an incident. RN #7 indicated nursing assistants are trained to use shower chairs in school and after they are hired by the facility, they are monitored closely regarding job performance. RN #7 identified one staff is required to transport in the regular shower chair but was unable to identify staff needed for the bariatric or reclining shower chairs. Interview on 5/16/25 at 11:45 AM with NA#8 identified that if a resident is a Hoyer lift, they are an assist of two and when transporting to and from the shower in the chair it also requires two people and indicated this has always been like that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10's resident care card identified Resident #10 was non-ambulatory and required transfers via Hoyer lift with an assist of 2 staff. A review of the guide for use identified a 450 lb. weight capacity, but did not mention guidance for transporting residents in the chair. Although requested, the facility failed to provide education or competencies regarding shower chair use. The facility policy for bathing and grooming identified that residents who need a shower trolley should be transferred onto the shower trolley and transported to the shower room and when shower is completed, transport to residents room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, review of facility policy and procedures, and interviews, the facility failed to ensure medication carts were secured when not in use. The findings include: Observation on 5/15/25 at 6:03 AM on Station 2 (the secured unit), identified the 2 South medication cart located in the hallway had the lock in the unlocked position and the top drawer slightly opened. There were oxygen tubing packets on the top of the cart. The 2 North medication cart's lock was also in the unlocked position. Additionally, one resident was wandering the North hallway near the common area approximately 10 feet from the medication cart. The charge nurse was in the nurses' office and could not see the carts. Interview on 5/15/25 at 6:10 AM with LPN #15 identified that the carts should be locked when not in use and not within the line of sight of the nurse. Interview on 5/15/25 at 6:15 AM with the night shift Nursing Supervisor (RN #15) identified that the medication carts should always be locked when not in use. RN#15 indicated that if the nurse is passing medications and the cart is facing in toward the room, the cart could remain unlocked because no one can access it, but the cart should be locked at other times. Interview on 5/16/25 at 12:12 PM with the ADNS identified the medication carts should be locked when not in use or out of sight. Review of the facility policy for medication storage identified medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel, and indicated the medication cart was to be kept locked at all times when not in use or in direct view of the nurse.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of three sampled residents (Resident #106) reviewed for food, the facility failed to ensure menu choice items were available. The findings included: Resident #106's diagnoses included hyperlipidemia, dysphagia, gastro-esophageal reflux disease without esophagitis. The care plan dated 4/1/25 identified Resident #106 was at risk for potential nutritional risk related to advance age, nutritional related diagnoses including dementia, history of significant weight loss with interventions that included diet and snacks per physician orders, encourage and document intake of food and fluids, and offer appropriate/available substitutes if resident has problems with the food being served. The quarterly MDS assessment dated [DATE] identified Resident #106 was cognitively intact, was independent with eating, and had a mechanically altered, therapeutic diet. Physician's order dated 5/6/25 directed TLC (the therapeutic lifestyle changes diet is a dietary pattern recommended by the National Institutes of Health to lower cholesterol levels and reduce the risk of heart disease) diet, regular consistency, and nectar thick liquids. Observation on 5/12/25 at 12:05 PM identified Resident #106 in the main dining room with a plate with one hot dog on it, one apple juice and one cup of water. Review of the resident's meal ticket identified a printed ticket with Resident #106's name and the listed items of hot dog, [NAME] beans, potato chips, nectar thick apple juice and pickle. Interview on 5/12/25 at 12:10 PM with Resident #106 identified the kitchen is frequently out of stock of multiple items, the other items listed on the ticket were not available with no substitutions offered. Interview on 5/12/25 at 12:20 PM with [NAME] #1 who was serving from the steam table in Resident #106's dining room identified that there were no baked beans, no chips and no pickles available to serve to the resident(s). She was uncertain as to why the menu items were not available, she noted that she does not handle the ordering. Interview on 5/16/25 at 8:50 AM with the Food Service Director identified that Resident #106's chosen meal of hotdogs, baked beans chips and pickles were not on the menu as the main choice or the alternative for that day but rather the food items were selected from a menu of items that are always available. The choices are entered into meal tracker and then orders are ordered on Tuesday for a Friday delivery. There should have been chips delivered on Friday 5/9/25; however, he believed they were out of stock of them at that delivery. Review of the shipment delivered on 5/9/25 did not indicate that the items were ordered to be delivered with that delivery, nor did it show that the items were out of stock. He further noted that if when the person who entered the meal choice into the food tracker noted the items were not available, then the resident should have been notified. (continued on next page)

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	075063	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avery Nursing Home/Noble Building	705 New Britain Ave Hartford, CT 06106

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/19/25 at 12:01 PM with the Dietician identified that she attended the monthly food committee meetings and has heard of concerns from the residents regarding receiving their chosen menu items, but she identified that she mainly addresses nutritionally related concerns, such as why a resident can't have certain foods. She noted that if certain foods are unavailable, an appropriate substitution should be offered to the resident. Interview on 5/19/25 at 2:30 PM with the Administrator identified there is a monthly food committee meeting however no notes of the meetings were available because the Food Service Director did not take any. Although a Food ordering and Menu Choices policy was requested one was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on review of facility documentation, review of facility policy, and interview, the facility failed to provide documentation that environmental rounds were conducted on a quarterly basis. The findings include: Review of the environmental rounds documentation for the period of August 2023 through April 0f 2025 with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify any documentation that the environmental rounds were completed for the first quarter of 2024 which includes the months of January, February and March. Interview with RN #6 on 5/16/25 at 11:39 AM identified that environmental rounds are completed quarterly by the infection control nurse. She identified it was the responsibility of the previous infection control nurse to ensure that the environmental rounds were completed, as she had only started working in the role of the Infection Preventionist nurse in June of 2024. RN #6 further identified that she was unable to locate any documentation of the environmental rounds for the first quarter in 2024 that was completed. Review of the Environmental Round policy identifies that environmental rounds will be completed on a regular basis, by the charge nurses, supervisors, and departmental heads on their own units/departments, as well as by the infection control practitioner. The policy further identifies that a report will be generated by the Infection Control Practitioner and will identify areas of noncompliance.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for five of five sampled residents (Residents #29, #36, #46, #91, and #161) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was assessed/and administered and failed to offer the influenza vaccine. The findings include: Resident #29 was admitted to the facility in February of 2025 and had diagnoses that included anemia, hypertension, and hyperlipidemia. The admission MDS assessment dated [DATE] identified Resident #29 had moderately impaired cognition. The assessment further identified Resident #29 had not received the pneumococcal vaccine. Review of the immunization consent form provided on admission under Pneumococcal vaccine consent section indicated that Resident #29 had received the pneumococcal vaccine 23 (PPSV23) in 2020 in the past and signed by responsible party on 2/20/25. Review of Resident #29's clinical records with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify that he/she had received any of the pneumococcal vaccines while at the facility. The records also did not contain any documentation that the resident had refused the vaccine. Interview with RN #6 on 5/16/25 at 11:39 AM identified she had not administered or offered the pneumococcal vaccine to the residents. She identified it was her responsibility to offer and ensure that the resident's pneumococcal vaccine was up to date, but she had been busy as she was new to the role of an Infection Preventionist nurse. She further identified that Resident #29 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. Resident #36 was admitted to the facility in November of 2024 and had diagnoses that included anxiety, hypertension, and depression. The quarterly MDS assessment dated [DATE] identified Resident #36 had moderately impaired cognition. The assessment further identified that Resident #36 had not received the influenza vaccine. Review of Resident #36 immunization consents and records with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify that the influenza vaccine was offered to the resident, or the resident had received the vaccine prior to admission. Interview with RN #6 on 5/16/25 at 11:39 AM identified she was unable to locate any records of Resident #36 receiving the influenza vaccine whether at the facility or outside of the facility. She identified it was her responsibility to offer and ensure that the resident's influenza vaccine was up to date. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Influenza Prevention, Control, and Treatment policy identified if possible, all residents should receive inactivated influenza vaccine annually before influenza season, The policy further identifies in the event a new patient or resident is admitted after the influenza vaccination program has concluded in the facility, the benefits of vaccination should be discusses, educational materials should be provided and an opportunity for vaccination should be offered to the new resident as soon as possible after admission to the facility. Resident #46's diagnoses included schizoaffective disorder, anemia, and nutritional deficiency. The quarterly MDS assessment dated [DATE] identified Resident #46 had moderately impaired cognition. The assessment further identified that Resident #46 had not received the pneumococcal vaccine as it was not offered. Review of the immunization consent form provided on admission under Pneumococcal vaccine consent section dated 5/12/23 indicated that Resident #46 had received the pneumococcal vaccine 23 (PPSV23) on 11/25/25 in the past. Review of Resident #46's clinical records with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM f failed to identify that he/she had received any of the pneumococcal vaccines while at the facility. The records also did not contain any documentation that the resident had refused the vaccine. Interview with RN #6 on 5/16/25 at 11:39 AM identified she had not administered or offered the pneumococcal vaccine to the residents. She identified it was her responsibility to offer and ensure that the resident's pneumococcal vaccine was up to date, but she had been busy given that she was new to the role of an Infection Preventionist nurse. She further identified it takes a while to get in contact with the resident's representative as she had made several attempts previous for other vaccine consent from them which took numerous attempts, however throughout those attempts she did not offer/ request consent for the pneumococcal vaccine. Resident #91's diagnoses included vascular dementia, nutritional deficiency, and epilepsy. The quarterly MDS assessment dated [DATE] identified Resident #91 had severely impaired cognition. Review of Resident #91's clinical records with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify that he/she had been offered/received any of the pneumococcal vaccines while at the facility. The records also did not contain any documentation that the resident had past pneumococcal vaccination history. Interview with RN #6 on 5/16/25 at 11:39 AM identified she had not administered or offered the pneumococcal vaccine to the residents. She identified it was her responsibility to offer and ensure that the resident's pneumococcal vaccine was up to date, but she had been busy given that she was new to the role of an Infection Preventionist nurse. She further identified that Resident #91 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. RN #6 identifies she will need to reapproach families as often they would refuse, then consent to administer the vaccine later. She added that she had planned to complete a facility audit of the pneumococcal vaccine immunization but had not done the audit. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #161 was admitted to the facility on [DATE] with diagnoses that included hypertension, hyperlipidemia, and diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #161 had intact cognition. Review of Resident #161 immunization consents and records with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify that the pneumococcal vaccine was offered to the resident or assessed for past pneumococcal vaccination history. Interview with RN #6 on 5/16/25 at 11:39 AM identified she had not administered or offered the pneumococcal vaccine to the residents. She identified it was her responsibility to offer and ensure that the resident's pneumococcal vaccine was up to date, but she had been busy given that she was new to the role of an Infection Preventionist nurse and plans to completed a facility wide pneumococcal vaccine audit. Review of the Pneumococcal Vaccination for Patients policy identified that each resident or their responsible party will be asked on admission id they have previously had the Pneumococcal Vaccination, would like to receive it or declines the vaccine at the time. The policy further identified that adults with a previous vaccination with PPSV23 only should receive one dose of either PCV20 or PCV15 one year after last dose of PPSV23. In addition, the policy identifies adults with previous vaccination with PCV14 only or in combination with PPSV23 vaccination with PCV20 or PCV15 is not recommended and to follow previous vaccination schedule for PPSV23 (if PPSV23 is not available, one dose of PCV20 may be used.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, review of facility policy, facility documentation, and interview for two of five sampled residents (Resident #36 and Resident #46) reviewed for immunizations, the facility failedd to ensure that the COVID-19 booster vaccine was administered as requested by the resident/responsible party and offered on admission. The findings include: Resident #36 was admitted to the facility in November of 2024 and had diagnoses that included anxiety, hypertension, and depression. The quarterly MDS assessment dated [DATE] identified Resident #36 had moderately impaired cognition. The assessment further identified that Resident #36 was not up to date with the COVID-19 vaccination. Review of the COVID-19 Vaccine Consent form provided to resident on admission identified Resident #36 gave the facility permission on 12/6/23 to administer the COVID-19 Pfizer-BioNTech vaccine, however no consent was identified for 2024-2025 covid booster vaccine. Review of Resident #36 clinical records on 5/16/25 failed to identify that he/she received the vaccination or documentation that the resident refused the vaccine. Review of Resident #36's immunization consent records, with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM failed to identify that the COVID-19 booster vaccine for 2023-2024 was administered to the residnet and failed to identity that the COVID-19 booster for 2024-2025 was offered and administered to the resident. Interview with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM identified she was responsible for ensuring consents were obtained, physician's orders were obtained, and the vaccine were administered to the resident. RN #6 was unable to state why the resident was not offered the COVID-19 booster vaccine nor why it was not administered to the resident. Review of the COVID-19 Prevention , Control and Treatment policy in the COVID-19 vaccination section identified in the event that a new patient or resident is admitted after a vaccine clinic has taken plan an opportunity for vaccination should be offered to the new resident after admission to the facility and vaccines will be given as proper paperwork regarding previous COVID-19 vaccinations are available to the facility staff. Resident #46's diagnoses included schizoaffective disorder, anemia, and nutritional deficiency. The quarterly MDS assessment dated [DATE] identified Resident #46 had moderately impaired cognition. The assessment further identified that Resident #46 was not up to date with the COVID-19 vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the COVID-19 24-25 Vaccine Consent and Administration Record form identified Resident #46's responsible party gave the facility permission on 1/21/25 to administer the COVID-19 (Spike Vax) 2024 -2025 vaccine. Review of Resident #46 clinical records on 5/16/25 failed to identify that he/she received the vaccination or documentation that the resident refused the vaccine. Interview with the Infection Preventionist (RN #6) on 5/16/25 at 11:39 AM identified she was responsible for ensuring consents were obtained, physician's orders were obtained, and the vaccine were administered to the resident. RN #6 was unable to state why the resident was not offered the COVID-19 booster vaccine nor why it was not administered to the resident. RN #6 further identified she had difficulty obtaining consent from the resident's responsible party, however when consent was received, she only had administered one vaccine and given the COVID-19 2024-2025 vaccine as requested. Review of the COVID-19 Prevention , Control and Treatment policy in the COVID-19 vaccination section identified in the event that a new patient or resident is admitted after a vaccine clinic has taken plan an opportunity for vaccination should be offered to the new resident after admission to the facility and vaccines will be given as proper paperwork regarding previous COVID-19 vaccinations are available to the facility staff.