STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075181	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Watertown	35 Bunker Hill Rd Watertown, CT 06795

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #8) reviewed for accidents, the facility failed to ensure that a resident's meal choices were honored. The findings include: Resident #8 was admitted to the facility on [DATE] with diagnoses that included multiple (MS) sclerosis, spasmodic torticollis, and dementia. The care plan dated 4/8/24 identified Resident #8 required assistance with ADLs due to history of MS. Interventions included providing total assistance with ADLs, transfers, and incontinent care. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel, utilized a nephrostomy tube, was dependent on staff for dressing, bathing and toileting and required set up only with meals. The reportable event form dated 5/6/24 identified Resident #8 called for staff assistance between 5:30 PM - 6:00 PM and reported he/she had spilt soup on his/her chest and gown. Further, Resident #8 was identified with a 3 cm x 2 cm reddened area with small, scattered blisters on the left upper quadrant of his/her abdomen/chest area. Interventions included to provide Resident #8 a clothing protecter with meals. The reportable event form failed to identify any additional information related to the soup and resulting burn, including if the soup was part of Resident #8's meal on 5/6/24 or from an outside source. A nurse's note dated 5/6/24 at 10:23 PM identified that Resident #8 had a burn from soup on his/her upper left abdomen and chest area. Further review of the clinical record failed to identify any further documentation related to this incident. An APRN note dated 5/7/24 identified Resident #8 had a second degree burn with blistering noted on his/her chest wall. Treatment included cleansing with normal saline, applying Silvadene and an ABD pad twice daily, and monitor the area for infection. Interview with Resident #8 on 6/16/24 at 8:53 AM identified he/she had spilled soup on his/herself causing a burn. Resident #8 identified that he/she waited 2 minutes, but it was still too hot. Resident #8 was unable to identify when he/she was burnt by the soup or if the soup was part of his/her meal or from an outside source. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with Person #2 on 6/16/24 at 10:00 AM identified that Resident #8 had a burn following the facility staff reheating soup on 5/6/24 that Person #2 had brought into the facility for Resident #8. Person #2 identified that Resident #8 had a favorite Italian wedding soup that was made by a local grocer for several years. Person #2 identified he/she would purchase several containers of the soup at a time, freeze them, and then bring 1 - 2 containers every couple of weeks to the facility for Resident #8. Person #2 identified Resident #8 would ask the facility staff to reheat the soup for him/her, and until 5/6/24 there had never been any issues regarding this. Person #2 identified that from the report he/she received from the DNS and Resident #8 on 5/6/24, Resident #8 requested a portion of the soup to be reheated, but instead of the full cup of soup, he/she only requested a half a cup of soup instead. Person #2 identified that Resident #8 then requested the soup be reheated for 2 1/2 minutes, as this is the amount of time the soup was usually reheated. Person #2 identified that Resident #8 was given the soup, which he/she assumed would have been much hotter due to the portion being smaller, and then at some point Resident #8 was left with the soup in his/her room and found later to have spilt the soup on his/herself, resulting in a burn. Person #2 identified that that he/she was notified of the burn on 5/6/24 and told that going forward Resident #8 would have the soup reheated by the facility but only by dietary staff or a nurse, and that the soup had previously been reheated by nurse aides. Person #2 further identified that while this information was provided to him/her on 5/6/24, Resident #8 identified to Person #2 that the facility had told Resident #8 that if he/she wanted to have any food provided from the outside going forward, that outside food would not be reheated by any staff of the facility under any circumstances, and only visitors coming to see Resident #8 could reheat any food for him/her, including soup. Person #2 identified that while he/she had not been notified by the facility of this, he/she hoped this was not true as Resident #8 looked forward to the soup and he/she would not be able to come to facility on a regular basis just to reheat the soup for Resident #8 to be able to enjoy. Interview with NA #1 on 6/17/24 at 10:25 AM identified that the facility staff had been instructed that any outside food brought in by visitors for residents of the facility could not be reheated by any facility staff following the burn sustained by Resident #8 on 5/6/24. NA #1 identified this had been the practice since she began working at the facility in 6/2023 until Resident #8 was burned on 5/6/24. Interview with the DNS on 6/18/24 at 10:13 AM identified that facility staff had been reheating food for residents prior to this incident, but that the policy of the facility was that no outside food was to be reheated by the facility and any outside food would have to be reheated by the resident, if able, or by a visitor to bring to the resident. The DNS identified that the reheating policy had been in place for several years, and that staff were not provided with or in serviced on reheating temperatures since this was not a policy of the facility. The DNS also identified since the policy dictated that staff were not to reheat food for residents, no thermometers were available on any of the resident units to check food temperatures. The DNS was unable to identify how the facility would be able to allow residents to have access to food from the outside, including reheating the food, if they were not physically able to do so themselves, or if visitors were not able to come and visit a resident to allow for reheating of food, and that the facility would have to look into this. The facility policy on food brought into the facility from home directed that dietary personnel would not be responsible for holding or reheating any food [NAME] in from an outside source, and that any food items would be stored in airtight containers with labels including the resident's name, date and contents, to be discarded after 3 days. The policy further directed cold foods should be kept at 41 degrees Fahrenheit or colder, and hot foods to at least 135 degrees Fahrenheit. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility policy on Resident Rights directed that residents of the facility had the right to make choices about aspects of their lives significant to them, and to be treated with consideration, respect and full recognition of their dignity and individuality.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 42117 Based on review of facility documentation, facility policy, and interviews, the facility failed to place resident council funds in an interest-bearing account and hold, safeguard, manage, and account for the funds. The findings include: The Resident Council Funds bank account statements dated 4/1/21 to 4/30/24 identified that the account was closed on 4/14/21 and there was $1808.64 withdrawn at that time. Review of the resident council meeting minutes from 1/1/23 to 3/24/24 failed to reflect any discussion of resident council funds. Interview with Residents #13, 17, 23, 33, 35, and 61 on 6/16/24 at 2:00 PM indicated that there was a council president and secretary but not a treasurer. Resident Council residents were in agreement they were not aware of any money or any account that had money for them to use as part of the resident council. Interview with the Director of Recreation on 6/16/24 at 2:45 PM indicated that there was not a treasurer for the resident council. The Director of Recreation indicated that were no monthly or quarterly bank statements for the residents since April 2012. The Director of Recreation indicated that the prior Director of Recreation had a resident council funds account at a local bank and the residents did receive the monthly statements for the monthly resident council meetings but when the prior Director of Recreation left, someone closed the account in April 2021. The Director of Recreation indicated that she was the Assistant Director of Recreation prior to being the Director of Recreation now. The Director of Recreation indicated that the prior Administrator, Administrator #2, informed her that the money, $1806.64, was being held in the business office. The Director of Recreation indicated that when she asked the new Business Office Manager about the money, she was informed it was not in the business office. The Director of Recreation indicated that she had asked Administrator #2 how to open a resident council bank account and was not given any guidance. The Director of Recreation indicated that the facility just had a resident council car show and raised $2400 that is being held in the business office. Interview with the Business Office Manager on 6/16/24 at 2:55 PM indicated that she had only worked at the facility since January 2024 and when she had started, she had heard about the resident council's $1806, but it was not in the business office. The Business Office Manager indicated that there was no ledger or accounting documentation for the resident council funds of $1806. The Business Office Manager indicated that the Recreation Director had asked her regarding the money but indicated she did not have it in the business office. The Business Office Manager indicated she had the $2400 from the car show to give to the Director of Recreation once she opens a bank account. The Business Office Manager pulled a white garbage bag from a file cabinet and inside was a small metal lock box. The Business Office Manager opened the locked box and indicated that was the $2400 from the car show and that she did not have the $1800, did not know where it was and she never saw that money. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with Administrator #1 on 6/18/24 at 11:34 AM indicated he had heard about the resident council having an account with $1806 that was closed but he did not know what happened to the money. Administrator #1 indicated subsequent to surveyor inquiry on 6/16/24 facility staff was looking into what happened to the money. Administrator #1 indicated that he thinks yesterday the accountant figured it out, but he could not explain it and recommended to ask the VP of Operations. Interview with the Business Office Manager on 6/18/24 at 12:00 PM indicated that the accountant does not know what happened to the $1806 and indicated that they could not find it. Interview with the VP of Operations on 6/18/24 at 12:10 PM indicated that he believes the last account was closed. The VP of Operations indicated there is a corporate account that contains resident council funds, but is not interest bearing, and he cannot account for the $1800 moving from the closed account in 2021 into this corporate account. After reviewing the corporate account dated from 4/1/2021 until 6/18/24, the VP of Operations indicated that he was not able to show a transfer or a deposit of the $1806 and identified that at the next resident council they will discuss opening a back account for the resident council funds. Interview with the Business Office Manager on 6/18/24 at 12:15 PM indicated that prior to today, she was not aware that there was a corporate account that contained resident council funds and after reviewing the corporate account dated 4/1/2021 until 6/18/24, the Business Office Manager indicated that there was no transfer or a deposit of $1806. Although attempted, an interview with Administrator #2 multiple times was not obtained. Review of the facility Resident Council Funds Policy identified the facility will maintain the resident council funds. The facility will encourage and assist in the establishment of a resident council through periodic communications with residents and families and/or such other means as the facility feels appropriate. Designating the Recreation Director to be approved by the resident council to assist the group and respond to grievances and recommendations of the resident council. Review of the Resident Rights Policy identified the residents have the right to manage their personal financial affairs and cannot be required to your personal funds with the facility. The residents have the right to have the facility to manage your personal funds if you authorize this in writing. The residents have the right to a quarterly accounting of their funds. A separate statement about how the facility manages residents' funds is provided.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 42117 Based on review of facility documentation, facility policy, and interviews the facility failed to ensure the residents private information was kept confidential. The findings include: Observation on 6/17/24 at 8:10 AM of medication administration identified LPN #7 moved the medication cart to the room of Resident #23. LPN #7 opened the medication cart and prepared the medications for Resident #23. At 8:15 AM, LPN #7 entered Resident #23's room, without the benefit of closing the computer screen, and gave Resident #23 his/her medications. LPN #7 then exited the room noting that the computer screen had been open with 16 residents' personnel demographics such as names, photo, and room number visible. LPN #7 prepared Resident #37's medications and without the benefit of closing the computer screen, proceeded into Resident #37's room and gave the medications to resident #37. Again, 16 residents' private information was visible on the computer screen. LPN #7 exited the residents' room. LPN #7 pushed the medication cart to the nurse's station and entered the medication room and left the computer screen open with the same 16 residents' information open on the computer screen. LPN #7 exited the medication room. LPN #7 proceeded to enter Resident #37's room and verbally stated she was going to give a tablet of Senna 8.6 mgs to Resident #37 and again, the computer screen was left open to the 16 residents' information. Interview with LPN #7 on 6/17/24 at 8:45 AM indicated that she was not aware that she could not leave the computer screen open with all the resident demographics including photos, room numbers, names, for the 16 residents that were on her unit. LPN #7 that she thought she only had to close the computer screen when the list of a resident's medications were visible. Interview with the DNS on 6/17/24 at 9:40 AM indicated LPN #7 was not supposed to leave the computer screen open with the any resident information unless the nurse was in front of the computer screen. The DNS indicated after she prepares the medication and is leaving the medication cart, the nurse either can close the computer screen or hit a button that makes the screen go to the screen saver so the screen will look blank. The DNS indicated that resident information including the names, room numbers and photos cannot be left on the computer screens when the nurse is not at the computer due to residents right to confidentiality. Review of the facility Medication Administration Policy identified that the nurse was to observe each residents' rights in accordance with applicable law such as blocking unnecessary access to the MAR. Review of the Resident Rights Policy identified residents have the right to privacy and confidentiality regarding all personal and health information kept by the facility pertaining to the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation, review of job descriptions, and interviews for 4 of 4 units, the facility failed to ensure the environment was clean, sanitary, maintained in good repair and homelike. The findings included: Review of the infection control surveillance & safety rounds form dated 4/24/24 identified rounds were completed by RN #1 and the Maintenance Supervisor. The infection control surveillance & safety rounds form failed to reflect documentation regarding resident room conditions. Observations on 6/16/24 at 2:08 PM through 2:35 PM, on 6/17/24 at 9:22 AM through 9:50 AM, and on 6/18/24 at 8:46 AM with the Maintenance Supervisor, Housekeeping/Laundry Supervisor, Administrator, and RN #1 identified the following: a. Damaged, missing and/or broken floor tiles in the bedroom on [NAME] unit in room [ROOM NUMBER], and on Cortland unit in room [ROOM NUMBER], and 213. b. Damaged, missing and/or broken floor tiles in the bathroom on [NAME] unit in rooms [ROOM NUMBER], c. Damaged, stains, chipped and/or marred bedroom walls, bathroom walls, on [NAME] unit in rooms 30, 31, 32, 33, 34, 35, 36, 37, 39, 40, 41, 42, 43, 44, and 45. On Crestbrook unit in rooms 50, 51, 52, 53, 54, 57, 58, 59, 60, 61, 62, 63, 64, and 65. And on Taft unit in rooms 220, 221, 223, 227, 229, and hallway. d. Damaged, broken, bent and/or rusty bathroom radiator covers, on [NAME] unit in rooms 32, and 44. On Crestbrook unit in room [ROOM NUMBER], and on Taft unit in rooms [ROOM NUMBER]. e. Damaged, broken, stains, chipped and/or marred bedroom radiators on [NAME] unit in rooms 30, 32, 33, 35, 40, 45, and on Taft unit in room [ROOM NUMBER]. f. Damaged, dirty and/or missing cove base in bedroom and bathroom on [NAME] unit in rooms 31, 33, 36, 39, 40, and 44. On Taft unit in room [ROOM NUMBER]. g. Stains, dirt, debris, discoloration and/or wax build up on the floor bedrooms on [NAME] unit in rooms 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, and 45. On Crestbrook unit in rooms [ROOM NUMBER]. On Cortland in rooms 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 215, shower room, and lounge. On Taft unit in rooms 214, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, and 229. h. Stains, dirt, debris, discoloration and/or wax build up on the floor in the bathroom on [NAME] unit in rooms 30, 31, 32, 33, 34, 35, 37, 38, 39, 40, 41, 42, 43, 44, and 45. i. Damaged, peeling, chipped and/or broken nightstand on [NAME] unit in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	j. Damaged, peeling, and/or brown stains on bedroom and bathroom ceiling, on [NAME] unit in rooms 31, 35, 37, 41, and hallway. On Crestbrook unit in rooms [ROOM NUMBER]. Cortland unit hallway, and lounge. k. Damaged and/or broken towel rack on [NAME] unit in room [ROOM NUMBER]. l. Damaged, rusty, and/or stain commode in the bathroom on [NAME] unit in rooms [ROOM NUMBER]. Cortland unit tub room. m. Damaged, and/or rusty overbed table legs on [NAME] unit in rooms 31. n. Rusty and/or stains bedframe in bedroom on [NAME] unit in room [ROOM NUMBER] and 45. o. Damaged, broken, and/or missing nightstand drawer knob in bedroom on [NAME] unit in rooms 32 (2nd and 3rd drawer knob missing). p. Damaged, broken, peeling, and/or missing dresser drawer knob in bedroom on [NAME] unit in rooms 35 (2nd and 3rd drawer knob missing), 39, 43, 44, and 45 (3rd drawer knob missing). Cortland unit in rooms 203, 205 (4th drawer knob missing), 206 (4th dresser knob missing), 215 (3rd drawer knob missing). Taft unit in rooms 218 (3rd drawer knob missing), 224 (1st drawer knob missing). q. Damaged, and/or stains privacy curtain in bedroom on [NAME] unit in rooms 33, and 35. r. Damaged and/or stains window curtain in bedroom on Crestbrook unit in room [ROOM NUMBER]. s. Damaged, peeling and/or staining toilet seat in the bathroom on Crestbrook unit in room [ROOM NUMBER]. t. Damaged and/or broken wall protector in hallway on Taft unit. Interview with the Housekeeper/Laundry Supervisor on 6/18/24 at 9:05 AM identified she has been employed with the facility for approximately 8 months. The Housekeeper/Laundry Supervisor identified she was not aware of the resident bedroom floors with stains, dirt, debris, discoloration and/or wax build up on the floors, and the privacy and window curtains dirty with brown stains. Interview with the Maintenance Supervisor on 6/18/24 at 9:10 AM identified he has been employed by the facility in the supervisor position since October 2023. The Maintenance Supervisor indicated he was aware of some of the issues. The Maintenance Supervisor indicated he and the Maintenance Assistant are trying to repair some of the damaged walls in the bedrooms and bathrooms. Interview with RN #1 on 6/18/24 at 9:10 AM identified she has been employed by the facility for approximately 3 years. RN #1 indicated she was aware of some of the issues that were identified during the tour. RN #1 indicated the Maintenance Supervisor, and she does environmental rounds quarterly. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 6/18/24 at 10:20 AM identified he has been employed by the facility for approximately 4 months. The Administrator indicated he was aware of some of the issues identified. The Administrator indicated going forward there will be a meeting with the Maintenance Supervisor, the Housekeeper/Laundry Supervisor, DNS, and RN #1 regarding the expectation of a home like environment. The Administrator indicated that maintaining the facility in a safe comfortable manner is always an ongoing priority. Interview with the DNS on 6/18/24 at 10:30 AM identified she was aware of some of the issues. The DNS indicated that going forward there will be a meeting with the Maintenance Supervisor, the Housekeeper/Laundry Supervisor, and RN #1 regarding the expectation of a home like environment. Review of the infection control surveillance and safety rounds identified to observe facility compliance with infection control policies and procedures. Surveillance rounds are to be conducted on a regular basis by the Infection Control Nurse or his/her designee. The ICN will coordinate times to conduct surveillance rounds. Review of the maintenance supervisor job description identified plans, organizes, and directs the maintenance and repairs of the physical plant, equipment and all essential building systems. Ensures the facility is safe and secure while fostering TQM and striving to attain the facility's mission statement. Review of the maintenance technician identified under direct supervision provides quality maintenance services. Assists in the maintenance and repair of the physical plant and grounds, equipment, and various buildings systems. Provides a clean, orderly, and safe environment for all facility residents and staff. Review of the housekeeping supervisor identified plans, organizes, and directs the provision of housekeeping services. Ensures the facility is safe and secure while fostering quality and striving to attain the facility's mission statement. Within budget guidelines, plans for needed supplies and equipment to maintain quality cleanliness standards. Review of the housekeeping assistant identified under direct supervision provides quality housekeeping services, and a clean, orderly and safe environment for all facility residents and staff.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 43032 Based on review of facility documentation, facility policies, and interviews for 5 of 16 residents reviewed for elopement (Resident #24, 40, 41, 43 and 79) the facility failed to effectively manage roam alert bracelets resulting in residents wearing expired roam alert bracelets, bracelet serial numbers improperly documented in the physician order and a resident wearing an elopement bracelet without a physician's order, and for 2 of 5 residents (Resident #41 and 51) reviewed for falls, the facility failed to ensure that neurological assessments and post fall assessments were completed following falls, and for 2 of 4 residents (Resident #46 and 53) reviewed for nutrition, the facility failed to ensure that the physician's orders were followed related to weight monitoring. The findings include: 1. Resident #24 was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnosis that included Alzheimer's disease, dementia, and a history of falling. The quarterly MDS dated [DATE] identified Resident #24 had severely impaired cognition, had the ability to walk 150 feet in a corridor or similar space with moderate assistance, had the ability to propel in wheelchair 150 feet in a corridor or similar space independently, and used a wander/elopement alarm daily. Resident #7 seeks out areas of exit, is cognitively impaired and leaves unit without staff knowledge. The corresponding care plan identified a concern with elopement with interventions that included roam alert on the right ankle, check expiration date, monitor function every shift. A physician's order dated [DATE] directed to monitor psychotropic behaviors including elopement, and roam alert to left ankle, check placement every shift, check function every night shift, expiration date ,d+[DATE] Serial Number: F03BC4 every shift check placement every shift. 2. Resident #40 was admitted to the facility [DATE] with a readmission of [DATE] with diagnoses that included dementia, history of falling, and anxiety disorder. The quarterly MDS dated [DATE] identified severe cognitive impairment, utilized a manual wheelchair for mobility and used a wander/elopement alarm daily. The care plan dated [DATE] identified a concern with elopement with interventions that included to monitor function of roam alert and monitor placement. A physician's order dated [DATE] directed roam alert to right side of wheelchair, check placement every shift, check function every night shift, expiration date ,d+[DATE] serial number F04B83. 3. Resident #41 was admitted to the facility on [DATE] with a readmission [DATE] with diagnoses that included dementia, anxiety disorder, and emphysema. (continued on next page)

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Apple Rehab Watertown	35 Bunker Hill Rd Watertown, CT 06795

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41's Nursing Admission assessment dated [DATE] identified that Resident #41 was an elopement risk and was identified with a cognitive impairment and leaves the unit without staff knowledge. The quarterly MDS dated [DATE] identified severely impaired cognition, ability to walk 150 feet with moderate assistance, and used a wander/elopement alarm daily. The care plan dated [DATE] identified a concern with elopement, and previous attempt to elope with interventions that included to apply roam alert, check the placement each shift, check functioning of roam alert every day as per facility policy, check functioning of roam alert each shift, discuss with my family risks of wandering and elopement. Resident #41 was seen by psychiatry monthly with the most recent evaluation dated [DATE] identifying restlessness with symptoms of wandering, will provide medications and interventions and continue to monitor mood, sleep, and behaviors, continue with current meds, and evaluate for gradual dose reduction (GDR) in the future. A physician's order dated [DATE] directed to monitor psychotropic behaviors including elopement every shift. 4. Resident #43 was admitted to the facility [DATE] and readmitted [DATE] with diagnosis that included dementia, disturbance psychotic, mood disturbance and anxiety. The quarterly MDS dated [DATE] identified severely impaired cognition, utilized a walker and a wheelchair for mobility, and used a wander/elopement alarm daily. The care plan dated [DATE] identified a focus for wandering with interventions that included to apply roam alert, check the placement each shift, and to check functioning every day per facility policy. A physician's order directed to check placement of roam alert Serial number F06FFB expiration date , d+[DATE] to left ankle every shift and check function every night, and a second order to check roam alert placement every shift and to check function every night for serial #F06FFB expiration ,d+[DATE]. 5. Resident #79 was admitted to the facility [DATE] and readmitted [DATE] with diagnoses that included dementia, hypokalemia (low potassium levels), hypertension. The quarterly MDS dated [DATE] identified Resident #79 had severely impaired cognition, did not utilize a wander/elopement alarm daily, and was able to walk 50 feet with 2 turns with moderate assistance. Resident #79's care plan failed to provide a focus on wandering or elopement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79 had several Elopement Risk evaluations after hospitalization s. The Elopement Risk evaluation identifies risk factors after determining the resident's mobility. One yes indicator out of 7 results in an elopement risk indicates the resident is at risk for elopement. The form identifies to institute the use of an elopement device (Wander guard/secure care) and follow the guidelines of the AHC Elopement Risk Policy or if it is determined (by) the interdisciplinary team that a resident's behavior does not constitute a risk for elopement, a care plan will be written to reflect appropriate interventions. Resident #79's Elopement Risk evaluations identified the following. [DATE]: 0 of 7 indicators were identified as yes however and Resident #79 was not identified as an elopement risk. [DATE]: 7 of 7 indicators were identified as yes however and Resident #79 was identified as an elopement risk. [DATE]: 3 of 7 indicators were identified as yes however the elopement risk was not addressed. [DATE]: 1 of 7 indicators were identified as yes however, the resident was identified as not an elopement risk. Observation and testing of the roam alerts on [DATE] at 2:20 PM with the ADNS following a reported malfunction identified the following. Using the facility's Roam Alert sheet, which consists of a photograph of the resident who is at risk for elopement and is kept at the main entrances of the facility and every nurse's station. The testing device tests the roam alert for functionality and identifies the serial number of the device worn by the resident at that time. The Roam Alert sheet identified 18 residents on roam alerts with 2 on hospice and currently immobile, one which was discontinued [DATE], 2 expired devices one ,d+[DATE] and the second ,d+[DATE], and 2 residents who had a device without orders. The ADNS could not provide an explanation regarding the use of expired roam alerts, serial numbers that did not match the clinical record for roam alerts and how roam alerts were checked when there was no physician's order. During the testing, the following discrepancies were identified. Resident #24; roam alert serial # F03BC4 had expired ,d+[DATE]. Resident #40; the MAR identified the roam alert serial #F04B83 with an expiration date of ,d+[DATE], and currently had roam alert serial #F0D277. The clinical record had an incorrect serial number, and the corresponding expiration date was unknown. Resident #41 did not have an active order for a roam alert, had a history of wandering, was assessed as an elopement risk, and found to be wearing roam alert serial #F079F2, expiration date unknown. Resident #43 roam alert serial #F06FFB had expired ,d+[DATE]. Resident #79 did not have an active order for a roam alert, had a history of wandering, was assessed as an elopement risk, and found to be wearing roam alert serial #F00260, expiration date unknown. (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 with the ADNS on [DATE] at 10:10AM identified the night supervisor has the responsibility to check the roam alerts nightly. She identified, although it is the night supervisor's job to test each roam alert nightly as the ADNS she is responsible for overseeing the process. On [DATE] at 9:50 AM the ADNS provided an updated facility Roam Alert sheet which consisted of 15 residents. Interview and clinical record review with DNS on [DATE] at 11:30 AM identified she had been made aware of the facility's roam alert discrepancies and indicated the facility is in the process of auditing each alert device and updating the clinical record to support resident monitoring for the device. She indicated all expired devices will be replaced. The facility policy for elopement risk identified an activated elopement bracelet (Wander guard) will be placed on the resident and documented in the medical record if deemed appropriate. Each shift placement of the elopement bracelet will be verified and documented in the medical record. The functioning of the elopement bracelet will be tested on ce a day by utilizing a tester unit and documented in the medical record. 46040 6. Resident #41 was admitted to the facility on [DATE] with diagnoses that included dementia, heart failure, and hypertension. The significant change MDS dated [DATE] identified Resident #41 had severely impaired cognition, was always continent of bowel, frequently incontinent of bladder, and required substantial assistance from staff with dressing, bathing, and toileting. The care plan dated [DATE] identified Resident #41 had a history of multiple falls. Interventions included every 15-minute checks and to analyze previous falls to determine whether a pattern/trend could be addressed. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 4:00 PM. The neurological checks documented for the 72 hours following the fall were incomplete related to vital signs, pupil reaction, and extremity strength. Review of the clinical record also failed to identify a fall assessment was completed or documented related to the fall on [DATE]. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 10:15 AM. The neurological checks following the fall failed to identify any documentation after 2:15 PM on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 3:15 PM. The neurological checks documented following the fall failed to identify any documentation related to vital signs after 8:15 PM on [DATE] and failed to identify any documentation related to neurological assessments on [DATE] after 4:15 AM. The neurological sheet also identified the following see attached, had another fall annotated at [DATE] at 8:15 AM. Further review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall [DATE] at 11:45 AM with corresponding neurological checks and post falls assessments beginning [DATE] at 11:45 AM. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 6:15 PM. The neurological checks documented related to this fall identified neurological checks began [DATE] at 6:00 PM, 15 minutes prior to the incident, and further review of the neurological checks failed to identify any documentation related to this fall after 11:15 AM on [DATE]. Further review of the facility reportable event form identified a form Fall Scene Investigation which failed to identify any resident's name, date, time of fall, or any legible information related to facility staff completing the form. In addition, a neurological check also attached to this form failed to identify any resident name or date of incident. Review of the reportable event investigation form, which identified an investigation was completed related to this fall, was identified as signed by the DNS on [DATE]. Review of the clinical record and facility reportable event form identified Resident #41 had second unwitnessed fall on [DATE] at 7:15 PM. The neurological checks related to this fall failed to identify vital signs or neurological checks were reinitiated at every 15-minute intervals per the facility neurological check flowsheet directions. The documentation related to neurological checks for this fall identified they were initiated at 6:00 PM on [DATE], a neurological check was completed at the time of this fall at 7:15 PM, with the next check done at 8:15 PM on [DATE]. Further review of the neurological checks failed to identify any neurological check documentation completed after [DATE] at 3:15 PM. Review of the clinical record and facility reportable event form identified Resident #41 had a witnessed fall on [DATE] at 3 PM and observed by LPN #3 to fall and on the floor in the unit lobby and had bleeding from the head. The clinical record identified Resident #41 was sent to the hospital for evaluation at 3:25 PM and returned to the facility with 2 sutures on [DATE] at 2:00 AM. Review of the clinical documentation failed to identify any post-accident assessments completed for this fall on Resident #41. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 1:45 PM. Further review of the facility reportable event form identified the form Interdisciplinary Fall assessment which failed to identify any documentation related to a resident name or date the form was completed, and the form Fall Scene Investigation which failed to identify any resident's name, date, or time of fall. In addition, a neurological check also attached to this form failed to identify any resident name or date of incident. Review of the reportable event investigation form, which identified an investigation was completed related to this fall, was identified as signed by the DNS on [DATE] and identified that Resident #41 was placed on every 15-minute checks following this fall. Review of the clinical record failed to identify any documentation related to neurological checks were initiated or completed, or that 15 minutes checks were implemented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 10:00 PM. Review of the neurological checks failed to identify any documentation related to an incident date and failed to identify any documentation of dates and times that neurological checks documented on the flowsheet were completed. Further review of the clinical record and facility reportable event form failed to identify any documentation related to dates and times that the post incident assessments following this fall were completed. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 7:00 PM. Review of the clinical record identified a resident locator for every 15-minute checks or 1:1 monitoring dated [DATE] with locations documented beginning at 3:00 PM, 4 hours prior to Resident #41's documented fall on [DATE]. The form failed to identify any staff member signatures or identifying information, including any issues, to verify who completed the form. The form failed to identify any documentation after 10:45 PM on [DATE]. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 3:15 PM. Further review of the facility reportable event form identified the form Interdisciplinary Fall assessment failed to identify any documentation related to a resident name or date the form was completed. Review of the reportable event investigation form, which identified an investigation was completed related to this fall, was identified as signed by the DNS on [DATE]. Further review of the clinical documentation also failed to identify any documentation that post A&I assessments were completed on [DATE]. Review of the clinical record and facility reportable event form identified Resident #41 had an unwitnessed fall on [DATE] at 12:00 PM. Review of the reportable event investigation form, which identified an investigation was completed related to this fall, was identified as signed by the DNS on [DATE], and identified corrective measures included every 15-minute checks would be conducted on Resident #41. Review of the clinical record failed to identify any documentation related to every 15-minute checks being performed prior to or after Resident #41's unwitnessed fall on [DATE]. Review of the clinical record and facility reportable event form identified Resident #41 had a witnessed fall on [DATE] at 3:00 PM. Review of the reportable event investigation form, which identified an investigation was completed related to this fall, was identified as signed by the DNS on [DATE], and identified corrective measures included education to the nurse aide that was assigned to Resident #41 to ensure that the resident was not left unattended. Included in the facility reportable event form was an in-service document completed by the ADNS with one nurse aide signature on [DATE] that the nurse aide review Resident #41's care card every shift, prior to beginning care and be a consistent care giver. Further review of the facility reportable event form identified the nurse aide who was in serviced by the ADNS on [DATE] was not assigned to, and did not provide any care for, Resident #41 at the time of the fall on [DATE]. Review of facility documentation within the facility reportable event form from [DATE] - [DATE] and interview with the DNS on [DATE] at 10:13 AM identified that it was the policy of the facility to complete neurological checks for 72 hours following an unwitnessed fall and if a resident had impaired cognition, and also to complete post-accident and incident assessments for 3 days following any accident or incident that occurred with a resident. The DNS identified that the staff had not completed the neurological checks or post A&I assessments and the facility would need to approach educating the staff differently to ensure that the checks and assessments were completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the post A&I assessment flowsheet directed that the assessment was to be completed each shift for 72 hours following an accident or incident and to notify the physician if the assessment revealed new or worsened symptoms, and included assessment areas for skin bruising, range of motion, pain, blood pressure, pulse and respirations. The facility policy on falls identified each time resident experienced a fall, post A&I assessments would be completed and documented on for 72 hours after the fall, and that neurological checks would also be completed for 72 hours after a fall for any resident that experienced an unwitnessed fall and was unable to accurately verbalize a head strike due to cognitive status or experienced any type of head injury. The facility policy on neurological assessments directed that neurological checks were used to assess a resident's neurological status following a head injury or any other situation that might alter the resident neurological status, including a fall when a resident was unable to cognitively verbalize a head injury. The policy further directed that the neurological flow sheet would be instituted by the nurse and would be completed every 15 minutes for the first hour, every hour for 4 hours, every 4 hours for the next 24 hours, and every shift for 48 hours after that. The policy directed that the flowsheet documentation should include the date and time of the assessment, the level of consciousness, the pupillary response, the strength and sensation of the extremities, and vital signs. 7. Resident #51 was admitted to the facility on [DATE] with diagnoses that included dementia, adjustment disorder with disturbance of conduct, history of falling, and left sided maxillary, orbital floor, radius, and ulna fractures. The admission MDS dated [DATE] identified Resident #51 had moderately impaired cognition, required a maximal assist with chair/bed-to-chair transfers, sustained a fracture related to a fall within the last 6 months prior to admission, and sustained 1 fall with no injury since admission. The care plan dated [DATE] identified Resident #51 was at risk for falls due to decreased mobility, history of a fall at home, Parkinson's disease, confusion, seizure disorder, and antipsychotic medication use. Interventions included keeping the call bell in reach, maintaining frequent checks on the resident, and the provision of a well-lit and clutter free environment. The nurse's note dated [DATE] at 11:38 PM identified that around 5:00 PM, Resident #51 was found on the floor by the dietary aide, sitting on his/her bottom to the right side of the bed, facing the bed. Water was on the floor secondary to Resident #51 throwing cups of water on the floor throughout the shift. No injuries were noted, Resident #51 denied pain, vital signs were stable, and the nursing supervisor was in to assess. Resident #51 was assisted back into wheelchair by the nurse and nurse aide. Around 6:15 PM, Resident #51 was sitting in front of the nurse's station and complained of increased pain to his/her right lower extremity. A message was left for the resident representative and the on-call APRN was updated and a new order for an x-ray to the right lower extremity was obtained. Resident #51 was assisted into bed around 7:00 PM and had been resting well, with the call light in reach. The nurse's notes dated [DATE] through [DATE] failed to identify neurological checks, including vital signs, and post fall assessments were completed, per the facility policy, following Resident #51's fall on [DATE] at 5:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The weights and vitals documentation dated [DATE] through [DATE] identified vital signs were obtained at the following times, prior to Resident #51's transfer to the hospital: [DATE] at 11:54 PM. [DATE] at 3:29 AM. [DATE] at 11:19 AM. The Reportable Event Summary dated [DATE] identified that Resident #51 spilled water onto the floor then when he/she attempted to get up sustained a fall. Resident #51 was sent to the hospital and was diagnosed with an acute displaced right femoral neck fracture and a small mildly hyper dense subdural hematoma, with no mass or midline shift. Interview and clinical record review with LPN #4 on [DATE] at 9:49 AM failed to identify neurological monitoring and post-fall assessments were completed following Resident # 51's fall, on [DATE]. LPN #4 indicated that she was the nurse caring for Resident #51, at the time of the fall. LPN #4 further indicated that Resident #51 had been living at the facility for less than 1 month, was agitated, and had been throwing cups of water on the floor during the shift. LPN #4 identified that the staff had gone into Resident #51's room to clean the water throughout the shift, and Resident #51 had refused to go into the dining room, for closer supervision. LPN #4 indicated that Resident #51 was found sitting on the floor around 5:00 PM, by the dietary aide, and that Resident #51 reported that he/she slipped on the water. LPN #4 identified that initially Resident #51 denied pain; the nursing staff put him/her into the wheelchair, and Resident #51 was brought out to sit by the nurse's station for closer monitoring. LPN #4 further identified that she notified the nursing supervisor and began neurological checks and post-fall assessments, immediately and throughout the remainder of her shift. Interview and clinical record review with LPN #5 on [DATE] at 9:49 AM failed to identify neurological monitoring and post-fall assessment documentation was completed following Resident #51's fall on [DATE]. LPN #5 identified that she was the nurse caring for Resident #51 from 11:00 PM until the time of the hospital transfer and that he/she did not complain of pain over night or during the first round of care in the morning; it wasn't until later the next morning that he/she began to complain of pain. LPN #5 further identified that all of Resident #51's neurological checks and post-fall assessments were completed during her shift and were all within normal limits. Interview and clinical record review with the DNS on [DATE] at 2:44 PM identified that they were unable to locate the accurate documentation for Resident #51's neurological checks and post-fall assessments, but that she would continue to look for the documentation, as it could have been misfiled. Interview and clinical record review with the DNS on [DATE] at 12:25 PM identified that she would expect neurological checks and post-fall assessments to be completed, per the facility policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Falls: Minimizing Risk of Injury policy directs each time a resident experience a fall, an Accident and Incident (A&I) report will be completed and an interdisciplinary fall assessment in order to identify the potential causes of the fall. Statements will be obtained from staff members at the time of the fall. A status post A&I assessment and neurological checks will be completed and any resident that experiences an un-witnessed fall and is unable to accurately verbalize if he/she hit head due to cognitive status or experienced any type of head injury. The post A&I assessment and neurological monitoring will be documented for 72 hours. 8. Resident #46 was admitted to the facility on [DATE] with diagnoses that included dysphagia, hypertension, and diabetes. A physician's order dated [DATE] directed to check Resident 46's weight every Monday, Wednesday, and Friday on day shift for CHF protocol. The quarterly MDS dated [DATE] identified Resident #46 had severely impaired cognition, was frequently incontinent of bowel, utilized a suprapubic catheter, and required substantial assistance with bathing, dressing, and set up for meals. The care plan dated [DATE] identified Resident #46 was at nutritional risk of weight loss. Interventions included obtaining weights as ordered. Review of the clinical record identified the following weights documented for Resident #46 from [DATE] - [DATE]. [DATE]: 209.7 lbs. [DATE]: 213.6 lbs. [DATE]: 211.0 lbs. [DATE]: 211.0 lbs. [DATE]: 214.0 lbs. [DATE]: 210.0 lbs. [DATE]: 210.9 lbs. [DATE]: 213.8 lbs. [DATE]: 211.9 lbs. [DATE]: 222.0 lbs. [DATE]: 211.9 lbs. [DATE]: 212.0 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]: 204.0 lbs. Further review of the clinical record failed to identify any additional weights documented for Resident #46. 9. Resident #53 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, atrial fibrillation, and COPD. Review of the clinical record identified Resident #53 was hospitalized from [DATE] - [DATE] due to acute kidney injury. Review of the clinical recorded identified Resident #53 weighed 338.5 lbs. upon readmission the facility on [DATE]. The physician's orders dated [DATE] directed Torsemide (a diuretic medication used for hypertension and fluid retention) 100 mg one daily and to obtain Resident #53's weight weekly for 4 weeks. Further review of the clinical record identified Resident #53 had previous physician's orders to obtain weights daily from [DATE] - [DATE]. The quarterly MDS dated [DATE] identified Resident # 53 had intact cognition, was continent of bowel and occasionally incontinent bladder, and required substantial assistance with bathing, dressing, and set up for meals. The care plan dated [DATE] identified Resident #53 was at risk for cardiac issues related to CHF and required use of a diuretic. Interventions included to monitor weights as ordered. Interview on [DATE] at 8:45 AM with Resident #53 identified he/she had been being weighed weekly due to his/her history of CHF for weight gain. Resident #53 identified that he/she had been weighed at least 2 - 3 times weekly prior to his/her hospitalization , however following readmission to the facility on [DATE], he/she had only been weighed once or twice. Resident #53 identified he/she had brought up the issue with a staff member on one prior occasion but could not remember the staff member's name or the date. Resident #53 identified he/she was concerned that his/her weights were not being checked as frequently due to his/her cardiac history and ongoing respiratory issues. Review of the clinical record identified Resident #53 weighed 315.5 lbs. on [DATE], a 23 lb. or 6.79% weight loss from [DATE], 13 days prior. The clinical record also identified Resident #53 weighed 306.0 lbs. on [DATE], 9.5 lb. weight loss from [DATE], 40 days prior, and a 32.5 lb. or 9.3% weight loss from [DATE], approximately 7 weeks prior. Further review of the clinical record failed to identify any additional weights documented for Resident #53. (continued on next page)

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Apple Rehab Watertown	35 Bunker Hill Rd Watertown, CT 06795

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on [DATE] at 8:00 AM identified that Resident #53 did have a previous order for daily weights, but that they were no longer needed due to Resident #53 having a history of stable weights prior to hospitalization on [DATE]. APRN #1 further identified that Resident #53 had not been receiving diuretics in the hospital, and that they were restarted following readmission to the facility, which accounted for his/her weight loss from [DATE]. APRN #1 identified that while Resident #53 did not need daily weights, he/she should have had an order placed for at least weekly weights due to his/her history of CHF and fluid retention while hospitalized . APRN #1 identified that she was responsible for placing the weight orders, and this was an oversight on her part. APRN #1 identified she would place a new order for weekly weights for Resident #53. Interview with the DNS on [DATE] at 10:13 AM identified that it was the policy of the facility to follow the physician's orders related to weight monitoring, that Resident #46 should have had weights obtained and documented 3 times weekly, and Resident #53 should have had weekly weight monitoring for 4 weeks following readmission to the facility on [DATE]. The DNS identified that she would reeducate her staff on the importance of following the physician's orders. The facility policy on heart failure directed that the physician would make recommendations for a resident that included monitoring weight, and that the physician would also monitor for adverse side effects of medications, including diuretics, including fluid imbalance. The facility policy on weight monitoring directed that residents would be weighed upon admission and readmission to the facility every week for 4 weeks and then at least monthly unless otherwise indicated by the physician's order. 47457

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 37293 Based on a review of clinical records, facility documentation, facility policy and interviews, for two of 5 residents (Resident #27 and 41) at risk for falls, the facility failed to implement interventions including adequate supervision to prevent falls consistent with the resident's needs resulting in injury. The findings include: 1. Resident #27 was admitted to the facility in June 2021 with diagnoses that included diabetes, atrial fibrillation, and convulsions. The care plan dated 10/25/23 identified Resident #27 was at risk to fall due to a history of frequent falls with injury, decreased mobility, worsening dementia, history of CVA, and noncompliance with calling and waiting for assistance due to decline in cognition and safety awareness. Interventions included assistance with ADL's and transfers, and to offer the resident early bedtimes. The physician's order dated 11/1/23 directed to provide the assistance of 2 with transfers and ambulation with platform rolling walker. The quarterly MDS assessment dated [DATE] identified Resident #27 had severely impaired cognition and required extensive assistance with transfer and toilet use. The reportable event form dated 11/20/23 at 7:00 PM identified Resident #27 was found on the floor in his/her room in front of the recliner bleeding from the top of the head. Review of the fall scene investigation form dated 11/20/23 identified Resident #27 had a history of prior falls, was alert and confused and the fall was unwitnessed. The nurse's note dated 11/20/23 at 7:24 PM identified Resident #27 had an unwitnessed fall and was observed on the floor in the room at 7:00 PM with bleeding from the head. The RN supervisor assessed the resident, notified the APRN and 911 was called. The revised care plan dated 11/20/23 identified Resident #27 was sent to the hospital for evaluation and was to be monitored every 1 hour upon return. The nurse's note dated 11/21/23 at 1:45 AM identified Resident #27 returned from the hospital with a diagnosis of laceration to the head repaired with 4 sutures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The reportable event form dated 11/23/23 at 1:45 PM identified staff responded to Resident #27's yelling for help and the resident was found on the side of the wheelchair and bed. Per the resident roommate, Resident #27 got up and fell . The RN assessment revealed no internal or external rotation and neurological assessment within normal limits. Resident #27 was alert and confused and required assist of 1 with transfers. Resident #27 initially complained of back pain. The physician and the resident's representative were notified with a decision to not send to the hospital for an evaluation. On 11/24/23, Resident #27 complained of left lower extremity pain, the physician was notified and a new order for an x-ray of the left hip was obtained. The x-ray result revealed acute very subtle impacted left femoral neck fracture, visible only on oblique view, CT scan work up advised. Resident #27 was sent to the hospital for further evaluation. The investigative report dated 11/23/23 identified the nurse aide (NA #2) last saw the resident at 12:15 PM when lunch was served, an hour and a half prior to the fall. The summary report dated 11/29/23 at 12:49 PM identified Resident #27 had an acute impacted left femoral neck fracture and underwent a left hip pinning on 11/25/23. Resident #27 returned to the facility on [DATE]. Review of the clinical record during the period of 11/21/23 - 11/23/23 at 1:45 PM failed to identify documentation that the resident was monitored every hour in accordance with the revised care plan. Review of the clinical record and interview with LPN #6 on 6/18/24 at 11:00 AM identified documentation of every 1 hour monitoring checks after the 11/20/23 fall between 11/21/23 - 11/23/23 could not be found and she was not aware the nurse aides were not monitoring the resident every hour. Review of the clinical record and interview with the DNS on 6/18/24 at 11:20 AM indicated she was not aware that the documentation of the 1 hour checks after the 11/20/23 fall between 11/21/23 - 11/23/23 were not completed. The DNS indicated the RN and the LPN on the units are responsible to give report to the nurse aides when the resident is on every 1 hour checks. The DNS indicated it was the responsibility of the nurse aides on the unit to monitor the resident and document his/her whereabouts every 1 hour. Although attempted, an interview with NA #2, (who last saw Resident #27 an hour and a half prior to the fall on 11/23/23 at 1:45 PM) was not obtained. Review of the Close Monitoring of a Resident policy identified to maintain the safety and well-being of all residents who are exhibiting behaviors that pose a high risk for harm or injury to self or others will be assessed by the RN or designee for close monitoring, which may include either 1:1 observation, or incremental checks (every 15 minutes, every 30 minutes, every 1 hour). Incremental checks (every 15 minutes, every 30 minutes, every 1 hour) are observations and documentation of a resident's status at a given point in time. Incremental checks may be used in instances where a resident may benefit from increased monitoring (i.e. at risk for falls). The close monitoring will be documented in the resident's medical record. 2. Resident #41was admitted to the facility on [DATE] with a diagnosis that included in part, dementia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The significant change MDS assessment dated [DATE] identified Resident #41 had severely impaired cognition, was always continent of bowel, frequently incontinent of bladder, required substantial assistance from staff with dressing, bathing, and toileting and partial to moderate assistance with walking once standing. The care plan dated 1/2/24 identified Resident #41 had a history of multiple falls. Interventions included completing every 15-minute checks and to analyze previous falls to determine whether a pattern/trend could be addressed. Review of the clinical record and reportable event forms identified Resident #41 had 13 falls between 1/24/24 and 5/30/24: a. Unwitnessed fall on 1/24/24 at 4:00 PM in his/her room. Care plan intervention included to sit in common areas when not doing activities for extra safety monitoring. The care card (generated from the care plan and utilized by staff to administer care), included 1 hour checks when the resident was in their room. b. Unwitnessed fall on 2/25/24 at 10:15 AM while in his/her room. c. Unwitnessed fall on 3/2/24 at 3:15 PM while in his/her room. Care plan intervention included the resident should sit in the lobby area during shift change. The care card, included every 1 hour monitoring checks. d. Unwitnessed fall 3/3/24 at 11:45 AM in his/her room. Review of the clinical record failed to identify 1 hour monitoring checks had been completed from 1/24/24 - 3/3/24. e. Unwitnessed fall 3/15/24 at 6:15 PM in the unit's dining room. Care plan intervention included Resident #41 was not to be left unattended in the dining room. f. Unwitnessed fall on 3/15/24 at 7:15 PM in his/her room. Care plan intervention included a pharmacy medication review was conducted with no new recommendations. g. Witnessed fall on 3/16/24 at 3:00 PM by LPN #3 in the unit lobby with subsequent bleeding from the head. Care plan intervention directed that staff perform purposeful staff rounding at shift change to identify Resident #41's location. The clinical record identified Resident #41 was sent to the hospital for evaluation on 3/17/24 at 3:25 PM and returned to the facility with 2 sutures on 3/17/24 at 2:00 AM. h. Unwitnessed fall on 3/20/24 at 1:45 PM in the unit lobby. The investigation form identified Resident #41 was placed on every 15-minute monitoring checks following this fall. The care plan and care card identified Resident #41 had been placed on every 15-minute monitoring checks. i. Unwitnessed fall on 4/1/24 at 10:00 PM the resident was found lying on the floor against a storage door on the unit. Care plan intervention included monitoring for mental status changes. j. Unwitnessed fall on 4/11/24 at 7:00 PM on the floor of the bathroom. Care plan intervention included every 15-minute checks. Review of Resident #41's care card identified Resident #41 was on every 15 minutes checks but needed 1:1 monitoring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the clinical record failed to identify documentation that monitoring checks were conducted during the period of 3/20/24 - 4/11/24. k. Unwitnessed fall on 4/29/24 at 3:15 PM in the unit's shower room. Review of the clinical record failed to identify documentation that the resident was in the lobby during shift change in accordance with the 3/2/24 care plan and that the resident was monitored every 15-minutes during the period of 4/11/24 - 4/29/24. l. Unwitnessed fall on 5/12/24 at 12:00 PM in his/her room. Care plan intervention included the continuation of 15-minute monitoring checks. Review of the clinical record failed to identify documentation that Resident #41 was monitored every 15 minutes during the period of 4/29/24 - 5/12/24. m. Fall on 5/30/24 at 3:00 PM witnessed by the resident's roommate in his/her room. Review of the clinical record failed to identify documentation that Resident #41 was monitored every 15 minutes during the period of 5/12/24 - 5/30/24. Review of Resident #41's care card, provided to this surveyor on 6/18/24, identified that Resident #41 was on every 15-minute checks beginning 5/30/24 and was not to be left unattended. Review of reportable events and the facilities investigations during the period of 1/24/24 - 5/30/24 and interview with the DNS on 6/18/24 at 10:13 AM identified she thought Resident #41 was being monitored every 15 minutes based on the fall history, and this was a nursing measure with no definitive timeframe on how long the monitoring would be completed. The DNS identified that Resident #41 had multiple falls since admission, and she was unable to identify the rationale as to why the resident was not monitored. The DNS indicated that the resident should have been monitored according to the care plan and care card. The facility policy on falls directed that residents would not be left unattended until deemed safe by a supervisor. The policy further directed that the resident's care card would include fall risk and prevention strategies. The policy also directed that each time a resident experienced a fall, a reportable event form would be completed along with an interdisciplinary fall assessment to identify the potential causes of the fall. The facility policy on close monitoring of a resident directed the purpose of the policy was to maintain the safety and wellbeing of all residents in a dignified manner. The policy further directed that residents who were exhibiting behaviors that posed a high risk of harm or injury to self would be assessed by an RN or designee for close monitoring, which would include 1:1 monitoring or incremental checks (i.e every 15 or 30 minutes, or every hour). The policy further directed that the resident's care plan would be updated to reflect the close monitoring status and that the close monitoring would be documented in the resident's medical record. 46040

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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** 43032 Based on review of facility documentation, facility policy and interview for 1 resident (Resident #91) who had orders to monitor oxygen saturation, the facility failed to monitor oxygenation saturation as ordered by the physician. The findings include: Resident #91 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, malignant neoplasm of breast, and supraventricular tachycardia. The care plan dated 2/20/24 identified a focus on cardiovascular disease with interventions that included oxygen therapy, oxygen saturations as ordered, and vital signs as ordered per policy. The quarterly MDS dated [DATE] identified Resident #91 had moderately impaired cognition, required moderate assistance with toileting, showering, upper and lower body dressing, and personal hygiene. Resident #91 was dependent with putting on and taking off footwear and was on oxygen therapy. A physician's order dated 6/1/24 directed to monitor oxygen saturation with pulse oximeter every 8 hours, titrate oxygen levels to maintain oxygen saturation above 90 % on room air. The oxygen saturation report dated 6/1/24 - 6/17/24 identified the following: Of 51 opportunities, oxygen saturations were only done 16 times. Interview and clinical record review with the DNS on 6/18/24 at 11:30AM identified it is her expectation that the physician's orders are followed, and oxygen saturations should have been measured and documented every shift for titration. The policy for oxygen administration indicates that a physician's order is necessary for the administration of oxygen.

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews, for 2 of 4 medication carts, the facility failed to ensure Insulin was dated when opened and discarded when expired. The findings include: Review of the medication cart on the upper level on [DATE] at 9:00 AM with LPN #3 identified a Humalog Insulin vial dated as opened on [DATE] and expired on [DATE]. A Lispro Insulin pen was opened but was not dated. Review of the medication cart on the lower level on [DATE] at 9:15 AM with LPN #7 identified a Lispro Insulin pen not dated when opened. A sticker on the Lispro Insulin pen indicated to discard after 28 days once opened. A Levemir Insulin pen was opened and not dated, and a sticker indicated to discard after 42 days once opened. Interview with the DNS on [DATE] at 9:20 AM indicated that all Insulin vials and pens were to be dated when first opened. The DNS indicated that all the Insulin pens and vials have a different number of days that they were good for once opened. The DNS indicated that the nurses were to discard the Insulin pens and vials based on date written on them per the pharmacy recommendation.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on a review of clinical records, facility documentation, facility policy and interviews for 1 of 5 residents reviewed for accidents (Resident #8) the facility failed to reheat soup to a safe temperature. The findings include: Resident #8 was admitted to the facility on ,d+[DATE] with diagnoses that included multiple sclerosis (MS), spasmodic torticollis, and dementia. The care plan dated 4/8/24 identified Resident #8 required assistance with ADLs due to history of MS. Interventions included providing total assistance with ADLs. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, had a functional limitation in range of motion on one side of the upper extremity and required set up only with meals. Review of a reportable event form dated 5/6/24 identified Resident #8 called for staff assistance between 5:30 PM - 6:00 PM and reported he/she had spilled soup and had a 3 cm x 2 cm reddened area with small, scattered blisters at the left upper quadrant of his/her abdomen/chest area. Interventions included to provide Resident #8 a clothing protecter with meals. An APRN note dated 5/7/24 identified Resident #8 had a second degree burn with blistering noted on his/her chest wall. Treatment included cleansing with normal saline, apply Silvadene and an ABD pad twice daily, and monitor the area for infection. Interview with Person #2 on 6/16/24 at 10:00 AM identified that Resident #8 sustained a burn following the facility staff reheating soup on 5/6/24 that Person #2 had brought into the facility for Resident #8. Person #2 identified that from the report he/she received from the DNS informed her Resident #8 on 5/6/24, Resident #8 requested a portion of the soup to be reheated on 5/6/24, but instead of the full cup of soup, he/she only requested a half a cup of soup instead. Person #2 identified that Resident #8 requested the soup be reheated for 2 1/2 minutes. Person #2 identified due to Resident #8's diagnoses of MS and spasmodic torticollis, Resident #8 had issues with positioning due to long standing contractures and that the contractures affected his/her left hand, that Resident #8 was left hand dominant, and that this would often require Resident #8 to use his/her right hand, which also had motor function issues. Interview with NA #1 on 6/17/24 at 10:25 AM identified that staff would assist residents with reheating food, however there was no system in place to check the temperature of the reheated food. NA #1 identified I am not sure how everyone else did it, but I would just heat the food for 30 seconds at a time, feel the container the food was in to see if it felt warm, and then stop once it felt like it was heated. NA #1 identified that the staff did not use any thermometers to check reheated food prior to providing to residents. NA #1 identified this had been the practice since she began working at the facility in 6/2023 until Resident #8 was burned on 5/6/24. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the DNS on 6/17/24 at 11:13 AM identified that she conducted the investigation and was present in the facility on 5/6/24 when Resident #8 spilled soup on his/herself. The DNS identified that facility staff had been reheating food for residents prior to this incident, but that the policy of the facility was that no outside food was to be reheated by the facility and any outside food would have to be reheated by the resident, if able, or by a visitor to bring to the resident. The DNS identified that the reheating policy had been in place for several years, and that staff were not provided with or in serviced on reheating temperatures since this was not a policy of the facility. The DNS also identified since the policy dictated that staff were not to reheat food for residents, no thermometers were available on any of the resident units to check food temperatures. The facility policy on Food Brought into the Facility from Home directed that dietary personnel would not be responsible for holding or reheating any food brought in from an outside source, and that any food items would be stored in airtight containers with labels including the resident's name, date and contents, to be discarded after 3 days. The policy further directed cold foods should be kept at 41 degrees Fahrenheit or colder, and hot foods to at least 135 degrees Fahrenheit.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure the refrigerator and freezers temperatures were recorded, prepared food items were labeled, dated and discarded timely, the kitchen fan was dust free, dietary staff wore a beard guard while preparing food, employee personal items were not stored in kitchen area, the nourishment refrigerator food items were labeled, dated, and discarded when expired, food temperatures were recorded prior to serving. The findings include: Tour of the kitchen with the Director of Dietary (DOD) #1 on [DATE] at 7:00 AM identified: 1a. Observation on [DATE] at 7:03 AM identified that the temperature log for the walk-in refrigerator and the walk-in freezer were not completed. The log indicated that the temperatures were not recorded between [DATE] - [DATE] in the mornings. Interview with the DOD #1 on [DATE] at 7:05 AM indicated that the cook was responsible for checking and recording the temperatures of the walk-in refrigerator and walk in freezer every morning. DOD #1 indicated that he did not know why it was not done from [DATE] - [DATE] but he had not done it today because he got called at the last minute due to the cook not showing up and had not had any time. b. Observation of the milk refrigerator and ice cream reach in freezer temperature logs on [DATE] at 7:06 AM for [DATE] identified they were not completed. The Temperature Log dated [DATE] identified that staff was to record the temperature of the refrigerator twice a day next to the correct date, all temperatures must be in the following range Freezer 0 degrees or colder, refrigerator 41 degrees of colder, and any temperature that was out of range contact your supervisor immediately. The log identified that the milk refrigerator temperatures were not recorded 4 out of 15 mornings, and 8 times out of 15 times in the evening. The ice cream reach in freezer temperature log identified 6 out of 15 times in the evening the temperatures were not recorded. Interview with DOD #1 on [DATE] at 7:06 AM indicated that the dietary aides were responsible to record the temperature twice a day for the milk refrigerator and the ice cream freezer. 2. Observation on [DATE] at 7:09 AM of the walk-in freezer identified very thick frost all around the freezer door, inside the freezer door, and on the fan inside the freezer. Interview with the DOD #1 on [DATE] at 7:10 AM indicated that the freezer frosting up like that started last year and the facility had a new door installed a few months ago. The DOD #1 indicated that after the door was changed the same problem had continued to occur. The DOD #1 indicated that the company that had installed the door was in the facility for something else and he had mentioned it to the company, but the Director of Maintenance was notified at that time and was responsible to set up the appointment for the company to return and fix the door. DOD #1 indicated he was not aware of the date when the company would return to fix the freezer door. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Maintenance on [DATE] at 7:35 AM indicated that he had been aware of the buildup of frost on the inside and the outside of the walk-in freezer door for about a month. The Director of Maintenance indicated that he had attempted to call the company prior but did not reach anyone and he did not recall any dates that he had attempted to call for service. The Director of Maintenance indicated that he was aware that it is still a problem with the frost build up in the freezer. After surveyor inquiry interview with the Director of Maintenance on [DATE] at 8:20 AM indicated that he had called the company, and they will be at the facility tomorrow morning to look at the freezer door to repair it. Interview with Person #1 on [DATE] at 8:30 AM indicated that he had not received a call from the Director of Maintenance for the freezer door but about 2 months ago the Director of Dietary #1 had informed him that there was buildup of frost on the freezer door and that maintenance would reach out. Person #1 indicated that after surveyor inquiry the Maintenance Director reached out to him about coming to the facility tomorrow, Monday morning, to look at the frost build up. Person #1 indicated that the facility had ordered a new freezer door in July of 2023, but it was not installed until [DATE] awaiting payment. Person #1 indicated normally it would take 5 weeks from the time the order for the door goes in through installation. Person #1 indicated after his people had installed the door that he had noted there was wood above the inside of the freezer door and that moisture would accumulate due to air not being able to move around. Person #1 indicated that he would have to apply metal and calking to fix it. Person #1 indicated that the facility was aware of the issue a couple of months ago, but he was waiting to hear from them to come out and fix it. 3. Observation on [DATE] at 7:12 AM of the prepared food items in the walk-in refrigerator identified hotdogs cooked dated [DATE], pork cooked dated [DATE], macaroni was not labeled or dated, a metal container of brown liquid dated [DATE] not labeled, pink large insulated mug with brown substance not covered, labeled, or dated, banana cream pie, 6 individual slices not covered, labeled, or dated, 1 employee personal water bottle not labeled or dated. Interview with the Director of Dietary #1 on [DATE] at 7:15 AM indicated that he or the cooks were responsible to discard any item after 3 days and to make sure everything was labeled and dated when being placed in the refrigerator. The Director of Dietary #1 indicated that he did not know why it was not being done. 4. Observation on [DATE] at 7:19 AM identified employee personal jackets and pocketbooks were being stored in the kitchen dry storage room for residents. Interview with DOD #1 on [DATE] at 10:02 AM indicated that employees were not to store personal belongings in the kitchen dry storage room. DOD #1 indicated that staff have an area outside of the kitchen to store their personnel items. DOD #1 told staff to immediately remove items. 5. Observation on [DATE] at 7:20 AM Director of Dietary #1 was making hot cereal over the stove adding the cereal mix into the pot of hot water stirring it without the benefit of a beard guard to cover his facial hair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Dietary #1 on [DATE] at 7:22 AM indicated that the scheduled cook had called out, so he came in to cover and forgot to put on the beard guard. The Director of Dietary #1 indicated that he was to wear a beard guard while in the kitchen preparing food. 6. Observation on [DATE] at 9:30 AM of 1 out of 2 resident nourishment rooms identified in the first-floor nourishment refrigerator was fruit with an expiration date of [DATE], a yogurt that expired on [DATE], 2 yogurt that expired on [DATE], 2 yogurt that expired on [DATE], 2 yogurt that expired on [DATE], and a go-go squeeze apple sauce expired on [DATE]. Additionally, there was a lunch box not labeled or dated. Additionally, the bottom right-side drawer was covered in a light brown dried liquid. Interview with the Director of Dietary #1 on [DATE] at 9:31 AM indicates that all the unopened prepackaged foods were to be discarded by the expiration dates on the packages. DOD #1 indicated that the lunch box was an employee lunch box and did not belong in the resident's refrigerator. DOD #1 indicated that it was the dietary departments responsibility to discard food items not labeled, dated, or expired and to clean out the refrigerators each day once in the morning and once in the evening when delivering the nourishments. DOD #1 indicated that he does not know why it has not been getting done. 7. Tour of the kitchen with DOD on [DATE] at 10:00 AM noted the wall fan in the kitchen was covered in thick dust. Interview with the DOD #1 on [DATE] at 10:01 AM indicated that he was responsible to make sure the fans were cleaned, and he tries to take it down and clean it once a month. DOD #1 indicated that he did not recall the date of when it was last cleaned. DOD #1 immediately removed the fan from the kitchen. 8. Review of the Meal Serving Temperature Chart form dated [DATE] to [DATE] identified that the temperatures were not completed for all food items for breakfast, and none were recorded for supper. Review of the Cooked Foods Temperature Chart form dated [DATE] to [DATE] identified that on [DATE] breakfast, lunch and supper were not recorded and on [DATE] breakfast was not recorded. Review of the Meal Serving Temperature Chart form dated [DATE] to [DATE] identified that the [DATE] supper was not reordered and that [DATE] breakfast was not recorded. Interview with [NAME] #1 on [DATE] at 10:45 AM indicated that he did not take the temperatures of the food at breakfast once prepared and when being to serve because the kitchen was short staffed today and he did not have time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietary Manager #2 on [DATE] at 10:50 AM indicated that the expectation was the cook takes the temperature of the food once they are prepared before going into the steam table and document on the cooked foods temperature chart for all foods prepared and cold items and then take the temperature again once the foods are on the steam table and document on the meal serving temperature chart. Review of the documents, DOD #2 indicated that from [DATE] - [DATE] only the hot cereal and milk was temped daily, and the cook did not take the temperature of the eggs or main meal at breakfast, and hot beverages were not temped daily, and nothing for supper was documented all week for the meal serving temperatures. Review of the forms dated [DATE] - [DATE], DOD #2 identified the temperatures were not taken on [DATE] all day and so far for breakfast on [DATE] today was missed. DOD #2 indicated that it was the responsibility of the cook to take the temperatures of all the hot and cold foods being served each meal twice and document at the time the temperatures are being taken. Review of the facility Procedure for Taking Serving Temperatures Policy identified to ensure that all foods are served at the correct temperatures. Minimum and maximum temperatures are outlined on the Serving Food Temperature Chart. Food items that do not meet these temperatures will not be served, until reheated to the proper temperatures. Using a calibrated bimetal thermometer measure the internal temperature of food items and record the temperatures on the Serving Food Temperature Chart. Serving temperatures should be taken when food is placed in the steam table, no longer than 15 minutes before serving time. Review of the facility Dress Code Policy identified to establish dress code for dietary employees. It is the responsibility of the Director of Dietary to make sure all employees meet the minimal requirements. [NAME] guard need to be worn as appropriate. Review of the facility Refrigerator and Freezer Temperature Logs Policy identified to assure that the proper temperature ranges are maintained in all refrigerators and freezers. A temperature log should be maintained on the piece of equipment. This includes refrigerators in the nourishment areas. Temperatures should be checked and recorded on the logs. Refrigerators range from ,d+[DATE] degrees and freezers at zero degrees. Review of the facility Snack Dating Policy identified to assure storage and rotation of snacks in resident areas. All items brought to the refrigerators will be dated with the current date. Discard dates once the product is opened. Unopened containers of yogurt discard date stamped on container.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record review, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #8) reviewed for accidents, the facility failed to ensure that the clinical record reflected clear, complete and accurate documentation related to a burn obtained during mealtime, for 1 of 4 residents (Resident #61) reviewed for pressure ulcers, the facility failed to ensure that the clinical record accurately reflected documentation related to a newly found pressure ulcer, and for 1 of 5 residents (Resident #51) reviewed for falls, the facility failed to ensure that the resident's clinical record reflected accurate documentation following an unwitnessed fall. The findings include: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS), spasmodic torticollis, and dementia. The care plan dated 4/8/24 identified Resident #8 required assistance with ADLs due to history of MS. Interventions included to provide total assistance with ADLs, transfers, and incontinent care. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel, utilized a nephrostomy tube, was dependent on staff to assist with dressing, bathing and toileting and required set up only with meals. A nurse's note dated 5/6/24 at 10:23 PM identified that Resident #8 had a burn related to soup on his/her upper left abdominal and chest area. Further review of the clinical record failed to identify any further documentation related to this incident. Review of a reportable event form dated 5/6/24 identified Resident #8 called for staff assistance between 5:30 PM - 6:00 PM and reported the resident had spilled soup on his/her chest and gown. The reportable event form identified Resident #8 had a 3 cm x 2 cm reddened area with small, scattered blisters at the left upper quadrant of his/her abdomen/chest area. Interventions included providing Resident #8 a clothing protecter with meals. The reportable event form failed to identify any additional information related to the soup and resulting burn. Interview with Resident #8 on 6/16/24 at 8:53 AM identified he/she had spilled soup on his/herself causing a burn. Resident #8 identified that he/she waited 2 minutes, but it was still too hot. Resident #8 was unable to identify when he/she was burnt by the soup or if the soup was part of his/her meal or from an outside source. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #2 on 6/16/24 at 10:00 AM identified that Resident #8 had a burn following the facility staff reheating soup on 5/6/24 that Person #2 had brought into the facility for Resident #8. Person #2 identified that Resident #8 had a favorite Italian wedding soup that was made by a local grocer. Person #2 identified he/she would purchase several containers of the soup at a time, freeze them, and then bring 1-2 containers every couple of weeks to the facility for Resident #8. Person #2 identified Resident #8 would ask the facility staff to reheat the soup for him/her, and until 5/6/24 there had never been any issues regarding this. Person #2 identified that from the report he/she received from the DNS and Resident #8 on 5/6/24, Resident #8 requested a portion of the soup to be reheated, but instead of the full cup of soup, he/she only requested a half a cup of soup instead. Person #2 identified that Resident #8 then requested the soup be reheated for 2 1/2 minutes, as this is the amount of time the soup was usually reheated. Person #2 identified that Resident #8 was then given the soup, which he/she assumed would have been much hotter due to the portion being smaller, and then at some point Resident #8 was left with the soup in his/her room and found later to have spilt the soup on his/herself, resulting in a burn. Person #2 identified due to Resident #8's diagnoses of MS and spasmodic torticollis, Resident #8 had issues with positioning due to long standing contractures and that the contractures affected his/her left hand, that Resident #8 was left hand dominant, and that this would often require Resident #8 to use his/her right hand, which also had motor function issues. Person #2 identified that that he/she was notified of the burn on 5/6/24 and told that going forward Resident #8 would have the soup reheated by the facility but only by dietary staff or a nurse, and that the soup had previously been reheated by nurse aides. Review of the clinical record and reportable event form failed to identify any of the information identified by Person #2 regarding the circumstances surrounding Resident #8's burn on 5/6/24. Interview with the DNS on 6/17/24 at 11:13 AM identified that she conducted the investigation and was present in the facility on 5/6/24 when Resident #8 spilled soup on his/herself. The DNS identified that facility staff had been reheating food for residents prior to this incident, but that the policy of the facility was that no outside food was to be reheated by the facility and any outside food would have to be reheated by the resident, if able, or by a visitor to bring to the resident. The DNS identified that the reheating policy had been in place for several years, and that staff were not provided with or in serviced on reheating temperatures since this was not a policy of the facility. The DNS also identified since the policy dictated that staff were not to reheat food for residents, no thermometers were available on any of the resident units to check food temperatures. The DNS was unable to identify how the facility would be able to allow residents to have access to food from the outside, including reheating the food, if they were not physically able to do so themselves, or if visitors were not able to come and visit a resident to allow for reheating of food, and that the facility would have to look into this. The DNS also identified that while she was aware of the circumstances regarding the burn sustained by Resident #8, including that the burn was due to soup from his/her visitor being reheated in a microwave by facility staff, the DNS did not include any of this information in the clinical record or the reportable event form, and did not identify why these pieces of information were not identified in the reportable event form or Resident #8's clinical record. The facility policy on accidents and incidents directed that the purpose of the policy was to accurately document a resident accident or incident, and that the DNS (or designee) would review to determine what preventative measures should be put in place. Although requested, the facility failed to provide policies related to maintaining a complete and accurate medical record and nursing documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #61 was admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease, and insulin dependent diabetes. A care plan dated 3/20/24 identified Resident #61 had a history of incontinence. Interventions included to monitor skin with ADLs. The quarterly MDS dated [DATE] identified Resident #61 had severely impaired cognition, was frequently incontinent of bowel and bladder and was dependent on staff to assist with bathing, eating, and transfers. A physician's note dated 5/24/24 at 1:34 PM by MD #2, the facility's wound care physician, identified Resident #61 was seen for an initial evaluation of a coccyx wound. The note identified findings of an unstageable coccyx pressure ulcer that measured 2.2 cm x 1.6 cm x 0.1 cm. Review of the clinical record failed to identify any documentation related to any nursing assessments of the pressure ulcer or provider notification regarding pressure ulcer prior MD #2's note on 5/24/24. Interview with MD #2 on 6/17/24 at 9:53 AM identified that she was notified by RN #1, the facility's wound care nurse, of Resident #61's newly identified ulcer on the morning of 5/24/24. MD #2 identified she did not discover the pressure injury, but that the facility nursing staff had identified the injury sometime prior to her visit on 5/24/24. Interview with RN #1 on 6/18/24 at 6:36 AM identified she had been notified of a newly identified skin issue for Resident #61 on 5/24/24 by LPN #3, the nurse assigned to care for Resident #61 that date. RN #1 identified that she notified MD #2 during wound rounds that morning that Resident #61 needed to be added to the list of residents to be seen, but that she did not see or assess Resident #61's wound prior to MD #2's exam. RN #1 identified she did not document any of this information in Resident #61's record since MD #2 completed an exam on the date the pressure ulcer was identified. Interview with LPN # 3 on 6/18/24 at 12:05 PM identified she was the nurse assigned to care for Resident #61 on 5/24/24. LPN #3 identified that she was notified by a nurse aide that Resident #61 had a newly identified skin issue during morning care on that date, and that she assessed the skin area after she was notified of the issue and identified Resident #61 had a reddened area on the coccyx that appeared to be new. LPN #3 then identified she notified RN #1 of the skin issue, and that MD 2 should add Resident #61 to wound rounds for that date. LPN #3 identified she did not document any of the information related to the discovery of the skin issue or subsequent notification to RN #1 or MD #2 due to an oversight on her part. Although requested, the facility failed to provide policies related to maintaining a complete and accurate medical record and nursing documentation. 47457 3. Resident #51 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, dementia, history of falling, and left sided maxillary, orbital floor, radius, and ulna fractures. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS dated [DATE] identified Resident #51 had moderately impaired cognition, required maximum assistance with chair to bed to chair transfers, sustained a fracture related to a fall within the last 6 months prior to admission, and sustained 1 fall with no injury since admission. The care plan dated 4/15/24 identified Resident #51 was at risk for falls due to decreased mobility, history of a fall at home, confusion, seizure disorder, and antipsychotic medication use. Interventions included keeping the call bell in reach, maintaining frequent checks on the resident, and the provision of a well-lit and clutter free environment. The nurse's note dated 4/29/24 at 11:38 PM identified that at approximately 5:00 PM, Resident #51 was found on the floor by the dietary aide and water was on the floor because the resident was throwing cups of water on the floor throughout the shift. No injuries were noted, Resident #51 denied pain, vital signs were stable, and the nursing supervisor completed an assessment. Resident #51 was assisted back into the wheelchair by the nurse and nurse aide. At approximately 6:15 PM, Resident #51 was sitting in front of the nurse's station and complained of increased pain to his/her right lower extremity. A message was left for the resident representative and the on-call APRN was updated. A new order for an x-ray to the right lower extremity was obtained. Resident #51 was assisted into bed at approximately 7:00 PM and had been resting well, with the call light in reach. The nurse's note dated 4/30/24 at 11:36 AM identified the right femur x-ray showed an age indeterminate fracture, correlate with timing of trauma and pain. Resident #51 was seen by the APRN and complained of increased pain during the evaluation. Resident #51's vital signs were within normal limits, the resident was medicated, and an ambulance was called at 11:35 AM. Review of nurse's notes identified Resident #51 was sent to the hospital on 4/30/24 at 11:50 AM and returned to the facility on [DATE] at 2:45 PM, (7 days later). On 6/16/24, during the standard recertification survey, a request was made for the neurological checks and the post A&I assessments for the fall that Resident #51 sustained on 4/29/24. Staff provided, and the surveyor received, neurological checks and the post A&I assessments for a fall that Resident #51 sustained 4/21/24, not 4/29/24. On 6/16/24, the surveyor again requested the neurological checks and the post A&I assessments for the fall that was sustained on 4/29/24. The following day, 6/17/24, the ADNS provided the surveyor copies (not originals) of a neurological checks flowsheet and a post A&I assessment flow sheet that was dated 4/29/24 and had Resident #51's name on it. Review of the copies (not originals) provided by the ADNS of a neurological checks flowsheet dated 4/29/24 identified that neurological assessments began on 4/29/24 at 12:30 PM (4.5 hours prior to Resident #51's fall which was at approximately 5:00 PM) and included the residents level of conscious, pupil reaction, strength of extremities, blood pressure, pulse and respirations. These neurological checks were documented as having been done on 4/29/24 at 12:30 PM, 12:45 PM, 1:00 PM, 1:15 PM, 1:30 PM, 2:30 PM, 3:30 PM, and 4:30 PM. (Resident #51 fell at approximately 5:00 PM). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further, although Resident #51 was sent to the hospital on 4/30/24 at 11:50 AM, and was no longer in the facility, staff continued to document on the neurological checks flowsheet the residents level of conscious, pupil reaction, strength of extremities, blood pressure, pulse and respirations for 4/30/24 at 12:30 PM, during the 3:00 PM - 11:00 PM shift, on 5/1/24 during the 11:00 PM - 7:00 AM, 7:00 AM - 3:00 PM, and 3:00 PM - 11:00 PM shifts, and on 5/2/24 during the 11:00 PM - 7:00 AM, 7:00 AM - 3:00 PM shifts. Review of a post A&I assessment flowsheet identified that staff continued to record the residents range of motion, pain level, blood pressure, pulse, respirations, temperature and oxygen saturation after the resident left the facility and was in the hospital on 4/30/24 during the 3:00 PM - 11:00 PM shift and on 4/31/24 (which does not exist), during the 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM and 11:00 PM - 7:00 AM shifts. Interview and review of the post A&I assessment flowsheet with LPN #4 on 6/17/24 at 9:49 AM, who documented an assessment of Resident #51 on 4/30/24 during the 7:00 AM - 3:00 PM shift and again on 4/31/24 during the 7:00 AM - 3:00 PM shift identified that although the signatures were hers, something did not seem right about the documentation because she would not have dated something 4/31/24, nor would she have completed neurological or post-fall assessments prior to the resident falling, or after the resident was transferred out of the facility. LPN #4 indicated that she did start the neurological checks and post fall assessments around 5:00 PM on 4/29/24, just after Resident #51's fall. In an interview and review of the neurological checks and post A&I assessment flowsheets with the ADNS, who provided the documentation to the surveyor, on 6/17/24 at 11:30 AM she was not able to say where those documents came from that showed neurological checks and post A&I assessments that were done prior to the resident falling on 4/29/24 at 5:00 PM, and after the resident had left the faciity on [DATE] at 11:50 AM and was in the hospital. The ADNS was unable to produce the original documents that showed neurological checks and post A&I assessments that were done prior to the resident falling on 4/29/24 at 5:00 PM, and after the resident had left the faciity on [DATE] at 11:50 AM and was in the hospital. The ADNS indicated that the neurological checks and post A&I assessments that were included in the original A&I report that was provided to the surveyor were dated 4/21/24, and that she had been looking through files and other A&I reports for the assessments completed following Resident #51's 4/29/24 fall, in case they were misfiled. The ADNS indicated that the copies of the neurological checks and post A&I assessments that were done prior to the resident falling on 4/29/24 at 5:00 PM, and after the resident had left the faciity on [DATE] at 11:50 AM and was in the hospital, that were provided to the survey team, had been left on her desk. The ADNS further indicated that she did not know who left those flowsheets on her desk, but she would try to find out. Interview with the DNS on 6/17/24 at 2:44 PM identified that the neurological checks and post A&I assessments that were documented as done prior to the resident falling on 4/29/24 at 5:00 PM, and after the resident had left the faciity on [DATE] at 11:50 AM and was in the hospital, that were provided to the survey team contained Resident #51's name and the date of the fall, but the assessment dates and times on the documents did not align with the timing of the fall or hospital transfer. The DNS could not explain why the documentation was incorrect, but she would continue to look for the 4/29/24 neurological checks and post A&I assessment flowsheets, as they were most likely misfiled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075181	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Watertown	35 Bunker Hill Rd Watertown, CT 06795

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the ADNS on 6/18/24 at 7:55 AM identified that in collaboration with the nurses that provided care to Resident #51 after his/her fall on 4/29/24 and vital signs obtained from documentation in the electronic health record, the neurological checks and post A&I assessments were now accurately completed (with the exception of 9 of the 12 required vital signs) and provided to the survey team. Interview and clinical record review with the DNS on 6/18/24 at 12:25 PM identified that she would expect neurological checks and post-fall assessments to be completed, per the facility policy. Although requested, the facility failed to provide policies related to maintaining a complete and accurate medical record and nursing documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 42117 Based on review of facility documentation, facility policy, and interviews the facility failed to ensure the nurse completed hand hygiene during the medication administration according to facility policy. The findings include: Inservice Education dated 1/12/24 identified LPN #7 was educated on hand washing. Licensed Nurse Competency for LPN #7 dated 3/26/24 identified infection control demonstrated hand washing and LPN #7 met the competency. Observation of medication administration on 6/17/24 at 8:10 AM identified LPN #7 moved the medication cart to the room of Resident #23, opened the medication cart and prepared Resident #23's 9:00 AM medications and administered Resident #23's medications without the benefit of hand hygiene prior. Further, while Resident #23 was taking the medications, LPN #7 went over to the resident's roommate and touched him/her on the hair and shoulder, exited the room and did not hand sanitize or wash her hands. LPN #7 moved the medication cart to Resident #37's room and prepared the residents medications and proceeded into Resident #37's room and gave Resident #37 his/her medications. LPN #7 was observed to touch the resident's chest and remove food from the resident's face. LPN #7 did not use hand sanitizer or wash her hands after administering medications and went to the medication room to prepare a medication for Resident #37. LPN #7 went to the nurse's station pushing her medication cart to the medication storage room, entered the medication room touching the door handle and went into the cabinets looking for a medication. LPN #7 exited the room after touching the door handle and administered the medication to Resident #37 without the benefit of hand hygiene. Interview with LPN #7 on 6/17/24 at 8:44 AM indicated that she knew she should conduct hand hygiene before and after providing a resident medication, but she does not know why she did not do it. LPN #7 indicated that after going to the medication room and returning to prepare the medication she should have hand sanitized. LPN #7 indicated that she had been educated on sanitizing her hands during a medication pass but did not know why she did not wash her hands all those times that she should have. Interview with the DNS on 6/17/24 at 9:20 AM indicated that the nurses must hand sanitize prior to preparing a resident's medications, after giving the resident the medications as they go back to the medication cart, and if they have direct contact with a resident. The DNS indicated the nurse must hand sanitize between residents during the medication pass. Interview with RN #1 (Infection Control Nurse) on 6/17/24 at 9:50 AM indicated that the nurse was to use hand sanitizer while doing a medication pass prior to preparing the medication and when exiting a room. RN #1 indicated that the nurses were educated many times on hand washing and the use of hand sanitizer during a medication pass. RN #1 indicated that nurses must hand sanitize between residents and if they touch anything. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the facility Medication Administration Policy identified that the nurse was to use appropriate hand hygiene. Prior to preparing or administrating medications, authorized and competent facility staff should follow the facility's infection control policy. Appropriate hand hygiene should be performed before and after direct resident contact.