STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy for 3 of 4 sampled residents, (Resident #13, Resident #285, and Resident #287), reviewed for advance directives, the facility failed to ensure that residents had the opportunity to make care decisions and obtain signed consents regarding care to be provided upon admission. The findings include: 1. Resident #13 was admitted on [DATE] with diagnoses that included epilepsy, dysphagia, and depression. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set up assistance with personal hygiene, and supervision with transfers and walking 150 feet. A review of physician's orders dated 10/22/24 through 4/30/25 identified that Resident #13 was receiving Seroquel (an antipsychotic medication), and had an order to administer Potassium Iodide in the event of a nuclear disaster. Although the Resident Care Plan (RCP) dated 1/22/2025 identified a problem for psychosocial well-being with interventions for psychotropic medication use and to provide opportunities for participation in decision making, the RCP failed to identify that permission for psychoactive medication use was obtained and failed to identify problems related to the use of potassium iodide, mental health services, or vaccinations. A review of Resident #13's paper chart identified unsigned consent forms for the use of psychoactive medications, emergency use of potassium iodide, provision of mental health services, and vaccination history or preference to receive vaccines. An interview with the Director of Nursing Services (DNS) on 4/30/25 at 9:18 AM identified that the Licensed Practical Nurse (LPN) or nurse supervisor were responsible for ensuring resident consent forms were signed no later than the second day after admission. The DNS was unable to explain why Resident #13's forms remained unsigned for greater than 6 months following admission. The DNS indicated that in the event of a nuclear emergency in the vicinity, Resident #13 would have been administered potassium iodide without his/her consent. Further, Resident #13 was currently being administered Seroquel (antipsychotic) but had failed to sign the facility consent in order to administer the medication and failed to sign the facility consent to receive mental health services. 2. Resident #285 's diagnoses included malignant neoplasm of tongue, diabetes and bipolar disorder. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Nursing assessment dated [DATE] identified Resident #285 was cognitively intact with a Brief Interview for Mental Status (BIMS- 14) and required supervision to limited assistance with bed mobility, transfer, toileting and dressing. Resident #285 was unable to consume anything by mouth and required a gastrostomy tube for eating. The admission Resident Care Plan failed to identify any admission related consents. Review of the clinical record admission documentation consent forms for potassium iodide, influenza, pneumococcal, and covid vaccines, psychoactive medications, and psychiatric group treatment failed to identify any signatures from Resident #285 or the Conservator of Person and estate and were left blank. 3. Resident #287's diagnosis included diabetes, congestive heart failure and chronic kidney disease. The admission assessment dated [DATE] identified Resident #287 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, and required substantial maximum to total assistance with bed mobility, transfers, dressing, and eating. The Resident Care Plan dated 4/29/25 failed to identify any admission related consents. Review of the clinical record admission documentation forms for potassium iodide, influenza, pneumococcal, covid vaccines, psychoactive medications, and psychiatric group treatment failed to identify any signatures from Resident #287 or the responsible party and were left blank. Review of the admission check list identified an area for the date of the influenza vaccine, pneumovax, and covid vaccine but was left blank. Subsequent to surveyor inquiry, Resident #287's advanced directive, consent for psychoactive medications, psychiatric services consent, consent for administering potassium iodide, influenza vaccine and pneumococcal vaccine were signed on 5/2/25. In an interview with the Director of Nursing on 5/1/25 at 11:23 AM, the admission forms and consents for immunization should be completed within 48 hours of admission. The nurse on the unit and/or the supervisor are responsible for ensuring the forms are completed. Although a policy for obtaining resdient consent prior to treatment was requested, the facility did not provide a policy. Review of the admission of a resident policy directed, in part, the admission Coordinator will meet with the resident and responsible party to complete all necessary paperwork. The unit nurse will be responsible for completing the necessary nursing documentation.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and interviews for 1 of 3 sampled residents (Resident #22) reviewed for choices, the facility failed to make a reasonable accommodation for an individual with mobility needs. The findings include: Resident #22's diagnoses included hemiplegia of the right side, aphasia, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, was dependent for transfers, required maximal assistance with personal hygiene and bed mobility, and utilized a motorized wheelchair. The Resident Care Plan (RCP) dated 3/5/2025 identified Resident #22 required assistance with Activities of Daily Living (ADLs). Interventions included assisting with ADLs, mechanical lift for transfers, and reposition Resident #22 in his/her power wheelchair every 2 hours. An interview with Resident #22 on 4/29/2025 at 9:54 AM identified he/she was unable to leave his/her room independently because there was insufficient room for the power wheelchair to exit between his/her roommate's dresser and the end of the bed. Resident #22 further indicated he felt locked up when he/she could not exit the room. An interview with Social Worker #1 on 5/1/2025 at 11:05 AM identified that she was aware Resident #22 could not exit his/her room independently due to space issues between the roommate's bed and dresser and stated to get Resident #22 out of his/her room in the power wheelchair, the roommate's bed needed to be scooted over by staff. Further, she indicated Resident #22 was in a private room on 8/1/2022 with no wheelchair mobility concerns but was moved into a shared room on 6/14/2023. She indicated moving Resident #22 into the shared room, where staff were required to move a bed and dresser each time Resident #22's wheelchair was to exit the room, was not accommodating the resident's need to leave his/her room at will. An observation with the Director of Nursing Services (DNS) on 5/1/2025 at 11:36 AM identified that the width of Resident #22's wheelchair and the distance from his/her roommates dresser and bed were both 90 inches. The DNS moved the dresser in a left direction towards the corner of the wall and measured a new distance from the dresser to the end of the bed of 92 inches. The DNS failed to identify if the new setup of the room, with an additional 2 inch clearance, would accommodate the resident's needs to independently go in and out of his/her room as the distance was measured at an angle. She stated the facility would need to test it to gauge if Resident #22 could exit the room. Although requested, the facility did not provide a policy on Accommodation of Needs for residents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 sampled residents (Resident # 23) reviewed for accidents, the facility failed to notify the physician following a fall with a major injury. The findings include: Resident #23's diagnoses included dementia, malignant neoplasm of the anal canal, morbid obesity, and was actively receiving chemotherapy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #23 was dependent on staff for bed mobility, toileting, bathing, and transfers. The Resident Care Plan dated 1/28/2025 identified Resident #23 was a fall risk related to a history of falling. Interventions included, keep the bed in lowest position, remind Resident #23 of self-limitations, and encourage the resident to ask for assistance with personal care. Review of the Physical Therapy Evaluation and Plan of Treatment report dated 3/27/2025 directed staff to use a mechanical lift for all transfers due to medical and safety needs. Review of the Facility Reported Incident (FRI) event form dated 3/31/2025 identified that on 3/31/2025 at 10:30 AM Resident #23 was being transferred from the bed to a wheelchair when his/her legs became weak. Three staff members assisted the resident to the floor, during which the resident's legs bent behind him/her. Resident #23 was then mechanically lifted from the floor to the wheelchair. Resident #23 was assessed and had no complaints and was transferred to his/her scheduled appointment. The FRI report indicated RN #7 notified MD #1 at 2:30 PM on 3/31/2025. Upon arrival to the physician's office, Resident #23 complained of chest pain and left lower extremity pain. The resident was transferred to the Emergency Department and was subsequently diagnosed with a tibia/fibula fracture. Interview with Resident #23 on 4/28/2025 at 11:42 AM identified that he/she experienced a fall on 3/31/2025 after multiple nursing assistants were helping him/her get out of bed without the benefit of a mechanical lift. The resident indicated that his/her legs felt weak, were giving out and he/she was then lowered to the floor and reported the inability to bear weight on his/her left leg. Resident #23 indicated that staff transferred him/her to the chair and proceeded to send him/her out to his/her scheduled gastrointestinal physician office visit. On arrival, the APRN assessed him/her, and he/she was subsequently transferred to the Emergency Department. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and facility documentation review with the Director of Nursing Services (DNS), on 5/5/25 at 2:53 PM identified that although the FRI report indicated RN #7 had notified MD #1 on 3/31/2025 at 10:30 AM, the DNS reported this did not occur. The DNS stated that the facility's policy directs the nurse supervisor to notify the DNS, the administrator, and the physician when there is a change in a resident's condition. The DNS indicated that the facility used an off-hour encrypted provider notification system to report changes in a resident's condition. The DNS stated during her investigation, after reviewing the data from encrypted call line, it was determined that RN #7 had never left a message on the secured line nor did she speak with a team provider. Further, MD #1 learned of the incident the following day when the facility received a call from the Emergency Department indicating Resident #23 had experienced a lower left leg fracture. Interview with MD #1 on 5/6/2025 at 1:36 PM identified that any change in a resident's condition must be reported immediately. MD #1 reported she was not informed of Resident #23's fall and only became aware Resident #23 sustained a fracture when she was contacted by the Emergency Department the following day. Review of the Notification Change in Condition, Change in Treatment/Services Policy that was in effect directed, in part, that the facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or any interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 4 sampled residents (Resident #22) reviewed for abuse, for the only sampled resident (Resident # 27) reviewed for hospitalization, and for 1 of 3 residents, (Resident #36) reviewed for smoking, the facility failed to develop and implement comprehensive Resident Care Plans. The findings include: 1. Resident #22's diagnoses included hemiplegia of the right side, aphasia, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, was dependent for transfers, required maximal assistance with bed mobility, and utilized a motorized wheelchair. The Resident Care Plan (RCP) dated 3/5/2025 identified Resident #22 had communication difficulties as a result of a stroke. Interventions included speaking directly to the resident while facing him/her, ask simple yes/no questions, and provide speech therapy as needed. An interview with Resident #22 on 4/29/2025 at 9:38 AM identified he/she had notified the facility of potential abuse/misappropriation of funds which had not yet been resolved. Resident #22 verbalized being upset that the facility had not provided an update on where the money was and that the police were not returning his/her phone calls. Review of the Reportable Event dated 2/28/25 identified that Resident #22 had reported that $2,000 was missing from his/her bedside table. Review of the summary of events dated 3/6/25 indicated that the facility was unable to substantiate Resident had any money missing. Review of the RCP in effect following the facility summary dated 3/6/2025 and through 5/1/2025 failed to identify Resident #22's had a RCP developed and implemented following an allegation of misappropriation. An interview with the Director of Nursing Services (DNS) on 5/1/2025 at 10:21 AM identified she was aware of the allegation of misappropriation of funds, an investigation had been conducted, and a report was filed with the State Agency on 2/28/2025. The DNS indicated the facility had offered Resident #22 a lock box, which was refused, but she failed to document the offering of the lock box or add the allegation of misappropriation of funds or any new interventions to Resident #22's RCP but indicated the RCP should have been updated. Subsequent to surveyor inquiry, on 5/1/2025 the DNS updated Resident #22's care plan to include his/her needs after an allegation of misappropriation of funds. 2. Resident #27 's diagnoses included respiratory failure, deep vein thrombosis, pulmonary emboli, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #27 required a walker for ambulation, was independent with eating, required supervision with transfers, and partial assistance with dressing and tub/shower transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Care Plan (RCP) dated 12/20/2025 identified that although Resident #27 had listed diagnoses of congestive heart failure (CHF), asthma, and pulmonary embolism, there were no problems, interventions, goals, or monitoring parameters related to CHF or respiratory distress noted in Resident #27's RCP. Interview and review of clinical record with the Chief Clinical and Safety Officer (CCSO) on 5/6/2025 at 11:33 AM identified that Resident #27 had a significant medical history including a recent hospitalization for shortness of breath, acute asthma exacerbation, pulmonary embolism, and a history of congestive heart failure. Although this information was documented on the facility's History and Physical Form, the resident's medical history was not reflected in the RCP. The CCSO confirmed these conditions should have been included and stated he would have expected them to be part of Resident #27's RCP. 3. Resident #36's diagnoses included anxiety, right sided hemiplegia (complete loss of strength on 1 side), and hemiparesis (partial weakness on 1 side) secondary to cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 36 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. Resident #36 used a wheelchair for mobility but could independently walk 10 feet. Resident #36 was independent with eating, personal hygiene, dressing, bed mobility and transfers. Review of the Resident Care Plan (RCP) from 4/4/2025 through 4/29/25 did not identify Resident #36 as a smoker, nor did the RCP include interventions related to smoking i.e. supervision level, staff assistance, safety measures, or behavioral concerns. Observation on 4/29/25 at 10:08 AM identified Resident #36 was seated in a wheelchair at the facility's designated outdoor smoking area located in the back of the facility's main building. Resident #36 wore a smoking apron; there were no identified issues with the observation. Interview with the Director of Nursing Services (DNS) on 5/5/25 at 3:28 P.M. identified that Resident #36 should have had a smoking care plan in place. The DNS indicated that Resident #36 had opted for a nicotine patch in lieu of smoking, but that when the resident decided to return to smoking the plan should have been updated. The DNS acknowledged the plan was incomplete and did not reflect current staff practices or the resident's preference for smoking. Subsequent to surveyor interview, the RCP was updated on 5/5/2025. The RCP reflected that the resident smokes three times per day. Interventions included completing a smoking assessment every 90 days and ensuring smoking materials are stored by nursing staff in a secured cart. Review of the Care Planning Policy, in part, directed that a comprehensive and individualized plan of care would be developed for each resident. The care plan would be used to guide caregivers to assist residents to achieve or maintain their highest practical level of well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and interviews for 1 of 3 sampled residents, (Resident #7), reviewed for choices, the only sampled resident (Resident #13) reviewed for rehabilitation, the only sampled resident, (Resident #22), reviewed for abuse, the only sampled resident (Resident # 27) reviewed for hospitalization, the only sampled resident (Resident #52) reviewed for care planning, and the only sampled resident (Resident #56) reviewed for hemolytic treatments, the facility failed to review and revise care plans per the requirement and failed to hold quarterly Resident Care Plan (RCP) meetings as required. The findings include: 1.Resident #7's was admitted [DATE] with diagnoses that included seizure disorder, chronic obstructive pulmonary disease, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition and was independent with transfers and walking 150 feet. The Resident Care Plan (RCP) dated 2/13/2025 identified Resident #7's quality of life should be maintained through providing activities of interest. Interventions included assess and discuss the resident's needs, interests, and communicate resident's preferences with staff via the care plan and verbal communication. a. Review of Resident #7's RCP meeting attendance sheets from 7/8/2024 through 5/1/2025 identified a RCP meeting was held on 10/16/2024. The facility failed to hold any subsequent RCP meetings for Resident #7. b. Review of the resident's clinical record identified quarterly Minimum Data Set (MDS) assessments were completed on 10/11/2024, and 11/9/2024. The facility failed to review and revise Resident #7's care plan within 7 days of the MDS. 2. Resident #13's admission date was 10/22/2024 for diagnoses that included epilepsy, dysphagia, and depression. The Resident Care Plan (RCP) dated 1/22/2025 identified Resident #13 was at risk for issues related to psychosocial wellbeing. Interventions included allow/encourage the resident to express feelings, and to participate in daily care and decision/goal making. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, and was independent with personal hygiene, transfers, and walking 150 feet. The facility failed to provide Resident #13's RCP meeting attendance sheets from 10/22/2024 through 5/1/2025 or any documentation that a RCP meetings for Resident #13 had taken place. 3. Resident #22's diagnoses included hemiplegia of the right side, aphasia, and diabetes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, was dependent on chair/bed-to-chair transfers, required maximal assistance with personal hygiene and rolling left and right, and utilized a motorized wheelchair. The Resident Care Plan (RCP) dated 3/5/2025 identified Resident #22 required assistance with ADLs. Interventions included assist with ADLs, mechanical lift for transfers, and reposition the resident in his/her power wheelchair every 2 hours. a. The facility failed to provide Resident #22's RCP meeting attendance sheets for Resident #22 for the calendar years 2024 and 2025. b. Review of the clinical record identified that although quarterly MDS assessments were completed on 8/3/2023, 1/16/2024, 4/11/2024, and 11/30/2024, the facility failed to review and revise Resident #22's care plan within 7 days of the MDS. An interview with Social Worker (SW) #1 on 5/1/25 at 11:05 AM identified that for Resident #7 RCP meetings were no longer held due to the conservator's unattendance, for Resident #13, there were no RCP meetings due to the residents' lack of a conservator for a long period of time, and for Resident #22, the last RCP meeting was held on 12/5/24 and she was unable to explain why there was no RCP meeting held in 2025. SW #1 indicated that she was aware of the requirement and timing to hold RCP meetings, but meetings had not been held. Additionally, SW #1 indicated that for Resident #'s 7 and 22, she was aware that RCP's were to be updated within 7 days after the completion of the MDS assessment but was unable to explain the lack of RCP review and revision. 4. Resident #27's diagnoses included congestive heart failure, pulmonary emboli, and opioid dependence. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #27 required a walker for ambulation, was independent with eating, bed mobility, and transfers. The Resident Care Plan (RCP) dated 3/26/2025 identified Resident #27 experienced chronic pain related to multiple conditions along with behavior problems with occasional medication refusal. Interventions included administering mediations as ordered, monitoring for potential side effects, and staff were to notify the physician of any changes. Physician's notes reviewed from 3/17/2025 to 3/27/2025 identified that during a routine check of the Connecticut's Prescription Monitoring Program, MD #1 identified Resident #27 had filled several prescriptions for narcotics at an outside pharmacy not the facility pharmacy. MD #1 indicated the facility was also filling and administering the same medication that had been allegedly filled by Resident #27. The facility implemented 1:1 constant observation to ensure the resident's safety. Observation and interview with Resident #27 on 4/30/2025 at 9:45 AM identified that Resident #27 was on 1:1 constant observation. Resident #27 reported that he/she made an error by filling prescribed narcotic medications from an outside pharmacy. Resident #27 denied self-administration of these medications. Resident #27 indicated the facility implemented constant observation to watch him/her. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the RCP in effect from 3/26/2025 through 4/30/2025 failed to identify that the RCP had been reviewed or revised to include the acquisition of medications from an outside pharmacy or the need for 1:1 constant observation. Interview with the Director of Nursing (DNS) on 5/1/2025 at 5:02 PM identified that the RCP had not been updated to include concerns related to the alleged drug diversion or the implementation of constant observation. The DNS stated that any of the nurses could have updated the RCP and that it was the facility's expectation that this should have been done. 5. Resident #52 's diagnoses included morbid obesity, lymphedema, and osteoarthritis of the knee and hip. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #52 required a wheelchair for mobility, was dependent on dressing, and transfers, and required some assistance with bed mobility. The Resident Care Plan (RCP) dated 4/4/2025 identified Resident #52's wished to be discharged home. Interventions directed staff to evaluate and document the resident's abilities and strengths in collaboration with family, caregivers, and the Interdisciplinary Team (IDT). Review of the Routine Quarterly Care Conference Attendance form dated 4/10/2025, identified in addition to Resident #52, and 2 family members, the IDT consisted of Social Worker (SW) #1 and the Administrator. During an interview with Resident #52 on 4/28/25 at 12:27 PM he/she indicated that he/she felt the interdisciplinary care team does not exist and stated that a representative was not present from the Nursing or Dietary Departments during the last few RCP meetings. Resident #52 expressed he/she felt unsupported due to the absence and lack of input from several clinical disciplines. Interview with SW #1 on 5/1/25 at 3:48 PM identified that she was aware Resident #52's care plan focused on discharge planning and reported that while the resident's 2 family members usually attended the meetings, other departments typically did not, nor did they provide input for the meeting. She stated that the absence of IDT participation had been escalated to the Director of Nursing Services (DNS), who advised her to do her best. SW #1 acknowledged that the lack of input from other IDT members had been a barrier to developing an effective personalized discharge RCP prioritized to meet Resident #52's goals. Interview with the DNS on 5/1/25 at 4:33 P.M. identified the facility had been without an MDS coordinator for approximately 9 months. The DNS stated that the facility policy required attendance and input from social work, nursing, the MDS coordinator, dietary, and recreation staff. The DNS acknowledged that the lack of IDT participation was a known issue and stated, We are just doing the best we can. 6. Resident #56's diagnoses included end stage renal disease, dependence on hemolytic treatment, anemia, and amputation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, independent for eating and bed mobility, dependence on staff for transfers, and was receiving hemolytic treatments. The Resident Care Plan (RCP) in effect for the month of April of 2025 identified Resident #56 was on hemolytic treatment. Interventions included encouraging Resident #56 to go for the scheduled hemolytic appointments, monitor lab work, and monitor for peripheral edema, infection to the access site, and obtain vital signs and weight per protocol. Report any significant changes to the physician. A physician order in effect for the month of April of 2025, directed to send Resident #56 to hemolytic treatments 3 times per week. Upon Resident #56's return, staff were to record the hemolytic center weight from the communication book. Review of the Routine Quarterly Care Conference attendance sheets from 6/6/2024 to 4/7/2025 identified that only the Social Worker (SW#1) and Resident #56 were present for 7 of 8 scheduled RCP meetings. Interview and record review with SW#1 on 5/5/2025 at 11:00 AM, identified that she was the only staff member who attended Resident #56's RCP meetings. SW#1 identified the Interdisciplinary Team (IDT) comprised of the dietician, charge nurse, rehabilitation, activities, social worker, and MDS care coordinator were responsible for attending RCP meetings. SW#1was unable to explain why the other IDT members did not attend Resident #56's RCP meetings. SW#1 indicated that she gave notices for Resident #56's scheduled IDT meetings on time, but only the Resident #56 ever showed up. SW#1 indicated that she was aware that Resident #56 was having issues with her rides for his/her hemolytic treatments and indicated that such issues would be discussed in RCP meetings. SW #1 indicated that it had been difficult for her to individually address any resident issues that require a multidisciplinary approach. Interview with the DNS on 5/5/2025 at 11:30 AM, identified that residents care conferences should be attended by all responsible members (IDT members) and could not explain why only SW #1 was attending. The DNS indicated that she will be looking into the issue. Review of the Care Planning - Interdisciplinary Team (IDT) Policy directed, in part, a resident's comprehensive care plan was to be developed by a care planning/interdisciplinary team which includes, the attending physician, the registered nurse, dietary, social services, activity director, physical, occupational, speech therapy, the DNS, charge nurse, nursing assistant, resident, and the resident's family or representative. Additionally, a comprehensive and individualized plan of care would be developed for each resident will be developed within 7 days of the completion of the Resident's MDS. The RCP would be reviewed and updated at least quarterly and as necessary to reflect changes in a resident's status.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 sampled residents (Resident # 23) reviewed for accidents, the facility failed to utilize a gait belt for transfers, failed to conduct a Registered Nurse (RN) assessment following a fall and prior to further movement, once transferred failed to conduct a thorough assessment, and failed to contact the physician representing a failure to maintain professional standards of practice. The findings include: Resident #23's diagnoses included dementia, malignant neoplasm of the anal canal, morbid obesity, and was actively receiving chemotherapy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #23 required a wheelchair and a walker for mobility and was dependent on staff for bed mobility, toileting, bathing, transfers. The Resident Care Plan dated 1/28/2025 identified Resident #23 was a fall risk related to a history of falling. Interventions included, keeping the bed in lowest position, remind Resident #23 of self-limitations, and encourage the resident to ask for assistance with personal care. Review of the Physical Therapy Evaluation and Plan of Treatment report dated 3/27/2025 directed staff to use a mechanical lift for all transfers due to medical and safety needs. Review of the Facility Reported Incident (FRI) event form dated 3/31/2025 identified that on 3/31/2025 at 10:30 AM Resident #23 was being transferred from the bed to a wheelchair when his/her legs became weak. Three staff members assisted the resident to the floor, during which the resident's legs bent behind him/her. Resident #23 was then mechanically lifted from the floor to the wheelchair. Resident #23 was assessed and had no complaints and was transferred to his/her scheduled appointment. The FRI report indicated RN #7 notified MD #1 at 2:30 PM on 3/31/2025. Upon arrival to the physician's office, Resident #23 complained of chest pain and left lower extremity pain. The resident was transferred to the Emergency Department and was subsequently diagnosed with a tibia/fibula fracture. An interview with Resident #23 on 4/28/2025 at 11:42 AM identified he/she experienced a fall on 3/31/2025. Resident #23 stated that multiple nursing assistants were helping him/her get out of bed when his/her legs felt weak, were giving out, and he/she informed the staff. Resident #23 was then lowered to the floor and reported to staff he/she was unable to bear weight on the left leg. Staff transferred Resident #23 to the chair and proceeded to send the resident to his/her scheduled colorectal office visit. Resident #23 reported that the APRN at the doctor's office noticed that he/she appeared as pale as a ghost and transferred him/her to the Emergency Department for evaluation. Resident #23 indicated that when he/she was transferred to the stretcher he/she screamed in pain when they moved the left leg. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #5 on 5/5/2025 at 11:54 AM identified that after providing morning care to Resident #23, NA #5 positioned him/her seated at the edge of the bed and placed a walker in front of him/her in preparation for transfer. NA #5 indicated that she and NA #1 failed to use a gait belt when transferring Resident #23. Instead, both NAs attempted to transfer Resident #23 by positioning their arms under the resident's armpits in a hook like manner in order to lift Resident #23 from the bed. When the resident attempted to stand, he/she complained of pain, so they stopped the transfer. NA #5 observed that Resident #23's left leg was slightly twisted, and the resident was unable to straighten the leg, NA #5 notified LPN #5, who then assisted with a second attempt to stand Resident #23 before notifying the RN to assess the pain or the slightly twisted leg. While both NAs were positioned on either side of Resident #23, LPN #5 was on the bed pushing the resident up from behind. Resident #23 again expressed pain and an inability to stand. A third attempt was made, the resident was asked by staff to pivot, stated Put me down, and indicated he/she was unable to continue. NA #5 reported that Resident #23's legs just gave out, so they assisted to lower him/her to the floor. Once on the floor, Resident #23 began screaming, My leg, my leg, my leg. NA #5 stated they realized the resident's left leg had been twisted underneath him/her. LPN #8 then lifted the resident's lower body while NA #1 repositioned Resident #23's left leg, and the resident was transferred via a mechanical lift, all prior to RN notification and assessment. NA #5 stated that when RN #7 arrived, she assessed the resident's bandage on her leg (a skin tear that was sustained during a fall on 3/18/2025) and changed the dressing (bandage), but no further assessment of the resident was conducted by RN #7. Staff put a blanket over Resident #23's lap; NA #5 accompanied the resident to the front of the facility and then accompanied Resident #23 to his/her scheduled doctor's appointment. NA #5 indicated that when she and Resident #23 arrived at the doctor's appointment, the resident was noted to be sweating, reported feeling dizzy, his/her blood pressure was elevated, and he/she complained of chest pain. Resident #23 was evaluated by the physician's staff at the appointment and subsequently was transferred to the Emergency Department. NA #5 reiterated that staff had not used a gait belt to transfer Resident #23 during any of the 3 attempts to stand the resident, nor was a mechanical lift considered until after the fall. NA #5 indicated that she knew a gait belt should be used when standing a resident, but she did not have one at the time. NA #5 indicated that a gait belt could have offered support, but she did not request one, despite knowing the facility would have provided one. Interview with the Director of Nursing (DNS) on 5/5/2025 at 12:35 PM identified that if a resident expressed difficulty standing and stated he/she could not stand, staff should have stopped, and a mechanical lift should have been used. The DNS stated that lifting a resident under the axilla was not an appropriate transfer method and a gait belt should have been used. Furthermore, staff should have stopped immediately when the resident stated he/she could not continue. The situation should have been escalated to a Registered Nurse Supervisor to assess the resident's condition prior to proceeding with any transfer or manipulation of Resident #23's leg. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Re-interview with the DNS on 5/5/25 at 2:53 identified that although it was indicated on the Reportable Event following Resident #23's fall that the provider (MD or APRN) was notified, through the investigation process, she was unable to substantiate provider notification had occurred. The DNS stated that the facility's policy directed the nurse supervisor to notify the DNS, the administrator, and the physician when there is a change in a resident's condition. The DNS indicated that the facility used an off-hour encrypted provider notification system to report changes in a resident's condition. The DNS indicated that the facility MD never found out that Resident #23 had fallen until the following day when the hospital called the facility. Interview with the Director of Rehabilitation Services on 5/5/2025 at 3:13 PM indicated that using a gait belt to transfer any resident was the standard practice for all resident transfers. Interview with the Chief Clinical and Safety Officer on 5/5/2025 at 3:15 PM identified that staff should have used a gait belt when transferring residents. Interview with MD #1 on 5/6/2025 at 1:36 PM identified that any change in a resident's condition must be reported immediately. MD #1 reported she was not informed of Resident #23's fall and only became aware Resident #23 sustained a fracture when she was contacted by the Emergency Department. MD #1 stated that had she been notified she would not have allowed the resident to leave for her scheduled appointment, instead she would have evaluated the resident herself. If she had not been on-site, she would have evaluated the situation and sent the resident to the Emergency Department. Although requested, the facility did not have a transfer policy. Review of the Notification Change in Condition, Change in Treatment/Services Policy that was in effect directed, in part, that the facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or any interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. According to the American Nurses Association Safe Patient Handling and Mobility, manual patient handling is hazardous for both health care workers and patients. The most common patient related tasks that lead to injury are lifting repositions and transferring. According to American Nurse, if you're walking with a patient who becomes dizzy or experiences a syncopal event, you may not be able to prevent a fall. But you can help to prevent injury by holding on to the gait belt and guiding the patient to the floor, supporting him or her on your thigh and with your large quadricep muscle as you slow descent to the floor.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #18) reviewed for Activities of Daily Living (ADL), the facility failed to provide showers as scheduled for a dependent resident. The findings include: Resident #18 's diagnoses included Parkingson's disease, anxiety disorder, and spinal stenosis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was moderately cognitively impaired and required substantial maximum assistance with bed mobility, transfers, and dressing, and required total assistance of staff with personal hygiene. The Resident Care Plan dated 4/14/2025 identified Activities of Daily Living (ADLs) Interventions included assisting with bathing, dressing, and hygiene as ordered. Interview with a family member on 5/1/2025 at 1:20 PM identified that Resident #18 was scheduled to get a shower on Tuesdays and Thursdays and Resident #18 had not received showers on Tuesday 4/29/2025 or Thursday 5/1/2025. In an interview and clinical record review with the Director of Nursing Services (DNS) on 5/5/25 at 10:06 AM, failed to reflect documentation a shower had been provided to Resident #18 on 4/1/2025, 4/3/2025, 4/10/2025, 4/22/25, 4/24/2025, and 4/29/25 as identified by blanks on the shower record. The DNS indicated that the charge nurses should check the shower list at the beginning of their shift and provide the list to the NAs to identify which residents were scheduled for showers the day. Additionally, the DNS identified that if there was no documentation of a shower being given, the shower was not given. The nurse and the NA were responsible for ensuring showers were completed for the residents scheduled. The DNS was unable to explain why Resident #18 had not received a shower, but, at times, Resident #18 was known to refuse a mechanical lift to transfer into the shower bed and insisted on using the sit-to-stand lift which was unsafe. Further, the DNS indicated the shower bed had been broken in the past. The DNS was unable to provide documentation that the Resident #18 had refused transfers for showering or the unavailability of the shower bed. Review of the activities of daily living (ADLs) supporting policy directed, in part, residents will be provided care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out ADLS independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. In the event that care is declined by the resident, the staff shall ask the resident when they would like care to be provided and notify their nurse/immediate supervisor and reoffer care at a later time. Although requested, a facility policy for shower scheduling was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy, and interviews for 1 of 3 sampled residents (Resident #20) reviewed for pressure ulcers, the facility failed to follow physician orders for wound care, failed to obtain physician orders for wound care treatment, failed to report a change in skin integrity, and failed to ensure the wound care nurse conducted weekly head to toe skin assessments for a resident with a pressure ulcer per the facility practive, and for 1 of 4 sampled residents, (Resident #52) reviewed for nutrition, the facility failed to follow a physician order to obtain weekly weights. The findings include: 1. Resident #20's diagnoses included epilepsy, bullous pemphigoid, diabetic/pressure ulcer, and cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 had a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment, was dependent on transfers, required extensive assistance with bed mobility, and was at risk for pressure ulcer development. Additionally, Resident #20 was always incontinent of bowel and had 1 unstageable pressure area upon admission. The Resident Care Plan (RCP) dated 4/9/2025 identified Resident #20 had skin integrity problems and bilateral heel pressure areas. Interventions included treatments as ordered, reposition as it meets the resident's needs, follow the skin protocol, record/report any new changes to the physician/nurse, and conduct weekly skin checks. A Physician order dated 4/29/2025 for Resident #20's left heel pressure ulcer directed to cleanse the wound with wound cleanser, apply betadine to the base of the wound, and secure with a dry clean dressing 2 times a day for wound treatment and for the right heel pressure ulcer cleanse the wound with wound cleanser and apply betadine to the base of the wound 2 times a day for wound treatment. 1. Interview and observation on 4/30/2025 at 1:57 PM of Resident #20's wound care by Licensed Practical Nurse (LPN) #3 identified that Resident #20 had both feet wrapped in gauze. When the resident's feet were unwrapped, Xeroform was noted to be present on the outside of his/her left foot. LPN #3 identified there was no physician's order for Xeroform to be applied and was unable to explain why Xeroform had been applied to the left foot. LPN #3 indicated she would speak with the Infection Preventionist/Wound Care Nurse and left the room to go get her. An interview and observation with Registered Nurse (RN) #2, the Infection Preventionist, on 4/30/2025 at 2:29 PM identified RN #2 resumed wound care. RN #2 stated although there was no physician's order for Xeroform, because it was present under the bandage at the beginning of wound care she was going to reapply Xeroform to the left foot wound without a physician's order. Continued observation observed RN #2 apply Xeroform to Resident #20's foot. RN #2 completed the wound care and left the room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A re-interview with RN #2 on 4/30/2025 at 3:40 PM identified that it was not within her scope of practice to change a physician's order and she did not call the physician to change the order but should have. Further, RN #2 could not explain why she placed the Xeroform without a physician's order but did identify she should have followed the current physician wound care orders per facility policy and that subsequent to surveyor inquiry she would be calling the physician to obtain a new wound care order. An interview with the Director of Nursing Services (DNS) on 4/30/2025 at 3:44 PM identified that if there was no physician's order, RN #2 should not have changed the treatment. Further, if RN #2 felt that Resident #20's order needed to be changed there was a telephone number that nurses could call to obtain a new physician's order. 2. A second observation of Resident #20 on 5/5/2025 at 10:40 AM identified his/her hospital gown was wet with exudate (drainage) that was clear to pink tinged and there were several dried red blood spots on the front of his/her hospital gown. The surveyor requested the nurse to evaluate to determine the source of the exudate. After obtaining the resident's permission to observe, an interview and observation, with LPN #4 on 5/5/2025 at 10:46 AM, identified when Resident #20 was turned onto his/her left side, an uncovered wound was observed in the crease of Resident #20's buttocks near the coccyx. A second wound was on the middle right buttocks covered with an undated non-foam 4 by 4 bandage and saturated with brown exudate. A third wound was observed on the upper right buttock area with an undated 4 by 4 foam dressing that was saturated and falling off the area. Review of the physician orders, and the nursing, physician and APRN notes from 1/1/2025 through 5/1/2025 failed to identify Resident #20 had any of the open areas observed, any documentation of the open areas, or that the physician and/or RN was notified of the open areas or gave the treatment orders for the bandages that were currently in place. An observation, interview, and review of clinical record with RN #2 on 5/5/2025 at 10:53 AM identified an open wound to Resident #20's coccyx which measured approximately 2 inches by ¾ inches in size. The wound had partial thickness skin loss with exposed dermis (the middle layer of skin) and a red wound bed. RN #2 indicated that she was not aware of the coccyx wound or the 2 wounds on Resident #20's right buttock. RN #2 identified that she was responsible to perform weekly head to toe skin assessments for any resident with a known skin condition per the facility practice. Although RN #2 stated it was the facility practice for her to perform head to toe skin assessments, she responded she had failed to do so since she had been evaluating Resident #20's heel ulcers which were first identified on 2/13/2025. RN #2 was unable to explain why she had not performed Resident #20's weekly head to toe skin assessments, who placed the bandages to the wounds, how long the bandages had been in place, why staff would treat a wound without a provider order or notification, and/or why she was never notified of a change in Resident #20's skin integrity. Review of the facility's weekly skin check dated 4/29/2025, which lacked identification as to who performed the skin assessment, failed to identify the new areas to Resident's coccyx and buttocks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 5/5/2025 at 11:40 AM with the Director of Nursing Services (DNS) identified RN #2, the Infection Preventionist, per facility practice was responsible for performing head to toe skin assessments for every resident with a known skin issue on a weekly basis. In addition to the head to toe assessments by the Infection Preventionist, RN #2, on residents with known skin issues, the unit charge nurse was responsible for performing skin checks on every resident weekly and any new findings were to be reported to RN #2 for assessment. The DNS further identified that she was unaware of Resident #20's new skin issues prior to notification on 5/5/2025 by LPN #4. Review of the facility's Weekly Skin Audits Policy identified in part that Certified Nursing Assistants will perform skin checks on a daily basis during incontinence care. The nurse will complete body audits on a weekly basis on an assigned day and as needed. When a newly identified area is identified, the RN Supervisor will be notified, a skin evaluation will be completed, and the physician and wound nurse will be contacted. 2. Resident #52's diagnoses included morbid obesity, lymphedema, and osteoarthritis of the knee and hip. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #52 required a wheelchair for mobility, required maximal assist with dressing, and all transfers, required partial assistance with bed mobility, and was independent with eating. The Resident Care Plan dated 1/14/2025 identified Resident #52 was at risk for fluid volume imbalance related to chronic kidney disease and lymphedema. Interventions included weight monitoring as ordered, monitor skin turgor, and staff to offer small amounts of food and fluids. A physician's order dated 1/20/2025 directed staff to weigh Resident #52 weekly. Review of the clinical weight records dated 1/31/2025 through 5/5/2025 identified Resident #52 was weighed a total of 7 times (1/31/2025, 2/5/2025, 2/12/2025, 3/2/2025, 3/26/2015, 4/5/2025, 5/5/20250), out of 14 weekly weights opportunities. In an interview with Resident #52 on 4/28/2025 at 12:30 P.M. he/she identified last being weighed about a month ago. Interview with LPN #5 on 5/1/2025 at 3:05 P.M. identified that Resident #52 had a physician order for weekly weights and that weekly weights should have been completed on Resident 52's shower day (Wednesdays). LPN #5 was unable to explain why Resident #52 had not been weighed as ordered by the physician, adding that it was ultimately the nurse's responsibility to ensure weights were completed and documented. Interview with the Director of Nursing (DNS) on 5/1/2025 at 4:45 PM identified that Resident #52 should have been weighed weekly according to the physician's order. The DNS stated staff were expected to obtain resident weights on shower days or more frequently as needed. Additionally, she indicated the charge nurse on the unit was responsible to ensure NAs obtained the resident's weight which was then documented by the charge nurse, that the dietitian was responsible to monitor for weight changes, and she was unable to explain why weekly weights had not been completed. The DNS stated education would be provided for nursing staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 5/5/2025 at 11:05 AM identified she was not aware Resident #52 required weekly weights. NA #1 stated that most residents are weighed monthly, and that the schedule was usually posted near the desk. NA #1 further stated that nurses were responsible for informing NAs when a resident requires weight measurements more frequently than monthly. Interview with Dietitian #1 on 5/5/2025 at 9:45 A.M. identified she was not aware of Resident #52's weekly weight order. Dietitian #1 stated she reviewed resident orders at the time of admission and quarterly thereafter. Dietitian #1 stated she did not have Resident #52 on her weekly weight list. She stated she must have missed the order, indicating that she often struggled to get staff to complete the ordered weights for several residents and has voiced her concerns at the facility's weekly At Risk Meetings, but no action had been taken. Review of facility policy titled, Weight Assessment and Intervention, identified in part, that, the multidisciplinary team will strive to prevent, monitor, and intervene for unstable weight loss for residents.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 sampled residents (Resident # 23) reviewed for accidents, the facility failed to ensure a resident was transferred appropriately, failed to end the transfer and call for the Registered Nurse to assess the resident when he/she complained of pain, failed to ensure a Registered Nurse conducted a thorough assessment that included a range of motion prior to transferring the resident off the floor, and failed to notify the physician of the fall which resulted in a major injury. The findings include: Resident #23's diagnoses included dementia, malignant neoplasm of the anal canal, morbid obesity, and was actively receiving chemotherapy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #23 required a wheelchair and a walker for mobility and was dependent on staff for bed mobility, toileting, bathing, transfers. The Resident Care Plan dated 1/28/2025 identified Resident #23 was a fall risk related to a history of falling. Interventions included, keeping the bed in lowest position, remind Resident #23 of self-limitations, and encourage the resident to ask for assistance with personal care. Review of a Fall Risk Evaluation dated 3/18/2025 directed the facility to observe the resident status using 11 clinical condition parameters, then assign the corresponding risk score, and if the total score was 10 or greater, the resident should be at HIGH RISK for potential falls. Although the evaluation was completed, the facility failed to assign a total score to indicate the level of Resident #23's fall risk. Review of the Physical Therapy Evaluation and Plan of Treatment report dated 3/27/2025 indicated that Resident #23 was seen after hospitalization and was to be mechanically lifted to the wheelchair as the air mattress and bed frame/environmental situation was unsafe at this time for transfers until the patient gains strength. Review of the physician orders, nursing notes, and Resident Care Plan from 3/27/25 through 3/31/2025 failed to identify that the Physical Therapy Evaluation recommendation for a mechanical lift had been implemented. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Reported Incident (FRI) event form dated 3/31/2025 identified that on 3/31/2025 at 10:30 AM Resident #23 was being transferred from the bed to a wheelchair when his/her legs became weak. Three staff members assisted the resident to the floor, during which the resident's legs bent behind him/her. Resident #23 was then mechanically lifted from the floor to the wheelchair. Resident #23 was assessed and had no complaints and was transferred to his/her scheduled appointment. The FRI report indicated RN #7 notified MD #1 at 2:30 PM on 3/31/2025. Upon arrival to the physician's office, Resident #23 complained of chest pain and left lower extremity pain. The resident was transferred to the Emergency Department and was subsequently diagnosed with a tibia/fibula fracture. The physical status before the event was noted to include assisting the resident with 2 staff and a rolling walker for transfers to the wheelchair. After the event, the physical status reflected that Resident #23 required a mechanical lift. Review of the Hospital Discharge summary dated [DATE] identified x-rays taken on 3/31/2025 indicated Resident #23 had a spiral, mildly displaced fracture of the distal fibular metadiaphysis, a transverse mildly displaced fracture of the medial malleolus (distal tibia and fibula fracture), and a hemorrhagic blister on the left shin, which required debridement at the hospital. Observation and interview with Resident #23 on 4/28/2025 at 11:42 AM identified he/she experienced a fall on 3/31/2025. Resident #23 stated that multiple nursing assistants were helping him/her get out of bed when his/her legs felt weak, were giving out, and he/she informed the staff. Resident #23 was then lowered to the floor and reported to staff he/she was unable to bear weight on the left leg. Staff transferred Resident #23 to the chair and proceeded to send the resident to his/her scheduled colorectal office visit. Resident #23 reported that the APRN at the doctor's office noticed that he/she appeared as pale as a ghost and transferred him/her to the Emergency Department for evaluation. Resident #23 indicated that when he/she was transferred to the stretcher he/she screamed in pain when they moved the left leg. Resident #23 was then transferred to the Emergency Department. Interview with NA #5 on 5/5/2025 at 11:54 AM identified that around noon on 3/31/2025, she assisted Resident #23 with morning care in preparation for a 2:30 PM scheduled doctor's appointment. Once Resident #23 was ready, NA #5 positioned him/her seated at the edge of the bed and placed a walker in front of him/her in preparation for the transfer. She indicated that she and NA #1 assisted Resident #23 without the benefit of a gait belt. The transfer was completed by the NAs positioning their arms under the resident's armpits in a hook like manner in order to lift Resident #23 from the bed. When the resident attempted to stand, he/she complained of pain, so they stopped the transfer. NA #5 observed that Resident #23's left leg was slightly twisted, and the resident was unable to straighten the leg. NA #5 notified the LPN. NA #5 stated that when LPN #5 entered the room, a second attempt was made to stand Resident #23. Both NAs were positioned on either side of Resident #23 and LPN #5 was on the bed pushing the resident up from behind. Resident #23 again expressed pain and an inability to stand. A third attempt was then made when LPN #8 entered the room. LPN #8 stood on one side, while both NA #5 and NA#1 stood on Resident #23's opposite side. Resident #23 was brought to a standing position, and they told the resident to pivot. NA#5 stated the resident said, Put me down, and indicated that he/she was unable to continue. NA #5 reported that Resident #23's legs just gave out, so they assisted to lower the resident to the floor. Once on the floor, Resident #23 began screaming, My leg, my leg, my leg. NA #5 stated they realized the resident's left leg had been twisted underneath him/her. LPN #8 then lifted the resident's lower body while NA #1 repositioned Resident #23's left leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	NA #5 reported that a mechanical lift pad was placed under the resident, and LPN #8 used a mechanical lift to transfer Resident #23 to the wheelchair. After Resident #23 was seated in the wheelchair, LPN #5 assessed Resident #23's leg and left to get RN #7. NA #5 stated that when RN #7 arrived, she assessed the resident's bandage on her leg (a skin tear that was sustained during a fall on 3/18/2025) and changed the dressing (bandage), but no further assessment of the resident was conducted. Staff put a blanket over Resident #23's lap, NA #5 accompanied the resident to the front of the facility and then accompanied Resident #23 to his/her scheduled doctor's appointment. When NA #5 and Resident #23 arrived at the doctor's appointment the resident was noted to be sweating, reported feeling dizzy, his/her blood pressure was elevated, and he/she complained of chest pain. NA #5 indicated Resident #23 stated he/she felt as though he/she was spinning. Resident #23 was evaluated by the physician's staff at the appointment and subsequently was transferred to the Emergency Department. NA #5 reiterated that staff had not used a gait belt to transfer Resident #23 during any of the 3 attempts to stand the resident, nor was a mechanical lift considered until after the fall. NA #5 indicated that she knew a gait belt should be used when standing a resident, but she did not have one at the time. NA #5 indicated that a gait belt could have offered support, but she did not request one, despite knowing the facility would have provided one. Additionally, she stated a staff member told her that that the resident now required transfers with a mechanical lift, but that no one had communicated the information to use the mechanical lift for Resident #23 prior to the fall. Interview with the Director of Nursing (DNS) on 5/5/2025 at 12:35 PM identified that if a resident expressed difficulty standing and stated he/she could not stand, staff should have stopped, and a mechanical lift should have been used. The DNS stated that lifting a resident under the axilla was not an appropriate transfer method and a gait belt should have been used. Furthermore, staff should have stopped immediately when the resident stated he/she could not continue. The situation should have been escalated to a Registered Nurse Supervisor to assess the resident's condition prior to proceeding with any transfer or manipulation Resident #23's leg. Re-interview with the DNS on 5/5/25 at 2:53 identified that although it was indicated on the Reportable Event following Resident #23's fall, through the investigation process, the DNS was able to substantiate that RN #7 never notified a provider, MD or APRN, that Resident #23 had fallen. The DNS indicated that the facility MD was not notified until the following day when the hospital called the facility. Interview with the Director of Rehabilitation Services on 5/5/2025 at 3:13 PM indicated that using a gait belt to transfer any resident was the standard practice for all resident transfers. Interview with the Chief Clinical and Safety Officer on 5/5/2025 at 3:15 PM identified that staff should have used a gait belt when transferring residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with MD #1 on 5/6/2025 at 1:36 PM identified that any change in a resident's condition must be reported immediately. MD #1 reported she was not informed of Resident #23's fall and only became aware Resident #23 sustained a fracture when she was contacted by the Emergency Department. MD #1 stated that had she been notified she would not have allowed the resident to leave for her scheduled appointment, instead she would have evaluated the resident herself. If she had not been on-site, she would have evaluated the situation and sent the resident to the Emergency Department. She further noted that while an orthopedic specialist would be the best suited to speak to the exact cause of the injury, a fall with a twisting mechanism could reasonably result in the type of spiral fracture Resident #23 had sustained. Although requested, the facility did not have a transfer policy. Review of the Notification Change in Condition, Change in Treatment/Services Policy directed, in part, that the supervisor/ RN Manager conduct a complete physical/mental assessment and document the findings. The facility will inform the resident, resident's physician, and the resident's family/legal representative when there is a change in condition.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 2 of 4 sampled residents (Resident #54 and Resident #285) reviewed for nutrition, for Resident #54, the facility failed to reweigh a resident after a significant weight loss and for Resident #285 the facility failed to obtain a timely admission weight and and failed to reweigh a resident with noted weight loss and receiving nutrition via a gastrostomy tube. The findings include: 1. Resident #54 was admitted to the facility in July of 2024 with diagnoses that included dysphagia (difficulty swallowing), dementia, diabetes and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #54 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment, required partial/moderate assistance for personal hygiene, bed mobility and transfers. A Resident Care Plan in effect in January of 2025 identified Resident #54 was on mechanically altered diet secondary to dysphagia. Interventions included mechanical soft diet with ground meats, extra sauces/gravies, extra syrups and jellies, supervision of meals, checking ticket for the correct diet, weekly weights and labs as ordered. A physician's order dated 1/2/2025 directed to obtain weekly weights on Thursday evening on the 3:00 to 11:00 PM shift. Review of MAR, Weights and Vitals Summary from 1/2/2025 through 2/14/2025, identified the following weights. Date Weight in pounds (Lbs.) Discrepancy 1/2/2025 242.2 Lbs. 0 1/9/2025 241.0 Lbs. -1.2 Lbs. 1/16/2025 230.8 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10.2 Lbs. 2/1/2025 228.6 Lbs. -2.2 Lbs. 2/5/2025 230.2 Lbs. +1.6 Lbs. 2/6/2025 230.0 Lbs. -0.2 Lbs. 2/7/2025 230.0 Lbs. 0 Lbs. 2/14/2025 225.6 Lbs. -4.4 Lbs. Clinical Record review failed to identify reweight documentation or reweight refusals after a 10.2 lbs. weight loss in 1 week as documented on 1/16/2024. Interview and record review with the RN #1 on 5/1/25 at 11:00 AM identified that NAs obtain residents weights and nurses document weights in the Electronic Medical Record (EMR). RN #1 identified that Resident #54 was not reweighed after a significant weight loss documented on 1/16/25. RN #1 could not give a reason why Resident #54 was not reweighed but indicated that he/she should have been reweighed immediately to confirm the weight. Interview with the Dietician, on 5/1/25 at 2:00 PM, identified that she was not notified by nursing staff when Resident#54 lost 10.2 lbs. in one week. The Dietician indicated that she learned of the weight loss about two weeks after the weight loss occurred. The Dietician indicated that any resident with a weight change of 5 lbs. or more from the previous weight should be re-weighed for weight confirmation, and appropriate notifications should be made. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/5/25 at 12:30 PM failed to identify if attempts to reweigh Resident #54 were made after he/she lost 10.2 Lbs. within a week. The DNS indicated that Resident #54 should have been reweighed, and nursing staff should have notified the dietician. 2. Resident #285 was admitted on [DATE] with diagnoses that included malignant neoplasm of the tongue, gastrostomy tube, and adult failure to thrive. The Nursing admission assessment dated [DATE] identified Resident #285 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition, and required supervision to limited assistance with bed mobility, transfers, toileting and dressing. Resident #285 was unable to consume anything by mouth and required a Gastrostomy Tube (G-tube) for nutrition. Additionally, the area where the weight should have been documented was blank. The baseline Resident Care Plan (RCP) dated 4/26/2024 identified Resident #285 could not have anything by mouth and would tolerate tube feedings without difficulty and without a significant weight change. Interventions included providing tube feedings, administering/monitoring, and weighing the resident as ordered, and that the dietician was to follow up as needed. A physician's order dated 4/26/2025 directed Resident #285 was to take nothing by mouth and to administer the tube feeding formula via G-tube continuously at 40 milliliters (ml) per hour until seen by the dietician, weigh upon admission and continue to weigh the resident for 4 consecutive weeks. Review of nurse's note dated 4/26/2025 through 4/28/2025 failed to identify an admission weight was obtained. A Nutrition Assessment signed on 4/28/2025 by the dietician identified that Resident #285's admission weight was pending, his/her ideal body weight was 120 pounds (lbs.), and a hospital weight was noted to be 118 lbs. Interview with Registered Nurse (RN) #1 on 4/28/2025 at 2:24 PM failed to identify that Resident #285's admission weight had been obtained per the physician order dated 4/26/2025. RN #1 was unaware that an admission weight had not been obtained stating that she would get one now. Subsequent to surveyor inquiry, Resident #285's weight was obtained (3 days post admission) on 4/29/2025 and noted to be 109.8 lbs. representing a 6.95% weight loss from the hospital weight. In an interview and review of the clinical record with the Director of Nursing Services (DNS) on 5/5/25 at 10:06 AM, documentation failed to reflect an admission weight or that a reweight had been completed. The DNS could not explain why the initial weight was not obtained until 3 days after admission and could not explain why a reweight had not been completed, per the facility policy, and following the significant loss of weight noted from the hospital weight. The DNS further indicated that the nurse and NA were responsible to obtain the admission weight on admission or the next day and obtain a reweight when a significant weight loss was noted. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weight assessment and intervention policy directed, in part, the nursing staff will measure the resident's weight on admission, the next day, and weekly for 4 weeks thereafter. Weights will be recorded in the electronic health record under the individual's medical record. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. Verbal notification must be confirmed in writing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident # 27) reviewed for hospitalization, the facility failed to assess a symptomatic resident with a history of congestive heart failure and for the only sampled resident (Resident #44) reviewed for respiratory care, the facility failed to change oxygen tubing in a timely manner. The findings include: 1. Resident #27 's diagnoses included respiratory failure, deep vein thrombosis, pulmonary emboli, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #27 required a walker for ambulation, required supervision with transfers, and partial assistance with dressing and tub/shower transfers. The Resident Care Plan (RCP) dated 12/20/2024 did not address conditions related to the Resident #27's admitting diagnoses including congestive heart failure (CHF), asthma, and recent pulmonary emboli. Additionally, the RCP did not include interventions, goals, or monitoring parameters related to CHF or respiratory distress. Review of the facility Vitals Summary documentation and nursing notes identified Resident #27's oxygen saturation was 96% on 2/21/2025 at 9:20 PM, was 94% on 2/22/2024 at 4:41 PM, was 88% on 2/23/2025 at 11:59 PM, was 90% on 2/23/2025 at 5:37 AM, and decreased to 72% at 2/23/2025 at 4:34 AM. A nurse's note written by LPN #6 dated 2/23/2025 at 5:37 AM identified Resident #27's oxygen saturation was 90% (normal 95% to 100%). LPN #6 indicated that the resident had mild congestion, chills, and was cool to touch. The note failed to identify an assessment of lung sounds, a repeat oxygen saturation level, or that the Registered Nurse (RN) supervisor was notified. A nurse's note written by LPN #7, dated 2/23/2025 at 11:09 AM identified that Resident #27 called for help as he/she was concerned with bilateral leg swelling. LPN #7 indicated that Resident #27 had 1 plus bilateral lower leg edema, and the information was noted in the physician book. Review of the Nursing/Physician communication log dated 2/23/2025 failed to identify an entry for the provider to evaluate Resident #27. A nurse's note dated 2/24/2025 at 1:15 AM identified Resident #27 called LPN #6 into the room with complaints of shortness of breath, and chest tightness. Resident #27 was found to be hypoxic (insufficient oxygen), tachypneic, (rapid breathing), and grimacing. LPN #6 notified RN #6. The nurse's note dated 2/24/2025 at 5:59 AM written by RN #6 identified that he was alerted by the charge nurse that Resident #27 was short of breath, identified that Resident #27 complained of pain, non-radiating, lung sounds were tight, and the resident was congested. A non-rebreather mask was applied; maximum oxygen was given and Resident #27's oxygen saturation was noted to increase to 92%. EMS was called and the resident was transported to the hospital for further evaluation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Discharge summary dated [DATE] identified Resident #27 was admitted on [DATE] related to acute hypoxic respiratory failure, shortness of breath, and lower extremity edema. Resident #27 was subsequently diagnosed with an acute onset of Chronic Heart Failure (CHF). Interview with Resident #27 on 4/30/2025 at 9:45 AM identified he/she reported expressing concerns to staff for 2 days prior to being transferred to the hospital for hypoxia, shortness of breath, and lower extremity edema. Interview and review of clinical record with the Chief Clinical and Safety Officer (CCSO) and the Director of Nursing (DNS) on 5/6/2025 at 11:02 AM identified that they would have expected LPN #6 to listen to lung sounds for a resident with a drop in oxygen saturation and a history of CHF when documenting mild congestion. The CCSO indicated if LPN #6 felt as though there was a change in condition the LPN should have escalated the change to the Registered Nurse. According to standard nursing practice, it is expected that a resident with a history of congestive heart failure who potentially exhibits signs of congestion be assessed for respiratory changes, including auscultation of lung sounds and report abnormal finding to a nurse supervisor. 2. Resident #44's diagnoses included diabetes, hypertension, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 had a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment, required set-up assistance with eating, was dependent on staff for toileting and personal hygiene and required the use of oxygen. The Resident Care Plan (RCP) in effect in April and May of 2025 failed to identify a RCP for oxygen use. Physician's orders in effect for the month of May 2025, directed the administration of oxygen at 2-4 Liters Per Minute (lpm) via a nasal cannula, change the oxygen tubing weekly every night shift on Sunday, and check oxygen saturation levels every shift. Observations on 4/28/2025 at 11:54 AM and 4/29/2025 at 11:30 AM identified Resident #44 lying in bed with continuous oxygen being administered via nasal cannula at 2 lpm in place. The oxygen tubing was dated as last being changed on 3/16/2025. Review of Treatment Administration Record (TAR) identified that staff had signed off that the oxygen tubing had been changed on 4/5/2025, 4/12/2025, 4/19/25, and 4/26/25 Interview and observation with the Director of Nursing Services (DNS) on 4/29/2025 at 12:40 identified Resident #44's oxygen tubing with a label dated 3/16/2025 (44 days prior to the observation). The DNS indicated the date of the tubing represented the last time the Resident #44's nasal cannula tubing was changed. The DNS identified that oxygen tubing should have been changed weekly per the physician's order, for infection control purposes, and to maintain the integrity and accuracy of the tubing which could cause ineffective oxygen delivery and pose a safety risk to Resident #44. The DNS indicated that staff should not have signed off the TAR if the tubing had not been changed, that she would need to re-educate staff, and would implement a system to audit weekly tubing changes. (continued on next page)

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Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Oxygen Administration, identified that oxygen tubing would be changed weekly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy, and interviews for the only sampled resident (Resident #56) reviewed for hemolytic treatments, the facility failed to ensure the treatment center was notified when appointments were going to be missed due to transportation and failed to reschedule the appointment per the hemolytic center's request. The findings include: Resident #56's diagnoses included end stage renal disease, dependence on hemolytic treatment, anemia and amputation. A quarterly Minimum Data Set assessment dated [DATE] identified Resident #56 had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, was dependent on staff for personal hygiene and transfers and was receiving hemolytic treatment. The Resident Care Plan (RCP) in effect for the month of April of 2025 identified Resident #56 was on hemolytic treatment. Interventions included encouraging Resident #56 to go for the scheduled hemolytic appointments, monitor lab work, monitor for peripheral edema, and obtain vital signs and weigh per protocol. Report any significant changes to the physician. A physician's order in effect for the month of April 2025, directed to send Resident #56 to hemolytic treatments 3 times per week on Tuesdays, Thursdays and Saturdays. Interview on 4/28/2025 at 11:30 AM with Resident #56 identified that he/she had missed two consecutive hemolytic treatments on 4/22/2025 and 4/24/2025 due to transportation issues. Resident #56 identified he/she was on time and ready to be picked up both days by the facility arranged transportation, but a transportation vehicle never arrived. Resident #56 identified that there was a history of the early transportation vehicle arrivals, ahead of the schedule pick up time, and that led to cancellations and/or rescheduling of hemolytic treatments. Resident #56 indicated that due to having set scheduled times for treatments, it was unfair to be picked up too early because that led to extended wait time at the center making him/her uncomfortable in the wheelchair. Interview on 4/30/25 at 2:16 PM with the Scheduler identified that the transportation company failed to pick up the rides (book) that had been requested by the facility, in advance for the 4/22/2025 and 4/24/2025 hemolytic treatments. The Scheduler indicated that she had informed the Administrator and the DNS of the issue. The Scheduler indicated that the resident had not refused rides for the 2 days indicated and that Resident#56 had missed hemolytic treatments on both days due to a lack of transportation arrangements. Review of the clinical record, nursing progress notes by RN #1 identified that on 4/25/2025, Resident #56 blood pressure was 182/99 after he/she missed the second hemolytic treatment scheduled for 4/24/2025. RN#1 identified that physician was notified and ordered immediate lab work be drawn. An attempt was made to draw labs on 4/26/2025 at 7:05 AM but Resident #56 declined and indicated that he/she preferred to have labs drawn at the hemolytic center later during the day on his/her rescheduled visit. Further review of Resident #56 clinical record identified that Resident #56 blood sugar was elevated to 509 on 4/25/2025 at 10:41 PM. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's progress note dated 5/1/2025 by MD #1 identified that Resident #56 had missed 2 sessions of hemolytic treatments due to transportation issues and that she had discussed this with the Scheduler, Social Worker, the DNS, and the [NAME] Administrator. MD #1 further indicated that Resident #56, in the past, cancelled the ride when transport did not arrive exactly at the time the resident wanted, but that should not effect the resident's transportation booking as she thought insurance covered the cost of the rides. Interview with the DNS on 5/1/2025 at 11:30 AM, identified that she learned of the transportation issue on 4/22/2025 when Resident #56's ride failed to show up. The DNS indicated that Resident #56 did not receive make-up hemolytic treatments because, in the past, he/she had cancelled hemolytic appointments after the transportation arrived. When a ride was booked it goes into a computer generated ride bank and the transportation companies have to book the ride. Resident #56 did not have a transportation company confirm they would book his/her rides on 4/22/2025 and 4/24/2025 due to the resident having a history of cancelations. The DNS indicated that the facility's policy directed that no further action was necessary if a resident missed the first two hemolytic treatments, and that the resident would be transferred to the emergency room if they missed a third hemolytic treatment. Interview with RN #5 (hemolytic treatment center nurse) on 5/5/2025 at 1:54 PM identified that they offered a make-up treatment the next day when a resident missed their scheduled appointment. RN #5 indicated that the facility never notified the hemolytic treatment center of Resident #56's transportation issue or that they were not going to be able attend their appointment. Further, RN #5 stated that the hemolytic center had to reach out to the facility on both days when Resident #56 did not show up for his/her scheduled treatments and that she had requested the facility to reschedule Resident #56 for make-up treatments the next day. RN #5 indicated that the facility never contacted the hemolytic center to schedule make-up appointments for Resident #56 for either of the missed treatments. Review of facility hemolytic treatment policy, identified in part, that any issues such as concerns, labs, medication, diet, weights, vital signs etc. that affect the resident's plan of care are to be communicated and ensure the resident's transportation is arranged in a timely fashion to and from the hemolytic treatment center .Monitor weights as ordered in the facility and document per the policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, review of the clinical record, facility policy, and interview for 1 of 5 residents (Resident #1) observed for medication pass the facility failed to ensure unused medications were properly stored/destroyed. The findings include: Resident #1's diagnosis included thyroid disease and heart failure. Observations on the South Center Unit on 5/1/2025 at 8:42 AM, with LPN #2, identified she disposed of medications that were unused into a garbage can attached to the side of the medication cart. LPN #2 prepared to repour medications that had been disposed of, and was stopped by the surveyor. LPN #2 indicated that the unsued medications should not have been placed in the trash can due to safety concerns as the medications would be accessible to residents. Subsequent to surveyor inquiry, LPN #2 donned, gloves, removed the medications from the garbage and placed all unused medications in the covered and locked sharps container affixed to the other side of the medication cart. Review of the undated Medication Destruction and Disposal policy, identified, in part, that medications will be stored in a locked area until destroyed and that medications considered a hazard are placed in appropriate containers (sharps/biohazarous recepticale.)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, and interviews for 1 of 5 sampled residents (Resident #69) reviewed for unnecessary medications, the facility failed to ensure pharmacy recommendations were reviewed and acted upon. The findings include: Resident #69's diagnoses included Non-Alzheimer's dementia, anxiety, and depression. A physician order dated 9/26/2024 directed to administer 2 tablets of 325 milligram (mg.) acetaminophen by mouth every 4 hours as needed for general discomfort. The Resident Care Plan (RCP) dated 3/5/2025 identified Resident #69 had depression and anxiety. Interventions included medications as ordered, evaluation of the drug regimen to be reviewed by the medical doctor and allowing the resident to verbalize feelings related to the disease process. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #69 had a Brief Interview of Mental Status (BIMS) score of 0 indicating severe cognitive impairment, required moderate assistance with personal hygiene, and was independent with transfers. A review of pharmacy recommendations for October 2024, December 2024, February 2025, and April 2025 identified a pharmacy recommendation to update Resident #69's order for acetaminophen to include the maximal daily dose (4000 mg. a day). An interview with the Director of Nursing Services (DNS) on 5/5/2025 at 2:53 PM identified that although the physician was presented with the 4 pharmacy request forms many times to address the recommendation to ensure Resident #69 did not exceed the maximal daily dosage of acetaminophen, the physician failed to address or return the provided forms. The DNS stated it was facility policy for pharmacy recommendation forms to be addressed and signed by the physician as a physician order was needed to make any changes to Resident #69's medication regimen. Although requested, the facility did not provide a policy on pharmacy recommendations.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy, and interviews on 1 of 4 units reviewed for medication to residents, (Resident #1, Resident #4, Resident #8, Resident #16, Resident #17, Resident #36, Resident #37, Resident #38, Resident #39, Resident #45, Resident #46, Resident #49, Resident #50, Resident #55, Resident #56, Resident #66, Resident #68, Resident #75, Resident #77, Resident #233 and Resident #282), the facility failed to ensure meds given greater than once daily were administered at the correct time per the physicians orders. The findings include: Based on observations, review of clinical records, facility documentation, facility policy, and interviews for Residents #1, #4, #8, #16, #17, #37, #38, #39, #46, #49, #50, #55, #56, #68, #75, #77, #233, #282, the facility failed to ensure medications were administered at the correct time per the physician's orders. The findings include: 1. Resident 1's diagnosis included chronic obstructive pulmonary disease, heart failure, old myocardial infarction and chronic respiratory failure with hypoxia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. Physician's orders for the month of April 2025, directed to administer Apixaban 5mg, give 1 tablet by mouth every 12 hours for anticoagulation, Budesonide suspension 0.25 milligrams (mg)/2 milliliters (ml) give 2 ml inhalation orally via nebulizer every 12 hours for COPD exacerbation for 14 days, natural balance tears solution 0.1-0.3% (Dextran 70-Hypromellose) instill 2 drop in both eyes 2 times a day, and Formoterol Fumarate inhalation nebulization solution 20 (mcg) micrograms/2ml (Formoterol Fumarate) give 2ml inhalation orally via nebulizer every 12 hours for COPD exacerbation for 14 days. Record review identified that Resident #1's scheduled medications for 4/28/2025 at 9:00 AM were administered at 11:21 AM, an hour and 21 minutes after the acceptable timeframe. 2. Resident #4's diagnoses included diabetes, schizophrenia and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #4 a BIMS score of 5 indicating severe cognitive impairment Physician's orders for the month of April 2025 directed to administer Haloperidol Lactate Concentrate 2mg/ml, give 5 ml by mouth in the morning and 7.5 ml by mouth at bedtime for schizophrenia, Trazodone HCl oral tablet 50 mg (Trazodone HCl). Give 0.5 tablet by mouth 2 times a day for anxiety, and Valproate Sodium oral solution 250mg/5ml (Valproate Sodium), give 2.5 ml by mouth 2 times a day related to schizophrenia. Record review identified that Resident #4's scheduled medications for 4/28/2025 at 9:00 AM were administered at 11:00 AM, an hour and after the allowed timeframe. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 8's diagnoses included hypertensive heart disease with heart failure, other specified disorders of urinary system. The quarterly MDS assessment dated [DATE] identified Resident #8 had a BIMS score of 3 indicating severe cognitive impairment. Physician's orders for the month of April 2025 directed to administer Metoprolol tartrate tablet 50 mg by mouth 2 times a day related to hypertension and Potassium Chloride powder 40 mEq by mouth 2 times a day for hypokalemia. Record review identified that Resident #8's scheduled medications for 4/28/2025 at 9:00 AM were administered at 2:10 PM, 4 hours and 10 minutes after the allowed timeframe. 4. Resident 16's diagnoses included diabetes, dysphagia and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #16 had BIMS score of 14 indicative no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Insulin Lispro injection solution 100 unit/ml (Insulin Lispro). Inject 6 units subcutaneously before meals related to type 2 diabetes mellitus 3 times a day with meals. Record review identified that Resident #16's scheduled medications for 4/28/2025 at 9:00 AM were administered at 1:24 PM, 1 hour and 24 minutes after the allowed timeframe. 5. Resident 17's diagnoses included dementia, chronic kidney disease, and generalized muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #17 had a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment Physician's orders for the month of April 2025 directed to administer Potassium Chloride Extended Release (ER) Capsule 10 MEQ (Potassium Chloride ER), give 10 mEq by mouth 2 times a day for vitamin/mineral deficiency and hypokalemia and Promod liquid protein 2 times a day for wound healing 30cc orally twice a day for wound healing. Record review identified that Resident #17's scheduled medications for 4/28/2025 at 9:00 AM were administered at 6:30 AM, 1 hour and 30 minutes before the allowed timeframe. 6. Resident 37's diagnoses included glaucoma, hallucinations, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #37 had a BIMS score of 7 indicating severe cognitive impairment (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for the month of April 2025 directed to administer levetiracetam oral tablet 500mg (Levetiracetam), give 1 tablet by mouth 2 times a day for seizure disorder, Timolol Maleate ophthalmic solution 0.5 % (Timolol Maleate (Ophthalmic), instill 1 drop in both eyes 2 times a day for glaucoma, and Brimonidine Tartrate ophthalmic Solution 0.2 % (Brimonidine Tartrate), instill 1 drop in both eyes 2 times a day for glaucoma. Record review identified that Resident #37's scheduled medications for 4/28/2025 at 9:00 AM were administered at 6:35 AM, 1 hour and 35 minutes before the allowed timeframe. 7. Resident 38's diagnoses included hypertension, acute embolism and thrombosis and atrial fibrillation. The quarterly MDS assessment dated [DATE] identified Resident #38 BIMS score was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Apixaban Oral Tablet 2.5 mg give 1 tablet by mouth 2 times a day related to acute embolism and thrombosis of unspecified deep veins of right proximal lower extremity, Combigan ophthalmic solution 0.2-0.5%, Brimonidine Tartrate-Timolol maleate). Instill 1 drop in both eyes every 12 hours for glaucoma, and Gabapentin capsule100mg, give 200mg by mouth 2 times a day for neuropathic pain. Record review identified that Resident #38's scheduled medications for 4/28/2025 at 9:00 AM were administered at 12:00 PM, 2 hours after the allowed timeframe. 8. Resident 39's diagnoses included cardiomyopathy, anemia, epilepsy and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #39 BIMS score was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Acyclovir Oral tablet 400 mg give 1 tablet by mouth every 12 hours related to personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues, Carvedilol oral tablet 6.25 mg give 1 tablet by mouth every 12 hours for hypertension, Keppra oral tablet 500 mg (Levetiracetam), 1 tablet by mouth 2 times a day for seizure disorder, Midodrine HCl oral tablet 5 mg (Midodrine give1 tablet by mouth 3 times a day related to cardiomyopathy and Magnesium oxide 400 mg oral tablet (magnesium oxide supplement) give 2 tablet by mouth 3 times a day related to personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. Record review identified that Resident #39's scheduled medications for 4/28/2025 at 9:00 AM were administered at 1:00 PM, 3 hours after the allowed timeframe. 9. Resident 46's diagnoses included anemia, diabetes and heart failure. The quarterly MDS assessment dated [DATE] identified Resident # 46 BIMS 6 indicating severe cognitive impairment. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for the month of April 2025 directed to administer Ferrous Sulfate tablet 325 (65 Fe) mg. Give 1 tablet by mouth 2 times a day for supplement and ProSource Oral liquid (Nutritional Supplements), give 30 ml by mouth 2 times a day for low albumin. Record review identified that Resident #46 's scheduled medications for 4/28/2025 at 9:00 AM were administered at 1:00 PM, 3 hours after the allowed timeframe. 10. Resident 49's diagnoses included dementia, anxiety and depression. The quarterly MDS assessment dated [DATE] identified Resident #49 BIMS 7 indicating severe cognitive impairment. Physician's orders for the month of April 2025 directed to administer Calcium 600+D tablet 600-200 mg-unit(Calcium Carbonate-Vitamin D). Give 1 tablet by mouth 2 times a day for Vitamin/ Mineral deficiency. Record review identified that Resident #49's scheduled medications for 4/28/2025 at 9:00 AM were administered at 11:37 PM, 1 hour and 37 minutes after the allowed timeframe. 11. Resident 50's diagnoses included chronic kidney disease, diabetes and heart failure. The admission MDS assessment dated [DATE] identified Resident #50 BIMS was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Probiotic oral capsule (Saccharomyces boulardii), give 1 capsule by mouth 2 times a day for antibiotic use, and Saccharomyces boulardii oral packet 250 mg (Saccharomyces boulardii), give 250 mg by mouth 2 times a day related to osteomyelitis. Record review identified that Resident #50 's scheduled medication for 4/28/2025 at 9:00 AM were administered at 1:53 PM, 3 hours 53 minutes after the allowed timeframe. 12. Resident 55's diagnoses included diabetes, hypertension and depression. The quarterly MDS assessment dated [DATE] identified Resident #55 BIMS was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025, directed to administer Eliquis tablet 5 mg (Apixaban) 5 mg by mouth 2 times a day for anticoagulant, Gabapentin tablet 400 mg by mouth 3 times a day for neuropathy, and Tylenol extra strength tablet 500 mg (Acetaminophen) 2 tablets by mouth 2 times a day for pain. Record review identified that Resident #55 's scheduled medications for 4/28/2025 at 9:00 AM were administered at 1:30 PM, 3 hours 30 minutes after the allowed timeframe. 13. Resident 56's diagnoses included end stage renal disease, diabetes and anxiety. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #56 BIMS was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Novolog Flex pen subcutaneous solution Pen-injector 100unit/ml (insulin Aspartate) inject 15 unit subcutaneously before meals for diabetes. Record review identified that Resident # 56's scheduled medications for 4/28/2025 at 8:00 AM were administered at 10:08 AM, 1 hours 8 minutes after the allowed timeframe. 14. Resident 68's diagnoses included coronary artery disease, retention of urine depression, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #68 BIMS was 14 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Acetaminophen Oral Tablet, give 325 mg by mouth 4 times a day for pain related to atherosclerotic heart disease of native coronary artery without angina pectoris. Record review identified that Resident #68's scheduled medications for 4/28/2025 at 9:00 AM were administered at 11:30 PM, 1 hour and 30 minutes after the allowed timeframe. 15. Resident 75's diagnoses included dementia, hemiplegia and muscle weakness. The admission MDS assessment dated [DATE] identified Resident #75 BIMS was 13 indicating no cognitive impairment. Physician's orders for the month of April 2025, directed to administer Diclofenac Sodium external gel 1 % (topical), apply to the back of the neck topically 4 times a day for pain/inflammation 2 g. Record review identified that Resident #75 's scheduled medications for 4/28/2025 at 9:00 AM medications were administered at 12:21 PM, 2 hours and 21 minutes after the allowed timeframe. 16. Resident 77's diagnoses included diabetes, hypertension and muscle weakness. The admission MDS assessment dated [DATE] identified Resident #77 BIMS was 99 indicating severe cognitive impairment. Physician's orders for the month of April 2025 directed to administer Lovenox injection solution prefilled syringe 60 mg/0.6ml (Enoxaparin Sodium). Inject 60 mg subcutaneously every 12 hours for right lower extremity deep venous thrombosis and Humalog injection solution 100 unit/ml (Insulin Lispro), inject as per sliding scale: subcutaneously before meals and at bedtime for diabetes. Record review identified that Resident #77 's scheduled medications for 4/28/2025 at 9:00 AM were administered at 12:44 PM, 2 hours, 44 minutes after the allowed timeframe. 17. Resident 233's diagnoses included hypertension, anxiety and arthritis. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #233 BIMS was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025, directed to administer Apixaban oral tablet 2.5 mg give 1 tablet by mouth 2 times a day for anticoagulant, buspirone HCl oral tablet 5 mg give 1 tablet by mouth every 12 hours for mood, Loperamide HCl oral capsule 2 mg, give 1 capsule by mouth 2 times a day for antidiarrheal, and clonidine HCl oral tablet 0.1 mg give 1 tablet by mouth 3 times a day for blood pressure. Record review identified that Resident #233 's scheduled medications for 4/28/2025 at 9:00 AM medications were administered at 1:41 PM, 3 hours and 41 minutes after the allowed timeframe. 18. Resident 282's diagnoses included diabetes, hypokalemia (low potassium) and iron deficiency anemia. The admission MDS assessment dated 2/25 /2025 identified Resident #282 BIMS was 15 indicating no cognitive impairment. Physician's orders for the month of April 2025 directed to administer Tums oral tablet 10mg (Calcium carbonate (antiacid)). Give 1 tablet 2 times a day for hypocalcemia. Record review identified that Resident #282's scheduled medications for 4/28/2025 at 9:00 AM were administered at 1:25 PM, 3 hours and 25 minutes after the allowed timeframe. Observation and interview with RN #2 on 4/28/25 at 12:30 PM identified that she was in the hallway still passing 9:00 AM meds. RN #2 identified that facility had experienced 3 nurse call outs for the 7:00 AM to 3:00 PM shift and efforts for replacements had failed. RN #2 identified that she was fairly new to the facility and had been hired as an Infection Prevention nurse. RN #2 further identified that she had been scheduled to attend her infection control training/orientation in a different facility but while on her way, she was told to come back to the facility and work as a floor RN due to multiple call outs. RN #2 identified that she had arrived back to the facility about 9:00 AM, received report and assumed her role as a floor nurse. Additionally, RN #2 identified that several residents were still awaiting their 9:00 AM meds and indicated that she was slow in passing meds because she started the medication pass late and she had never worked or received orientation on the unit. RN #2 indicated that she had reached out to the DNS about 10:00 AM and expressed concern about the delay in medication pass, but the DNS indicated that she was aware of the situation and had encouraged her to do the best she could. Interview with the Chief Clinical and Safety Officer (CCSO) on 4/28/2025 at 1:00 PM, identified that he had learned of the delay in resident medication administration not long ago and had reallocated staff to help with the medication pass. The CCSO indicated they had experienced multiple call outs and were unable to find replacements. The CCSO indicated that he was not aware that RN #2 had reached out to the DNS and had expressed her concern of the delay in medication administration. Re-interview with the CCSO on 4/28/2025 at 2:00PM identified that he had reached out to the facility's Medical Director, who was physically in the building conducting residents' assessments, to identify any harm or potential harm due to the delay in medication administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of residents' medical records identified that there was no actual harm that resulted due to the delay in medication administration. A review of the Administration of Medications Policies and Procedures policy directed, in part, that medications should be administered within 60 minutes of the scheduled administration time except before, with or after meal orders, which are administered based on mealtimes. The five rights of medication administration, right resident, right drug, right dose, right route and right time are applied for each medication being administered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility documentation, facility policy, and interviews for 1 of 4 medication carts reviewed for medication storage and labeling, the facility failed to ensure medication carts were locked when not attended and failed to remove expired medications. The findings include: Observations on 4/29/2025 at 11:53 AM on the South Wing identified the medication cart lock in the open position and left unattended at the end of the hallway near room [ROOM NUMBER]. The surveyor pulled on the medication cart drawers and all of the drawers were opened allowing access to the residents' medications. The surveyor immediately asked the staff to get the Director of Nursing Services (DNS) while continuing to monitor the unsecured medication cart. Interview with the DNS on 4/29/2025 at 12:00 PM identified the medication cart was unsecured and unattended. She could not explain why the nurse had left the medication cart unlocked and unattended and locked the cart herself. The DNS indicated she would address the issue with the employee. Observations on 4/30/25 at 11:30 AM, identified in the emergency intravenous (IV) supply tackle box, 1 liter of Normal Saline with 20 milliequivalent of potassium chloride had an expiration date of 11/20/2024, a plastic bag of 10 heparin IV flushes with an expiration date of 1/2025, and 2 Covid vaccines with an expiration date of 4/17/2025. Interview with Director of Nursing Services (DNS) on 4/3/25 at 11:35AM identified the IV fluid, bag of heparin and Covid vaccines were expired. The DNS removed and discarded the expired medications. The DNS indicated that she was responsible for checking the emergency medication box and that it was an oversight that the medications had expired and remained in the emergency box. Review of the Medication Administration policy directed, in part, the medication cart is to be kept closed and locked when out of site of the medication nurse. The Medication Administration policy failed to identify the storage of expired medications.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and interviews for 1 of 2 residents, (Resident #22), reviewed for food, the facility failed to accommodate a resident's preferences for meal items. The findings include: Resident #22's diagnoses included hemiplegia of the right side, aphasia, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, was dependent on transfers, required maximal assistance with bed mobility, and utilized a motorized wheelchair. A Nutrition assessment dated [DATE] identified Resident #22 was on a LCS diet, had food preferences that should be honored, was to receive large portions, and was to receive a bedtime snack daily. The Resident Care Plan (RCP) dated 3/5/2025 through 4/29/2025 identified Resident #22 was on a regular LCS diet. Interventions included ethnic foods, encourage to eat healthier options, and provide bedtime snacks every evening shift. Physician orders in effect from 11/1/2019 though 4/29/2025 identified Resident #22 was on a low calorie sweetener (LCS) diet of regular texture with liquids at a thin consistency. An interview with Resident #22 on 4/29/2025 at 9:49 AM identified he/she is given boneless pieces of chicken, instead of chicken legs and boned chicken thighs, and provided with bland tasting meals despite making the facility aware of his/her food preferences. Resident #22 further stated he purchased his/her own food outside of the facility and kept peanut butter and jelly, fruit, and other food items in his room because the facility did not accommodate his food requests. Review of the clinical record identified a Social Services note dated 6/27/2023 and written by Social Worker #1 identifying that the Director of Food Services was made aware of Resident #22's preferences, at that time, and indicated he had ordered meat pies, jerk seasoning, and bone-in chicken wings and thighs to meet Resident #22's preference for cultural meals. An interview with the Director of Food Services on 5/5/2025 at 8:14 AM identified he was aware of Resident #22's cultural requests for food and had purchased Jamaican meat pies and fresh fruit. The Director of Food Service stated he would not buy bone in meat because he believed it was a choking hazard and should never be in a long term care facility. He identified Resident #22's needs were being met with the Jamaican meat pies. The Director of Food Service failed to provide evidence that any Jamaican meat pies were currently in the facility's freezer or refrigerator and stated he must have used them all up. An interview with the Director of Nursing Services (DNS) on 5/5/2025 at 9:58 AM identified she was aware of Resident #22's food preferences and indicated the Director of Food Services was responsible for accommodating food requests. She further identified that she was not aware that Resident #22's food preferences were not being accommodated according to his/her request and RCP. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Although requested the facility failed to provide a policy for accommodating a resident's food preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility documentation, facility policy, and interviews the facility failed to ensure the steam table was washed and sanitized after every use, failed to ensure open food items were appropriately dated, and failed to ensure expired foods were removed from storage. The findings include: During a tour of the kitchen with the Director of Food Services on 4/28/2025 at 9:50 AM the following was identified: a. 2 half gallons of milk, each with an expiration date of 4/23/2025, were on a drink cart and were not set in ice. 1 half gallon was 1/2 full and 1 half gallon was full. An interview with the Director of Food Services identified that he was not aware the milk was expired and indicated the milk was intended to be used to serve the residents. b. The walk-in fridge had a soup bowl containing tuna salad dated 4/10/2025. c. 1 tray of cranberry jelly/sauce was dated 2/9/2025. d. 1 tray of cranberry jelly/sauce was dated 4/9/2025. e. 1 open plastic container of cranberry jelly was dated 4/6/2025. f. 2-12 ounce open bags of non-dairy topping, both 1/8 full, was noted to be undated. g. The walk-in freezer was found to have 1 bag of approximately 4 dozen frozen egg patties. The bag was open to air and undated. h. The milk refrigerator was found to have an open and undated 5 pound bag of shredded white cheese that still contained approximately 1 ½ pounds. Tour of the resident dining room with the Director of Food Services on 4/28/2025 at 10:45 AM identified the following: i. The steam table was found to have crusted red food on the sneeze guard. j. One ant was crawling in and out of a chafing dish. k. Crumbs of food were located on the table of the steam table and around 4 chafing dishes. l. Water in 3 of the chafing dishes was discolored and had floating food particles. m. There were stuck on food particles on the outside of the steam table cart. n. Three dirty plates were in chafing dish #2. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Food Services identified the water in the chafing dishes had not been changed in a few days. A second observation of the steam table with the Director of Food Services on 4/29/25 at 9:15 AM identified the chafing dish lids had food debris on the edges and the side tabletop and bottom shelf had not been cleaned. Further, he indicated that the steam table and side table were not cleaned with sanitizing spray as he uses a scouring powder instead. An interview with the Director of Food Services on 5/1/2025 at 12:25 PM identified the water in the chafing dishes should be emptied after every meal and the steam table should also be cleaned at that time. A third observation of the steam table with the Director of Food Services on 5/5/2025 at 8:06 AM identified the water in the chafing dishes had floating food particles. The Director of Food Services identified that the chafing dishes were not scrubbed and should have been run through the dishwasher. The facility's food policy identified, in part, that all items stored in the refrigerator will be covered, labeled with the contents and date, and prepared foods must be discarded within 3 calendar days of preparation. Further the policy stated that the steam table will be maintained in a safe and sanitary condition.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F814 [NAME] final Scope and Severity: E Based on observation and interview, the facility failed to ensure the dumpster area was maintained in a clean and sanitary manner and refuse was appropriately contained. The findings include: Observation of the facility's dumpster area with the Director of Food Service on 4/28/2025 at 10:24 AM identified the following items littered on the ground in front of 2 dumpsters: a. One, 3 cushion sized couch, flipped upside down, with visible water stains and dirt. b. One wood table with padding, upside down with wood in various stages of decomposition/rot. c. One tabletop with cover and foam. Foam was disintegrating and pieces of foam had been chewed away. d. Five cardboard boxes. e. One pedestal table with a metal base. f. One snow shovel. g. One used incontinence disposable under pad (Chux pad). h. Multiple used face masks, used bandages, paper scraps, plastic bags, and Styrofoam cups. An interview with the Director of Food Service on 4/28/2025 at 10:24 AM identified that he had just swept the area around the dumpster and indicated the wind often blew trash against the fence. He further indicated he was aware of a rodent problem near the dumpster and the pest control contractor had placed multiple traps outside of the dumpster area to catch the rats before they entered the facility. The Director of Food Services stated the couch, and tables had been on the ground for about a year and the Director of Maintenance was responsible for removal. An interview on 4/28/2025 at 10:28 AM with the Director of Maintenance identified he was aware of the garbage and used furniture in front of the dumpsters. He stated his request for a dumpster from corporate was denied and calls to local trash haul-away companies were too expensive. An interview with the facility's Chief Clinical Officer on 4/29/2025 at 8:56 AM identified he was made aware of the trash problem near the dumpster on 4/28/2025 by the Director of Maintenance but he had not personally seen the trash issue. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and observation with the facility's Chief Clinical Officer on 4/29/2025 at 9:02 AM of the facility's dumpster area identified that the items observed with the Director of Food Service remained as previously observed. The Chief Clinical Officer stated the amount of garbage was greater than what he understood it to be, and he would need to order a dumpster to remove all of the items. The Chief Clinical Officer identified that he was uncertain of the specifics of the facility's policy, but the facility should ensure garbage bags are tied, and all medical/procedure gloves must be bagged and tied. Although requested a facility policy on refuse and garbage storage and disposal was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy, and interviews for 1 of 5 residents, (Resident #1), reviewed for medication administration, the failed to ensure medications were handled in a clean manner, for 1 of 3 sampled residents, (Resident #20), reviewed for pressure ulcers, and for 1 of 4 residents reviewed, (Resident #285), for nutrition, the facility failed to ensure Personal Protective Equipment (PPE) was worn for residents on Enhanced Barrier Precautions (EBP), for Resident #20 failed to perform hand washing and changing gloves during wound care, and for 1 of 2 medication rooms reviewed, failed to ensure a clean and sanitary environment in the medication room was maintained. The findings include: 1. Resident #1's diagnosis included thyroid disease and heart failure. Observations on the South Center Unit with LPN #2 on 5/1/2025 at 8:42 AM, during the medication administration pass, identified LPN #2 pour Resident #2 Medications. During the medication pour, a tablet of Levothyroxine was dropped. LPN #2 picked up the tablet with her ungloved hand and placed it back in the cup with the medications that had already been poured. LPN #2 was stopped by the surveyor just prior to adding the next medication to the cup. LPN #2 indicated that she should not have replaced the medication in the cup once it had come in contact with the surface of the cart and her hand due to infection control practices. Review of the undated medication Administration General Guideline policy directed, in part, that gloves should be worn when splitting tablets to prevent touching of tablets during the administration process. 2. Resident #20's diagnoses included epilepsy, bullous pemphigoid, and cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 had a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment, was dependent for transfers, required extensive assistance with bed mobility, and was at risk for pressure ulcers. The Resident Care Plan (RCP) dated 4/9/2025 identified Resident #20 had a problem with skin integrity. Interventions included repositioning per resident's needs, treatments as ordered, record/report any new changes to MD/nurse, and weekly skin checks. A Physician's order dated 4/17/2025 directed EBP for wounds and foley catheter. An observation on 4/29/2025 at 10:15 AM identified signage posted on Resident #20's door, visible prior to entry, which indicated EBP with directions that providers and staff must wear gloves and a gown for high contact activities. a. An observation and interview on 4/30/2025 at 1:57 PM with LPN #3 identified that she entered Resident #20's room to provide wound care. LPN #3 set up Resident #20's wound care supplies and was stopped by the surveyor at the moment wound care was to begin being provided. LPN #3 identified that she was aware Resident #20 was on EBP but forgot to put on her PPE. Further she indicated she was aware the reason for the EBP order was due to skin issues and an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. An observation and interview on 4/30/2025 at 2:29 PM with RN #2 of Resident #20's wound care identified that RN #2's dirty glove fell off while wrapping the wound area with gauze. Although the dirty glove fell off, RN #2 replaced the same dirty glove instead of replacing it with a clean glove and failed to sanitize her hands. RN #2 identified that she was aware she should have washed her hands and placed new gloves when her dirty glove fell off. RN #2 failed to explain why she had replaced the dirty glove and failed to sanitizer her hands but stated the facility policy instructed staff to change gloves and not replace the dirty glove. An interview with the Director of Nursing Services (DNS) on 4/30/2025 at 2:54 PM for the provision of Resident #20's care identified the expectation for staff was to wear a gown, gloves, and mask when providing care to a Resident on EBP. Additionally, the DNS indicated if a glove fell off during wound care, the expectation was to wash hands and change gloves. c. An interview and observation on 5/5/2025 at 10:20 AM identified that hospice person #1 was providing direct care to Resident #20. Hospice person #1 was touching Resident #20's bare skin with gloves but had failed to wear on a gown. Hospice Person #1 identified she was aware that she should wear the appropriate PPE when providing care for a Resident on EBP, but she failed to notice the EBP sign hung on Resident #20's door. d. An interview and observation on 5/5/2025 at 10:35 AM identified that Hospice Person #2 was in Resident #20's room providing direct care. Hospice Person #2 was touching Resident #20's bare skin and failed to place a gown and gloves on prior to the start of care. Hospice Person #2 identified that she saw the EBP sign stating to gown and glove, but she failed to do so because it didn't click. Subsequent to surveyor inquiry, Hospice Person #2 placed a gown and gloves to provide Resident #20's care. 3. Resident #285 's diagnoses included malignant neoplasm of tongue, diabetes, and bipolar disorder. The Nursing admission assessment dated [DATE] identified Resident #285 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition, required supervision to limited assistance with bed mobility, transfers, toileting and dressing and he/she was unable to consume anything by mouth and required a Gastrostomy Tube (G-tube) for nutrition. A physician's order dated 4/29/25 directed EBP due to a wound and an indwelling urinary catheter. Observation on 4/29/25 at 10:11 AM identified a sign posted outside of Resident #285's room indicating Enhanced Barrier Precautions should be used. An observation and Interview with OTR #1 on 4/29/25 at 10:11 AM identified OTR #1 was noted to be moving Resident #285's urinary catheter. The privacy curtain was partially closed and OTR #1 failed to be using appropriate PPE (a gown and gloves). Further observation identified OTR #1 provided direct resident care when she transferred Resident #285, wearing gloves but without the benefit of a gown. OTR #1 was stopped by the surveyor. Interview with OTR #1 indicated that although she had been giving direct care to Resident #285, she was not aware she was required to wear a gown. OTR #1 indicated she thought the gown was only for staff who were accessing a gastrostomy tube. After reviewing the EBP sign, she removed her gloves, completed hand hygiene, and placed a gown and gloves on prior to reentering Resident #285's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Enhanced Barrier Precautions Policy identified, in part, signage should be posted on the door or wall outside a resident's room indicating the need for EBP. Further the policy identified visitors are to be educated on enhanced precautions and the use of alcohol-based hand rub. 4. Observation and interview with LPN #5 on 5/1/2025 at 11:09 A.M. identified that the medication room was cluttered and dirty. Items were stored in the splash zone of the sink, and the sink required cleaning. The counters were cluttered with boxes, and there was no space to prepare medications. LPN #5 stated that housekeeping was responsible for the daily cleaning of the medication room, but that housekeeping was only allowed to clean the room in the presence of nursing staff. LPN #5 reported the condition of the medication room was not acceptable for preparing medications. Subsequent to surveyors observation the medication room was cleaned to meet professional standards. Review of the facility's Medication Administration General Guidelines Policy and Environmental Services Guidelines Policy did not identify specific procedures or responsibilities for maintaining a clean and sanitary medication room. According to the CMS State Operations Manual facilities must ensure a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This includes maintaining a clean and sanitary medication room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 4 of 5 residents (Resident #13, Resident #282, Resident #285, Resident #287) reviewed for immunizations, the facility failed to obtain a current status for immunizations, failed to offer immunizations, and failed to obtain consent for immunizations. The findings include: 1. Resident #13 had diagnoses that included epilepsy, dysphagia, and depression. The Resident Care Plan (RCP) dated 1/22/2025 failed to identify a contraindication or allergy to any immunizations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, and was independent with personal hygiene, transfers, and walking 150 feet. A review of Resident #13's clinical record identified that consent forms for vaccination administration forms were blank and unsigned. 2. Resident #282's diagnoses included sepsis, (a life-threatening infection), diabetes and end stage renal disease. A physician's order dated 4/16/2025 directed to administer Pneumovax 23, 25 micrograms per 0.5 milliliters, inject 0.5 milliliters intramuscularly as needed for pneumonia prophylaxis and defer if the resident has been previously vaccinated. The admission Minimum Data Set assessment dated [DATE] identified Resident #282 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment, and required partial moderate assistance with bed mobility, personal hygiene and eating, substantial maximum assistance with dressing and total assistance with transfers and toileting. The Resident Care Plan dated 4/24/25 failed to identify a contraindication or allergy to any immunizations. Review of Resident #282's clinical record immunization section failed to identify any immunization status. Immunization consent forms for Covid 19, Influenza, and Pneumococcal vaccines were blank and unsigned. 3. Resident #285' s diagnosis included malignant neoplasm of the tongue, diabetes and adult failure to thrive. The admission assessment dated [DATE] identified Resident #285 had a BIMS of 14 indicating intact cognition, and required supervision to limited assistance with bed mobility, transfers, and dressing. Resident #285 was unable to consume anything by mouth and required a gastrostomy tube for nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 4/26/25 failed to identify a contraindication or allergy to any immunizations. Review of Resident #285's clinical record immunization section, failed to identify any immunization status. Immunization consent forms for Covid 19, Influenza, and Pneumococcal vaccines were blank and unsigned. 4. Resident # 287's diagnosis included diabetes, chronic kidney disease stage 5 and chronic congestive heart failure. The admission Nursing Assessment identified a BIMS score of 15 indicating intact cognition, and required extensive to total assistance with bed mobility, transfers and toileting, partial moderate assistance with personal hygiene, dressing and set up assistance with eating. The Resident Baseline Care plan dated 4/28/2025 failed to identify a contraindication or allergy to any immunizations. Review of Resident #287's clinical record immunization section failed to identify any immunization status. In an interview and review of clinical records for Residents #282, #285, and #287 with RN # 1 on 5/1/2025 at 11:15 AM failed to reflect documentation for immunization status, consent for immunizations, or any history of immunizations. An interview with Director of Nursing Services (DNS) on 5/1/25 at 11:23 AM identified that the admission documents including the consents for immunizations were to be completed within 48 hours of admission. The unit nurse and the supervisor were responsible for completing immunization documentation. After a new resident was admitted , the following morning, the clinical record was to be reviewed for completion and a list generated of missing items. The DNS was unable to explain why this process had not occurred. Subsequent to surveyor inquiry, the DNS indicated that a review of the 4 resident records would be conducted and completed for immunizations. The facility's admission of Resident Policy identified in part that the designated Admissions Coordinator will meet with the resident and responsible party to complete all necessary paperwork. The facility's Influenza Vaccination Policy identified in part that the admission Coordinator is responsible for informing all new residents and their responsible [party] of the annual flu vaccine and will notify the infection control nurse of any declines in vaccination offering. The facility's Pneumococcal Vaccination Policy identified in part that the admission Coordinator is responsible for informing all new residents and their responsible party of the vaccination policy and will notify the infection control nurse of any declines in vaccination offering. Further the policy identified that Residents over the age of 65 should have a second pneumococcal vaccine if their first dose was before the age of 65 and if more than 5 years have passed since the vaccination was administered. Although requested, a facility policy for Covid vaccination was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy for 1 of 3 residents, (Resident #13), reviewed for advance directives, the facility failed to offer a covid vaccine. The findings include: Resident #13's admission date was 10/22/2024 and had diagnoses that included epilepsy, dysphagia, and depression. The Resident Care Plan (RCP) dated 1/22/2025 failed to identify any contraindications with vaccination. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, and was independent with personal hygiene, transfers, and walking 150 feet. A review of Resident #13's clinical record identified that consent forms for vaccination administration were unsigned. An interview with the Director of Nursing Services (DNS) on 4/30/2025 at 9:18 AM identified that the Licensed Practical Nurse (LPN) or Nurse Supervisor was responsible for ensuring resident consent forms were signed no later than the second day after admission. The DNS failed to identify why Resident #13's forms remained unsigned greater than 6 months after admission. Further the DNS identified that Resident #13 was not up to date with his/her Covid vaccine (last administration date was 6/22/2021). The facility's admission of Resident Policy identified in part that the designated Admissions Coordinator will meet with the resident and responsible party to complete all necessary paperwork. The facility failed to provide a Covid Vaccination Policy.