STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075105	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrington Center for Nursing & Rehabilitation LLC	80 Fern Dr Torrington, CT 06790

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47900 Based on review of the resident council meeting minutes, review of facility documentation, review of facility policy and interviews, the facility failed to respond to concerns identified by the resident council regarding the need to speak with a Social Worker in the facility. The findings include: Review of the Resident Council meeting minutes dated 4/26/24, 5/31/24, 6/28/24, and 7/26/24 identified the expressed wish to speak with the Social Worker and although, there were designated resident council department response forms that were utilized to answer resident council requests, concerns and grievances, there were no resolutions identified to the residents' expressed aspirations and no indication that the social worker had attended any of the meetings to address the requests from the period of 4/26/24 through 7/26/24. The group interview held on 8/22/24 with nine members of resident council identified their on-going concern of wanting to speak with a social worker during their monthly resident council meetings and they further identified that it had been a while since they'd had a full-time social worker. Additionally, the Residents noted they were told that the facility was working on hiring someone for the position, but they still did not have a full-time social worker and their requests to see a social worker had not been obliged. Interview with the Director of Recreation on 8/22/24 at 2:15 PM identified that she is responsible for documenting the resident council minutes, completing the top portion of the Resident Council Department Response form and distributing the forms to the appropriate departmental heads. She identified that after the meeting concludes, the expectation is for the Resident Council Department Response form to be completed and returned to her within a week. The Director of Recreation further identified the concern of wanting a social worker was an ongoing concern of the residents that she has brought to the Administrator's attention, who has not addressed the concerns regarding the lack of a social worker at any of the resident council meetings. Interview with the Administrator on 8/22/24 at 2:52 PM identified the Director of Recreation provides him with the Resident Council Department Response forms after the resident council meetings and he returns the form within a week. The Administrator further identified that he is responsible for concerns related to the Social Worker. He noted that he made the Social Worker aware of the residents' requests to see the social worker, but he could not provide any information regarding the follow up with the resident council by the Social Worker or himself. (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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 8/26/24 at 1:31 PM with Social Worker #1 (employed from January 11 to May 1, 2024) identified that she started working at the facility in January of 2024 one day a week until April of 2024. During this timeframe she worked on money follows the person (MFP), discharges, PASRR (Preadmission Screening and Resident Review), Level of Consciousness (LOC) and some 72 hours initial assessments. She identified that she was not able to complete all the task as she was only in the building for one day and worked remotely if the facility had any concerns. Social Worker #1 identified when shown her timesheet for the time period of January 2024 through May 2024, that for most of those hours she was at another facility that was owned by the same company, when this facility would call with questions or concerns which she would address remotely. Interview with the Administrator on 8/26/24 at 2:54 PM identified that he could not recall if he had returned the Resident Council Department Response forms, as the issue of the Social Worker was an ongoing concern, and he was unable to recall if he notified the Social Worker at the time. Review of the Resident Council policy identified that a Resident Council Response form will be utilized to track issues and their resolution, and the facility department related to any issues would be responsible to address the item (s) of concern. The policy further identified that the Administrator would review minutes and any response from the departments within the facility and responses are presented at the next meeting, or sooner if indicated.

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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** 47457 Based on review of the clinical record, review of facility policy, and interviews for one of three sampled residents (Resident #27) reviewed for advance directives, the facility failed to accurately document the resident's life support choices. The acute care Hospital discharge summary dated 5/2/24 identified Resident #27's code status (directs the medical team to administer or withhold life support systems in the event of a cardiac or respiratory arrest) was: full resuscitation (all resuscitative and aggressive curative treatments are provided). Resident #27 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, dementia, and pneumonia. The Advance Directive form dated 5/2/24 and signed by the Resident #27's Representative and the Physician on 5/3/24 identified Resident #27's options for medical care and treatment were do not resuscitate (DNR) and do not intubate (DNI). Review of physician's orders from 5/2/24 through 8/22/24 directed Resident #27's code status was full code (resuscitate and directed to ensure Resident #27 signs the Advance Directive form and place a copy in the chart. The admission MDS dated [DATE] identified Resident #27 had severely impaired cognition. Interview and clinical record review with RN #3 on 8/22/24 at 9:43 AM failed to identify that the advance directive form and the physician's order were congruent. RN #3 indicated that Resident #27 was a full code on admission, and that the face sheet had been updated to reflect Resident #27's DNR/DNI status, but the physician's order was not updated to reflect the change. RN #3 further indicated that it was the responsibility of the charge nurse or nursing supervisor to update the orders when the advance directive form was completed. Interview with the DNS on 8/22/24 at 2:48 PM identified that when a code status is changed, she expects the order to be updated in the resident's clinical record by the charge nurse or RN supervisor. The Advance Directives policy directs that resident preferences regarding end-of-life decisions and medical decisions are always respected. Nursing reviews the advanced directive options and completes the form, the form is filed in the medical chart, and a doctor's order is written into the electronic medical record. The policy further identified that advance directives can be changed at any time by the appropriate party and in all cases, the decision of the individual resident and/or designee will be respected within the state and federal guidelines. These wishes will be brought to the attention of staff on the advance directives form and in the electronic medical record.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 17723 1. Based on observations, and interviews, the facility failed to provide a homelike, safe, and sanitary environment for two shower rooms on the central and middle unit and for the identified carpeted areas on the central unit. The findings include: Observation of the shower room area on 8/21/24 at 10:16 AM identified two of three shower rooms in the central shower area to have several items stored to include two rolling shower chairs stacked two high, six IV poles, a lounging shower chair, a utility cart, a cardboard box, and a black substance on the ceiling and a shower curtain with holes in it. The third shower room contained two rolling shower chairs. Observation on 8/21/24 at 10:25 AM of the south wing hallway identified several dark brown stains of unknown substance on the carpet. Interview with Resident #61 on 8/21/24 at 11:08 AM identified that she/he had an issue with the shower rooms being so cluttered and that it did not provide a homelike environment. The shower rooms had been like this for some time and was unsure if the two that were cluttered even functioned anymore, one had a leak at one point. Anytime someone had to go in the shower room they had to see all the clutter, and could not utilize the other shower areas, just one was able to be utilized. Also, the shower chairs that were utilized by the residents did not have a basin under them so when a resident is wheeled through the hallway in the shower chair they sometimes are incontinent of urine or feces and there are several stains on the carpet in the hallways due to this. Interview with NA#2 on 8/22/24 at 11:17 AM identified the one shower room was utilized a couple times each day, and that items had been stored in the shower for about two years. Interview with Housekeeper #1 on 8/22/24 at 11:25 AM identified that the black substance on the ceiling in the shower room was mold or dirt and was unsure when the area was last cleaned. Interview with the Maintenance Director on 8/27/24 at 1:45 PM identified the shower rooms were being utilized for storage due to the lack of storage in the building. The shower leaks in the wall and will be part of the remodel project where the wall will be removed to make a bigger shower. The rug in the hallway needs to be replaced as well and was unsure what the substance on the rug was. Interview with the administrator on 8/28/24 at 10:45 AM identified that the items were now cleaned from the shower area and the area has been cleaned, but the items were stored there due to lack of storage. Environmental rounds were conducted however just with a hot list and not a formal documentation. This list would then be given to whomever it was designated on the list to fix it. The showers were not identified to be an issue because they were being utilized for storage. Interview with the Infection Preventionist on 8/28/24 at 12:56 PM identified she did complete environmental rounds however did not list the shower room stalls on the environmental rounds as an issue due to the fact they had been like that for approximately two years, and it wasn't something new that jumped out at her. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Environmental Round Policy indicated it is the policy of the facility to provide a safe, clean, comfortable homelike environment in a such a manner to acknowledge and respect resident rights to the extent possible. This includes providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. the facility failed to provide a homelike, safe, sanitary environment for three of three showers sampled. The findings include: Observation of the shower room area on 8/21/24 at 10:16 AM identified two of three shower rooms in the central shower area to have several items stored to include two rolling shower chairs stacked two high, six IV poles, a lounging shower chair, a utility cart, a carboard box, and a black substance on the ceiling and a shower curtain with holes in it. The third shower room contained two rolling shower chairs. Observation on 8/21/24 at 10:25 AM of the south wing hallway identified several dark brown stains of unknown substance on the carpet. Interview with Resident #61 on 8/21/24 at 11:08 AM identified that she/he had an issue with the shower rooms being so cluttered and that it did not provide a homelike environment. The shower rooms had been like this for some time and was unsure if the two that were cluttered even functioned anymore, one had a leak at one point. Anytime someone had to go in the shower room they had to see all the clutter, and could not utilize the other shower areas, just one was able to be utilized. Also, the shower chairs that were utilized by the residents did not have a basin under them so when a resident is wheeled through the hallway in the shower chair, they sometimes are incontinent of urine or feces and there are several stains on the carpet in the hallways due to this. Interview with NA#2 on 8/22/24 at 11:17 AM identified the one shower room was utilized a couple times each day, and that items had been stored in the shower for about two years. Interview with Housekeeper #1 on 8/22/24 at 11:25 AM identified that the black substance on the ceiling in the shower room was mold or dirt and was unsure when the area was last cleaned. Interview with Maintenance Director on 8/27/24 at 1:45 PM identified the shower rooms were being utilized for storage due to the lack of storage in the building. The shower leaks in the wall and will be part of the remodel project where the wall will be removed to make a bigger shower. The rug in the hallway needs to be replaced as well and was unsure what the substance on the rug was. Interview with the Administrator on 8/28/24 at 10:45 AM identified that the items were now cleaned from the shower area and the area has been cleaned, but the items were stored there due to lack of storage. Environmental rounds were conducted however just with a hot list and not a formal documentation. This list would then be given to whomever it was designated on the list to fix it. The showers were not identified to be an issue because they were being utilized for storage. Interview with the Infection Preventionist on 8/28/24 at 12:56 PM identified she did complete environmental rounds however did not list the shower room stalls on the environmental rounds as an issue due to the fact they had been like that for approximately two years, and it wasn't something new that jumped out at her. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Environmental Round Policy indicated it is the policy of the facility to provide a safe, clean, comfortable homelike environment in a such a manner to acknowledge and respect resident rights to the extent possible. This includes providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 2. Observation on 8/21/24 at 9:53 AM of the Central unit shower room identified kit was filled with numerous items such as intravenous poles, rolling plastic cart (not for laundry), cardboard box, a bucket, a bedpan, and multiple ripped shower curtains. Observation on 8/22/24 at 11:15 AM of the Central unit shower room identified the following items: 4 intravenous poles, 1 unopened box sitting on the bottom of the intravenous pole, 1 rolling plastic cart that had a cardboard box on it, 1 bucket, and 1 bed pan. Observation on 8/22/24 at 9:03 AM of the Middle unit shower room identified it was untidy, and did not appear homelike. A rusty pipe was observed along the ceiling of the shower room, a dirty glove was on the floor, the ceiling light fixture cover was cracked and had a burnt-out light bulb, there was a ripped shower curtain that contained holes and was ripped along the top causing it to not be able to hang properly. In addition, there were also numerous areas of the shower room that appeared to be stained with rust and a brown substance. Interview with NA#2, on 8/22/24 at 11:17 AM identified that she utilized the both the Central and Middle shower rooms for residents. NA#2 identified that the Central shower room has had multiple items stored in it for over a month and that the facility was limited on storage. NA#2 identified that maintenance oversees maintaining the shower rooms, equipment and that the showers was not homelike. Interview with Housekeeper #1 on 8/22/24 at 11:25 AM identified that the brown substance was mold and Housekeeper #1 was unsure of when the Middle shower room was cleaned last. Interview with Maintenance Director on 8/22/24 at 11:39 AM identified that the Central shower room had parts that were used for storage because the facility was limited on storage. Also identified was that the Middle shower room brown substance was dirt and dust, had a cracked light cover, and a ripped shower curtain. Interview with Administrator on 8/22/24 at 2:49 PM identified that he was aware of the rusty wire cover, burnt out light bulb, and broken cover on overhead light and that they will be fixing those items. The Administrator identified that the Middle shower room was not homelike.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on clinical record reviews, review of facility documentation, review of facility policy, and interviews for two of two sampled residents (Resident #35 and #73) reviewed for hospitalization and discharge, the facility failed to provide the required notification of the transfer to the state Ombudsman's office. The findings included: 1. Resident #35's diagnoses included acute respiratory failure with hypoxia, chronic osteomyelitis, morbid obesity and cirrhosis of liver. The acute care hospital discharge summary dated 5/14/24 identified Resident #35 was hospitalized from 5/8/24 to 5/14/24 with diagnoses of parainfluenza and CRE (Carbapenem-resistant Enterobacterales, a group of bacteria that are difficult to treat and can cause serious infections and was on droplet precautions and also septic shock). A request for the Ombudsman's notice of transfers and/or discharges report for the month of May/2024 was made, but the facility was unable to provide the report. Interview with the Administrator on 8/26/24 at 1:22 PM identified that the Social Worker is responsible for sending the monthly report of residents transferred and/or discharged to the Ombudsman's office. He further identified that the report had not been sent to the Ombudsman since December/2023. Additionally, he noted that the facility had been sharing a social worker with a sister facility who only worked sixteen hours per week. Interview with Social Worker #1 on 8/26/24 at 1:30 PM identified she was on loan from another facility and did not have designated hours at this facility, but covered discharge or admission assessments. Social Worker #1 identified she was not making the Ombudsman notifications for the facility. Review of the Transfer/Discharge policy identified that when a resident is transferred or discharged , or hospitalized , the facility notifies the regional long term care Ombudsman using the long-term care portal. 2. Resident #73's diagnoses included venous hypertension with ulcer, inflammation of bilateral lower extremities, type 2 diabetes mellitus and atrial fibrillation. The admission MDS assessment dated [DATE] identified Resident #73 had moderate cognitive impairment, required moderate assistance for toileting hygiene, transfers, and maximal assistance with dressing and personal hygiene. RN #3's progress note dated 5/24/24 at 5:24 PM identified Resident #73 was discharged home Against Medical Advice (AMA), paperwork was signed acknowledging all risks factors involved. A request was made to the DNS on 8/27/24 for the monthly Ombudsman report for transfers and discharges for the last 6 months. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the documentation provided by the facility identified that the last report sent to the State Ombudsman office of residents who were transferred and/or discharged for the months of October 2023 and November 2023 was completed in November of 2023. Review of the facility's admission/discharge report for the month of December 2023 identified there were forty-nine residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of January 2024 identified there were thirty-six residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of February 2024 identified there were thirty-six residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of March 2024 identified there were forty-four residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of April 2024 identified there were forty residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of May 2024 identified there were fifty-nine residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of June 2024 identified there were twenty-four residents discharged and/or transferred from the facility. Review of the facility's admission/discharge report for the month of July 2024 identified there were thirty-three residents discharged and/or transferred from the facility. Interview with the Administrator on 8/28/24 at 11:21 AM identified that the Social Worker is responsible for sending the transfer/discharge report to the state Ombudsman's office monthly, but in the social worker's absence, the admissions person would be responsible. He identified that the last time the report was completed was in December of 2023 (although, the documentation provided indicated the last report was sent in November/2023) when the facility had a full time Social Worker. Additionally, the Administrator acknowledged that he had not instructed the admission's person to send the transfer/discharge report to the Ombudsman's office. On 8/27/24 (after surveyor inquiry) the facility updated the Ombudsman's office of all discharges and transfers that occurred during the period of December/2023 through July/2024. Review of the Transfer/Discharge policy identified that when a resident is transferred or discharged , the facility will notify the regional long term care Ombudsman using the long-term care portal. 47900

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility policy review, and interviews for 4 of 27 sampled residents (Resident #30, #35, #47, and #376) reviewed for resident assessment, the facility failed to ensure a yearly comprehensive assessment was completed. The findings include: Clinical record review of the following completion of the yearly comprehensive assessment identified: Resident #30 had an annual MDS assessment dated [DATE] the deadline for the completion date of the annual comprehensive MDS assessment was 6/3/24 (it should have been completed within 366 days of the last comprehensive assessment); however, the annual comprehensive assessment was not completed as of 8/27/24 making the assessment 85 days late at that point in time. Resident #35 had an annual MDS assessment dated [DATE]; however, the deadline for the completion date of the annual comprehensive MDS assessment was 8/8/24; however, the annual comprehensive assessment was not completed as of 8/27/24 making the assessment 19 days late at that point in time. Resident #47 had an annual MDS assessment dated [DATE] and a quarterly MDS assessment dated [DATE], the deadline for the completion date of the annual comprehensive MDS assessment was 6/14/24; however, the annual comprehensive assessment was not completed as of 8/27/24 making the assessment 74 days late at that point in time (it should have been completed within 92 days following the completion of the last quarterly and within 366 days of the last comprehensive assessment). Resident #376's was admitted to the facility on [DATE]. The admission MDS assessment was due by 7/26/24 and was not completed as of 8/27/24 making the completion of the comprehensive assessment 31 days late. Interview with LPN #3 (MDS Coordinator) on 8/25/24 at 10:30 AM identified that every resident should have a comprehensive assessment completed on admission, annually and/or when there is a significant change in condition. She identified that she is responsible for completing the comprehensive MDS assessments. She also identified that she is aware that the comprehensive assessments have prescribed time parameters for completion. In addition, she acknowledged that the comprehensive MDS assessments were late for Residents #30, #35, #47, and #376 because the facility did not have a full-time MDS person at that time and she began working in the MDS position on 7/15/24. Interview with the DNS on 8/25/24 at 11:30 AM identified that she was aware of the late MDS assessments for Residents #30, #35, #47, and #376. The facility's MDS policy identified that the facility conducts and submits the resident assessment in accordance with current federal and state submission timeframes. 47489 47900

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record reviews, facility policy review, and interviews for 21 of 27 sampled residents (Residents #1, #8, #9, #10, #13, #15, #21, #29, #32, #33, #40, #43, #49, #52, #57, #59, #61, #63, #64, #67, and #68) reviewed for resident assessment, the facility failed to ensure quarterly MDS assessments were completed timely. The findings include: Resident #1's quarterly MDS assessment dated [DATE] should have been completed by 6/20/24; however, the assessment remained in progress as of 8/27/24 making the completion of the MDS 68 days late as of that date. Resident #8 had a quarterly MDS assessment dated [DATE], which means the next quarterly MDS assessment should have been dated 6/8/24 and completed by 6/22/24; however, the assessment was not completed as of 8/27/24 making it 66 days late as of that date. Resident #9 had a quarterly MDS assessment dated [DATE], which means the next quarterly MDS assessment should have been dated 6/2/24 and completed by 6/16/24; however, the quarterly MDS assessment had not been completed as of 8/27/24 making it 72 days late. Resident #10 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/17/24 and completed by 7/1/24; however, the quarterly MDS assessment had not been completed as of 8/27/24 making it 57 days late. Resident #13 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/7/24 and completed by 7/21/24; however, the quarterly MDS assessment had not been completed as of 8/27/24 making it 37 days late. Resident #15 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/29/24, and completed by 7/13/24; however, assessment had not been completed as of 8/27/24 making it 45 days late. Resident #21's had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/11/24 and completed by 7/25/24; however, the quarterly MDS assessment had not been completed as of 8/27/24 making it 33 days late. Resident #29 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/1/24 and completed by 7/15/24; however, the assessment had not been completed as of 8/27/24 making it 43 days late. Resident #32 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/2/24, and completed by 7/16/24; however, the assessment had not been completed as of 8/27/24 making it 42 days late. Resident #33 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/2/34, and completed by 6/16/24; however, the assessment had not been completed as of 8/27/24 making it 72 days late. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrington Center for Nursing & Rehabilitation LLC	80 Fern Dr Torrington, CT 06790

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #40 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/22/24, and completed by 7/6/24; however, the assessment had not been completed as of 8/27/24 making it 52 days late. Resident #43 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/29/34, and completed by 7/13/24; however, the assessment had not been completed as of 8/27/24 making it 45 days late. Resident #49 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/28/34, and completed by 8/11/24; however, the assessment had not been completed as of 8/27/24 making it 16 days late. Resident #52 had an admission MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/12/24, and completed by 7/26/24; however, the assessment had not been completed as of 8/27/24 making it 32 days late. Resident #57 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/20/34, and completed by 8/3/24; however, the assessment had not been completed as of 8/27/24 making it 24 days late. Resident #59 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/29/34, and completed by 7/13/24; however, the assessment had not been completed as of 8/27/24 making it 45 days late. Resident #61 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/2/34, and completed by 6/16/24; however, the assessment had not been completed as of 8/27/24 making it 72 days late. Resident #63 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 7/3/34, and completed by 7/17/24; however, the assessment had not been completed as of 8/27/24 making it 41 days late. Resident #64 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/23/34, and completed by 7/7/24; however, the assessment had not been completed as of 8/27/24 making it 51 days late. Resident #67 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/15/34, and completed by 6/29/24; however, the assessment had not been completed as of 8/27/24 making it 59 days late. Resident #68 had a quarterly MDS assessment dated [DATE], which indicated that the next quarterly assessment should have been dated 6/13/34, and completed by 6/27/24; however, the assessment had not been completed as of 8/27/24 making it 61 days late. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with LPN #3 (MDS Coordinator) on 8/25/24 at 10:30 AM identified she is responsible for completing and submitting the MDS assessments. She also identified that she is aware that the MDS assessment is to be completed within 14 days of the assessment reference date. In addition, she acknowledged that the MDS assessments were late because the facility did not have a full-time MDS person, prior to her starting in the position on 7/15/24. She further identified that she completed the May 2024 MDS assessments and had started to work on the June 2024 MDS assessments. Interview with the DNS on 8/25/24 at 11:30 AM identified she was aware of the MDS assessments not being completed timely because the MDS nurse was on maternity leave. She further identified that the facility hired an outside consultant to help complete the MDS assessments. The Resident Assessment Instrument 3.0 user manual identified that the resident's assessment must be completed no later than the set assessment reference date (ARD) + 14 calendar days to be considered timely. The MDS policy identified that the facility conducts and submits the resident assessment in accordance with current federal and state submission timeframes. 47402 47489 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 - Minimal harm or potential for actual harm Residents Affected - Many	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 clinical record review, review of facility policy and interviews for nine sampled residents (#26, #27, #32, #43, #50, #61, #64, #69, and #376) reviewed for care planning, the facility failed to ensure the interdisciplinary team (IDT) resident care plan meetings were held following comprehensive and quarterly assessments and failed to ensure comprehensive care plans were developed by the IDT team with resident/family/responsible party involvement. The findings include: 1. Resident #26 admitted in the facility on 7/3/24 with diagnoses that included pericardial effusion, hypertensive heart disease with heart failure, orthostatic hypotension, atrial fibrillation, and implantable cardiac defibrillator. The admission MDS assessment should have been completed by 7/17/24 and the comprehensive care plan developed by the interdisciplinary team should have been developed by 7/24/24. Review of Resident #26's clinical record failed to identify that an interdisciplinary team care plan conference meeting inclusive of the resident and/or the resident's responsible party took place between 7/17/25 and 7/24/24. Interview on 8/26/24 at 11:00 AM with Resident #26 identified he/she had not seen the social worker since being admitted to the facility. Additionally, Resident #26 noted that he/she had not been invited or participated in a care plan meeting. Interview with LPN #3 (MDS Coordinator) on 8/25/24 at 10:30 AM identified she is responsible for completing and developing the resident care plans when a resident is admitted to the facility and an interdisciplinary care plan meeting is held to discuss resident goals of care. She further identified that the interdisciplinary care plan meeting and development of the comprehensive care plan should occur within 21 days of resident's admission in the facility. LPN #2 noted Resident #26 did not have a care plan meeting held because she just started in the position of MDS Coordinator, and they did not have a Social Worker to coordinate the care plan meetings. Interview with SW #1 (covering social worker) on 8/26/24 at 1:40 PM identified she was only in the building for one day and worked remotely if the facility had any concerns. Interview with the DNS on 8/27/24 at 10:30 AM identified that although, Resident #26 should have had an interdisciplinary care plan meeting held with the resident in attendance to discuss goals of care, no meeting had taken place, and the comprehensive care plan was not developed because they did not have an MDS Coordinator, and they did not have a full-time Social Worker to coordinate the meeting. The RAI user manual 3.0 identified that the comprehensive admission MDS needed to be completed on the 14th calendar day of the resident's admission (admitted + 13 calendar days), Care Area Assessment (CAA) also need to be completed on the 14th calendar day, and comprehensive care plan completion need to complete CAA completion date + 7 calendar days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Comprehensive care planning policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident. The policy further identified that the comprehensive care plan would be developed no later than 21 days after admission or day of the care planning meeting, whichever comes first. 2. Resident #27 was admitted to the facility on [DATE] with diagnoses that included pneumonia, dementia, and seborrheic dermatitis. The admission MDS assessment dated [DATE] identified Resident #27 had severely impaired cognition. The care plan dated 5/10/24 failed to identify that Resident #27 and/or his/her representative participated in choosing treatment options or were given the opportunity to have input in the development of the plan of care. Interview with Resident #27's representative on 8/21/24 at 12:25 PM identified that he/she had not yet attended a resident care conference but one was scheduled for the following day and he/she planned on attending. Interview with the DNS on 8/22/24 at 2:58 PM identified that resident care conferences were not being completed routinely, due to multiple staff changes in the facility's social work and MDS positions. The DNS further identified that while the facility had corporate support and the support of a consultant company, not having the social work and MDS positions filled with permanent employees created a break down in scheduling and implementing the resident care conferences. The DNS indicated that the facility had hired an MDS coordinator and that she had been in the position for less than one month and over the past 2 weeks had started to schedule and complete resident care conferences; including Resident #27's care conference, which was completed earlier that afternoon. The DNS further indicated that she would have expected Resident #27 to have had an initial meeting, completed within 72 hours of admission, and then another conference around Day 14. The DNS identified that the meetings include participation from various members of the interdisciplinary team, as well as the resident and resident representative. The facility's Resident Participation-Assessment/Care Plans policy directs the resident, and his/her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The resident and his/her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan. The policy further directs that the resident/representative's right to participate in the development and implementation of his/her plan of care includes the right to: participate in the planning process, identify individuals to be included in the planning process, request meetings, request revisions, participate in establishing goals and expected outcomes of care plan, participate in the type, amount, frequency and duration of care, receive the services and/or items included in the care plan, refuse, request changes to and/or discontinue care or treatment offered or proposed, be informed in advance of the risks and benefits of the care or treatment proposed, have access to and review the care plan, and be informed of, review & sign the care plan after any significant changes are made. Resident assessments are begun on the first day of admission and completed no later than the 14th day after admission, and a comprehensive care plan is developed within seven days of completing the resident assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Resident #32's diagnoses included Type 2 diabetes mellitus, anemia, and vitamin D deficiency. The quarterly MDS assessment dated [DATE] identified Resident #32 had intact cognition, required maximal assistance with personal hygiene, transfers and utilized a wheelchair for mobility. Resident #32's care plan identified that it was last reviewed and revised on 4/28/24. Interview on 8/22/24 at 10:30 AM with Resident #32 identified that he/she had not been invited and or attended a care conference meeting since 2023. Review of the care conference sign in records identified the last interdisciplinary care plan conference meeting was held on 8/2/2023. Review of the clinical record identified the resident had an annual MDS assessment dated [DATE], and quarterly assessments dated 12/18/23 and 4/1/23 (care plan conferences should have been held after each of the stated quarterly assessments as well as the annual assessment in September but were not according to the documentation and the interviews). Interview with Social Worker #1 on 8/26/24 at 1:31 identified she worked one day per week from January to April of 2024. SW#1 further identified that on a daily basis, there should be social work contact with the residents and at a minimum there should be monthly notes and quarterly reviews and participation in the quarterly care conferences. Interview with the Administrator on 8/22/24 at 2:52 PM identified that he was aware of the concerns that the residents had regarding not having a Social Worker in the building and that he was actively seeking a full-time social worker; however, he identified he had not had success in finding a qualified social worker to fill the position. Review of Comprehensive care planning policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative would develop and implement a comprehensive, person-centered care plan for each resident. The policy further identified that the IDT must review and update the care plan at least quarterly, in conjunction with the required quarterly MDS assessment. Review of the Resident Participation-Assessment/Care plans policy identified that the Social Service Director or designee was responsible for notifying the resident/representative and for maintaining records of such notices of the care conferences. 4. Resident #43's diagnoses included dementia, heart failure, depression, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #43 had severe cognitive impairment and required total assistance with dressing, toileting, hygiene, and transfers. Review of the clinical record and the care plan dated 3/9/24 on 8/27/24 identified that there had not been an interdisciplinary care conference (inclusive of the resident/responsible party) held to review and/or revise the comprehensive care plan. A care conference should have been held in July/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LPN #3 (MDS Coordinator) on 8/25/24 at 10:30 AM identified she is responsible for reviewing the quarterly care plans and scheduling the care plan conference meetings. She further identified that the care plan indicates the dates when it was last reviewed. In addition, she identified that care plan conferences are held at least every quarter where the care plans are all reviewed. Further, LPN #3 identified Resident #43's care plan was not reviewed because the facility did not have an MDS Coordinator. Interview with the DNS on 8/25/24 at 11:30 AM identified she was aware that the interdisciplinary care conference meetings were not being held every quarter and care plans were not being reviewed and/or revised because the MDS position had been vacant. The care plan policy identified that required assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 5. Resident #50's diagnoses included alcoholic cirrhosis of the liver, anxiety and respiratory failure. The quarterly MDS assessment dated [DATE] identified Resident #50 was cognitively intact, required set up for eating, required substantial assistance with bed mobility and utilized a manual wheelchair for mobility. review of Resident #50's care plan identified several revision dates throughout the document, the most recent reviewed and revised date was noted as 8/17/24. Interview on 8/21/24 at 10:46 AM with Resident #50 identified he/she had never been invited, attended and/or anyone discussed his/her plan of care with him/her. Interview on 8/22/24 at 12:11 PM with the Director of Nursing (DNS) identified that the position of Minimum Data Set Nurse had been filled for the past 3 weeks, the previous MDS nurse had taken a leave for about 4 months and in the interim, a consultant company was hired. She also identified that the facility was limited on having care plan meetings because the facility did not have a Social Worker employed in the building for a long time. Interview on 8/22/24 at 1:36 PM with LPN #3 identified Resident #50 had not had a care plan meeting held since being admitted to the facility (7/17/23). Review of the clinical record identified Resident #50 had an admission assessment dated [DATE], and quarterly assessments dated 10/23/23, 1/14/24 and 4/15/24. Interdisciplinary care conferences should have been held following each of these assessments (four in total) Review of Comprehensive care planning policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident. 6. Resident #61's diagnoses included Type 2 diabetes mellitus, and right and left below knee amputations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The annual MDS assessment dated [DATE] identified Resident #61 was without cognitive impairments, utilized a wheelchair, utilized set up or clean up assistance for eating, was independent for oral hygiene, toileting hygiene, and shower and bathing as well as upper body dressing. Resident #61's care plan dated 6/2/24 identified resident is at risk of an alteration in psychosocial wellbeing related to possible temporary room change and loud noise due to construction in building with interventions that included: assist the resident to a quiet area if one is available, afford the resident the opportunity to ventilate feeling and concerns regarding room change, and social work intervention as indicated to assist with resolution of concerns related to the change. Interview with Resident #61 on 8/21/24 at 10:30 AM identified he/she had not been invited and/or attended a care conference meeting or had anyone discussed his/or care plan with him/her since last year. Resident #61 further identified that he/she was interested in being considered for the Money Follows the Person (MFP) program and discharge to the community. He/she further noted that there had not been a Social Worker in the building to speak to about the above in the past year. Review of the care conference sign in records identified the last interdisciplinary care plan conference meeting was held was on 8/16/23 (Resident #61 was noted to attend) Review of the clinical record identified the resident had a quarterly MDS assessments dated 11/3/23, 1/29/24 and 3/22/24 (care plan conferences should have been held after each of the stated quarterly assessments as well as the annual assessment in June). Review of the social service notes identified that there were no notes documented after 2/22/24. Interview with Social Worker #1 on 8/26/24 at 1:31 identified she worked one day per week from January to April of 2024. SW#1 further identified that on a daily basis, there should be social work contact with the residents and at a minimum there should be monthly notes and quarterly reviews and participation in the quarterly care conferences. Interview with the Administrator on 8/22/24 at 2:52 PM identified that he was aware of the concerns that the residents had regarding not having a Social Worker in the building and that he was actively seeking a full-time social worker; however, he identified he had not had success in finding a qualified social worker to fill the position. The comprehensive care plan policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident. 7. Resident #64's diagnoses included type 2 diabetes mellitus, obstructive and reflux uropathy, depression, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #64 had severe cognitive impairment and required extensive assistance with dressing, toileting, hygiene, and transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the clinical record and the care plan dated 11/11/23 on 8/27/24 identified that there had not been an interdisciplinary care conference (inclusive of the resident/responsible party) held to review and/or revise the comprehensive care plan in March/2024 or July/2024 following the dates where MDS assessments were due to be completed. Interview with LPN #3 (MDS Coordinator) on 8/25/24 at 10:30 AM identified she is responsible for reviewing the quarterly care plans and scheduling the care plan conference meetings. She further identified that the care plan indicates the dates when it was last reviewed. In addition, she identified that care plan conferences are held at least every quarter where the care plans are all reviewed. Further, LPN #3 identified Resident #64's care plan was not reviewed because the facility did not have an MDS Coordinator. Interview with the DNS on 8/25/24 at 11:30 AM identified she was aware that the interdisciplinary care conference meetings were not being held every quarter and care plans were not being reviewed and/or revised because the MDS position had been vacant. The care plan policy identified that required assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 8. Resident #69 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction due to embolism, ischemic cardiomyopathy, and unspecified psychosis. The admission MDS assessment dated [DATE] identified Resident #69 had moderate cognitive impairment, utilized a walker and wheelchair for mobility, utilized set up or clean up assistance with eating, oral hygiene, moderate assistance with shower/bathing, personal hygiene and utilized moderate assistance with dressing. Review of the facility documentation on Resident's Care Conferences held for Resident #69 failed to identify that a Resident care conference was completed upon admission or thereafter. Interview with Resident #69 on 8/21/24 at 10:40 AM identified that he/she had not attended a care plan meeting since admission to the facility. Review of Resident #69's clinical record failed to identify that an interdisciplinary team care plan conference meeting inclusive of the resident and/or the resident's responsible party took place between 6/25/24 and 7/9/24. Interview with Social Worker (SW #1) (who worked from January 11th, 2024, to May 1, 2024) on 8/26/24 at 1:31 PM identified that she started working in the facility in January of 2024 only one day per week for 8 hours until April of 2024. During this timeframe she would work on MFP, discharges, PASSR, Level of Consciousness (LOC) and some 72 hours initial assessments. She identified that she was not able to complete all the task as she was only in the building for one day, and worked at another facility, which was owned by the same company, where she would be contacted to work remotely on urgent concerns for this facility. She further identified that the Administrator contacted her on 8/16/24 to return to the facility as he was unable to reach the previous Social Worker, hence her first day back was on 8/21/24. SW#1 identified that daily there should be social worker contact with the residents, minimum a monthly note and quarterly review for the resident care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 8/22/24 at 2:52 PM that he was aware of the concerns that the resident's had regarding not having a Social Worker in the building and that he was actively seeking a full-time social worker however had not had success in finding a qualified one. Review of the Social Worker hours from October of 2023 to August of 2024 with the Administrator on 8/26/24 at 1:30 PM identified the following: From October 16, 2023, to December 27, 2023, the facility had one full time Social Worker. From January 11, 2024, to May 1, 2024, the facility had one Social Worker who was not full time and was in the building 1-2 days weekly for 16 hours and would work remotely at times. From May 11, 2024, to August 14, 2024, the facility had one Social Worker who worked part time and was in the building infrequently at least twice weekly. Review of Comprehensive care planning policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident. The policy further identified that the comprehensive care plan would be developed no later than 21 days after admission or day of the care planning meeting, whichever comes first. 9. Resident #376 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, anxiety, depressive episodes, and extended spectrum eta lactamase (ESBL) resistance. The admission nursing assessment dated [DATE] identified Resident #376 was alert and oriented to person, place and time, required assistance with bed mobility, transfers, and dressing. The admission MDS assessment should have been completed by 7/26/24 and the comprehensive care plan developed by the interdisciplinary team should have been developed by 8/2/24. Review of Resident #376's clinical record on 8/26/24 failed to identify that an interdisciplinary team care plan conference meeting inclusive of the resident and/or the resident's responsible party took place between 7/26/24 and 8/2/24 (making the comprehensive care plan 24 days late at that point in time). Review of Comprehensive care planning policy directed the Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident. The policy further identified that the comprehensive care plan would be developed no later than 21 days after admission or day of the care planning meeting, whichever comes first. 47402 47457 47489 47900 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	48950

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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** 47489 Based on observation, clinical record review, review of facility policy, and interviews for one of five sampled residents (Resident #59) observed for medication administration, the facility failed to ensure that an extended-release medication was not crushed and that a physician's order was in place to administer crushed medications to a resident. The findings include: Resident #59's diagnoses included Alzheimer's disease, dysphagia, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #59 had severe cognitive impairment, required set up assistance for meals, had no swallowing difficulties and was on a therapeutic diet. The physician's order dated 5/7/24 directed regular diet, regular texture, thin liquids, magic cup every day with Boost (nutritional supplement), aspiration precautions, upright for all meals, set up for all meals, assist of one as needed for initiation. The orders further directed; Metoprolol Succinate tablet extended release 24 hr., 25mg, 1 tab by mouth once a day, Depakote Sprinkles delayed release capsule 125 mg by mouth once a day, Buspirone tablet 12.5 mg by mouth twice a day, Cranberry capsule once in the morning. The Care Plan dated 5/17/24 identified Resident #59 had dysphagia and was an aspiration risk with interventions that included: alternate liquids with solids, small sips and bites, monitor for signs and symptoms (s/s) of coughing and aspiration during meals, observe for s/s of respiratory infection from silent aspiration: cough, fever, wheeze, dyspnea, malaise, provide dietary consistency per physician's orders, provide supervision and assistance per therapy recommendations. Observation on 8/27/24 at 7:42 AM of medication administration identified LPN #7 prepared the following medications for Resident #59: 1 tablet of Buspirone 10mg, 1 tablet of Buspirone 5 mg, 1 capsule of Divalproex 125 mg delayed release,1 tablet of Irbesartan 300 mg, 1 tablet of Metoprolol Succinate 25mg extended release, and 1 Cranberry capsule 425 mg. LPN #7 placed the Buspirone, the Irbesartan, and the Metoprolol Succinate into a plastic envelope and crushed the medication, she then mixed the crushed medications into chocolate pudding and then opened the Divalproex and Cranberry capsules and sprinkled the contents onto the chocolate pudding mixture. She mixed all of the medications into the chocolate pudding and went into the resident room to administer the medications to Resident #59. Once LPN #7 approached the resident, this surveyor interrupted and asked to speak with LPN #7 in the corridor. Interview with LPN #7 identified Resident #59 did not have a physician's order to crush medications and noted that extended-release medications should not be crushed. She further noted that administering the medications mixed with pudding was a better way to administer the medications to Resident #59 because the resident chewed the medications. LPN #7 further identified that she did not know if this behavior had been reported to the physician. Observation of the medication administration following the interview and following LPN #7 pouring the same medications into a medication cup and administering them to the residents with water, identified the resident chewed the medications prior to swallowing them. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the RN Supervisor on 8/27/24 at 8:10 AM identified there is usually an order for medications to be crushed. The RN supervisor identified that aspiration precautions could indicate there are swallowing problems but there should still be an order for crushed medications, if that is how they are to be administered. Interview with the DNS on 8/27/24 at 9:05 AM identified medications should be administered whole unless there is an order for the medications to be crushed or the capsules opened. The aspiration precautions in the care plan do not indicate the medications should be crushed. Interview with Pharmacist #3 on 8/29/24 at 1:39 PM identified that there should be a physician's order if medications are to be crushed for administration. Pharmacist #3 identified that extended-release medications should not be crushed because they lose the extended-release properties and act faster than intended. The Metoprolol Succinate could cause decreased blood pressure. Pharmacist #3 further identified that Depakote Sprinkles can be opened and sprinkled but should be swallowed in the pudding and not chewed or crushed because it could change the timed effect and could affect the resident negatively. The Medication Administration policy identified a provider order is required before administration of any medication and should include the five rights: right person, right medication, right route, right dose, right time. Right route gives further direction to check the provider's order and ensure that the medication can be safely administered to the resident via this route.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, review of facility policy, and interviews for one of three sampled residents (Resident #26) reviewed for discharge planning, the facility failed to develop a discharge plan in a timely manner. The findings include: Resident #26 was admitted in the facility on 7/3/24 with diagnoses that included pericardial effusion, hypertensive heart disease with heart failure, orthostatic hypotension, atrial fibrillation, and implantable cardiac defibrillator. The initial care plan dated 7/4/24 identified the focused area of discharge planning with and intervention to evaluate short-term or long-term stay placement and social service evaluation. The admission MDS assessment dated [DATE] identified Resident #26 was without cognitive deficits, and required extensive assistance for toileting, hygiene, bed mobility, dressing, and transfers. The assessment further identified the resident received occupational and physical therapy and had a discharge plan in place. Review of social service progress notes from 7/3/24 to 8/27/24 failed to identify Resident #26 discharge plan was discussed with the resident. Interview on 8/26/24 at 11:00 AM with Resident #26 identified he/she had not had any interaction with a Social Worker since being admitted to the facility. Resident #26 further identified he/she had not participated in the care plan process and/or the discharge planning process. He/she further noted his/her goal was to return to the community but did not know at that point when this would occur or what was needed for this to occur. Interview with SW#1 (covering social worker) on 8/26/24 at 1:40 PM identified that the social worker is responsible for timely discharge planning, and it should start when a resident is admitted to the facility. She also identified that members of the interdisciplinary team should meet with the resident within 72 hours to discuss the resident's discharge plan. SW #1 further noted that the social worker ascertains the resident's living arrangements, equipment needed, resident support in the community and his/her primary care physician in the community to plan for effective discharge. The discharge planning is documented in the social service progress notes. Additionally, she identified that no discharge planning had been addressed for Resident #26 either in the social work progress notes or the comprehensive care plan. Interview with the DNS on 8/28/24 at 12:30 PM identified that discharge planning would start upon admission of the resident in the facility. The discharge planning would be documented in the progress notes and/or the coordination of discharge planning would be reflected in the care plan, and it would be updated as needed. She identified that Resident #26 did not have a discharge plan timely because the facility did not have a full-time social worker.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, review of facility documents, review of facility policy, and interviews for one sampled resident (Resident #69) reviewed for activities. The facility failed to provide weekend recreation activities. The findings include: Resident #69's diagnoses include cerebral infarction due to embolism, ischemic cardiomyopathy, and adjustment disorder with depressed mood. The admission MDS assessment dated [DATE] identified Resident #69 had moderate cognitive impairment, utilized a walker and wheelchair for mobility, utilized set up assistance with eating, and utilized moderate assistance with dressing. It further identified the resident did not have behaviors and it was somewhat important for him/her to read books, listen to music, have access to the news, have access to his/her favorite activities and to be able to experience fresh air. The care plan dated 7/8/24 identified Resident #69 preferred in room activities, with an interventions to offer transport to programs. Interview with Resident #69 on 8/21/24 at 10:35 AM identified he/she did not like that there were no activities offered through recreation on the weekends. Resident #69 further noted that although he/she sometimes prefers in room activities, he/she also prefers to attend group activities and would like the option of having weekend activities available. The resident further noted that there is no recreation staff working on the weekend and it is boring because he/she does not receive visitors. Review of the activities calendar for the month of August identified that the only activities noted for Saturday and Sunday were family visits. Interview with the Director of Activities on 8/27/24 at 2:15 PM identified there was no recreation programming on the weekend due to budgetary constraints. She noted that prior to the COVID pandemic there were two recreation staff members; one scheduled for twenty-four hours a week and one scheduled for eight hours a week, in addition to herself who worked forty hours a week. Further, she identified that post pandemic, she works 40 hours but is in charge of maintaining the website, going out to the community to promote the facility, is in charge of petty cash for the residents, and resident funds. Additionally, there is one other recreation staff member who works twenty hours a week (M-F 10 AM-2 PM). She noted that the estimated time per week she spends on recreation activities with the residents is about twenty hours per week and no extra hours are permitted per management. The Director of Activities further identified that she has spoken to the Administrator and the owner of the facility regarding the need for more hours/staff, and was told it was not in the budget. She added that she feels the residents get bored and restless on the weekends and feel that if they had more activities there may be fewer behavioral episodes. The Activity Programs policy directed activity programs are designed to meet the interests of and support the physical, mental and psychosocial wellbeing of each resident. Activities are scheduled 7 (seven) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs. Individualized and group activities are provided that: Reflect the schedules, choices and rights of the 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** 47457 Based on observations, review of the clinical record, review of facility policy and review of facility documentation for two of four sampled residents (Resident #1 and #27) reviewed for skin conditions, the facility failed to implement the neurologist's orders for over 3 months and failed to ensure a compression glove ordered for dependent edema and comfort was applied and removed, per the physician's orders. The findings include: 1. Resident #1's diagnoses included chronic obstructive pulmonary disease, Type 2 diabetes mellitus, dementia, and skin-picking disorder. The quarterly MDS assessment dated [DATE] identified Resident #1 had intact cognition, required set up assistance with eating, oral and personal hygiene, and upper and lower body dressing. The assessment further identified the resident was independent mobility but required supervision or touching assistance with shower transfers. Review of the clinical record identified a neurology consultant's physician's order dated 7/11/2024 that directed Primidone (a barbiturate medication that is used to treat partial and generalized seizures and essential tremors. It's common side effects include sleepiness, poor coordination, nausea, and loss of appetite. Severe side effects may include suicide and psychosis) was to be discontinued and the resident was to start Sinemet 10-100mg three times daily with meals for persistent tremor, due to the resident being poorly responsive to primidone. Review of the Medication Administration Record (MAR) for July 2024 identified two orders. The first was Primidone tablet 50 mg with directions to administer 1/2 tab to equal 25 mg as part of 75 mgs every night for tremors. This medication was administered every day in July with the exception of July 18th, where there was no indication of administered or not administered. The second order identified an order for Primidone tablet 50 mg with directions to administer 1 tablet by mouth every night for tremors as part of 75 mg dose at bedtime. The MAR identified this medication had been administered July 1 through July 10, 2024, and was marked not administered for the rest of the month. Physician's orders dated 8/1/24-8/27/2024 identified resident was prescribed Primidone tablet 50mg 1/2 tab at bedtime with instructions to take 25 mgs = 1/2 tab as part of 75 mg QHS for tremors. Review of the MAR for August 2024 identified an order for Primidone tablet 50 mg with directions to administer 1/2 tablet to equal 25mg at bedtime as part of 75 mg at bedtime for tremors. There were no additional orders for Primidone. There were not orders for Sinemet. Review of the neurology consultation progress note dated 8/8/2024 indicated Resident #1 was seen in July (2024) and Primidone was discontinued due to lack of therapeutic benefit, but Primidone had not been discontinued at that time. Recommendations were to trial Sinemet 10-100mg three times daily with meals for persistent tremor, poorly responsive to Primidone and Cogentin, and to discontinue Primidone at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident visit list dated 8/8/2024 indicated Resident #1 was seen as a follow-up to a visit on 7/11/2024 with recommendation to add Sinemet 10-100mg three times a day. Interview and record review with PA #1, neurology consultant, on 08/26/24 at 9:58 AM indicated when recommendations are made for a resident, PA #1 gives a list of the recommendations to the nursing supervisor to either make the changes when approved by the provider or write a note if it is something that won't be implemented. PA #1 indicated she made the recommendation on the resident visit list and gave it to the nursing supervisor. PA#1 identified she had been working at the facility for three years and that had been the practice. PA#1 further indicated the medication she wanted to discontinue wasn't at a high enough dose to be toxic or have negative side effects, but it was not providing a benefit to the resident and another medication might. Interview with RN#2 on 8/22/24 at 11:57 AM indicated the RN supervisor on shift is responsible for inputting the consultant recommendations. Additionally, RN #2 identified that the RN supervisors are able to be pulled to the floor to work and RN#2 also held other positions, Infection Control and Staff Development and that being pulled in several directions made it difficult to complete all tasks. In the event that something is not completed by one supervisor, it is passed on to the next shift. Interview and chart review with the DNS on 8/22/24 at 1:41 PM identified the supervisors on duty make sure the consultant or MD recommendations were reviewed or put in place. Review of the neurology visit for 7/11/24 with the DNS and it was indicated that the nursing supervisor should have changed the orders as directed at that time. Review of the facility policy for MD consults/Appointments identified the purpose of the policy was to ensure residents receive timely and coordinated care. Additionally, the policy identified follow-up included to review any instructions or recommendations provided and implement any necessary care plan changes or follow-up needed. 2. Resident #27 was admitted to the facility on [DATE] with diagnoses that included pneumonia, dementia, and seborrheic dermatitis. The admission MDS assessment dated [DATE] identified Resident #27 had severely impaired cognition, was dependent for lower body dressing and required moderate assistance with upper body dressing. The care plan dated 6/11/24 identified Resident #27 had cellulitis to the right upper extremity and was on antibiotic therapy with an intervention to observe and report signs of localized infection (localized pain, redness, swelling, tenderness, loss of function, and heat at the infected area). A physician's order dated 6/18/24 directed to apply a compression wrap to the right upper extremity during the day and remove nightly. A care plan intervention dated 7/4/24 directed to apply a compression glove to the right-hand during AM care, remove after 8 hours, hand wash the glove and allow to drip dry. Review of the Medication Administration Records (MAR) and the Treatment Administration Records (TAR) from 6/18/24 through 8/22/24 failed to identify documentation that the compression glove and/or wrap was applied during AM care, removed after 8 hours, hand washed and drip dried, and/or that the resident's skin was assessed for signs and symptoms of localized infection. (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 Resident #27's representative on 8/21/24 at 12:25 PM identified Resident #27 had occasionally complained that his/her right hand hurt and that sometimes the skin felt dry and itchy due to wearing the compression wrap. Observation on 8/22/24 at 1:50 PM identified the skin to Resident #27's right upper arm was intact, skin color was normal, sporadic dry patchy areas observed with no noted swelling. Interview and clinical record review with APRN #1 on 8/22/24 at 2:09 PM identified that in June Resident #27 was treated for cellulitis to the right upper extremity. APRN #1 further identified that she ordered a compression sleeve for dependent edema and comfort, which was to be applied in the morning and removed nightly. Interview and clinical record review with the DNS on 8/22/24 at 2:47 PM identified that the order to apply a compression wrap to the right upper extremity during the day and remove nightly was not entered into the system correctly so the task did not populate to the MAR or the TAR, therefore the nurses were not prompted to sign off the task; the clinical record failed to reflect daily documentation that the compression sleeve was applied during AM care and removed at night. The DNS indicated that there were 2 progress notes documenting the presence of the compression sleeve, but she would expect daily documentation to be in the clinical record upon applying and removing the sleeve. The DNS further indicated that, in addition to the weekly skin assessments, ordered by the physician, she would expect the area under the compression sleeve to be assessed every shift and documented on the MAR or TAR. The facility's Skin and Wound Management policy directs the following information should be recorded in the resident's medical record utilizing facility forms: the type of assessment conducted, the date/time and type of skin care provided, the name and title of the individual who conducted the assessment, any change in the resident's condition, the condition of the skin, how the resident tolerated the procedure and/or ability to participate in the procedure, any problems or complaints related to the procedure, and observations of anything unusual exhibited by the resident. 47489

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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** 46117 Based on clinical record review, facility policy review, and interviews for one of three sampled residents (Resident #36) reviewed for accidents, the facility failed to ensure adequate supervision was provided during toileting resulting in a fall. The findings include: Resident #36 was admitted to the facility with diagnoses that included Alzheimer's disease, schizoaffective disorder, spinal stenosis, and delusional disorder. The Resident Care Plan (RCP) dated 7/20/23 identified Resident #36 was at risk for falls related to decline in functional mobility. Care plan interventions directed to encourage resident to come and sit at the nurses' station, check wheelchair brakes and instruct on proper use, and provide assistance with toileting. A fall risk assessment dated [DATE] identified Resident #36 was not at high risk for falls. The annual MDS assessment dated [DATE] identified that Resident # 36 had severe cognitive impairment, required extensive assistance for toilet transfers, required total assistance with toileting hygiene, was frequently incontinent of bowel and bladder, utilized a wheelchair mobility, and had not sustained falls within the past three months but the care area of falls triggered, and the assessment indicated that it would be included on the care plan. The nurse's note dated 8/15/24 at 10:28 PM identified Resident #36 sustained an unwitnessed fall in the bathroom, while attempting to transfer himself/herself to an unlocked wheelchair. The note further identified Resident #36 had been left unattended in the bathroom while on the toilet. In addition, when discovered, Resident #36 was crying and complained of back pain when attempting to move. The note further indicated that the on-call Physician and the family were notified, and Resident #36 was sent to the acute care hospital to be evaluated. The nurse's note dated 8/16/24 at 12:45 AM identified Resident #36 returned to the facility and was alert and at baseline mentation, denied pain and/or discomfort; in addition, the hospital record identified that the Computed Tomography (CT) scan (a medical imaging to create 3D images of the inside of the body) for cervical spine, head, and lumbar spine without contrast were unremarkable. The note further noted that the resident was resting in bed and would be monitored. Interview with LPN #1 on 8/22/24 at 10:50 AM identified Resident #36 fell in the bathroom when NA#1 left the resident unattended while the resident was seated on the toilet. She identified that Resident #36 required assistance for toilet use and was not safe to be left alone in the bathroom. She further identified that NA #1 was a new nurses' aide and NA #1 was provided education to not leave the resident alone in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Rehabilitation Manager (OT #1) on 8/22/24 at 11:10 AM identified Resident #36 required assistance to use the bathroom and should not have been left alone in the bathroom. She also identified that Resident #36 was not safe to be alone in the bathroom and required supervision while using the toilet. She further identified that she was aware that Resident #36 had a fall in the bathroom because NA #1 left the resident alone in the bathroom. Interview with the DNS on 8/22/24 at 12:30 PM identified Resident #36 had a fall in the bathroom because NA #1 left the resident alone in the bathroom. She identified that Resident #36 should not be left alone in the bathroom and NA #1 was educated to not leave the resident alone in the bathroom. Interview with NA#1 on 8/23/24 at 10:40 AM identified that he transferred Resident #36 to the toilet and left the resident alone in the bathroom. He further identified that he was not aware that Resident #36 was not safe alone in the bathroom. The facility fall prevention policy identified that the facility would initiate interventions to prevent falls and reduce the risk of injury related to the fall.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record reviews and interviews for five sample residents (Resident #26, #35, #69, and #376) who required psychosocial support, the facility failed to ensure a Social Worker was available to meet resident needs. The findings include: 1. Resident #26 was admitted to the facility on [DATE] with diagnoses that included pericardial effusion, hypertensive heart disease with heart failure, orthostatic hypotension, atrial fibrillation, and implantable cardiac defibrillator. The RCP dated 7/4/24 identified Resident #26 was at risk for alteration in psychosocial well-being. Care plan interventions directed to encourage communication with visitation, monitor for psychosocial changes, observe and report any changes in mental status caused by situational stress, and provide opportunity to express feelings related to situational stressors. The admission MDS assessment dated [DATE] identified Resident #26 had intact cognition and required extensive assistance with toileting, hygiene, bed mobility, dressing, and transfers. Interview with Resident #26 on 8/26/24 at 11:00 AM identified he/she had not been seen by a social worker since his/her admission to the facility. Review of the clinical record failed to identify social service progress notes and /or social service assessments for the time period of 7/3/24 to 8/27/24. Interview with Social Worker #1 (covering social worker) on 8/26/24 at 1:40 PM identified that the Social Worker is responsible for evaluating residents upon admission to the facility and documenting in the progress notes. The Social Worker typically meets with the resident within 72 hours of admission to the facility and assesses needs such as the resident's community support, equipment that may be needed upon discharge, and any follow up necessary with the community physician. She further identified that the facility did not have a full-time social worker, and she only worked one day per week. Additionally, she confirmed that she had not seen Resident #26. 2. Resident #35's diagnoses included acute respiratory failure with hypoxia, other chronic osteomyelitis, morbid obesity and other cirrhosis of the liver. Review of the Social Service progress notes dated 1/31/2024, the last social service entry, indicated that an application for Money Follows the Person was submitted by Social Worker #1. The 5 day MDS dated [DATE] identified Resident #35 was cognitively intact, was dependent with toileting hygiene and transfers and required substantial/maximal assistance with lying to sitting or sitting to lying. Interview with Resident #35 on 8/21/2024 at 10:27 AM identified the resident was unhappy with care and follow up at the facility. Resident #35 identified he/she was waiting for updates on Money Follows the Person and was ready to be discharged from the facility over the previous year. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 6/1/2024 identified Resident #35 was very independent and self-scheduled medical appointments and contact with family. Resident #35 was care planned for ADLs and identified the resident was admitted for short-term rehab and expected to be discharged to the community with interventions that social work will utilize community resources to ensure a safe discharge. Interview with the Administrator on 8/26/2024 at 1:22 PM identified the facility hasn't had a social worker and identified SW #1 had been in the facility, since May, 16 hours weekly. Interview with Social Worker #1 on 8/26/2024 at 1:30 PM identified she had been intermittent, on loan, in this facility off and on over the last year but does not have dedicated hours. She indicated she was helping with discharges, getting caught up on admissions and significant things. SW #1indicated that discharge planning starts at admission and should be reflected in the care plan and social worker documentation. Additionally, she indicated that any resident with Money Follows the Person (MFP) there is a monthly meeting and there should be a monthly note or update In the progress notes. Specifically with Resident #35 there should have been a follow up with the resident regarding status of the MFP program, and at least a quarterly note. SW#1 indicated that based on the absence of social worker notes, it would appear that Resident #35 had not been interacted with since January. 3. Resident #69 was admitted to the facility on [DATE] with diagnoses included cerebral infarction due to embolism, ischemic cardiomyopathy, and unspecified psychosis. The admission MDS assessment dated [DATE] identified Resident #69 had moderate cognitive impairment, utilized a walker and wheelchair for mobility, utilized set up or clean up assistance with eating, oral hygiene, moderate assistance with shower/bathing, personal hygiene and dressing. The 48-hour baseline care plan dated 6/19/24 identified Resident #69 required assist with activities of daily living and functional mobility with interventions that included assist of one for bathing, bed mobility, personal hygiene and transfers. Interview with Resident #69 on 8/21/24 at 10:40 AM identified that he/she never had a care plan meeting upon admission and never saw a social worker since he/she has been admitted to the facility but has wanted to speak with a social worker. Review of the Social Worker progress notes from 6/18/24 to 8/27/24 failed to identify Resident #69 was seen or evaluated by the facility's Social Worker since admission. Review of the Social Worker hours from October of 2023 to August of 2024 with the Administrator on 8/26/24 at 1:30 PM identified the following: From October 16, 2023, to December 27, 2023, the facility had one full time Social Worker. From January 11, 2024, to May 1, 2024, the facility had one Social Worker who was not full time and was in the building 1-2 days weekly for 16 hours and would work remotely at times. From May 11, 2024, to August 14, 2024, the facility had one Social Worker who worked part time and was in the building infrequently at least twice weekly. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 8/22/24 at 2:52 PM identified he was aware of the concerns that the residents had regarding not having a Social Worker in the building and that he was actively seeking a full-time social worker however had not had success in finding a qualified one. Interview on 8/26/24 at 1:31 PM with Social Worker #1 (who worked from January 11 to May 1, 2024) identified that she started working at the facility in January of 2024 one day per week for 8 hours until April of 2024, when shown her timesheet for the time period of January 2024 through May 2024, Social Worker #1 identified that for most of those hours she was at another facility that was owned by the same company and would work remotely if this facility had any questions or concerns. She further identified that the Administrator contacted her on 8/16/24 to return to the facility as he was unable to reach the previous Social Worker, hence her first day back was on 8/21/24. SW#1 further identified that there should be daily contact with the residents with a note written monthly in the resident's record at minimum. The Social Worker job description provided by the facility identified that the Social Worker provides direct clinical case work and group work services to residents and their families through supportive services, participate in resident assessment process and discharge planning, available to deal with psycho-social-emotional or with family-related problems of the residents as they arise during the resident's stay in the facility, and interviews resident/family to obtain biographies, psychological and social history. 4. Resident #376 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, anxiety, depressive episodes, and extended spectrum eta lactamase (ESBL) resistance. The admission nursing assessment dated [DATE] identified Resident #376 was alert and oriented to person, place and time, required assistance with bed mobility, transfers, and dressing. The RCP dated 7/14/24 identified Resident #376 was at risk for alteration in psychosocial well-being with interventions that included: encourage communication with visitation, monitor for psychosocial changes, observe and report any changes in mental status caused by a situational stress, and provide opportunity to express feelings related to situational stressor. Interview with the Resident #376 on 8/26/24 at 1:40 PM identified he/she requested to see a Social Worker when first he/she was first admitted to the facility and has to date not been seen by the Social Worker. Review of the clinical record failed to identify social service progress notes and /or social service assessments for the time period of 7/12/24 to 8/27/24. Interview with the Administrator on 8/22/24 at 2:52 PM that he was aware of the concerns that the resident's had regarding not having a Social Worker in the building and that he was actively seeking a full-time social worker however had not had success in finding a qualified one. Review of the Social Worker hours from October of 2023 to August of 2024 with the Administrator on 8/26/24 at 1:30 PM identified the following: From October 16, 2023, to December 27, 2023, the facility had one full time Social Worker. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	From January 11, 2024, to May 1, 2024, the facility had one Social Worker who was not full time and was in the building 1-2 days weekly for 16 hours and would work remotely at times. From May 11, 2024, to August 14, 2024, the facility had one Social Worker who worked part time and was in the building infrequently at least twice weekly. Interview on 8/26/24 at 1:31 PM with Social Worker #1 (who worked from January 11 to May 1, 2024) identified that she started working at the facility in January of 2024 one day per week for 8 hours until April of 2024, when shown her timesheet for the time period of January 2024 through May 2024, Social Worker #1 identified that for most of those hours she was at another facility that was owned by the same company and would work remotely if this facility had any questions or concerns. She further identified that the Administrator contacted her on 8/16/24 to return to the facility as he was unable to reach the previous Social Worker, hence her first day back was on 8/21/24. SW#1 further identified that there should be daily contact with the residents with a note written monthly in the resident's record at minimum. On 8/28/24 (after surveyor inquiry) Resident #376 was seen by SW #1 who wrote a progress note that identified Resident #376 needed to return to the community and was requesting a referral for Money Follows the Person (MFP). The Social Worker job description provided by the facility identified that the Social Worker provides direct clinical case work and group work services to residents and their families through supportive services, participate in resident assessment process and discharge planning, available to deal with psycho-social-emotional or with family-related problems of the residents as they arise during the resident's stay in the facility, and interviews resident/family to obtain biographies, psychological and social history. 47402 47489 47900

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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. 47900 Based on observations, review of facility policy and procedures, and interviews, the facility failed to ensure expired medications were not in use and removed from the medication cart, and failed to ensure medications were stored according to the manufacture's recommendation. The findings include: Observation of the South unit's medication cart with LPN #5 on 8/27/24 at 10:10 AM identified an opened bottle of Lorazepam Intensol concentrate 2 milligram/milliliter (mg/ml) containing a label that identified the medication was ordered for Resident #13. The bottle contained 1.75 ml of liquid and contained instructions that the medication should be stored in the refrigerator and once opened should be discarded after 90 days. The bottle was labeled with an opened date of 7/19/24 but did not contain a discard date. Interview with LPN #5 on 8/27/24 at 10:30 AM identified the medication was being administered daily to Resident #13. She further noted that the medication is stored in the refrigerator until it is opened but once it is opened, it is dated and stored in the medication cart, but was unsure for how long it could remain opened and unrefrigerated in the cart. Interview with the Pharmacist (Pharmacist #1) on 8/27/24 at 1:15 PM identified Lorazepam Intensol Concentrate should be stored in the refrigerator but if opened and in use the medication can be stored at room temperature for 30 days and discarded after 30 days. The Pharmacist further identified that best practice is to follow the manufacture's guidelines to maintain the drug integrity and potency. The observed bottle of Lorazepam Intensol Concentrate contained an opened date of 7/19/24 and should have been discarded on 8/18/24, but was still in use nine days nine days after the date that it should have been discarded. Resident #13's physician orders for the month of August 2024 directed to administer Lorazepam Intensol Concentrate 2mg/ml by mouth 0.25ml every eight hours for anxiety disorder. The Controlled Drug Receipt and Record sheet identified that Resident #13 was administered Lorazepam Intensol Concentrate 0.25 ml at 6am, 2pm and 10pm daily from August 19, 2024, to August 27, 2024. Interview with the DNS on 8/27/24 at 1:45 PM identified that the Lorazepam should had been stored in the refrigerator. She further identified that she would contact the provider immediately for a new prescription and remove and discard the Lorazepam medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the South unit medication room refrigerator on 8/27/24 at 10:20 AM with Charge Nurse (LPN #5) identified an affixed locked box with the refrigerator thermometer read 40 degrees Fahrenheit that contained: One unopened bottle of Morphine Sulfate Oral Concentrate (Opioid) 100mg/5ml that contained 30ml for Resident #37 and had a manufacture's label that stated to store at 68 to 77 degrees Fahrenheit, room temperature and two unopened bottles of Morphine Sulfate Oral Concentrate (Opioid) 100mg/5ml that contained 15ml each for Resident #43 and had a manufacture's label that stated to store at 68 to 77 degrees Fahrenheit, room temperature. Interview with LPN #5 on 8/27/24 at 10:30 AM identified that she was unaware of whether the Morphine Concentrate should be stored in the fridge as the controlled medication lock box in the cart was full. LPN #5 indicated that she did not receive the medication from the pharmacy and the Morphine Sulfate medication was in the fridge during the shift-to-shift count, and during the count nurses would match the medication amount on hand with the controlled substance disposition record for accuracy. Interview with the Pharmacist (Pharmacist #1) on 8/27/24 at 1:15 PM identified that when medications such as the Morphine Concentrate is stored outside of the normal recommended temperature it can cause crystallization of the medication resulting in changes to the drug integrity and potency. He identified that it was best practice to follow the manufacture's guidelines, and that the pharmacy would affix a label on the medication which indicated the appropriate storage requirements. Interview with the DNS on 8/27/24 at 1:45 PM identified that the medication was stored incorrectly and should be in the cart. She also indicated that she would have to call the pharmacy as the drug may not be effective. Review of the Medication Storage policy and procedure identified that medications should be stored in accordance with the manufacturer's specifications. The policy and procedure further identified that prior to and after opening all medications, that the medication would expire on the date specified by the manufacturer on the product label, unless the manufacture has specifically indicated a shortened expiration once opened on the product label itself.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47489 Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure proper hand hygiene was utilized by staff and failed to ensure the infection prevention and control policies were reviewed and signed annually. The findings include: 1. Observation on 8/21/24 at 11:52 AM identified LPN #6 performed hand hygiene, donned gloves, and obtained a blood glucose level via glucometer from Resident #35. She then removed her gloves and went into the corridor to discard the used lancet into the sharps container and clean the glucometer with a bleach wipe. Interview with LPN #6 at the time of the observation identified that she forgot to wash her hands following the removal of her gloves and noted that she held the lancet in her ungloved hand because they are not allowed to wear gloves in the corridor. She further noted that the lancet has a safety cover on it. She further noted that she usually brings the treatment cart to the door of the room. Observation on 8/27/24 at 8:02 AM of the medication pass with LPN #7 identified LPN #7 completed hand hygiene prior to preparing medication for Resident #23, administered medications, performed hand hygiene in the resident room and exited the resident's room. LPN #7 then returned to Resident #23's room to complete the medication administration as the resident had not swallowed the medications completely. LPN#7 had to get more water for the resident and encouraged the resident to swallow the medication. LPN #7 then left the room, returned to the medication administration cart and began preparing medications for Resident #28. When asked about hand hygiene, LPN#7 identified that she should have completed hand hygiene after leaving Resident #23's room. LPN #7 performed hand hygiene and continued preparing the medication for Resident #28. LPN #7 administered medications to Resident #28 and returned to the medication administration cart and began preparing medications for Resident #59. LPN #7 popped 3 pills, Buspirone 10mg and 5mg and Divalproex 125mg capsule, for resident #59 when another resident, Resident #1, had a reported emergency, had slipped to the floor, and the NA was requesting LPN #7 to respond to the room. LPN#7 secured the medication and the cart and responded to Resident #1's room, physically assisted Resident #1 off of the floor and then returned to the medication cart and began preparing Resident #59's medications. LPN#7 then went into Resident #59's room and attempted to wake her. LPN#7 was stopped because of the preparation of medications. After leaving the room and returning to the cart and proceeded to access the computer. When asked, LPN #7 identified that hand hygiene should have been performed after contact with a resident and going in or out of resident rooms. Interview with the RN #2 on 8/27/2024 at 8:10 AM identified hand hygiene should be provided in between tasks or patient care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Infection control policies with the DNS and RN #2 on 8/27/2024 at 10:39 AM identified LPN #6 discussed infection control and glucometer use with the DNS and LPN#6 should not have carried the lancet bare handed and should have discarded the lancet in the resident's bathroom sharps box and washed hands with soap and water. The DNS also identified staff should be performing hand hygiene before and after patient care. Review of facility annual training and competencies identified LPN #6 and #7 both participated in annual competency training in June 2024 which included glucometer use and hand hygiene. The facility policy for Performing Hand Hygiene identified hand hygiene, either use of the hand sanitizer or hand washing, should be performed before and after resident care, and immediately after exposure to bodily fluids The facility policy for medication administration identified that staff should always wash hands before preparing or administering medications. 2. The facility policy for the IPCP identified the IPCP is reviewed at least annually and whenever the Facility Assessment is reviewed. The Facility Assessment 2023 identified 1 person designated as the Infection Control/Staff Development as one position and Lists RN #2 as holding that position. Additionally, the Infection Control section of the policy identified the Infection Control preventionist as a staff member not employed by the facility since February 2024. The Infection Control Policy Manual was reviewed 1/31/2024 and signed by the Administrator, Director of Nursing, and the Medical Director. The policy is not singed by the Infection Preventionist, nor is the facility able to provide signature pages from 2023 or 2022. Interview with the DNS on 8/27/2024 at 12:00 PM identified she was not able to locate the signature pages from 2023 or 2022.

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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. 47489 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 form was completed as directed and failed to ensure that the reports presented at the monthly and quarterly medical staff meetings contained the Antibiotic Stewardship review. The findings include: A review of the Antibiotic Stewardship program for the past two years with the DNS and the Infection Preventionist (RN#2) on 08/27/24 at 10:39 AM identified RN#2 had been the IP since the end of May, beginning of June 2024. The DNS indicated RN#2 had other duties that she is responsible for including weekly IP reports and is able to work remotely to complete these tasks. RN#2 indicated her practice for infection control included surveillance but was unable to show the tracking/surveillance when asked. RN#2 identified Antibiotic stewardship is tracked monthly and used McGeer's criteria to tract they labs are reviewed and checked off in the antibiotic stewardship book but the labs are not included in the book. RN#2 indicated that she reviewed the labs in the chart and marks on the stewardship book whether they are within range, however, was not able to produce the stewardship book. Interview with the DNS on 8/28/24 at 1:14 PM identified that Antibiotic stewardship is discussed at the Interdisciplinary Team meetings. However, she then identified that the meeting minutes do not document what exactly is discussed in the meetings and I am still attempting to locate the antibiotic stewardship paperwork. The DNS was able to provide antibiotic stewardship review from Trident care from 1/1/2022 to 12/31/2022 She had already given me the 10/23 through the 2/24 and identified that she was not able to locate anything that would identify they were reviewed or discussed. Review of the facility policy for antibiotic stewardship identified Antibiotic stewardship activities included regular review of antibiotic utilization patterns and sensitivity patterns at the committee meeting, including reports from the laboratory on sensitivity and resistance patterns over time (quarter, year, past years), and review of antibiotic utilization over time.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47489 Based on observations, interviews, facility documentation, and policy for the facility Infection Prevention position, the facility failed to ensure the Infection Preventionist had appropriate time to complete IP duties at the facility. The findings included: The Facility Assessment 2023, signed on 1/31/2024, identified RN #2 as the team member holding the Infection Preventionist/Staff Development position. Additionally, the Infection Control section of the Facility Assessment identified the facility conducted an infection control risk assessment yearly, which evaluated and determined the risk or potential vulnerabilities within the resident population and the surrounding community. According to CT Public Act 22-58 identified that each nursing home with more than 60 residents shall employ a full-time Infection prevention and control specialist and that each infection prevention and control specialist worked on a rotating schedule that ensures the specialist covered each eight-hour shift at least once per month. Review of the facility Monthly schedules from May 16th, 2024 through September 4th, 2024 identified RN #2 was scheduled 7a-3p at least 5 days per week and was scheduled as the RN supervisor. Review of the daily schedules for this time period identified RN #2 was scheduled as the RN Supervisor almost daily. Interview with the DNS and RN #2 on 8/27/24 at 10:39 AM identified RN #2 had been the Infection preventionist since the beginning of June 2024. The DNS identified that RN #2 does not have designated hours for Infection Prevention. The DNS identified RN #2 is in the building as the RN Supervisor and is sometimes pulled to the floor to cover call-outs or short staffing. The DNS identified the RN supervisor position as a free float supervisor position, so RN #2 is able to get other work done if time allowed and RN #2 was able to work from home. Interview with the DNS on 8/28/2024 at 10:30 AM identified the previous IP/staff development person worked 32 hours as the IP and 8 hours at staff development. The previous position holder was not an RN supervisor. The DNS identified the corporate entities identified there was no Federal minimum for hours for an Infection Preventionist, and, now the position is a combined position of IP/staff development and RN supervisor. The DNS identified that RN #2 is scheduled predominantly as the RN Supervisor and completed other tasks as time allowed. Facility documentation reviewed 8/27/2024 at 1 PM identified RN #2 had completed the Nursing Home Infection Preventionist training 3/2/2024 and had the appropriate education for the Infection Prevention position.