STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075159	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cassena Care at Norwalk	23 Prospect Avenue Norwalk, CT 06850

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of clinical records, review of facility policy and interviews for five of six sampled residents (Residents #1, #9, #21, #33 and #82) who resided on a secured unit, the facility failed to ensure there was documentation of the clinical criteria met for placement in the unit and that the secured unit was the least restrictive setting for the residents. The findings include: Observation of the East 1 Unit on 10/07/24 at 11:14 PM identified that to enter and/or exit the unit through the doors to the unit required a code (sequence of numbers) be entered into a keypad located on the wall by the doors. The doors at the end of the hallways (both left and right) were also secured and required code entry into a keypad. Further observation on the unit identified two closed doors that opened to stairwells, which were identified as the fire exits and contained wanderguard alarm sensors. Interview with the DNS on 10/7/24 at 3:37 PM identified the 1 East unit is a secured unit and placement on the unit is dependent on the resident's history of dementia and wandering. Interview with the Administrator on 10/7/24 at 3:47 PM identified the secured unit is a memory care unit. He further identified that he was unfamiliar with the criteria for placement on the unit but indicated that each resident is assessed for placement on the unit. Interview with the Corporate Social Worker on 10/7/24 at 4:02 PM identified she could not identify the criteria for placement on the secured unit but indicated that residents residing on the unit had been assessed appropriately for placement on the unit. Resident #1's diagnoses included dementia with behavioral disturbances, and monoplegia affecting the right lower limb. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, exhibited physical and verbal behavioral symptoms, was totally dependent for transfers, hygiene and toileting. The assessment further identified the resident did not ambulate and utilized a wheelchair for mobility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care plan dated 7/16/24 identified Resident #1 had problems related to behavior, inappropriate/harmful agitation and combative behaviors with an intervention to provide a calm structured environment. The monthly physician's orders for October/2024 directed to monitor for behaviors including agitation, hitting, kicking, spitting, delusions, hallucinations, psychosis, aggression, and refusals of care. Review of the clinical record identified a special care unit (secured unit) consent form dated 4/2/24 that identified the resident's conservator agreed to Resident #1's placement on the unit. Further review of the clinical record identified a form titled Interdisciplinary Team Preference to Leave Unit Independently dated 7/3/2024 at 4:56 PM and indicated the Resident #1 had problems with communication, memory, mobility, and inability to navigate the elevator that interfered with independent function. The assessment further noted Resident #1 was not safe to leave the unit independently. The form was signed by the Social Worker, dietary representative, Recreation, Rehabilitation Director; However, the form failed to include required signatures from nursing, psychiatric provider, or the attending physician. The Social Services Care meeting note dated 7/16/24 at 10:27 PM identified Resident #1 continued to reside on the behavioral/dementia unit. Review of the Behavior Monitoring and Interventions Report from 8/1/24 through 10/9/24 identified Resident #1 exhibited behaviors of grabbing others 5 days, cursing at others 9 days, agitated 1 day, screaming at others 1 day, and repetitive motions 1 day. Psychiatry notes dated 9/10/24 identified Resident #1 was not currently a danger to self and not currently a danger to others and had a history of behavioral disturbance. The record failed to include documentation by the physician of the clinical criteria met for placement on the secured unit and it failed to identify that the secured unit was the least restrictive setting/approach for the resident. Resident #9's diagnoses included muscular dystrophy, schizoaffective disorder, mild intellectual disabilities, and major depressive disorder. The quarterly MDS assessment dated [DATE] identified Resident #9 had intact cognition, did not exhibit wandering behaviors, did not use assistive devices, was independent withal transfers, mobility, and personal care. The care plan dated 7/30/24 identified Resident #9 was at risk for leaving the unit (does not specify the unit) independently related to safety with interventions that included: escort resident to and from activities of choice and to therapy or facility programs. The physician's orders for October 2024 directed behavior monitoring for agitation, hitting, kicking, spitting, delusion, hallucinations, psychosis, aggression, and refusing care. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Interdisciplinary Team (IDT) Assessment for Preference to Leave Unit Independently forms dated 1/19/24, 4/16/24, and 7/17/24 identified Resident #9 voiced a preference to leave the unit on 2 of the assessments. All three assessments identified the resident had the capacity to leave the unit, was independent or required supervision with mobility and could communicate a destination but identified the outcome of the assessments as not safe to leave the unit independently. These assessments were signed by the Social Worker, Dietician, Recreation and Rehabilitation. The designated area for the nurse to sign was not signed. Review of the physician's progress notes from 6/1/24 through 10/9/24 failed to address the resident's placement in the secured unit. Review of psychiatric progress notes dated 7/17/24, 8/13/24, 9/5/24, and 10/01/24 identified Resident #1 exhibited anxiety and delusions and was not a danger to self or others. Recommendations were to monitor behaviors. The notes did not address Resident #9's placement on the secured unit The Special Care unit consent form dated 8/17/21 identified the resident's conservator had consented for the resident to be placed on the secured unit. Review of the Behavior Monitoring and Interventions Report from 8/1/24 through 10/9/24 identified Resident #9 was monitored for physical and verbal behaviors directed at others, socially inappropriate behaviors, and other behaviors not directed at others. The documentation identified Resident #9 had not exhibited any of the identified behaviors. Interview with Resident #9 on 10/7/24 at 11:34 AM identified the resident referred to living on the secured unit as a prison and indicated he/she was not able to make independent choices to sit outside or attend programs in other areas of the building. The record failed to include documentation by the physician of the clinical criteria met for placement on the secured unit and it failed to identify that the secured unit was the least restrictive setting/approach for the resident. Resident #21 was admitted to the facility on [DATE]. Diagnoses included metabolic encephalopathy, rhabdomyolysis, schizoaffective disorder, major depressive disorder, and a history of substance abuse. The admission MDS assessment dated [DATE] identified Resident #21 had moderately impaired cognition, did not exhibit hallucinations, delusions, or physical or verbal behavioral symptoms, nor had the resident exhibited wandering behaviors. The MDS indicated the resident was dependent with toileting, showering, and upper and lower body dressing. The Care Plan dated 8/28/24 identified Resident #21 could not safely leave the unit independently with interventions that included: escort the resident to and from activities of choice, to therapy or facility programs. The physician's orders for October 2024 did not identify an order for placement on a secured unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Nursing Progress Notes from 8/8/24 through 10/10/24 identified Resident #21 was alert and oriented to person, place, and time, was able to communicate verbally with clear speech, and able to be understood. Additionally, Resident #21 consistently had pleasant mood with no unwanted behaviors displayed. The review further identified Resident #21had difficulty with decision making, showed poor decision making, and needed cues or supervision. The physician's progress note dated 8/26/24 at 11:20 AM identified Resident #21 was alert and at baseline and indicated the resident's behavior was normal and directed to continue to monitor mood and behavior related to schizoaffective disorder. The psychiatric progress note dated 9/10/24 identified Resident #21 was alert and oriented to person, place, time and situation, was not currently a danger to self or others, had a complex pharmacological regimen and required behavioral monitoring for medications. The Special Care unit consent form dated 8/13/24 identified that due to present status with Alzheimer's/Dementia/Schizophrenia/Bi-Polar disorder, the resident shall be evaluated quarterly as needed according to facility policy for continued stay if the evaluation finds the continued stay on the unit is no longer appropriate, the resident or designee shall be informed. The record failed to include documentation by the physician of the clinical criteria met for placement on the secured unit and it failed to identify that the secured unit was the least restrictive setting/approach for the resident. Resident #33's diagnoses included heart failure, dementia, anxiety disorder and visual loss. The quarterly MDS assessment dated [DATE] identified Resident #33 was cognitively intact, had not exhibited physical and verbal behavioral symptoms directed to others and no other behavioral symptoms not directed towards others, had rejection of care behavior type that occurred 1 to 3 days. The assessment further identified Resident #33 required limited assistance with personal hygiene, upper body dressing, transfers, ambulation and utilized a wheelchair and walker for mobility. The care plan dated 9/26/24 identified Resident #33 could not leave the unit independently with an interventions to assess for safety to leave the unit. Review of the physician's orders for September 2024 thru October 9, 2024, did not address Resident #3's placement on a secure/special care unit. The record failed to include documentation by the physician of the clinical criteria met for placement on the secured unit and it failed to identify that the secured unit was the least restrictive setting/approach for the resident. Resident #82 was admitted to the facility on [DATE]. Diagnoses included schizophrenia, dementia, anxiety, bipolar disorder, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #82 had severely impaired cognition, did not exhibit hallucinations, Delusion, physical or verbal behavioral symptoms directed toward others, did not wander, and did not refuse care. The MDS identified the resident required partial/moderate assistance with position changes and used a wheelchair for mobility. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan dated 7/9/24 identified Resident #82 was appropriate for long term placement but failed to identify housing placement on a secured unit. The Special Care Unit consent form dated 12/21/23 was signed by the resident's Power of Attorney (POA). The physician's progress note dated 2/7/24 identified the resident's mentation/behavior was at baseline without specifics, and that in the judgment of the physician, the resident did not have the capacity to make health care decisions. The physician's progress note did not identify an assessment or review for placement on a secured unit. Review of nursing progress notes from 3/20/24 through 10/7/24 identified weekly behavior Progress notes that indicated Resident #82 did not have abnormal behavior that was observed and indicated the resident was calm and cooperative. Review of Social services care plan meeting notes dated 3/20/24, 4/9/24, 7/9/24, and 10/8/24 identified Resident #82 continued in the behavioral unit with family in agreement with placement. Review of psychiatric progress notes from 6/27/24 through 10/9/24 identified Resident #82 had intermittent anxiety, structure, and treatment of unpredictable agitation, anxiety, depression and confusion. Additionally, the psychiatric notes indicated that the resident's present medications were effective in managing behavior and mood, and that the resident was not a danger to self or others. Review of the facility Interdisciplinary team (IDT) Assessment form for Preference to Leave Unit Independently dated 9/24/24 identified Resident #82 had not voiced a preference to leave the unit. The assessment identified the resident did not have the capacity to leave the unit, was not independent or did not require supervision with mobility and could not communicate a destination and identified the outcome as not safe to leave the unit independently. This assessment was signed by social work, dietician, Recreation, and Rehabilitation. There is also a spot for a nursing signature which was not signed. The Social Services note dated 10/8/24 at 2:40 PM as a late entry identified Resident #82 could not safely leave the unit independently and directed to continue with goals and interventions. The record failed to include documentation by the physician of the clinical criteria met for placement on the secured unit and it failed to identify that the secured unit was the least restrictive setting/approach for the resident. Interview with LPN #20 on 10/8/24 at 10:41 AM identified that if a resident wants to go outside or leave the unit, staff would redirect and assure the resident that the unit was their home. LPN #20 indicated she might take the resident for a walk on the unit, and that the residents residing on the unit do not go outside. She further identified that some residents were able to attend other activities in other parts of the facility if there is enough staff to escort the resident(s). Interview with APRN #1 on 10/8/24 at 10:45 AM identified she does not take part in the assessment or review for placement on the secured unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Social Worker #1 on 10/8/24 at 11:20 AM identified that residents were referred for placement on the secured unit based on hospital discharge recommendations, and behavior reviews by the admission nurse. The Interdisciplinary team responsible for the assessment included recreation, social services, nursing, dietary, and therapy. SW #1 indicated they would only consult with the psychiatric physician for placement on the unit for appropriateness and did not know if the doctor documented the consultation. Interview with the Medical Director (MD#1) on 10/9/24 at 12:53 PM identified that he does not review the documentation, nor does he provide input or an order for placement on the secured unit. MD#1 identified that placement on a secured unit would be a psychiatric determination and that as the Medical Director, he reviews the medical conditions. Interview with the Corporate Medical Director on 10/9/24 at 1:35 PM identified that evaluation for placement on the secured unit would be the responsibility of the attending of record for the resident. He indicated that recognition of the placement should be made by the attending physician of record and placed as an order in the resident's clinical record with the criteria for placement. The policy for the secured unit Titled: 1 East Criteria and identified the purpose of the unit was to provide a safe and appropriate placement for those residents whose needs would best be met in a Special Care Unit as it relates to their safety, security, and individualized plan of care. The policy indicated the interdisciplinary team and the resident and/or their representative shall identify those who present with needs to be placed within the secure unit. This included, but was not limited to diagnoses, cognitive status, functional status, behavioral health needs and/or individual request. The policy further directed that the social worker completes quarterly assessments that includes the review of the resident's plan of care and preference to leave the unit. 47900

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of the clinical record, review of facility policy, and interviews for one sampled resident (Resident #62) reviewed for pre-admission screening and resident review (PASARR), the facility failed to ensure that a resident with a qualifying diagnosis was referred to the state-designated authority for the consideration for a level II assessment. The findings include: Resident #62's diagnoses included major depressive disorder, unspecified psychosis not due to a substance or known physiological condition, and generalized anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #62 was cognitively intact, had no behaviors, required supervision or touching assistance with eating, and oral hygiene, required total assistance for toileting, showers, and moderate to maximal assistance with dressing and transfers. The assessment further identified the resident did not ambulate and utilized a wheelchair for mobility. The care plan dated 7/17/24 identified Resident #62 was at risk for psychotropic drug use complications related to the use of antidepressant medication with interventions that included: behavior monitoring and interventions, monitor and evaluate for signs and symptoms of confusion, change in activities of daily living (ADL) functioning, monitor for decreased nutrition/hydration/weight, difficulty in communication, and medication side effects. Social Worker #2's (SW #2) progress note dated 9/17/24 at 5:53 PM identified Resident #62 had the new diagnosis of major depressive disorder with an onset date of 9/18/24. Interview with SW#1 on 10/8/24 at 1:50 PM identified major depressive disorder would be a qualifying diagnosis that would trigger a referral to the state-designated authority responsible for conducting the PASARR level II assessment. SW#1 identified that information is relayed to their office through the MDS Coordinator, and once the diagnosis is received, she is responsible for submitting the referral to the state-designated authority to see if the resident qualifies for a level II screening. SW#1 further identified she was unaware of Resident #62's new diagnosis. Interview with SW#2 on 10/8/24 at 2:05 PM identified she wrote the note on 9/17/24 and should have notified SW#1 of the new diagnosis so that the referral for the level II assessment could have been made to the state-designated authority. Interview with the Regional MDS Coordinator on 10/8/24 at 2:30 PM identified that there is a weekly meeting with the psychiatric provider(s) that the Social Worker attends. She further noted that at the meeting the Social Worker is made aware of any new psychiatric diagnoses that would require a referral to the state-designated authority for a level II PASARR assessment. The Pre-Admission Screen and Annual Resident Review (PASRR) policy directs that a resident who has not been previously identified as having a serious mental disorder (SMI) will require a level II assessment if a new diagnosis of mental illness is identified during the stay or during hospitalization .

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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** 47489 Based on observations, review of the clinical records, review of facility policy and interviews for five of six sampled residents (Resident #1, #9, #21, #33 and #82) who resided on a secured unit, the facility failed to ensure the residents' care plans reflected the residents' placement on a secured unit. The findings include: Observation of the East 1 Unit on 10/7/24 at 11:14 PM identified that to enter and/or exit the unit through the doors to the unit required a code (sequence of numbers) be entered into a keypad located on the wall by the doors. The doors at the end of the hallways (both left and right) were also secured and required code entry into a keypad. Further observation on the unit identified two closed doors that opened to stairwells, which were identified as the fire exits and contained wanderguard alarm sensors. 1. Resident #1's diagnoses included dementia with behavioral disturbances, and monoplegia affecting the right lower limb. The facility Special Care Unit Consent dated 4/2/24 identified verbal consent for placement on the Special Care Unit for safety and security due to present status with Alzheimer's/Dementia/Schizophrenia/Bi-Polar disorder from the resident's Conservator. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, exhibited physical and verbal ((e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)e. g., threatening others, screaming at others, cursing at others)behavioral symptoms directed toward others and behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 1 to 3 days out of 7 days, and was totally dependent for transfers using mechanical lift. Additionally, the MDS identified Resident #1 did not exhibit wandering behavior, had impairment of the upper and lower extremities on both sides and used a wheelchair for all mobility. The care plan dated 7/16/24 identified Resident #1 had problems related to behavior, inappropriate/harmful agitation and combative behaviors with interventions to provide calm structural environment and provide a calm, safe environment to decrease stress, and to remove hazards. The care plan failed to identify the resident resided on a secured unit, failed to identify criteria for resident to be on the unit and failed to identify that the secured unit was the least restrictive setting. 2. Resident #9 was admitted to the facility on [DATE]. Diagnoses included muscular dystrophy, schizoaffective disorder, mild intellectual disabilities, and major depressive disorder. The quarterly MDS assessment dated [DATE] identified Resident #9 had intact cognition, did not exhibit wandering behaviors, did not use and assistive devices, was independent withal transfers, mobility, and personal care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 7/30/24 identified Resident #9 was at risk for leaving the unit independently related to safety with interventions that included to escort resident to and from activities of choice and to therapy or facility programs with a goal that the resident will not leave the unit independently through next review period. Additionally, the care plan identified the resident had been assessed for discharge and it was determined that long-term placement was appropriate with interventions to involve resident in activities of interest and psychological consultation, or treatment as needed. Review of Physician's progress notes from 6/1/24 through 10/9/24 failed to identify any mention of review of resident for placement on a secured unit. Interview with Resident #9 on 10/7/24 at 11:34 AM identified the resident referred to the housing as a prison and indicated the resident was not able to make independent choices to sit outside or attend programs in other parts of the building. The care plan failed to identify the resident resided on a secured unit, failed to identify criteria for resident to be on the unit and failed to identify that the secured unit was the least restrictive setting. 3. Resident #21 was admitted to the facility 8/8/2024. Diagnoses included metabolic encephalopathy, Rhabdomyolysis, schizoaffective disorder, major depressive disorder, single episode, other psychoactive substance abuse. The admission MDS assessment dated [DATE] identified Resident #21 had moderately impaired cognition, did not exhibit hallucinations, delusions, or physical or verbal behavioral symptoms, nor had the resident exhibited wandering behaviors. The MDS indicated the resident was dependent with toileting, showering, upper and lower body dressing. The care plan dated 8/28/24 identified the resident cannot safely leave the unit independently with interventions to escort the resident to and from activities of choice and to therapy or facility programs. Review of Nursing Progress Notes from 8/8/24 through 10/10/24 identified Resident #21 was alert and oriented to person, place, and time, was able to communicate verbally with clear speech, and able to be understood. Additionally, Resident #21 consistently had pleasant mood with no unwanted behaviors displayed. But was noted to have difficulty with decision making, showed poor decisions, and needed cues or supervision. Review of Physician's Progress Notes dated 8/26/24 at 11:20 AM identified the resident's mental status is alert and at baseline and indicated the resident's behavior was normal and directed to continue to monitor mood and behavior related to schizoaffective disorder. Psychiatric Progress notes dated 9/10/24 identified Resident #21 was alert and oriented to person, place, time and situation, was not currently a danger to self or others, had a complex pharmacological regimen and required behavioral monitoring for medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan failed to identify the resident resided on a secured unit, failed to identify criteria for resident to be on the unit and failed to identify that the secured unit was the least restrictive setting. 4. Resident #33's diagnoses included heart failure, dementia, anxiety disorder and visual loss. The quarterly MDS assessment dated [DATE] identified Resident #33 was cognitively intact, had not exhibited physical and verbal behavioral symptoms directed to others and no other behavioral symptoms not directed towards others, had rejection of care behavior type that occurred 1 to 3 days. The assessment further identified that Resident #33 required limited assistance with personal hygiene, upper body dressing, transfers, ambulation and utilized a wheelchair and walker for mobility. The care plan dated 9/26/24 failed to identify that Resident #33 resided on a secured/special care unit along with the reason for placement. The physician's order for the month September 2024 thru October 9, 2024, failed to identify a physician's order directing Resident #33 placement on a secure/special care unit. 5. Resident #82 was admitted to the facility on [DATE]. Diagnoses included schizophrenia, Unspecified dementia, unspecified severity without behavioral disturbance, mood disturbance and anxiety, bipolar disorder, difficulty in walking and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #82 had severely impaired cognition, did not exhibit hallucinations, Delusion, physical or verbal behavioral symptoms directed toward others, did not wander, and did not refuse care. The MDS identified the resident required partial/moderate assistance with position changes and used a wheelchair for mobility. The care plan dated 7/9/24 identified Resident #82 was appropriate for long term placement. Physician's orders dated October 2024 failed to identify any orders for monitoring behaviors and failed to identify an order for resident placement on a secured unit. Review of Nursing progress notes dated 3/20/24 through 10/7/24 identified weekly behavior Progress notes that indicated Resident #82 did not have abnormal behavior that was observed and indicated the resident was calm and cooperative. Review of psychiatric progress notes from 6/27/24 through 10/9/24 identified Resident #82 had intermittent anxiety, required SNF care for safety, structure, and treatment of unpredictable agitation, anxiety, depression and confusion. Additionally, the psychiatric notes indicated that the resident's present medications were effective in managing behavior and mood, and that the resident was not a danger to self or others. Social Services note dated 10/8/24 at 2:40 PM as a late entry identified Resident #82 could not safely leave the unit independently and directed to continue with goals and interventions. The care plan failed to identify the resident resided on a secured unit, failed to identify criteria for resident to be on the unit and failed to identify that the secured unit was the least restrictive setting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 10/9/24 at 9:12 AM identified that care plans should be individualized, and special circumstances should be reflected in the plan of care so that care could be directed appropriately. Interview with MD#1, the Medical Director, on 10/9/24 at 12:53 PM identified that he would expect the secured unit placement to be reflected somewhere and indicated it should probably be in the care plan although he had not seen it there before. Facility policy for the secured unit was Titled: 1 East Criteria and identified the purpose of the unit policy was to provide a safe and appropriate placement for those residents whose needs would best be met in a Special Care Unit as it related to their safety, security, and individualized plan of care. The policy indicated the interdisciplinary team and the resident and/or their representative shall identify those who present with needs to be placed within the secure unit. This included, but was not limited to diagnoses, cognitive status, functional status, behavioral health needs and/or individual request. The facility care planning process policy identified that Comprehensive Care plans would include the services that are provided to maintain the resident's highest practicable physical, mental and psychosocial wellbeing. The policy indicated that the care plan shall describe the services that are being provided and are created to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental and psych-social well-being. The care plan should address risk factors identified in the screens and shall address the triggered Care areas to include, but not limited to, special care needs, medical diagnoses/condition, ADL functional ability, Resident strengths, socialization patterns, daily customary routine, strengths and needs, and personal preferences. 47900

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Cassena Care at Norwalk	23 Prospect Avenue Norwalk, CT 06850

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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** 46117 Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one of four sampled residents (Resident #35) reviewed for a skin condition, the facility failed to ensure a physician's order was obtained for a surgical wound treatment. The findings include: Resident #35 was readmitted to the facility on [DATE] with diagnoses that included right femur fracture, polyneuropathy, and type 2 diabetes mellitus. The hospital discharge summary dated 6/15/24 identified Resident #35 underwent a partial replacement of the right hip. The right hip had surgical wound care instructions that directed to keep the incision covered with the current dressing for 7 days and dressing to the right hip could be removed after 7 days (the dressing should have been removed on 6/22/24). The nurse's note dated 6/15/24 at 4:42 PM identified Resident #35 was readmitted to the facility with a diagnosis of right femur fracture. It further noted Resident #35 was alert and oriented and had a surgical wound with staples to the right hip covered with a surgical dressing. The nurse's note did not specifically identify the type of surgical dressing that was in place to the right hip. The typical surgical dressing for a hip incision is usually an occlusive dressing that provides the area with protection and may have antibacterial properties to prevent wound/incision site infections. Review of physician's orders and the treatment administration record (TAR) from 6/15/24 to 6/19/24 failed to identify a treatment order to the right hip surgical wound. A review of the nurses' notes from 6/16/24 to 6/19/24 identified Resident #35 had a surgical wound to the right hip and noted the right hip wound had no foul-smelling odors and no signs and symptoms of infection. The note also noted that the dressing to the right hip was intact. The nurse's note dated 6/20/24 at 7:07 PM written by RN #2 (former wound nurse) identified Resident #35's surgical dressing to the right hip had fallen off and the dressing to the right hip was replaced. The wound size was documented as 11.7 centimeters (cm) in length and 1.0 cm in width and noted to have 35 staples to the surgical right hip incision, with no drainage (the dressing was replaced on the 5th day after admission, which was two days before the dressing should have been removed). The nurse's note did not identify what type of dressing was applied to the surgical site, nor did it identify that the physician was contacted regarding the dressing that fell off or orders to address the replacement of the dressing. Review of the physician's orders identified there were no physician's orders related to the right hip surgical wound dated 6/20/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The significant change MDS assessment dated [DATE] identified Resident #35 with intact cognition, required extensive assistance with toileting, hygiene, bed mobility, transfers, and ambulation. It further identified Resident #35 had a surgical wound. Review of the nurses' notes from 6/21/24 to 7/1/24 identified Resident #35 had a surgical wound to the right hip, see TAR for details, no foul-smelling odor, no sign/symptoms of infection and dressing intact. Although, the nurses' notes make reference to the TAR (treatment administration record), review of the TAR identified no orders related to the right surgical wound. The nurses' notes also do not identify what type of dressing was in place. The nurse's note dated 7/2/24 at 2:59 PM identified Resident #35's right hip surgical wound had become red, warm to touch and had a strong foul odor. The right hip surgical wound was cleaned with normal saline and covered with an abdominal pad and secured with tape. The nursing supervisor and the APRN were made aware (this was 17 days after the resident was admitted with no physician's orders in place to address the right hip surgical wound). The physician's order dated 7/2/24 directed to cleanse the right hip surgical incision with Dermaklenz (wound cleanser) and cover with a dry abdominal pad and secure with tape daily and Cephalexin (antibiotic) capsule 500 milligram (mg) by mouth twice per day for 7 days. The RCP dated 7/3/24 identified Resident #35 had actual skin impairment related to right hip surgical wound. Care plan interventions directed to educate resident/family/caregiver measure to prevent skin injury, keep skin clean and dry. Interview with RN #1 (wound nurse) on 10/8/24 at 9:30 AM identified that when a resident is admitted with a wound, the nurses should follow the surgeon's instructions for wound care and the charge nurses are responsible for providing the treatment. She further identified that the physician's orders should contain the wound care orders and that the nurses wound sign off on the wound care in the TAR. She further identified that she was not the wound care nurse at the time Resident #35 was readmitted to the facility. Interview and clinical record review with the DNS on 10/8/24 at 10:00 AM identified that the nursing supervisors are responsible for ensuring the treatment for a surgical wound is included in the physician's orders. Review of the physician's orders with the DNS failed to identify a wound care dressing order. Interview with RN #2 (former wound nurse) on 10/9/24 at 10:00 AM identified she was responsible for wound monitoring including surgical wounds. She identified that she follows the surgeon's wound treatment recommendations. She identified that Resident #35's dressing to the right hip had fall off and she replaced the dressing to the right hip. She could not remember the details of the treatment she provided to Resident #35, and she could not recall whether she notified the physician or not, but review of the record failed to identify a dressing change order or that the physician was notified. Attempts to interview the nurse that readmitted Resident #35 on 6/15/24 were unsuccessful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Non-Pressure Related Skin Ulcer/Wound policy identified that dressing changes and cleaning of a surgical wound should be in accordance with the surgeon's orders.

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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. 17723 Based on observations, review of facility policy and review of facility documentation on one of three medication administration carts reviewed, the facility failed to ensure that the controlled medication count was correct, and the medication was signed out on the control disposition record. The findings include: A review of the controlled medications identified the following: A blister pack of Alprazolam 0.5mg tab for Resident #69 contained 11 tabs; however, the control drug receipt and disposition record stated there were 12 tabs. A blister pack of Tramadol 50mg tab for Resident #99 contained 3 tabs however, the control drug receipt and disposition stated there were 4 tabs. A blister pack of Alprazolam 0.25mg tab for Resident #7 contained 1 tab however, the control drug receipt and disposition stated there were 2 tabs. Interview with RN #4 on 10/8/24 at 1:45 PM identified that it was everyone's responsibility to ensure expired medications were not stored in the medication cart, and controlled medications should be behind two locks, the cart and the lock box located within the cart. She further noted that when insulin is opened it should be labeled with the opened date and the discard date. According to RN#4 she should have signed the control drug receipt and disposition record when she administered the medication. Interview with the DNS on 10/9/24 at 9:45 AM identified that expired medication should be removed from the cart by any of the nurses who use the cart. She further noted that controlled medications should be secured behind two locks, and insulin should be labeled with the open date and the discard date. Additionally, she identified that medications should be signed off on the control drug receipt and disposition when it is retrieved from the cart to be dispensed to a resident. The Medication Administration Guidelines identified that both the controlled substance drawer lock and the outer lock are to be locked if the cart is unattended. The nurse preparing any medication administers it and records it, and to affix date and initial when starting a multi vial medication. The Control Substances, Delivery Storage, Count, Administration, Wasting, and Return policy directs that all controlled substances are to be stored in a double door, double locked container. During administration enter on front of individual controlled medication record the dose taken out. Accountability and security must be maintained at all times.

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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. 47402 Based on observations, review of the clinical record, review of facility policy and interviews for one of three medication carts reviewed, the facility failed to store medications appropriately. The findings include: Observation of the 2 East medication administration cart with RN#4 on 10/8/24 at 1:32 PM identified the following: Two bottles of Oyster Shell Calcium with Vitamin D with an expiration of 9/2024. One bottle of Lantus 100 units/ml with no open date approximately 1/4 full in a plastic sandwich bag with the last name of Resident #54 written in black marker worn away and barely visible with no open date and no discard date written. The narcotic box located in the medication administration cart was not locked; however, the medication cart itself was secured and was located behind the nurses' station. Interview with RN #4 on 10/8/24 at 1:45 PM identified that it was everyone's responsibility to ensure expired medications were not stored in the medication cart, and controlled medications should be behind two locks, the cart and the lock box located within the cart. She further noted that when insulin is opened it should be labeled with the opened date and the discard date. According to RN#4 she should have signed the control drug receipt and disposition record when she administered the medication. Interview with the DNS on 10/9/24 at 9:45 AM identified that expired medication should be removed from the cart by any of the nurses who use the cart. She further noted that controlled medications should be secured behind two locks, and insulin should be labeled with the open date and the discard date. Additionally, she identified that medications should be signed off on the control drug receipt and disposition when it is retrieved from the cart to be dispensed to a resident. The Medication Administration Guidelines identified that both the controlled substance drawer lock and the outer lock are to be locked if the cart is unattended. The nurse preparing any medication administers it and records it, and to affix date and initial when starting a multi vial medication. The Control Substances, Delivery Storage, Count, Administration, Wasting, and Return policy directs that all controlled substances are to be stored in a double door, double locked container. During administration enter on front of individual controlled medication record the dose taken out. Accountability and security must be maintained at all times.

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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. 46117 Based on observations, review of facility policy and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. The findings include: Observations during a tour of the kitchen on 10/7/24 from 9:40 AM to 10:20 AM with the Corporate Food Service Director (FSD) identified the following: The kitchen floor was sticky and had scattered food debris and water was noted on the floor under the 3-bay sink near the cooking area. One ceiling vent cover and ceiling in the 3 bay sink area had a moderate amount of black dusty buildup. Multiple vent covers near the coffee station were noted to have black dusty buildup. The side and the front of the stove oven had a buildup of brownish/grey matter. The ice machine metal piece inside the machine was covered with brown stains that appeared to be rusted areas. The ice cream freezer plastic covering inside the freezer had cracks and there was a black stain noted inside the plastic cover. The prep counter had scattered food debris and was smeared with white stains, papers, and pens were on top of the counter. Interview with Dietary Aide #1 on 10/7/24 at 9:35 AM identified the kitchen staff is responsible for ensuring the cleanliness of the kitchen. She identified that the floor was cleaned after each meal, equipment is cleaned after each use. She was not sure who was responsible for cleaning the ceiling and/or vents in the kitchen. Interview with corporate FSD on 10/7/24 at 10:35 AM identified he was not sure of the cleaning schedule for the kitchen but would provide a cleaning schedule if available. He identified that the kitchen staff are responsible for the cleanliness of the kitchen. He could not identify when the last time the vent or ceiling was cleaned. A cleaning log was requested but no documentation was provided during the survey. An interview with the facility's Food Service Director (FSD) was not available during the survey. The policy for the cleaning schedule identified vent and ceiling would be cleaned monthly, the oven cleaned weekly and as needed, and the floor and counters cleaned after each use and as needed.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of the facility assessment, and interviews, the facility failed to identify the presence of a secured unit within the facility and failed to include the criteria for entrance into the secured unit and failed to include the physical and environmental characteristics of the unit. The findings include: Observation of the East 1 Unit on 10/07/24 at 11:14 PM identified that to enter and/or exit the unit through the doors to the unit required a code (sequence of numbers) be entered into a keypad located on the wall by the doors. The doors at the end of the hallways (both left and right) were also secured and required code entry into a keypad. Further observation on the unit identified two closed doors that opened to stairwells, which were identified as the fire exits and contained wanderguard alarm sensors. Review of the Facility assessment dated [DATE] on 10/7/24 at 12:30 PM failed to identify the presence of a secured unit in the building. It also did not address the criteria required for placement on the secured unit. The assessment had signatures of the former administrator, the former DNS, and a former medical director. Next to these signatures were lines drawn in pen with the current administrator and DNS's signatures dated 9/2024. All of the information in the facility assessment was from the 2023 assessment and the staff listed were no longer employed at the facility. The matrix and resident status that was printed in the assessment was dated 2023. Interview with the DNS on 10/07/24 at 3:37 PM identified she signed the 2023 assessment because she was told to do so. The DNS identified she had been the DNS since February 2024 and had not participated in a facility assessment and was not familiar with the facility assessment that she signed. The DNS indicated that the secured unit was not included in the facility assessment and that none of the staff listed worked at the facility. Interview with the Administrator on 10/07/24 at 3:47 PM identified that, although he signed the facility assessment dated 2023, he had not reviewed the document, nor had he participated in the completion of the assessment. He identified that he had meant to update the assessment and staff listed but hadn't done it as of that time. While reviewing the facility assessment, the Administrator indicated that the assessment would remain the same when updated and the secured unit had been there for as long as the company had owned the building. The Administrator identified he had never participated in completion of a facility assessment and referred to the secured unit as the memory care unit. Subsequent to surveyor inquiry, on 10/8/24, the Corporate Administrator provided the survey team with a newly printed facility assessment dated [DATE] which still did not identify a secured unit. The facility assessment did not identify the physical environment, services and other physical plant considerations that are necessary to care for the population housed on the secured unit. The assessment was only signed by the Administrator with no date listed in the line titled date assessment completed. (continued on next page)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview with the Corporate Administrator on 10/08/24 at 2:59 PM identified that the Administrator, DNS, Medical Director, and a corporate representative conducted the facility assessment. The Administrator is the only member of the team that signed the new assessment. Interview with MD#1 on 10/09/24 at 12:53 PM identified he did not know what the facility assessment was, nor did he participate in creating or updating it. He indicated that there was corporate oversight and does not believe he participates in conducting a facility assessment. Interview with the Corporate Medical Director, on 10/09/24 at 1:35 PM identified the facility assessment should outline parameters for the secured unit, but he did not participate in the assessment. Review of the facility policy for the secured unit titled 1 East Criteria on identified criteria for placement that included, but not limited to diagnosis, cognitive status, functional status, behavioral health needs and/or individual request. Additionally, the policy indicated residents would be assessed quarterly by the Interdisciplinary Team and the plan of care and preference to leave the unit reviewed quarterly and this status would be reflected in the plan of care. Although requested, the facility could not provide policies and procedures for the secured/locked unit or ongoing assessments that included physician input to assure the resident continues to meet the criteria, attempted alternatives to placement and resident response to interventions, or inclusion of the physician in identifying appropriateness of placement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of facility documentation, review of facility policy/procedures, and interviews, the facility failed to ensure the infection prevention and control program policies and procedures were reviewed at least annually, and the facility failed to provide documentation that monthly infection surveillance reports and analysis of the infection trends within the facility were completed, and the facility failed to provide documentation that the Infection Control Surveillance report analysis of trends were completed quarterly, and failed to ensure that a positive legionella water sampling test result was reported to the State Agency. The findings include: 1. Review of the facility's Infection Control Program Policies and Procedure manual for the past two and half years with the Infection Preventionist Nurse (RN #1) on 10/9/24 at 10:30 AM identified that the policies and procedures manual was reviewed and approved in July of 2022 and on July 5, 2023, but the facility failed to provide any documentation that the Infection Control Program Policies and Procedure manual was reviewed in 2024. Interview with RN #1 on 10/9/24 at 10:30 AM identified that she was recently hired in July of 2024 as the Infection Preventionist nurse and was unable to locate the signature page that the Infection Control policies and procedure manual was reviewed and approved for 2024. RN #1 identified that the infection control manual is usually reviewed and approved annual at the quarterly meeting. Interview with the DNS on 10/9/24 at 12:38 PM identified that the facility reviews the infection control policies and procedure manual annually at the quarterly meeting but was unable to locate the documentation that it was completed for 2024. Review of the Infection Prevention Control Program policy identified that the program would be reviewed and updated/revised yearly to include additional requirement. 2. Review of the Infection Control Surveillance documentation for the past two and half years with the Infection Preventionist (RN #1) on 10/8/24 at 2:30 PM and on 10/9/24 at 10:30 AM identified that the monthly infection surveillance analysis of infections trends within the facility were not completed for April 2022 thru September of 2024. Interview with the Infection Preventionist nurse (RN #1) on 10/8/24 at 2:31 PM identified that it was the responsibility of the Infection Preventionist (IP) nurse to complete the monthly infection report analysis of the various infections within the facility. RN #1 indicated that she had only started working as the IP in July of 2024 and was provided training on completing the monthly statistical reports. RN #1 indicated that she had completed it a different way, however failed to provide documentation as to how she did the report. Interview with RN #1 on 10/9/24 at 10:30 AM identified she was unable to locate the monthly report analysis reports for 2022, 2023 and 2024 after searching through the binders and the previous IP office that was located upstairs. RN #1 identified that they were a new team and had not read through the facility's infection control policies and procedures in its entirety. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Surveillance of Infection policy and procedures identified that the IP programs investigate, controls and prevents infections, decides what precautionary measures are to be instituted and enables the facility to analyze clusters and/or significant increases in the rates of infection. The policy and procedure further identified the surveillance monthly form shall be maintained by each unit by the infection control nurse listing all infections: nosocomial infection surveillance form, a monthly report is to be compiled to help pinpoint areas of high incidences. The policy further identifies that the nosocomial rates are calculated by the number of healthcare associated infections divided by population at risk multiplied by 100. 3. Review of the Infection Control Surveillance documentation for the past two and half years with the Infection Preventionist (RN #1) on and 10/8/24 at 2:3:30 PM and 10/9/24 at 10:30 AM failed to identified that quarterly infection statistical report/analysis were completed for January of 2024, April of 2022; April of 2023, April of 2024; July of 2022,2023, and 2024; and October of 2022, and 2023. Interview with RN #1 on 10/8/24 at 2:31 PM identified that the Infection Preventionist (IP) nurse was responsible for completing the quarterly statistical report/analysis of the infection trends within the facility. RN #1 indicated that she had only started working as the IP in July of 2024. Interview with RN #1 on 10/9/24 at 10:30 AM identified that they were only able to locate the quarterly meeting infection control rate for January 23, 2023, after they had searched through the binders and the previous IP office that was located upstairs. RN #1 identified that the quarterly reports are due in January, April, July and October of each year. RN #1 identified that she had just started in July of 2024 when a quarterly meeting was scheduled and was currently focused on wounds. Interview with the DNS on 10/9/24 at 12:38 PM identified that the infection control nurse would present at the quarterly meeting but was unable to locate the reports. The DNS added that they were a new team, and the IP had recently started working as the IP nurse and her herself had started working as the DNS since February of 2024. Review of the Surveillance of Infection policy and procedures identified that a quarterly statistical report would be completed by the IP nurse and submitted to the infection control committee for its review and discussion at the quarterly infection control meeting. 4. Review of the facility's Water Management plan identified positive water sampling results of Legionella that the facility failed to report to the State Agency: A water sample collected from the kitchen sink dated 3/23/23 with a final result date of 4/3/23 identified a positive test result with a concentration of 760.0 colony forming per milliliter or swab (CFU/mL) of species L. pneumophilia, not serogroups 1-6. A water sample collected from the HW Recri Loop dated 3/23/23 with a final result date of 4/3/23 identified a positive test result with a concentration of 5.0 CFU/mL of species L. pneumophilia, not serogroups 1-6. A water sample collected from the Basement sink dated 3/23/23 with a final result date of 4/3/23 identified a positive test result with a concentration of 5.0 CFU/mL of species L. pneumophilia, not serogroups 1-6. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A water sample collected from the Basement sink dated 10/10/23 with a final result date of 10/18/23 identified a positive test result with a concentration of 5.0 CFU/mL of species L. pneumophilia, not serogroups 1-6. A water sample collected from room [ROOM NUMBER] sink north wing dated 3/6/24 with a final result date of 3/14/24 identified a positive test result with a concentration of 35.0 CFU/mL of species L. pneumophilia, serogroup 1. Review of the facility's interventions for the positive legionella testing with a result date of 4/3/23 identified the kitchen faucet was removed soaked in bleach and the other identified positive areas (HW recri loop, kitchen sink, basement sink) aerators were cleaned and flushed for 3 times per day for 4/4/23, 4/5/23, and 4/6/23. Review of the facility's interventions for the positive legionella testing with a result date of 10/18/23 identified the basement sink faucet was change and flushed 3 times per day for 10/18/23, 10/19/23 and 10/20/23. Review of the facility's interventions for the positive legionella testing with a result date of 3/14/24 identified the facility had a water management meeting to review report, and a legionella test was reorder for 3/21/24 and completed which showed a not detected result for the previously positive sampled location on 3/14/24. Interview with the RN #1 and the DNS on 10/8/24 at 4:00 PM identified that the facility did not have a positive human case of Legionaries Disease within the facility. Interview with the Director of Maintenance on 10/9/24 at 1:30 PM identified that the cooperate office would notify the facility regarding when to flush based on the test result. He identified that he was responsible for flushing the areas when identified but does not keep a log. Interview with the Administrator and the Regional Administrator (Person #1) on 10/9/24 at 2:43 PM identified that it was the responsibility of the Administrator to notify the State Agency regarding the positive result, however the current Administrator was not the Administrator at the facility during the times when the water sample had tested positive for Legionella. Person #1 identified that the previous Administrator indicated that the facilities consultant for the water management informed the facility that the State Agency was not needed to be notified. Person #1 indicated that the water management consultant was familiar with the neighboring state laws which had required reporting to the state agency when the number of positive sites were greater than 30%. Person #1 further identified that the facility should have reported the positive result, however, it was not done. Attempts to contact the former Administrator for an interview were unsuccessful Review of the Prevention and Remediation policy identified that the facility reports any positive Legionella testing results to the Connecticut Department of Public Health.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interview for two of five sampled residents (Resident #26 and Resident #87), reviewed for immunizations, the facility failed to administer the pneumococcal and influenza vaccine as requested by the resident upon admission and failed to offer and/or assess for the pneumococcal vaccine upon admission. The findings include: 1. Resident #26 was admitted to the facility in the month of September of 2023 with diagnoses that included anemia, end stage renal disease and major depressive disorder. The quarterly MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition and had not received the pneumococcal vaccine as it was not offered. Review of the electronic medical record system under the immunization tab identified that Resident #26 required the pneumococcal vaccine (PCV20) but failed to identify that the vaccine was administered. A request was made on 10/8/24 at 2:31 PM and on 10/9/24 at 10:30 AM to the Infection Preventionist Nurse (RN#1) for Resident #26 pneumococcal vaccine consent form and proof of administration of the vaccine in which the facility failed to provide the surveyor. Review of Resident #26 clinical records failed to identify that he/she had received the vaccination historically or at the facility. Interview with the Infection Preventionist (IP) nurse RN #1 on 10/8/24 at 2:31 PM identified when asked about the process of obtaining and assessing vaccination history and consent, she responded that the supervisor at the time of the resident's admission was responsible to assess and obtain vaccination consent and status from the resident. RN #1 further added that the infection control nurse would follow up on the vaccine consent documentation and if it was not done by the admitting supervisor, the night shift nurse would notify the DON and the IP nurse via email. RN #1 further identified she had only started working as the IP in July of 2024, as Resident #26's vaccination assessment and consent should have been obtained on admission. RN #1 identified that when the vaccine was administered to the resident, the proof of administration would have been located under the immunization tab in the electronic medical record. RN #1 further indicated that she is currently in the process of reviewing the resident's vaccination information. Review of the Pneumococcal Vaccine Program policy identified that each resident is offered a pneumococcal immunization unless medically contraindicated or the resident/representative refused or already received the immunization. The policy further identified that all new admissions are to be assessed for the need for these vaccines as part of the admission medical work-up and documentation regarding administration of the pneumovax vaccine must be made on the immunization record. 2. Resident #87 was admitted to the facility in the month of November of 2022 with diagnoses that included chronic obstructive pulmonary diseases (COPD), hypertension and pulmonary nodule. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #87 was cognitively intact, had not received the pneumococcal vaccine. Review of the Immunization Consent form for pneumococcal vaccination identified that Resident #87 gave the facility permission to administer the pneumococcal vaccine on 11/7/22. Review of the electronic medical record system under the immunization report identified that Resident #87 required the pneumococcal vaccine (PCV20), gave consent on 11/7/22 but failed to identify that the vaccine was administered. Interview with the Infection Preventionist (IP) nurse RN #1 on 10/8/24 at 2:31 PM identified that the infection control nurse would follow up on the vaccine consent documentation and obtained a physician's order to administer the vaccine. RN #1 further identified she had only started working as the IP in July of 2024, as Resident #87's vaccination assessment and consent should have been obtained on admission. RN #1 identified that when the vaccine was administered to the resident, the administration record would be located under the immunization tab in the electronic medical record. RN #1 further indicated that she is currently in the process of reviewing the resident's vaccination information. Review of the Pneumococcal Vaccine Program policy identified that each resident is offered a pneumococcal immunization unless medically contraindicated or the resident/representative refused or already received the immunization. The policy further identified that all new admissions are to be assessed for the need for these vaccines as part of the admission medical work-up and documentation regarding administration of the pneumovax vaccine must be made on the immunization record. 3. Resident #87 was admitted to the facility in the month of November of 2022 with diagnoses that included chronic obstructive pulmonary diseases (COPD), hypertension and pulmonary nodule. The quarterly MDS assessment dated [DATE] identified Resident #87 was cognitively intact. Review of the Immunization Consent form for influenza vaccination identified that Resident #87 gave the facility permission to administer the influenza vaccine on 11/7/22. Review of the electronic medical record system under the immunization report identified that Resident #87 required the influenza vaccine and gave consent on 11/7/22 but failed to identify that the vaccine was administered. Review of Resident #87's clinical records failed to identify that he/she had received the vaccination historically or at the facility. Interview with the Infection Preventionist (IP) nurse RN #1 on 10/8/24 at 2:31 PM identified that the infection control nurse would follow up on the vaccine consent documentation and obtained a physician's order to administer the vaccine. RN #1 further identified she had only started working as the IP in July of 2024, as Resident #87's vaccination assessment and consent should have been obtained on admission. RN #1 identified that when the vaccine was administered to the resident, the administration record would be located under the immunization tab in the electronic medical record. RN #1 further indicated that she is currently in the process of reviewing the resident's vaccination information. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Influenza Vaccination Program identified that all residents are to receive the influence vaccine on a yearly basis unless medically contraindicated, or the resident/representative refuse or was already immunized. The policy further identified that all residents admitted to the facility during the influenza season shall be offered the influenza vaccine and administration of the vaccine and refusal are to be reflected as permanent entry in the electric medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47900 Based on review of the clinical records, review of the facility policy, review of the facility documentation, and interview for two of five sampled residents (Resident #26 and Resident #52) reviewed for immunizations, the facility failed to ensure the COVID-19 vaccine was administered as requested by the resident upon admission and failed to offer and/or assess for COVID-19 immunizations upon admission. The findings include: 1. Resident #26 was admitted to the facility in the month of September of 2023 with diagnoses that included anemia, end stage renal disease and major depressive disorder. The quarterly MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition. Review of the Immunization Consent form for COVID-19 vaccination identified that Resident #26 gave the facility permission to administer the COVID-19 vaccine on 9/20/23. Review of Resident #26 clinical records failed to identify that he/she had received the vaccination historically or at the facility. Review of the electronic medical record system under the immunization tab identified that Resident #26 had refused the COVID-19 vaccine. A requested was made on 10/8/24 at 2:31 PM and on 10/9/24 at 10:30 AM to the facility and the Infection Preventionist Nurse (RN#1) for Resident #26's COVID-19 vaccine consent form where he/she declined the vaccine which the facility provided a consent dated 9/20/23 consenting for the administration of the COVID-19 vaccine. The facility failed to provide a COVID-19 consent form identifying that the Resident #26 had refused the vaccine. Interview with RN #1 on 10/8/24 at 2:31 PM identified that Resident #26 had declined the COVID-19 vaccine on 6/7/24 but was unable to locate the consent form. RN #1 further identified she had only started working as the IP in July of 2024, as Resident #26's vaccination assessment and consent should have been obtained on admission and administered if requested. RN #1 further indicated that she was currently in the process of reviewing and obtaining consent for the newly updated COVID-19 vaccine for residents. Review of the regulations for COVID-19 Vaccination Program policy identified that the facility shall ensure that every new resident admitted /readmitted to the facility had an opportunity to receive the first or any required next dose of the COVID-19 vaccine within 14 days of having been admitted to the facility. The policy further identified that for residents who are vaccinated, the nurse admitting the resident will update the resident's care plan and immunization tab in Point click Care (PCC) to reflect receipt of the COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #52 was admitted to the facility in the month of October of 2022 with diagnoses that included chronic kidney disease, type 2 diabetes mellitus, and legal blindness. The quarterly MDS assessment dated [DATE] identified Resident #52 had moderate impaired cognition. Review of the immunization records in the paper chart of Resident #52 on 10/9/24 at 12:30 PM failed to identify that the COVID-19 vaccine was offered and/or assessed for past immunization. A requested was made on 10/8/24 at 2:31 PM and on 10/9/24 at 10:30 AM to the facility and the Infection Preventionist Nurse (RN#1) for Resident #52's COVID-19 vaccine consent form where he/she declined the vaccine, and the facility failed to provide a consent form/documentation that Resident #52 was offered and/or assessed for COVID-19 vaccine wherein he/she had declined. Interview with the Infection Preventionist Nurse (RN #1) on 10/8/24 at 2:31 PM identified when asked about the process of obtaining and assessing vaccination history and consent, she responded that the supervisor at the time of the resident's admission was responsible to assess and obtain vaccination consent and status from the resident. RN #1 further added that the infection control nurse would follow up on the vaccine consent documentation and if it was not done by the admitting supervisor, the night shift nurse would notify the DON and the IP nurse via email. RN #1 further identified she had only started working as the IP in July of 2024, as Resident #52's vaccination assessment and consent should have been obtained on admission. RN #1 identified that when the vaccine was administered to the resident, the proof of administration would have been located under the immunization tab in the electronic medical record. RN #1 further indicated that she is currently in the process of reviewing the resident's vaccination information Review of the regulations for COVID-19 Vaccination Program policy identified that the facility shall ensure that every new resident admitted /readmitted to the facility had an opportunity to receive the first or any required next dose of the COVID-19 vaccine within 14 days of having been admitted to the facility. The policy further identified that for residents who are vaccinated, the nurse admitting the resident will update the resident's care plan and immunization tab in Point click Care (PCC) to reflect receipt of the COVID-19 vaccine.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 46117 Based on observations and interviews, the facility failed to ensure kitchen equipment was maintained in a safe and functional manner. The findings include: Observation on 10/7/24 at 8:15 AM identified the facility used disposable plates and cups to serve breakfast to all of the residents. An observation during a tour of the kitchen on 10/7/24 from 9:20 AM to 9:35 AM with Dietary Aide #1 identified the following: 1. The kitchen dishwasher was not functional. 2. The 3-bay sink near the oven area had continuous leak of water onto the floor. 3. Two of four ovens were not functional. Interview with Dietary Aide #1 on 10/7/24 at 9:30 AM identified that the dishwasher had been broken for months. She also identified that the dishwasher could no longer be repaired, and a new dishwasher is needed. She identified that the facility was using paper plates and cups for all meals. She further identified that the Maintenance Director, and Administrator are aware of the dishwasher not functioning. Interview with the Maintenance Director on 10/8/24 at 11:00 AM identified that he just started his position a month ago. He identified that the dishwasher was already not functional when he started his position and had been told that a new dishwasher was being ordered. He could not identify whether a new dishwasher had already been ordered or the timeline of when the new dishwasher would be installed. He identified that he was not aware of the 2 ovens not working and the continuous water leak in the 3-bay sink. He further identified that he would reach out to the vendor to check the ovens and check the water leak. Interview with [NAME] #1 on 10/8/24 at 11:10 AM identified the dishwasher and 2 ovens were not functional for months. He could not identify the exact date when the dishwasher and ovens were broken. He identified that the Maintenance and Administration were aware of the broken equipment in the kitchen. Interview with Vendor Representative #1 on 10/9/24 at 1:30 PM identified that the facility had obtain a price quote for a new dishwasher machine on 10/2/24, but the facility had not paid a deposit to in order for them to process the order of the new dishwashing machine.