STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Saybrook	1775 Boston Post Rd Old Saybrook, CT 06475

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical records, review of facility policy, and interviews for two sampled residents (Resident #5, and #17) who had annual MDS assessments, the facility failed to ensure the assessments were completed. The findings include: 1. Resident #5's diagnoses included type 2 diabetes mellitus, cirrhosis of liver, and dependence on renal dialysis. The annual MDS assessment dated [DATE] identified the following assessment areas were incomplete: section C which indicates the resident's cognitive function, section D which indicates mood, and section E which indicates behaviors. Review of the clinical record failed to identify a note indicating a reason Resident #5's assessment was incomplete in the identified areas. Interview with the Corporate Director of Social Services (SW #1) on 1/8/25 at 11:20 PM identified she had been assisting in the facility since February 2024 but has been more involved in the last two months because the social worker position has been vacant during that time. She identified the social workers are responsible for completing section C, D, E and Q of the MDS assessment. She further identified that in the event the resident does not want to participate, the social worker should make additional visits to assess, if the resident refuses, then social worker should complete a progress note as to why the assessment was not completed. SW #1 further identified Resident #5's annual assessment should have been completed in all the designated areas. Although several attempts were made to interview the prior social worker on 1/8/25 and 1/9/25 they were unsuccessful. The MDS policy identified that the MDS will be completed in accordance with the procedures and directives outline in the MDS Resident Assessment Instrument (RAI) manual. The policy further identified The Resident Care Coordinator (RCC) shall determine the schedule of MDS assessments to be completed and notify all disciplines responsible for completing on the MDS. 2. Resident #17 was admitted to the facility in October of 2023 with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side. lymphedema, and other specified depressive episodes. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The annual MDS assessment dated [DATE] identified the following assessment areas were incomplete: section C which indicates the resident's cognitive function, section D which indicates mood, section E which indicates behaviors and section Q which indicates participation in assessment and goal setting. Interview on 1/5/25 at 2:13 PM with NA#8 identified the resident needs physical help but communicates with a tablet and was able to answer yes/no questions and make needs known. Observation and interview on 1/5/25 at 2:15 PM with Resident #17 identified the resident was able to communicate adequately with physical gestures, answered questions by shaking head or saying yes or no, and denied any problems with care. Interview on 1/8/25 at 12:20 PM with the Corporate Director of Social Work (SW #1) identified she had been assisting in the facility since February 2024 but has been more involved in the last two months because the social worker position has been vacant during that time. She identified the social workers are responsible for completing section C, D, E and Q of the MDS assessment. She further identified that in the event the resident does not want to participate, the social worker should make additional visits to assess, if the resident refuses, then social worker should complete a progress note as to why the assessment was not completed. SW#1's review of Resident #17's chart indicated there was no reason listed as to why the annual MDS was incomplete. Interview on 1/9/25 at 10:57 AM with the DNS identified SW#1 was aware of some of the concerns, but the facility had not identified some of the missing work until after the old social worker left. Unsuccessful attempts were made to contact the previous social worker who was responsible for completing the designated areas on the annual MDS assessment. The MDS policy identified that the MDS will be completed in accordance with the procedures and directives outline in the MDS Resident Assessment Instrument (RAI) manual. The policy further identified The Resident Care Coordinator (RCC) shall determine the schedule of MDS assessments to be completed and notify all disciplines responsible for completing on the MDS. 47900

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on review of the clinical record, review of facility policy, and interviews for one sample resident (Resident #53) reviewed for foot care, the facility failed to ensure the care plan was comprehensive and did not indicate resolved problems. The findings include: Resident #53 's diagnoses included type 2 diabetes mellitus, cerebrovascular disease, and hemiplegia and hemiparesis affecting right dominant side. Resident #53's care plan was dated 8/13/23 and there were no other dates on the care plan identifying when the care plan was reviewed or revised. The admission MDS assessment dated [DATE] identified Resident #53 had severe cognitive impairment and required assistance with activities of daily living ranging from set-up help to substantial assistance from staff. Review of the MDS assessments identified quarterly assessments dated 11/18/23, 1/19/24, 4/20/24, 5/25/24, and 11/1/24 were completed and an annual assessment dated [DATE] was completed. Further review of the care plan identified concerns that were no longer relevant, they included: the risk of bruising and abnormal bleeding related to the use of anti-coagulant therapy dated 8/14/23, a rash to bilateral groin dated 1/26/24, and skin impairment to the right ankle dated 8/29/24. Review of physician's orders for December 2024 did not identify treatment orders for a rash to the groin, or to the right ankle, and did not contain orders for anti-coagulant medication. The facility failed to provide documentation that Resident #53's care plan was reviewed and revised on at least a quarterly basis following the completion of the annual and quarterly MDS assessments. Interview and review of the care plan with RN #1 (MDS Coordinator) on 1/6/25 at 10:45 AM identified he was responsible for updating the resident care plan and the care plan should be reviewed at least quarterly after each MDS assessment. He identified that the electronic medical record indicates when the care plan was last reviewed. RN#1 could not provide any documentation of the last time Resident #53's care plan was reviewed. He further identified that he was not familiar with the facility's electronic health record system, so he has been documenting the review of the care plan on paper; however, he did not have a paper record that documented the review and/or revisions made to the care plan. In addition, RN #1 identified that Resident #53 was no longer receiving anti-coagulant medication, the bilateral groin rash was resolved, and the skin impairment to the right ankle was also resolved. He acknowledged that those problems should not be on the current care plan as concerns the resident is experiencing at the present time but should show as resolved. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the DNS on 1/7/25 at 1:30 PM identified RN #1 was responsible for reviewing the resident's care plan and she expects the resident's care plan to be reviewed and/or revised every quarter. She further identified, she is aware RN #1 is behind in updating the resident's care plan, but she was not aware that the care plan was not reviewed for a long time. The care planning policy identified a comprehensive and individualized plan of care will be developed for each resident. The care plan is reviewed and updated at least quarterly and as necessary to reflect changes in the resident's status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observations, review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for two sampled residents (Resident #24 and Resident #55) observed with medications at the bedside, the facility failed to ensure medications were administered as ordered and for one of three sampled residents (Resident #50) reviewed for choices, the facility failed to ensure medications were administered according to prescribed times. The findings include: 1. Resident #24's diagnoses included gastro-esophageal reflux disease without esophagitis (GERD), anemia, major depressive disorder and peripheral vascular disease. The quarterly MDS assessment dated [DATE] identified Resident #24 was cognitively intact, dependent on care for toileting hygiene, dressing and personal hygiene, was non-ambulatory and utilized a wheelchair for mobility. The monthly physician's orders for January 2025 directed Clopidogrel Bisulfate 75 milligram (mg) one tablet by mouth once a day for antiplatelet; Ferrous Sulfate Iron 325mg by mouth two times daily for anemia; Gabapentin 600mg one tablet by mouth three times daily for neuropathy; Protonix 20mg one tablet by mouth once daily for GERD; and Venlafaxine 75 mg one capsule by mouth once daily with Venlafaxine 150 mg capsule for depression; Multivitamin one tablet by mouth once daily for supplement. Observation on 1/5/2025 at 10:53 AM identified Resident #24 lying upright awake in bed with the bedside table over the bed. The bedside table contained a medicine cup containing 6 pills, a cup of water, and other personal items. Resident #24 indicated he/she was taking the medication the nurse left at the bedside. Observation on 1/5/25 at 10:55 AM with the DNS and the Charge Nurse (RN #7) identified Resident #24 was awake, lying in bed with the medicine cup containing 6 pills on the bedside table. The medications in the cup were identified as Resident #24's prescribed medications. Review of Resident 24's clinical records failed to identify a physician's order directing self-administration of medication or a completed self-administration assessment. Review of the electronic medication administration audit detail report dated 1/5/25 identified the medications scheduled for 9:00 AM with the exception of Protonix which was scheduled for 8:00 AM. The report identified the Protonix was signed off as having been administered at 7:26 AM and the resident of the scheduled medications were signed off as being administered at 9:23 AM. Interview with RN #7 on 1/5/25 at 10:55 AM identified she left the medications at the resident's bedside at 9:30 AM. RN #7 indicated she had parked the medication cart outside of the room in view of the residents to observe when they took the medication but may have been called away to attend to another resident. RN #7 identified she should not have left the medications at the resident's bedside as the resident did not have a self-administration order and it was her responsibility to ensure the resident takes the medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 1/5/25 at 11:10 AM identified medications should not be left at a resident's bedside who do not to have a self-administration order. The DNS further identified it is the expectation of the nurse to watch a resident take their medications and not to leave the medications at the bedside. The Medication Pass policy identified that the nurse should stay with resident until medications have been taken. The Medication Administration policy identified that documentation of the administration of medications should be completed immediately after giving the medication. 2. Resident #55 was admitted to the facility in the month of March 2024 with diagnoses that included anemia, hypertension, type 2 diabetes mellitus, and benign prostatic hyperplasia. The quarterly MDS assessment dated [DATE] identified Resident #55 had moderate cognitive impairment, required setup or clean up assistance with personal hygiene, independent with toileting hygiene, bed mobility and ambulation using walker. The care plan dated 12/24/24 identified Resident #55 was at risk for cardiac issues with interventions that included medications as ordered and vital signs as ordered. The monthly physician's orders for January 2025 directed Amlodipine Besylate 5mg by mouth two times daily for hypertension; Finasteride 5mg by mouth in the morning for prostatic hypertrophy; Hydralazine 25mg by mouth twice daily for hypertension; Metoprolol Succinate extended release 25mg by mouth in the morning for hypertension and hold for heart rate less than 55; and Protonix 40mg by mouth daily for indigestion. Observation on 1/5/2025 at 10:53 AM identified Resident #55 asleep in bed with the bedside table to the left of the bed, the left side of the bed and a medicine cup containing 5 pills, a cup of water, and other personal items. Observation on 1/5/25 at 10:55 AM with the DNS and the Charge Nurse (RN #7) identified Resident #55 asleep in bed with a medicine cup containing 5 pills, along with a cup of water was left at the bedside. RN #7 picked up the medication cup and woke the resident up to take his/her medications. The resident then took the medication cup from RN #7, poured all the medication into his/her mouth and drank the water. Resident #55 later stated he/she was unaware the medications were at the bedside. The medications in the cup were identified as Resident #24's prescribed medications. Review of Resident 55's clinical record failed to identify a physician's order directing self-administration of medication or a completed self-administration assessment. Review of the electronic medication administration audit detail report dated 1/5/25 identified the medications were scheduled for 9:00 AM were signed off as being administered at 9:22 AM. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Interview with RN #7 on 1/5/25 at 10:55 AM identified she left the medications at the resident's bedside at 9:30 AM. RN #7 indicated she had parked the medication cart outside of the room in view of the residents to observe when they took the medication but may have been called away to attend to another resident. RN #7 identified she should not have left the medications at the resident's bedside as the resident did not have a self-administration order and it was her responsibility to ensure the resident takes the medications.

Interview with the DNS on 1/5/25 at 11:10 AM identified medications should not be left at a resident's bedside who do not to have a self-administration order. The DNS further identified it is the expectation of the nurse to watch a resident take their medications and not to leave the medications at the bedside.

The Medication Pass policy identified that the nurse should stay with resident until medications have been taken.

The Medication Administration policy identified that documentation of the administration of medications should be completed immediately after giving the medication.

3. Resident #50's diagnoses included chronic systolic congestive heart failure, hypokalemia, hypothyroidism, and hypertension.

The admission MDS assessment dated [DATE] identified Resident #50 was cognitively intact, had no behaviors, required limited assistance with bed mobility and transfers, was dependent for personal hygiene and required moderate assistance with bathing. The assessment further identified the resident utilized a walker and a wheelchair for mobility.

The care plan dated 12/24/24 identified Resident #50 was at risk for cardiac/respiratory distress related to cardiac heart failure (CHF) with interventions that included, provide medications as ordered, and vital signs and weights as ordered.

Physician's orders dated 12/9/24 directed the following:

Amiodarone Hcl Oral tablet 200mg by mouth one time a day for CHF

Furosemide Oral Tablet 20mg by mouth one time a day for CHF

Lidocaine External Patch 4% Apply to left hip topically one time a day in the morning, and remove at night

Senior tab Multivitamins 1 tablet by mouth one time a day for nutrition deficit

Physician's order dated 12/11/24 directed the following:

Vitamin D oral tablet give 25mcg by mouth one time a day for vitamin deficiency Potassium Chloride ER oral tablet extended release 10 MEQ by mouth two times a day for hypokalemia do not crush, break, or chew

Levothyroxine Sodium oral tablet 50 mcg by mouth one time a day related to hypothyroidism.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/5/25 at 10:15 AM with Resident #50 identified he/she had been receiving medications late and identified that he had not yet received his/her medications. Observation on 1/5/25 at 10:25 AM identified LPN #2 passing medications to residents on Resident #50's unit. Interview on 1/5/25 at 10:30 AM with LPN #2 identified she was late in passing the medications and indicated she had been employed within the last month or two and was just getting into a flow of knowing who the residents were and their medications. LPN #2 acknowledged that she was aware that she had one hour before the scheduled time to one hour after the scheduled time to administer medications. A review of the nurse's notes from 1/5/25 failed to reflect there was a notification to the provider for medications administered late. Review of the electronic medication administration audit detail report from 1/1/25 to 1/8/25 identified the following medications ordered to be administered at 9:00 AM were administered at the following times: On 1/4/25 Lidocaine External patch was administered at 1:44 PM On 1/5/25 Amiodarone HCL 200mg was administered at 10:24 AM On 1/5/25 Furosemide 20mg was administered at 10:24 AM On 1/5/25 Senior tab multivitamin was administered at 10:25 AM On 1/5/25 Senna plus 8.5-50mg was administered 10:25 AM On 1/5/25 Vitamin D 25mcg was administered at 10:27 AM On 1/5/25 Potassium Chloride ER 10 mEq was administered at 10:27AM On 1/5/25 Lidocaine External patch was administered at 11:59 AM On 1/7/25 Potassium Chloride ER 10mEq was administered at 10:41AM On 1/7/25 Lidocaine External patch was administered at 10:40 AM On 1/7/25 Amiodarone Hcl 200mg was administered at 10:39 AM On 1/7/25 Vitamin D 25mcg was administered at 10:41 AM On 1/7/25 Senna Plus 8.6-50mg was administered at 10:41 AM On 1/7/25 Furosemide 20mg was administered at 10:39 AM On 1/7/25 Senior tab multivitamin was administered at 10:41AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/8/25 Lidocaine external patch 4% was administered at 11:36 AM Interview on 1/9/25 at 10:30 AM with the DNS identified medications are expected to be administered within a two-hour window of one hour before or one hour after the scheduled time of administration and noted she was aware that LPN #2 was new to the facility and that could be why LPN #2 was administering the medications outside of the administration parameters. The DNS further identified she would expect the nurse to notify the physician/provider when medications are administered late. Review of the medication administration policy directed medications to be distributed one hour before or one hour after the ordered time and to document all actions taken in the resident's medical record and notify the supervisor. 47900

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident #53) reviewed for foot care, the facility failed to ensure the resident was seen by a podiatrist. The findings include: Resident #53's diagnoses included type 2 diabetes mellitus. The Resident Care Plan (RCP) dated 8/14/23 identified Resident #53 was at risk for hypoglycemia related to type 2 diabetes mellitus. Care plan interventions directed to administer medications as ordered, wash and dry feet thoroughly, note any changes in skin condition, watch for sign and symptoms of hypoglycemia, and check blood glucose per physician order. The physician's orders for December 2024 directed for podiatry services as needed, the order's origination date was 8/14/23. The annual MDS assessment dated [DATE] identified Resident #53 had severe cognitive impairment, required extensive assistance with lower body dressing, toileting, and bathing. The nurse's note dated 9/10/24 at 2:01 PM identified Resident #53 had long toe nails and a request for podiatry services was sent to the podiatrist (podiatric service). The nurse's note dated 12/2/24 at 12:29 PM identified Resident #53 had long toe nails and a request for podiatry services was sent to the podiatric service contracted with the facility. Review of the clinical record from September 2024 through December 2024 failed to identify Resident #53 was seen by a podiatrist. Review of the documentation detailing the podiatric service's schedule identified the podiatrist made visits to the facility on [DATE] and on 12/31/24. Review of the list of residents seen by the Podiatrist on 10/28/24 and 12/31/24 identified Resident #53 was listed as Do Not Treat (DNT) related to missing information needed to process podiatry payment. Observation with LPN #2 on 1/6/25 at 1:20 PM identified Resident #53 lying in bed. LPN #2 removed the resident's shoes from both feet and all of his/her toe nails were approximately 0.6 cm in length from the toenail tip. Interview with Person #1 (podiatry customer service representative) on 1/6/25 at 12:10 PM identified she had the podiatry service request for Resident #53 dated 9/11/24. She identified that Resident #53 was flagged DNT because the facility had not provided the medical necessity for the request for podiatry services. She further identified the facility was notified Resident #53 had missing information that needed to be completed before podiatry services could start. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #2 on 1/6/25 at 1:30 PM identified the nursing staff was not allowed to trim toe nails for any resident with a diagnosis of diabetes mellitus. She identified that Resident #53 had long toenails and should have been referred to podiatry services. Interview with the DNS on 1/6/24 at 2:00 PM identified the facility has a standing order for podiatric services as needed and residents with a diagnosis of diabetes mellitus are offered podiatric services. She further identified that Resident #53 was noted to have long toe nails on 9/10/24 and again on 12/2/24 and should have been seen. She noted that the Podiatrist was in the facility on 10/28/24 and 12/31/24. Additionally, she identified that she received the podiatry schedule that indicated Resident #53 was labeled DNT because of missing information, but she did not follow through with the podiatric service provider to supply the missing information which is typically the medical necessity for podiatric services. The Ancillary Services policy identified that the facility would provide podiatry services as required by the resident's conditions. The ancillary services will be provided by the facility or through coordination with qualified external providers.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 48335 Based on review of facility documentation, review of facility policy and interviews for 2 of 3 nurses' aides reviewed (NA #4 & NA #9) the facility failed to ensure annual performance reviews were completed, the findings include: Review of NA #4's employee file on 1/8/25 identified he/she was hired on 9/12/1983. The file failed to contain an annual performance evaluation for 2023 or 2024. Review of NA #9's employee file on 1/8/25 identified he/she was hired on 4/20/2002. The file failed to contain an annual performance evaluation for 2023 or 2024. Interview on 1/9/25 at 11:02 AM with the Regional Nurse (RN #5) indicated the performance reviews for 2023 and 2024 had not been completed and she did not give a reason why they were not conducted. Interview on 1/9/25 at 11:41 AM with the DNS identified she is responsible for completing the performance reviews and she has not prioritized doing them. The DNS further noted that a monthly email is received from human resources (HR) that indicates which employees are due for performance reviews. The Performance and Review policy directed that a formal and documented performance review would be provided at the end of an employee's introductory period and at least annually thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075070	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

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Apple Rehab Saybrook	1775 Boston Post Rd Old Saybrook, CT 06475

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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 0842

Level of Harm - Potential for minimal harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47900

Based on review of clinical records, review of facility documentation, review of facility policy and interviews for two of five sampled residents (Resident #20 and Resident #53) reviewed for immunizations, the facility failed to ensure the resident's completed and signed vaccination consent forms were included in the medical records. The findings include:

1. Resident #20's diagnoses included anemia, acute respiratory failure with hypoxia, and heart failure.

The quarterly MDS assessment dated [DATE] identified Resident #20 was cognitively intact, dependent on care for toileting hygiene, dressing and required substantial or maximal assistance with personal hygiene. The assessment further identified Resident #20 was non-ambulatory and utilized a wheelchair for mobility.

Review of the electronic and paper clinical records failed to identity a copy of the COVID-19 booster vaccine consent form provided to the resident prior to the vaccine administration in June of 2023, and the paper clinical records identified vaccination consent forms that were not completed.

Physician's order dated 6/13/23 directed Pfizer COVID-19 Vac Bivalent Intramuscular Suspension (COVID-19 mRNA Bivalent Virus Vaccine (Pfizer)) inject 0.3 milliliters (ml) intramuscularly vaccine for a one time dose.

Review of the Medication Administration Record (MAR) for the month of June in 2023 identified Pfizer COVID-19 Vac Bivalent Intramuscular Suspension (COVID-19 mRNA Bivalent Virus Vaccine (Pfizer)) inject 0.3 ml was administered on 6/13/23 to the resident.

Review of the immunization record detailed report on 1/8/25 at 1:31 PM identified Resident #20 received the COVID-19 booster vaccine on 6/13/24 and consent was confirmed.

Although requested during the survey for Resident #20 immunization consent and vaccination records, the facility failed to provide any written consent signed by the resident/resident representative to administer the COVID-19 vaccine in 2023.

Interview with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/9/24 at 10:30 AM identified that they were unable to locate the consent form for the COVID-19 vaccine that was administer in 6/2023 after searching through the overflow records and the residents current clinical records.

2. Resident #53's diagnoses included type 2 diabetes mellitus, hypertension, and cerebrovascular disease.

The quarterly MDS assessment dated [DATE] identified Resident #53 was severely impaired cognitively impaired and dependent with care for toileting hygiene, personal hygiene, non-ambulatory and utilized a wheelchair for mobility.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the electronic and paper clinical records failed to identity a copy of the COVID-19 booster vaccine consent form provided to the resident prior to the vaccine administration in December of 2023, and the paper clinical records only identified vaccination consent forms that were not completed. Physician's order dated 12/12/23 directed Spikevax Intramuscular suspension 50 micrograms (mcg)/0.5 milliliters (ml) (COVID-19 (SARS-CoV-2) mRNA virus vaccine) inject one does intramuscularly one time for the prevention of COVID-19. Review of the Medication Administration Record (MAR) for the month of December in 2023 identified Spikevax Intramuscular suspension 50mcg/0.5 ml (COVID-19 (SARS-CoV-2) mRNA virus vaccine) was administered on 12/12/24. Review of the immunization record detailed report on 1/8/25 at 1:31 PM identified Resident #53 received the COVID-19 booster vaccine on 12/12/24 and consent was confirmed, and education was provided to the resident. Although requested during the survey for Resident #53 immunization consent and vaccination records, the facility failed to provide any written consent signed by the resident/resident representative to administer the COVID-19 vaccine in 2023. An attempt was made on 1/9/24 to interview the former IP but was unsuccessful, as he did not answer the call nor did he returned the phone call. Interview with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/9/24 at 10:30 AM identified that they were unable to locate the consent form for the COVID-19 vaccine that was administer to Resident #53 in December of 2023 after searching through the overflow records and the residents current clinical records. LPN #4 identified she was only able to locate the previous IP tracking sheet which indicated consent obtained. Interview with RN #6 and LPN #4 on 1/9/24 at 10:30 AM identified it was the practice and policy of the facility to obtain written consent from the resident/resident representative prior to administering a vaccine to a resident and a copy of the consent should be kept in the clinical records. LPN #4 further added that she would keep the signed vaccine consent forms in the IP's office but they are accessible to staff. Interview with the DNS on 1/9/24 at 11:18 AM identified vaccine consent should be kept in the resident's clinical chart after they are obtained as it is a part of the resident's record. Review of the Medical Records Retention policy identified that all medical records maintained, including electronic and paper records for all residents. The policy further identified that medical records will be retained for 7 years from the date of the resident's discharge or last encounter. Review of the COVID-19 vaccine policy identified the facility should obtained historical COVID-19 vaccination history and collaborate with the MD to determine appropriate vaccine needs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47900 Based on review of facility documentation, review of facility policies and procedures, and interviews, the facility failed to ensure that the infection prevention control program policies and procedures were reviewed annually, the facility failed to ensure that environmental rounds were conducted/completed quarterly, the facility failed to ensure Infection Control Surveillance data collection reports, analysis of infection trends within the facility were completed monthly, along with quarterly reports, and the facility failed to ensure documentation of quarterly water management plan meetings were conducted. The findings include: 1. Review of the facility's Infection Control Program Policies and Procedure manual for the period of August 2022 to December 2024 with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/7/25 at 11:41 AM identified that the policies and procedures manual was reviewed on 3/21/22 and 8/30/24 but failed to provide any documentation that the Infection Control Program Policies and Procedure manual was reviewed in 2023. Interview with RN #6 and LPN #4 on 1/8/25 at 1:31 PM identified the infection control policy and procedures manual should be reviewed annually, and it was the responsibility of the DNS and the Administrator to complete. RN #6 and LPN #4 further added that they were not working at the facility during the time for the annual review as she started working at the facility in May of 2024. Interview with the DNS on 1/9/25 at 11:18 AM identified she had not started working at the facility until November of 2023 and the facility had an infection control nurse at the time. A policy and procedure related to the annual review of the infection control policy and procedures manual was requested but was not provided. Interview with RN #6 and LPN #4 on 1/8/25 at 1:31 PM identified they were unable to locate a policy related to the annual review of the IP policy and procedure manual, but it was the practice of the facility to review the policy and procedure manual annually with a signature page consisting of the staff who reviewed the policy. 2. Review of the infection control environmental round documentation for the for the period of August 2022 to December 2024 with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/8/25 at 1:31 PM identified the quarterly environmental rounds were not completed for the last quarter in 2022, first quarter (January) of 2023, second quarter (April) of 2023, and third quarter (July) of 2023. Interview with RN #6 and LPN #4 on 1/8/25 at 1:31 PM identified they were unable to locate any documentation for environmental rounds completed in the last quarter of 2022, and the first three quarters of 2023. The LPN #4 and RN #6 further identified that environmental rounds are completed quarterly and it was the responsibility of the previous IP nurse to ensure they were completed, as LPN #4 only started working at the facility in May of 2024. Review of the Environmental Surveillance policy identified the Infection Preventionist and supporting department heads will complete environmental rounds quarterly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the infection control program for the period of August 2022 to December 2024 with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/7/25 at 11:41 AM failed to identify that monthly surveillance infection reports and analysis of infection trends were completed for August of 2022 to April of 2024, along with the quarterly reports for October 2022, January 2023, April 2023, July 2023, October 2023, January 2024 and April 2024. Review of the quarterly Medical Staff Meeting agendas and documentation provided for the first, the second, and the third quarter of 2023, as well as the first quarter of 2024, the facility failed to identify any documentation related to monthly rates, trends and analysis of infections within the facility that were presented at the Medical Staff Meeting by the Infection Preventionist. The facility also failed to provide the agenda or documentation presented at the last quarterly meeting in 2022. Interview with LPN #4 on 1/7/25 at 11:41 AM identified it was the responsibility of the IP nurse to identify, track and analyze infection rates within the facility monthly. LPN #4 further identified the monthly report and analysis data included the rate of healthcare/facility acquired infections and community acquired infections within the facility, and at the end of each month the total infection rate is calculated using a formula. RN #6 and LPN #4 identified that they had searched for the reports thoroughly, contacted the previous IP nurse, and was still unable to locate the previous reports and only have the ones LPN #4 had completed. Interview with the DNS on 1/9/24 at 11:18 AM identified it was the responsibility of the IP nurse to provide a written infection control report to present at the quarterly medical staff meeting, which should be submitted to the administrator prior to the meeting date. Interview with the Administrator on 1/9/25 at 11:26 AM identified all department heads are responsible for submitting their reports to present at the quarterly meeting prior to the meeting via an email, however, was unable to locate a report from the previous IP nurse. The Administrator added if the department head failed to provide her a copy of the report prior to the meeting it was their responsibility to ensure that she had received the written copy to attach to the minutes and agenda. Review of the Infection Surveillance Data Collection policy and procedure identified an infection surveillance form shall be completed by the infection control nurse (ICN) for each resident who has an infection and these reports shall be maintained on file by the ICN for a period of no less than three years. The policy further identified the data collected shall be analyzed monthly for trends and incorporated into the quarterly infection control report. 4. Review of the facility Water Management Plan and quarterly meeting minutes from August 2022 to December 2024 with the Director of Maintenance on 1/9/25 at 9:19 AM failed to identify any documentation of quarterly meetings held in October of 2022, January of 2023, July of 2023, and October 2023. Interview with the Director of Maintenance on 1/9/25 at 9:19 AM identified apart of the facility's water management plan/policy is to conduct a quarterly water management meeting, annual water sample testing and monthly flushing. The Director of Maintenance identified they were unable to locate the quarterly meeting minutes as the facility had a high turnover in Administrators, whose responsibility was to keep the water management plan binder with all the documents related to the water management plan including the meeting minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 1/9/24 at 11:26 AM identified that the facility should conduct water management meetings quarterly, however she was unable to locate the meeting minutes for 2023 and the last quarter of 2022. The Administrator further identified she had only started working at the facility since November of 2023 and it was the responsibility of the Administrator to kept the water management binder with all the meeting minutes. Review of the Annual Water Management Plan identified the facility to develop and assign water committee members and review plan and protocol on a regular/routine basis. Review of the Legionella Committee Member Meeting Agenda identifies members are recommended to meet quarterly to review plan.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 47900 Based on review of facility documentation, facility policy and interviews, during a review of the facility antibiotic stewardship program, the facility failed to ensure that the facility's antibiotic surveillance tracking report of antibiotic use, patterns and resistant trends was completed and reviewed at the quarterly medical staff meetings for a multidisciplinary collaboration. The findings include: Review of the antibiotic stewardship program for the period of August 2022 to December 2024 with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/8/25 at 1:31 PM failed to identify any documentation related to monthly review of the antibiotic stewardship program for the period of August 2022 to September 2023. Review of the quarterly Medical Staff Meeting agendas and documentation provided for, the first, the second, and the third quarter of 2023, and first quarter of 2024, the facility failed to identify any documentation related to infection control and antibiotic usage/antibiotic stewardship program within the facility that was presented at the Medical Staff Meeting by the Infection Preventionist. The facility also failed to provide the agenda or documentation presented at the last quarterly meeting in 2022. Interview with RN #6 and LPN #4 on 1/8/25 at 1:31 PM identified she was only able to locate the monthly Antibiotic Tracking tool and at risk meeting minutes from September 2023 to April of 2024. LPN #4 identified an antibiotic tracking form is completed monthly and reviewed at the weekly at risk meetings with the medical provider for feedback. LPN #4 identified the Infection Preventionist was responsible to provide a report at the quarterly medical staff meeting which included antibiotic usage and monthly infection rates. LPN #4 also indicated that the pharmacy and the laboratory vendor would provide additional data at the meeting. LPN #4 further added that she started the role of the facility's IP in May of 2024, and it would have been the responsibility of the previous IP to complete and present the reports at the quarterly medical staff meeting. Interview with the DNS on 1/9/24 at 11:18 AM identified it was the responsibility of the IP nurse to provide a written infection control report to present at the quarterly medical staff meeting, which should be submitted to the administrator prior to the meeting date. Interview with the Administrator on 1/9/25 at 11:26 AM identified all department heads are responsible for submitting their reports to present at the quarterly meeting prior to the meeting via an email, however, was unable to locate a report from the previous IP nurse. The Administrator added if the department head failed to provide her a copy of the report prior to the meeting it was their responsibility to ensure that she had received the written copy to attach to the minutes and agenda. Review of the Antibiotic Stewardship policy process included monitoring and reporting which is to track and report antibiotic use patterns and resistance trends and provide feedback to prescribers regarding adherence to guidelines and stewardship goals. Review of the Infection Surveillance policy identified that data collected shall be analyzed monthly for trends and incorporated into the quarterly Infection Control Report.

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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** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for two of five sampled residents (Resident #20, and Resident #55) reviewed for immunizations, the facility failed to offer and/or assess for pneumococcal immunizations upon admission and when offered the pneumococcal vaccine the facility failed to administer the vaccine as requested. The findings include: 1. Resident #20 was admitted to the facility in March of 2023 with diagnoses that included anemia, acute respiratory failure with hypoxia, and heart failure. The quarterly MDS assessment dated [DATE] identified Resident #20 was cognitively intact. Review of the immunization records for Resident #20 on 1/7/25 at 2:25 PM failed to identify that the pneumococcal vaccine was offered to the resident on admission. Review of the Pneumococcal Vaccine Consent form identified Resident #20 gave the facility permission to administer the pneumococcal based on the guidance provided by the Centers for Disease Control and Prevention (CDC) guidelines with the provider oversight on 10/15/24. Review of Resident #20 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision. Interview with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/7/25 at 2:25 PM identified that based on a review of Resident #20's pneumococcal vaccination history and CDC guidelines Resident #20 could have been offered either the PCV20 vaccine or pneumococcal vaccine PPSV23 on admission. LPN #4 identified that she had assessed and offered pneumococcal vaccine to Resident #20 in October of 2024 but was unable to identify why the vaccine was not given after she had obtained consent from the resident. 2. Resident #55 was admitted to the facility in March of 2024 with diagnoses that included anemia, hypertension, type 2 diabetes mellitus, and benign prostatic hyperplasia. The quarterly MDS assessment dated [DATE] identified Resident #55 had moderate cognitive impairment. The assessment further identified that Resident #55 did not receive the pneumococcal vaccine. Review of the immunization records for Resident #55 on 1/7/25 at 2:25 PM failed to identify that the pneumococcal vaccine was offered and/or assessed for past immunization. Review of the Pneumococcal Vaccine Consent form identified Resident #55 gave the facility permission to administer the pneumococcal based on the guidance provided by the Centers for Disease Control and Prevention (CDC) guidelines with the provider oversight on 9/30/24. Review of Resident #55 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Regional Director of Nursing Services (RN #6) and the Infection Preventionist (IP) Nurse (LPN #4) on 1/7/25 at 2:25 PM identified that based on review of Resident #55's pneumococcal vaccination history and CDC guidelines Resident #55 should have been offered the PCV20 vaccine on admission as he/she had no pneumovax that was given historically. LPN #4 identified that she had assessed and offered pneumococcal vaccine to Resident #55 in September of 2024 but was unable to identify why the vaccine was not given after she had obtained consent from the resident. Interview with the RN #6 and LPN #4 on 1/7/25 at 2:25 PM identified that on admission residents are assessed and offered the pneumococcal vaccination. LPN #4 identified the process for administering vaccine to the resident, a consent is received from the resident/the resident responsible party to administer the vaccine, then a physician's order is obtained, and the vaccine is administered by the IP nurse. Both LPN #4 and RN #6 was unable to locate a signed pneumococcal vaccination consent form that was completed on admission, as the form located in both Resident #20's and Resident #55's was not completed. LPN #4 further identified it was the responsibility of the previous IP nurse to assessed/offer the PCV20 vaccine or pneumococcal vaccine PPSV23 to the resident on admission as she had only started working as the IP in May of 2024. Review of the Pneumococcal policy identified residents or their responsible party will be offered the pneumococcal vaccine according to their specific eligibility that aligns with the current Center for Disease Control (CDC) Adult immunization schedule upon admission. The policy further identified the facility would document date and location of injection site, refusal and re-offer and historical pneumococcal vaccine administration in the medical record if given in the community.