STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Rehabilitation and Healthcare Center	55 Grand Street New Britain, CT 06052

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, review of facility policy, and interviews for one of three sampled residents (Resident #101) reviewed for facility acquired pressure ulcers, the facility failed to ensure the physician was notified after the development of a pressure ulcer. The findings include: Resident #101 was admitted to the facility on [DATE] with diagnoses that included dementia, anemia, heart failure, thrombocytopenia, malignant neoplasm of the rectum, and presence of ileostomy. The physician's order dated 7/23/24 directed to complete skin monitoring and observation weekly. The skin assessment dated [DATE] identified Resident #101 had intact skin. The Braden scale assessment (used to predict risk for development of pressure ulcer/injury) dated 7/23/24 identified Resident #101 had a score of 16 which is indicative of the resident being at risk for the development of a pressure ulcer. The Resident Care Plan (RCP) dated 7/24/24 identified Resident #101 was at risk for the potential for skin breakdown related to decreased mobility, ileostomy, and incontinence. Care plan interventions included: follow facility protocol for treatment of injury, keep skin clean and dry, and staff to provide frequent incontinence care. The admission MDS assessment dated [DATE] identified Resident #101 had severe cognitive impairment, did not display behaviors, required extensive assistance with toileting, bed mobility, hygiene, dressing, and transfers. The assessment further identified Resident #101 was non-ambulatory, utilized a wheelchair for mobility, did not have range of motion deficits, was frequently incontinent of bladder and had an ileostomy in place for bowel function. It further noted the resident was at risk for the development of pressure ulcers, but did not currently have a pressure ulcer, and had a pressure reducing device to the bed. The assessment did not identify that the resident was on a turning and repositioning program or that the resident had a pressure reducing device to the wheelchair. The nurse's note dated 8/2/24 at 11:13 PM written by LPN #1 identified that the assigned nurse's aide and Resident #101's responsible party reported the resident had a small open wound to the coccyx, Resident #101 denied pain and/or discomfort, and the nursing supervisor was notified. Further review of the nurse's note failed to identify any further documentation about the wound such as a description, measurements, the presence or absence of an odor (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify that the wound to Resident #101's coccyx was assessed and/or that a treatment order was put in place. Review of the clinical record failed to identify that the weekly skin monitoring and observation for the week of 8/9/24 was completed as ordered by the physician. The nurse's note dated 8/16/24 at 4:32 PM written by LPN #2 (wound nurse) identified Resident #101 had two small open wounds to the coccyx. The first wound size was documented as 0.8 centimeters (cm) in length by 0.5 cm in width and 0.1 cm in depth and the second wound size was documented as 1.0 cm in length by 0.8 cm in width and 0.1 cm in depth. The APRN was updated, and new orders obtained that directed to cleanse the wound with normal saline followed by the application of Calcium Alginate and cover with a dry clean dressing. The wound bed was noted with 100 percent granulation (wound bed characteristics described as red and/or pink in color) and a scant amount of serosanguineous drainage was also noted. Resident #101 denied pain and/or discomfort during the treatment. The resident's responsible party was notified and updated. The physician's order dated 8/16/24 directed to apply pressure reducing air mattress to the bed and check function every shift per resident's weight and comfort. The revised RCP dated 8/16/24 identified Resident #101 had an unstageable pressure ulcer. Care plan interventions directed to check mattress for function every shift and mattress setting adjusted in accordance with patient weight, RN will assess wound and provide appropriate wound treatment per physician orders, and staff will provide frequent incontinent care ensuring bedding and skin remain dry. APRN #1's (wound specialist) initial wound progress note dated 8/19/24 at 7:58 AM identified Resident #101 had a new unstageable pressure ulcer and/or injury to the coccyx related to pressure. The wound size was documented as 0.5 cm in length by 1.5 cm in width and 0.2 cm in depth. The wound bed was covered with 100 percent slough (a yellow and/or white material dead cell that accumulates in the wound bed) and with moderate amount of serosanguineous drainage. The treatment plan directed to apply Santyl (chemical wound debridement) ointment followed by calcium alginate daily and as needed, to follow facility pressure ulcer prevention protocol, apply pressure redistribution mattress per facility protocol, wheelchair pressure redistribution cushion per facility protocol, offload pressure wound and reposition patient every two hours. The physician's order dated 8/19/24 directed to cleanse coccyx wound with normal saline, apply nickel thick layer of Santyl ointment followed by Calcium Alginate and cover with dry clean dressing. The weekly physician's wound progress note dated 8/26/24 at 4:35 PM identified Resident #101 continued with unstageable pressure injury to the coccyx. The wound bed remains with 100 percent slough and the wound size was documented as 0.8 cm in length by 0.5 cm in width and 0.2 cm in width and with small amount of serosanguineous drainage. The treatment plan was to continue to cleanse the wound with normal saline and apply Santyl ointment at the base of the wound and cover with dry clean dressing. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The weekly APRN#1 wound progress note dated 9/2/24 at 8:06 AM identified the unstageable wound to the coccyx had worsened. The wound size was documented as 0.5 cm in length by 1.5 cm in width and 0.2 cm in depth and the wound bed remained at 100 percent slough with moderate amount of serosanguineous drainage noted. The treatment plan noted to apply Santyl ointment followed by Calcium Alginate and cover with dry clean dressing daily.

The social services progress note dated 9/6/24 at 9:41 AM identified Resident #101 was discharged to the community with rehabilitation and nursing services.

Interview with LPN #1 on 9/9/24 at 12:30 PM identified the NA reported Resident #101 had a new open wound to the coccyx on 8/2/24. She could not recall who the Na was that reported the wound to the coccyx. She identified that she visualized Resident #101's coccyx and noted an open wound to the coccyx. She did not measure the open coccyx wound, nor did she call the physician to obtain a treatment, but she immediately reported the open coccyx wound to the nursing supervisor. She further identified that she was an agency staff nurse, and it would be the nursing supervisor's responsibility to assess the coccyx wound, to call the physician and to obtain a treatment order. She further noted that she did not receive any further instruction from the nursing supervisor related to Resident #101 coccyx wound.

Interview with RN #1 (nursing supervisor) on 9/9/24 at 1:30 PM identified that she could not remember whether there was a reported open wound to Resident #101's coccyx. She identified that she would document the wound assessment in the nursing progress notes and/or wound documentation, call the physician and obtain treatment orders, and update the wound nurse.

Interview with LPN #2 (7-3 charge nurse) on 9/9/24 at 2:00 PM identified that the charge nurse is responsible for checking and documenting the resident skin weekly on their shower day. She identified that she signs off in the TAR (treatment administration record) to indicate that the skin check is completed and completes the weekly skin monitoring assessment under the evaluation. Additionally, LPN #2 could not verify whether she did a skin check for Resident #101 because there was no weekly skin monitoring assessment completed and she did not sign off in the TAR. She further noted that she would report to the nursing supervisor immediately when there is a new wound.

Interview with LPN #3 (wound nurse) on 9/9/24 at 2:30 PM identified that she was responsible for monitoring the wounds weekly and also identified that the nursing supervisor or the DNS would assess the wound with her when there is a new onset of wound reported. On 8/16/24, she identified that the charge nurse on the unit reported that Resident #101 had open wound to the coccyx. She identified Resident #101 had 2 small open wound to the coccyx and she measured both wounds. When she referred Resident #101 to the APRN #1 (wound specialist) the following week, the 2 open wounds combine into one open wound to the coccyx. She was not made aware of Resident #101 open coccyx wound that was first noted on 8/2/24. She identified she would expect the physician to be notified, and a treatment to be initiated at the time of discovery to prevent the wound from worsening and the wound should be assessed weekly.

(continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 (wound specialist) on 9/9/24 at 2:45 PM identified that her initial consultation with Resident #101 was on 8/19/24 during her wound rounds. She identified that Resident #101 had an unstageable wound to the coccyx because the wound bed was covered with 100% slough. She also noted that the cause of the wound to the coccyx was related to pressure because of the wound's location. She identified that Resident #101 was at risk for pressure injury because of his/her dementia, decreased mobility, and anemia. She was not made aware of the wound to the coccyx on 8/2/24 and it would be the facility's responsibility to let her know when there is a new onset of a wound that needed to be evaluated. She further noted on her wound consult dated 9/2/24 that Resident #101 pressure wound to the coccyx had worsened because the measurement of the wound became larger from the previous wound assessment and the wound bed continued to be covered with 100% slough. She further identified that a pressure ulcer/injury could worsen quickly without a timely assessment and appropriate treatments and interventions provided. Interview with the DNS on 9/10/24 at 11:20 AM identified that he would expect the nurse to assess the wound promptly and call the physician to obtain and implement the treatment immediately. He also was aware that any pressure wound and/or injury could worsen without immediate intervention and treatment. He identified that the weekly skin check needed to be documented under the evaluation of weekly skin monitoring and done weekly. He was not made aware that Resident #101 had a new open wound to the coccyx on 8/2/24. He further identified the coccyx wound should have been assessed by a nurse and documented in a nurse's note that included the wound measurement, description and/or pressure wound stage, call to the physician and obtain and implement treatment, and the wound should have been monitored weekly from the time it developed. The facility policy title Documentation of Wound Treatment and Assessment identified that the physician or APRN would be notified of new onset of wound.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, clinical record review, review of facility policy and interviews, for one of seven sampled residents (Resident #94) reviewed for accidents, the facility failed to ensure the care plan was comprehensive to reflect the resident's status of not having a call bell or other hanging items in his/her room. The findings include: Resident #94's diagnoses included Alzheimer's disease, visual hallucinations, anxiety disorder, and schizoaffective disorder. The significant change in status MDS assessment dated [DATE] identified Resident #94 had significantly impaired cognition, behaviors of inattention and disorganized thinking, utilized a walker and required supervision or touching assistance with position changes and ambulation. The care plan dated 7/15/24 identified Resident #94 refused care and had interventions that included: one on one social services support, supervision as needed. The care plan also identified Resident #94 was unaware of safety needs with interventions to be sure the call light is within reach and encourage to use it for assistance as needed, promptly respond to all requests for assistance. Observation on 9/9/24 at 10:11 AM identified Resident #94 wandering around his/her room. The resident's room contained a bed, a chair, a side table, and a walker. There was a bracket secured to the wall for a television, although there was not a television. The bedside curtain had been removed from the room. There was a call bell box on the wall with a plug to receive the call bell cord; however, there was not a call bell in the room. Interview with LPN #15 on 9/10/24 at 12:15 PM identified Resident #94 did not have a call bell in his/her room because it was a safety concern because Resident #94 pulled items off of the walls and tied items up with cords. LPN #15 indicated that information was passed on to her from another staff member, although she could not remember who, and that she was not aware if the doctor was aware. LPN#15 indicated that should be something that was included in the care plan, and that nursing was able to add to the care plan. Interview with LPN #2 on 9/13/24 at 8:53 AM identified Resident #94 did not have a call bell in the room, nor anything that plugged in or hung in the room. LPN #2 indicated Resident #94 had pulled wires out of the wall and wrapped items up. LPN #2 indicated the resident had pulled the television off of the wall and the curtains off of the track and that leaving items such as call bell wires in the room was a safety hazard. LPN #2 further identified that at one time the resident was given a hand bell instead of the call bell and that the resident hid it somewhere and it had yet to be found. Physician's orders active as of date 9/13/2024 identified Behavior Monitoring for delusions, hallucinations, hitting, paranoia, anxiety, agitation, confusion, and furniture moving. Observation on 9/13/24 at 8:35 AM identified Resident #94 wandering around the perimeter his/her room attempting to take the television bracket off of the wall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #2 on 10/17/24 at 10:25 AM identified that the safety concern of Resident #94 having corded items should be represented in the care plan and possibly a doctor's order. Interview with the DNS and RN#6 on 9/16/24 at 3:10 PM identified that a safety issue or behavior should be identified in the care plan in order to direct proper care of the resident. Review of the facility policy for Comprehensive Care Plans identified the comprehensive care plan will be prepared by an interdisciplinary team, that included a nurse aide or a registered nurse with responsibility for the resident. The policy further indicated that the care plan would contain resident specific interventions that reflect the resident' needs. The facility failed to ensure the resident's care plan was revised to reflect the resident's behavior of pulling the call light out of the wall and pulling other items off of the wall. The care plan reflected the use of a call light when the resident did not have a call light in his/her room and when it was an accident hazard for him/her to have in his/her room.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on observations, interviews, and facility policy for eight of eight sampled residents observed for medication administration, the facility failed to ensure medications were administered on time and according to physician's orders. The findings include: A. Resident #13's diagnoses included Type II diabetes mellitus, nausea with vomiting, gastroesophageal reflux disease. Physician's orders for September 2024 identified the following orders: Flush G-tube with 30 cc water prior to medication administration, 10 cc water between each medication and 30 cc after medication administration every shift Glucerna 1.5-250 ml every 5 hours at 7 am, 12 pm Multi-vitamin tablet give 1 tablet via G-tube one time a day Ondansetron HCL oral solution 4mg/5ml give 10 ml via PEG tube every 8 hours as needed for nausea and/or, 5pm, and 10 pm. No feeds between 11 pm and 7 am. Total volume of 1000mls. Acetaminophen tablet 325mg Give 2 tablet via G-tube every 4 hours as needed for generalized pain. Not to exceed 3 gm in a 24-hour period. Aspirin 81 oral tablet chewable give 1 tablet via PEG tube in the morning for cardiac supplement. Banatrol plus oral packet give 1 unit via G-tube every 8 hours related to Nausea with vomiting. Carvedilol oral tablet 3.125 mg Give 1 tablet via PEG tube two times a day, Hold if sbp <100 and HR <60. Famotidine oral tablet 40 mg give 1 tablet via G-tube one time a day. Ipratropium-Albuterol Inhalation solution 0.5-2.5 3mg/3ml 1 vial inhale orally four times a day. Metoclopramide HCL oral tablet 5mg give 1 tablet via PEG tube four times a day. Multi-vitamin tablet give 1 tablet via G-tube one time a day. Ondansetron HCL oral solution 4mg/5ml give 10 ml via PEG tube every 8 hours as needed for nausea. Prosource oral liquid give 30 ml via G-tube one time a day. Observation of medication administration for Resident #13 on 9/10/24 at 10:12 AM identified the following medications were administered after the scheduled administration time and were placed in a medication packet and were crushed together and mixed with 30cc water for administration: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Aspirin 81 mg chewable 2. Metoclopramide HCL oral tablet 5 mg four times a day 3. Famotidine oral tablet 40 mg 4. Multivitamin tablet 5. Carvedilol 3.125 mg via PEG tube 2x daily 6. Acetaminophen 650 mg via G-tube Additional medications administered separately at 9/10/24 at 10:42 AM included: 7. Prosource oral liquid 30 mg via G-tube one time a day for supplement. 8. Banatrol plus oral packet give 1 unit via G-tube Q 8 hours related to nausea with vomiting. Additional medications observed at 9/10/24 at 10:48 AM included: 9. Ondansetron HCL oral solution 4mg/5ml (10ml) 10. Toujeo Solostar SQ 5 units QD left upper arm 11. Ipratropium albuterol via mask Interview with LPN #15 on 9/10/14 at 10:45 AM indicated that medication administration is usually finished by 10:30 AM. LPN#15 identified that she had other duties, including a bladder scan, from a newly admitted resident that took precedence this morning. LPN #5 also identified the G-tube administration takes a long time because Resident #13 gets nausea. LPN #15 indicated that crushing the medications together is normal practice. LPN#15 also indicated that she had other morning medications to administer. She indicated she had not notified anyone the administrations were late, nor did she identify to anyone that she needed assistance on the unit. B. Resident #15 was admitted to the facility on [DATE]. Diagnoses included Type II Diabetes Mellitus, Chronic Kidney disease, and other specified depressive episodes. The Physician's orders dated September 2024 identified the following medication orders: Apixaban oral tablet 5mg give 1 tablet by mouth two times a day Aspirin Oral tablet delayed release 81mg give 1 tablet by mouth one time a day Cyanocobalamin oral tablet 1000 mcg give 1 tablet by mouth in the morning for supplement Fish oil oral capsule 1000 mg give 2 capsule by mouth two times a day for supplement Gabapentin oral capsule 100 mg give 2 capsules by mouth two times a day (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lasix oral tablet 20 mg give 1 tablet by mouth one time a day every Tue, Thu, Sat Lidocaine Pain relief 4% patch apply to right knee topically one time a day for pain and remove per schedule Metformin HCL oral tablet 500 mg give 1 tablet by mouth two times a day Propranolol HCL oral tablet give 30 mg by mouth two times a day Rexulti oral tablet 0.5mg give 0.5 mg by mouth one time a day Thiamine mononitrate oral tablet 100mg give 2 tablet by mouth one time a day Trazodone HCL oral tablet 50 mg give 1 tablet by mouth three times a day for anxiety/agitation Wellbutrin SR oral tablet extended release 12 hour 100mg give 1 tablet by mouth two times a day Observation of medication administration for Resident #15 on 9/10/24 at 11:02 AM identified the following medications administered outside of the medication administration time: 1. Aspirin 81 mg 2. Vitamin B12 1000mcg 3. Fish oil 1000mg 4. Bupropion hcl sr 100 mg BID 5. Eliquis 5mg tab BID 6. Furosemide 20 mg (T,TH,Sat) 7. Gabapentin 100 mg capsule (2) 8. Metformin 500mg BID 9. Lidocaine patch exp 3/15/2027 (dated and initialed) 10. Propanolol 10mg tabs (30mg BID) 11. Rexulti 0.5mg QD 12. Thiamine B-1 13. Trazodone 50 mg 1-tab TID (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the medication administration audit report for 9/10/24 identified all morning medications were scheduled for 9:00 AM. All recorded administrations were between 11:03 AM and 11:11 AM. Trazodone 50mg was prescribed TID and was administered at 2:13 PM and 4:51 PM for the 2nd and 3rd doses.

C. Resident #92 was admitted to the facility on [DATE]. Diagnoses included dysphagia, oropharyngeal phase, dementia, unspecified severity with other behavioral disturbance, anxiety disorder, unspecified.

The Physician's orders dated September 2024 identified orders for the following medications:

Lisinopril oral tablet 10 mg give 10 mg by mouth one time a day.

Tramadol HCL oral tablet 50 mg give 0.5 tablet by mouth two times a day

Zoloft oral tablet (sertraline) Give 50 mg by mouth in the morning

Observation of medication administration for Resident #92 on 9/10/24 at 11:17 AM identified the following medications were all crushed together and mixed together with vanilla pudding:

1. Lisinopril 10mg every day

2. Sertraline 50 mg one time in the AM

3. Tramadol 50 mg 1/2 tablet BID

The medication administration audit report for 9/10/2024 indicated the above medications were administered between 11:17 AM and 11:20 AM.

D. Resident #51 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, and gastro-esophageal reflux disease without esophagitis.

Physician's orders for Resident #51 dated September 2024 identified the resident was a regular diet and identified the following medications:

Bictegravir-Emtricitab-Tenofov tablet 50-200-25 mg give one tablet by mouth one time a day

Lipitor oral tablet 20 mg give one tablet by mouth one time a day

Multivitamin adults tablet give 1 tablet by mouth in the morning for supplement

Nuedexta Capsule 20-10 mg give 1 capsule by mouth two times a day

Trazodone HCL tablet give 25 mg by mouth two times a day

Observation of medication administration on 9/10/24 at 11:27 AM identified the following medications were crushed together, the capsule was opened, all mixed together with vanilla pudding and administered to Resident #51:

(continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Atorvastatin 20 mg QD 2. Biktarvy 50/200/25 mg 3. Multivitamin 4. Nuedexta 20-10mg cap BID 5. Trazodone 50 mg BID The medication administration audit report for 9/10/24 identified the above mentioned medications were scheduled for 9:00 AM and were marked administered between 11:27 and 11:28 AM. Interview with LPN #15 on 9/10/24 at 11:32 AM identified that she was trained by the previous nurse that whatever the diet order was identified whether to crush the medications or not. LPN#15 indicated that she didn't think she needed an order to crush medications. LPN#15 indicated that Resident #51 was a pureed diet and that she believed crushing the medication is decided on their diet order. LPN #15 indicated that although she was oriented to the facility she didn't recall if crushing medications required an order. Interview with RN #2, nursing supervisor, on 9/10/24 at 11:41 identified there should be a set of batch orders that identify that the medications can be crushed. There is not a crushed order for Resident #51 nor Resident #92. E. Resident #91 was admitted to the facility on [DATE]. Diagnoses included dementia in other disease classified elsewhere unspecified severity with agitation dysphagia unspecified, anxiety disorder, and Alzheimer's disease. Physician's orders dated September 2024 identified Resident #91 was a regular diet mechanical soft texture, thin consistency and the following medications: Buspirone HCL oral tablet 10 mg give 2 tablets by mouth two times a day Lipitor oral tablet 20 mg give 1 tablet by mouth in the morning Multivitamin oral tablet give 1 tablet by mouth one time a day Trazodone HCL oral tablet give 25 mg by mouth two times a day Observation of medication administration for Resident #91 on 9/10/24 at 11:45 AM identified the following medications administered: 1. Atorvastatin 20 mg QAM 2. Buspirone 10 mg 2 tabs BID 3. Trazodone 50 mg 25 mg PO q 6 hrs. as needed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Daily vitamin QD The medication administration audit report for 9/10/24 identified the above listed medications were scheduled for 9:00 AM and were administered from 11:48 AM to 11:50 AM. F. Resident #94 was admitted to the facility on [DATE]. Diagnoses included dysphagia unspecified, delusional disorders, unspecified psychosis not due to a substance or known physiological condition, and dementia in other diseases moderate with other behavioral disturbance. Physician's orders dated September 2024 identified Resident #94 was on a 2-gram Sodium diet with mechanical soft texture, thin consistency and medications that included the following: Furosemide oral tablet 20 mg give 1 tablet by mouth one time a day every other day Trazodone HCL oral tablet 50 mg give 25 mg by mouth three times a day Observation of medication administration on 9/10/24 at 11:55 AM identified the following medications were administered to Resident #94: 1. Furosemide 20 mg qod 2. Trazodone 50 mg 1/2 tablet PO TID The medication administration audit report dated 9/10/24 identified the above listed medications for Resident #94 were scheduled to be administered at 9:00 AM and the administration time was 11:56 AM Interview with the DNS on 9/10/24 at 12:00 PM identified the facility expectation would be that the nurse has an hour on either side of the ordered time for administration. He indicated that sometimes medications are difficult to administer on time depending on what is going on. The DNS indicated the facility would fix the batch orders immediately to include crushing medications and include it for residents who would have medications crushed. Additionally, the DNS indicated the doctor, and the pharmacist were responsible for making sure the medications were able to be crushed. G. Resident #104 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia with psychotic disturbance, unspecified psychosis not due to a substance or known physiological condition, and anxiety disorder, unspecified. Physician's orders dated September 2024 identified Resident #104 had a regular diet, regular texture, thin consistency and orders that included the following medications: Amlodipine Besylate oral tablet 5 mg give 1 tablet by mouth one time a day Hydrochlorothiazide oral tablet 12.5 mg give 1 tablet by mouth one time a day Levothyroxine Sodium oral tablet 25 mcg give 1 tablet by mouth in the morning Risperdal oral tablet 1 mg give 1 mg by mouth in the morning (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Trazodone HCL oral tablet give 25 mg by mouth in the morning Observation of medication administration on 9/10/24 at 12:02 PM identified the following medications were administered to Resident #104 1. Amlodipine 5mg qd 2. Levothyroxine 25mcg QAM 3. Hydrochlorothiazide 12.5 mg 4. Trazodone 50 mg tab 25 mg 5. Risperidone 1 mg tab QAM The medication administration audit report for 9/10/24 identified the above listed medications were scheduled for administration at 9:00 AM and administration times from 12:01 PM to 12:03 PM. H. Resident #21 was admitted to the facility on [DATE]. Diagnoses included unspecified dementia, unspecified severity with other behavioral disturbance, schizoaffective disorder bipolar type, and other psychotic disorder not due to a substance or know physiological condition. Physician's orders dated September 2024 identified Resident #21 was ordered the following medications: Acetaminophen tablet 500mg give 500mg by mouth every 12 hours for pain Depakote oral tablet delayed release 250 mg give 1 tablet by mouth every 12 hrs Depakote oral tablet delayed release 500mg give 1 tablet by mouth every 12 hrs Gabapentin capsule 400 mg give 1 capsule by mouth two times a day Lopressor oral tablet give 25 mg by mouth in the morning Seroquel oral tablet give 12.5 mg by mouth in the morning Tradjenta tablet 5 mg give 1 tablet by mouth one time a day Trazodone HCL oral tablet 50 mg give 0.5 tablet by mouth in the morning Observation of medication administration on 9/10/24 at 12:07 PM identified the following medications were administered to Resident #21 1. Acetaminophen 500 mg 1 tab Q 12 hrs 2. Depakote 250 mg DR tab 1 tab Q 12 hours (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Gabapentin 400mg cap BID 4. Divalproex 500mg DR tab Q12 hrs 5. Metoprolol tartrate 25 mg qam 6. Quetiapine 25mg 12.5 mg po qam 7. Tradjenta 5mg tab qd 8. Trazodone 50 mg tab 1/2-tab qam The medication administration audit report dated 9/10/24 identified that the above listed medications for Resident #21 were scheduled for administration at 9:00 AM and were marked administered between 12:07 PM and 12:12 PM. Interview with RN #6, (Independent Nurse Consultant) on 9/11/24 at 10:06 AM identified that the medications should be administered separately for a g-tube administration. Additionally, RN #6 indicated that in order to administer medications crushed, there needed to be a physician's order that directed a crushed administration. Interview with Pharmacist #2 on 9/13/24 at 12:19 PM identified that late administration could be a problem if the medication had multiple doses throughout the day. If the medication was administered three TID or three times a day the prescription doesn't list administration times but if the first administration was late, the nurse would adjust the next dose if needed. If the medication was every 12 hrs, the next dose would have to be at least 9 to 10 hours later, then this wouldn't pose a problem. In order to administer crushed medications Pharmacist #2 identified there should be a physician's order stating the medications would be administered in that manner. Additionally, Pharmacist #2 indicated the medications administered through the G-tube were okay to be crushed together regarding the efficacy of the medication, however, there should be an order for them to be crushed together as G-tube medications were usually administered separately. The provider should be notified of late medications and BID, TID, or QID medications should have the next administration times adjusted. Interview with the Medical Director on 9/17/24 at 11:45 AM identified there was clinically very little effect to taking medications at a later time than prescribed. TID medications should be delayed for the next doses because there was too short of a window if one was administered after 11 AM and then again at 1 PM. Typically, the nurse should adjust the time and notify the provider to adjust the time. The sedative drug should be spread out. Additionally, the Medical Director indicated he was not at the facility on 9/10/24 and didn't recall being notified of late medications. He also identified that another provider, such as the Psych APRN or the APRN could have been notified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Medication administration schedule identified the standard administration time for medications scheduled for once a day or daily will be administered at 9 am. Medications scheduled 2 times a day, BID, would be administered at 9 am and 5 pm. Medications scheduled 3 times a day, TID, would be administered at 9 am, 1 pm, and 5 pm. Medications scheduled 4 times a day, QID, would be administered 9am, 1 pm, 5 pm, and 9 pm. Medications scheduled every 12 hours, Q12H, would be administered at 9 am and 9 pm. Medications scheduled every 8 hours, Q8H would be administered at 6 am, 2 pm, and 10 am. Medications administered every 6 hours, Q6H would be administered 12 am, 6 pm, 12 am, and 6 pm. Medications administered every 4 hours, Q4H, would be administered 12 am, 4 pm, 8 am, 12 pm, 4 pm, and 8 pm. Medications scheduled to be administered at bedtime, HS, would be administered at 9 p. Medications administered with meals would be administered at 7:30 am, 11:30 am, and 5 pm. The facility policy for the administration procedures for all medications identified that prior to removing the medication from the cart, the staff administering the medication would check the MAR/TAR for the order and at a minimum, review the 5 rights at each of the steps of medication administration. The 5 rights of medication administration included the right patient, the right drug, the right time, the right dose, and the right route. The facility policy for Enteral tube medication administration identified the medication should be prepared one at a time, and tablets that must be crushed prior to administration via feeding tube must have a specific order related to crushing. Further preparation directions indicated each immediate-release tablet should be crushed one at a time, into a fine powder and dissolve in at least 15 ml (or prescribed amount) of warm purified or sterile water, and that each immediate release capsule one at a time and crush the contents into a fine powder and dissolve in a t least 15 ml (or prescribed amount) of warm purified or sterile water. The policy identified to administer each medication separately and flush the tubing between each medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record reviews, review of facility policy, and interviews for one of five sampled residents (Resident #2) reviewed for unnecessary medications, the facility failed to ensure the medication was administered in accordance with the physician's order and for one of three sampled residents (Resident #48) reviewed for possible misappropriation of medication, the facility failed to ensure a medication used to treat anxiety was administered as ordered. The findings include: 1. Resident #2 had diagnoses included dementia, type 2 diabetes mellitus, chronic kidney disease, and anemia. The quarterly MDS assessment dated [DATE] identified Resident #2 had moderate cognitive impairment and required extensive assistance with toileting, hygiene and dressing, was independent with transfers and ambulation and received insulin injections. The RCP dated 5/14/24 identified Resident #2 had diabetes mellitus. Care plan interventions directed to administered diabetic medications as ordered by the physician, monitor side effects and effectiveness, dietary consult for nutrition regimen and on-going monitoring, and monitor for signs and symptoms of hypoglycemia (low blood sugar) not limited to sweating, tremors, increased heart rate and confusion. The physician's order dated 5/20/24 directed to administer insulin Humalog (a fast-acting insulin) 8 units at 8:00 AM, 12:00 PM, and 4:30 PM every day. Special instruction to the medication included: hold when blood sugar was less than 110 and notify physician when blood sugar was less than 70. Review of the medication administration record (MAR) from 7/1/24 to 7/31/24 for Resident #2 identified the following: On 7/1/24 at 12:00 PM, Resident #2 blood sugar was documented as 103, and the MAR indicated that the Humalog insulin was administered. On 7/4/24 at 12:00 PM, Resident #2 blood sugar was documented as 92, and the MAR indicated that the Humalog insulin was administered. On 7/8/24 at 12:00 PM, Resident #2 blood sugar was documented as 106, and the MAR indicated that the Humalog insulin was administered. On 7/9/24 at 8:00 AM, Resident #2 blood sugar was documented as 103, and the MAR indicated that the Humalog insulin was administered. On 7/11/24 at 12:00 PM, Resident #2 blood sugar was documented as 94, and the MAR indicated that the Humalog insulin was administered. On 7/17/24 at 4:30 PM, Resident #2 blood sugar was documented as 108, and the MAR indicated that the Humalog insulin was administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 8:00 AM, Resident #2 blood sugar was documented as 107, and the MAR indicated that the Humalog insulin was administered. On 7/23/24 at 12:00 PM, Resident #2 blood sugar was documented as 78, and the MAR indicated that the Humalog insulin was administered. On 7/25/24 at 8:00 AM, Resident #2 blood sugar was documented as 98, and the MAR indicated that the Humalog insulin was administered. On 7/30/24 at 8:00 AM, Resident #2 blood sugar was documented as 90, and the MAR indicated that the Humalog insulin was administered. Resident #2 received Humalog insulin injection 10 out of 31 opportunities when his/her blood sugar was documented as less than 110. Interview and clinical record review of the MAR with the DNS on 9/10/24 at 11:10 AM identified that he expected all licensed nurses to follow the physician's order when administering medications. Review of the July 2024 MAR with the DNS indicated the Humalog insulin was administered on 7/1/24 at 12:00PM, 7/4/24 at 12:00PM, 7/8/24 at 12:00PM, 7/9/24 at 8:00AM, 7/11/24 at 12:00PM, 7/17/24 at 4:30PM, 7/22/24 at 8:00AM, 7/23/24 at 12:00PM, 7/25/24 at 8:00AM, and 7/30/24 at 8:00AM. He further identified that he would start an immediate education to all licensed nurses for medication administration. Interview with LPN #4 on 9/10/24 at 2:30 PM identified that she was aware of Resident #2's insulin administration parameters to not administer when his/her blood sugar was less than 110. She identified that she would not administer and documents in the MAR that Resident #2's insulin was held when his/her blood sugar was less than 110. She further identified that she was not sure why the MAR would indicate that the insulin injection was administered despite the blood sugar of less than 110. The Administration Procedure for all Medications policy identified that the medications would be administered in a safe and effective manner. The license nurse would obtain and record any vital signs or other monitoring parameters ordered by the physician as deemed necessary prior to medication administration. 2. Resident #48's diagnoses included displaced fracture of base of neck of right femur, unspecified fall, and generalized anxiety disorder. The significant change MDS assessment dated [DATE] identified Resident #48 had intact cognition and was independent with toileting, eating, dressing, and personal hygiene, and required set up clean up assistance with bathing and oral hygiene. Resident #48's care plan dated 8/2/24 identified the resident had anxiety and depression. Interventions directed to administer psychotropic medications as ordered and monitor for side-effects, allow resident to express their emotions/feelings, have resident evaluated and treated by psychiatric services. The physician's order dated 9/4/24 directed Clonazepam 1mg to be administered three times daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #48 on 9/16/24 at 1:45 PM identified he/she had not received his/her last few doses of Clonazepam (benzodiazepine) and was experiencing a lot of anxiety due to not getting it and identified that the nurse knew. LPN #14's note dated 9/15/24 at 11:06 PM identified Resident #48 complained that he/she could not sleep, Clonazepam medication was re-ordered from pharmacy and would arrive the following day. The on call APRN was contacted after no more Clonazepam was found in the Omni-cell, and an order was given for Lorazepam, no Lorazepam was found in the omni cell as well. APRN stated to give Melatonin to help patient sleep. When LPN #14 returned to patient room, patient was sleeping. Review of the Medication Administration Record (MAR) identified Resident #48 did not receive the 8pm dose on 9/15/24 and the 8am dose on 9/16/24 of the Clonazepam 1mg. Interview with LPN#5 on 9/16/24 at 1:54 PM identified that she had received in report that Clonazepam 1mg was not available but had been ordered the night before so it should arrive at some point that day. Review of pharmacy orders received identified the 9/4/24 order of Clonazepam was not received by the pharmacy. On 9/4/24 pharmacy received a discontinue order for Clonazepam 1mg tab- 1 tab by mouth once daily for anxiety with breakfast and once daily at bedtime (take with 0.25mg for a total dose of 1.25mg) and a discontinue order for Clonazepam 0.5mg 1 tablet by mouth once daily and 1 half tablet at bedtime (take with 1mg for a total dose of 1.25mg.) Interview with Pharmacy Tech #1 on 9/16/24 at 12:48 PM identified there was no order received by pharmacy for the Clonazepam 1mg TID ordered on 9/4/24. There were two orders pending in their system. There was a refill request on a Clonazepam 1mg twice daily with an original order date of 8/19/24 which was requested on 9/15/24 at 7:22 PM to be refilled which would have been after their delivery cut off so not able to be delivered until 9/16/24, and there was a new order from 9/15/24 with a short fill order of 6 pills of Clonazepam 1mg TID ordered scheduled to go out. It looked like the 9/15/24 7:22 PM order was pending possibly due to the fact the medication was not due to be re-ordered yet as they had it down to be administered only twice daily. Interview with Pharmacist #1 on 9/16/24 at 2:35 PM identified that if this medication was not administered to the resident as scheduled the resident could experience increased restlessness and anxiety. Interview with RN Supervisor #2 on 9/17/24 at 11:15 AM identified that she had received the order from MD#1 on 9/4/24 and thought it had been sent electronically to the pharmacy from MD#1 but did not realize schedule IV medications needed a separate form to be filled out and sent to the pharmacy signed by the physician. Interview with MD#1 on 9/17/24 at 11:30 AM identified that he was not aware of the missed medication but that the on-call may have been made aware. He thought the order on 9/4/24 had originally come from the psychiatric provider in which they sometimes send him the changes to be signed, but in review remembered that the order came from a risk management meeting in which it was brought to his attention that Resident #48 had multiple orders, and it was confusing to the nurses administering the medications, so the clarification was made. He assumed the Schedule IV form to pharmacy would be filled out by the RN Supervisor and did not fill one out himself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 9/17/24 at 11:50 AM identified he was unaware how the pharmacy would not receive an order if it were in Point Click Care and that medication should be ordered when it is in the last week of the blister pack. The DND also identified the Omni-cell just had an inventory completed on it on 9/14/24 and a reorder of medication was being made to fill it. The previous ADNS who had left in early August was previously responsible for keeping it filled and he was unsure when an Audit of the contents was completed, and a refill last done. Review of the pharmacy policy titled Controlled Substance Prescriptions directed all new prescriptions for controlled medications to be transmitted via fax to the pharmacy by the prescriber or the prescriber's agent. Emergency/STAT orders not in Emergency supply are placed with the provider pharmacy and is scheduled to be given as soon as received. Review of the Electronic Interim Box directed inventory restock to be performed by an authorized pharmacy representative or by authorized nursing personnel. Authorized personnel will conduct an inspection and quality assurance check relating to drug storage, segregation, environmental control, labeling, device operation, inventory quality, security and system integrity at least monthly. 47402

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, review of facility policy, and interviews for one of three sampled residents (Resident #101) reviewed for facility acquired pressure ulcers, the facility failed to ensure interventions and treatments to prevent the development of a pressure wound were put in place and failed to ensure the wound was assessed appropriately and in a timely manner to prevent the worsening of a pressure ulcer/injury. The findings include: Resident #101 was admitted to the facility on [DATE] with diagnoses that included dementia, anemia, heart failure, thrombocytopenia, malignant neoplasm of the rectum, and presence of ileostomy. The physician's order dated 7/23/24 directed to complete skin monitoring and observation weekly. The skin assessment dated [DATE] identified Resident #101 had intact skin. The Braden scale assessment (used to predict risk for development of pressure ulcer/injury) dated 7/23/24 identified Resident #101 had a score of 16 which is indicative of the resident being at risk for the development of a pressure ulcer. The Resident Care Plan (RCP) dated 7/24/24 identified Resident #101 was at risk for the potential for skin breakdown related to decreased mobility, ileostomy, and incontinence. Care plan interventions included: follow facility protocol for treatment of injury, keep skin clean and dry, and staff to provide frequent incontinence care. The admission MDS assessment dated [DATE] identified Resident #101 had severe cognitive impairment, did not display behaviors, required extensive assistance with toileting, bed mobility, hygiene, dressing, and transfers. The assessment further identified Resident #101 was non-ambulatory, utilized a wheelchair for mobility, did not have range of motion deficits, was frequently incontinent of bladder and had an ileostomy in place for bowel function. It further noted the resident was at risk for the development of pressure ulcers, but did not currently have a pressure ulcer, and had a pressure reducing device to the bed. The assessment did not identify that the resident was on a turning and repositioning program or that the resident had a pressure reducing device to the wheelchair. The nurse's note dated 8/2/24 at 11:13 PM written by LPN #1 identified that the assigned nurse's aide and Resident #101's responsible party reported the resident had a small open wound to the coccyx, Resident #101 denied pain and/or discomfort, and the nursing supervisor was notified. Further review of the nurse's note failed to identify any further documentation about the wound such as a description, measurements, the presence or absence of an odor Review of the clinical record failed to identify that the wound to Resident #101's coccyx was assessed and/or that a treatment order was put in place. Review of the clinical record failed to identify that the weekly skin monitoring and observation for the week of 8/9/24 was completed as ordered by the physician. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The nurse's note dated 8/16/24 at 4:32 PM written by LPN #2 (wound nurse) identified Resident #101 had two small open wounds to the coccyx. The first wound size was documented as 0.8 centimeters (cm) in length by 0.5 cm in width and 0.1 cm in depth and the second wound size was documented as 1.0 cm in length by 0.8 cm in width and 0.1 cm in depth. The APRN was updated, and new orders obtained that directed to cleanse the wound with normal saline followed by the application of Calcium Alginate and cover with a dry clean dressing. The wound bed was noted with 100 percent granulation (wound bed characteristics described as red and/or pink in color) and a scant amount of serosanguineous drainage was also noted. Resident #101 denied pain and/or discomfort during the treatment. The resident's responsible party was notified and updated. The physician's order dated 8/16/24 directed to apply pressure reducing air mattress to the bed and check function every shift per resident's weight and comfort. The revised RCP dated 8/16/24 identified Resident #101 had an unstageable pressure ulcer. Care plan interventions directed to check mattress for function every shift and mattress setting adjusted in accordance with patient weight, RN will assess wound and provide appropriate wound treatment per physician orders, and staff will provide frequent incontinent care ensuring bedding and skin remain dry. APRN #1's (wound specialist) initial wound progress note dated 8/19/24 at 7:58 AM identified Resident #101 had a new unstageable pressure ulcer and/or injury to the coccyx related to pressure. The wound size was documented as 0.5 cm in length by 1.5 cm in width and 0.2 cm in depth. The wound bed was covered with 100 percent slough (a yellow and/or white material dead cell that accumulates in the wound bed) and with moderate amount of serosanguineous drainage. The treatment plan directed to apply Santyl (chemical wound debridement) ointment followed by calcium alginate daily and as needed, to follow facility pressure ulcer prevention protocol, apply pressure redistribution mattress per facility protocol, wheelchair pressure redistribution cushion per facility protocol, offload pressure wound and reposition patient every two hours. The physician's order dated 8/19/24 directed to cleanse coccyx wound with normal saline, apply nickel thick layer of Santyl ointment followed by Calcium Alginate and cover with dry clean dressing. The weekly physician's wound progress note dated 8/26/24 at 4:35 PM identified Resident #101 continued with unstageable pressure injury to the coccyx. The wound bed remains with 100 percent slough and the wound size was documented as 0.8 cm in length by 0.5 cm in width and 0.2 cm in width and with small amount of serosanguineous drainage. The treatment plan was to continue to cleanse the wound with normal saline and apply Santyl ointment at the base of the wound and cover with dry clean dressing. The weekly APRN#1 wound progress note dated 9/2/24 at 8:06 AM identified the unstageable wound to the coccyx had worsened. The wound size was documented as 0.5 cm in length by 1.5 cm in width and 0.2 cm in depth and the wound bed remained at 100 percent slough with moderate amount of serosanguineous drainage noted. The treatment plan noted to apply Santyl ointment followed by Calcium Alginate and cover with dry clean dressing daily. The social services progress note dated 9/6/24 at 9:41 AM identified Resident #101 was discharged to the community with rehabilitation and nursing services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER: Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 55 Grand Street New Britain, CT 06052	

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #1 on 9/9/24 at 12:30 PM identified the NA reported Resident #101 had a new open wound to the coccyx on 8/2/24. She could not recall who the Na was that reported the wound to the coccyx. She identified that she visualized Resident #101's coccyx and noted an open wound to the coccyx. She did not measure the open coccyx wound, nor did she call the physician to obtain a treatment, but she immediately reported the open coccyx wound to the nursing supervisor. She further identified that she was an agency staff nurse, and it would be the nursing supervisor's responsibility to assess the coccyx wound, to call the physician and to obtain a treatment order. She further noted that she did not receive any further instruction from the nursing supervisor related to Resident #101 coccyx wound. Interview with RN #1 (nursing supervisor) on 9/9/24 at 1:30 PM identified that she could not remember whether there was a reported open wound to Resident #101's coccyx. She identified that she would document the wound assessment in the nursing progress notes and/or wound documentation, call the physician and obtain treatment orders, and update the wound nurse. Interview with LPN #2 (7-3 charge nurse) on 9/9/24 at 2:00 PM identified that the charge nurse is responsible for checking and documenting the resident skin weekly on their shower day. She identified that she signs off in the TAR (treatment administration record) to indicate that the skin check is completed and completes the weekly skin monitoring assessment under the evaluation. Additionally, LPN #2 could not verify whether she did a skin check for Resident #101 because there was no weekly skin monitoring assessment completed and she did not sign off in the TAR. She further noted that she would report to the nursing supervisor immediately when there is a new wound. Interview with LPN #3 (wound nurse) on 9/9/24 at 2:30 PM identified that she was responsible for monitoring the wounds weekly and also identified that the nursing supervisor or the DNS would assess the wound with her when there is a new onset of wound reported. On 8/16/24, she identified that the charge nurse on the unit reported that Resident #101 had open wound to the coccyx. She identified Resident #101 had 2 small open wound to the coccyx and she measured both wounds. When she referred Resident #101 to the APRN #1 (wound specialist) the following week, the 2 open wounds combine into one open wound to the coccyx. She was not made aware of Resident #101 open coccyx wound that was first noted on 8/2/24. She identified she would expect the physician to be notified, and a treatment to be initiated at the time of discovery to prevent the wound from worsening and the wound should be assessed weekly. Interview with APRN #1 (wound specialist) on 9/9/24 at 2:45 PM identified that her initial consultation with Resident #101 was on 8/19/24 during her wound rounds. She identified that Resident #101 had an unstageable wound to the coccyx because the wound bed was covered with 100% slough. She also noted that the cause of the wound to the coccyx was related to pressure because of the wound's location. She identified that Resident #101 was at risk for pressure injury because of his/her dementia, decreased mobility, and anemia. She was not made aware of the wound to the coccyx on 8/2/24 and it would be the facility's responsibility to let her know when there is a new onset of a wound that needed to be evaluated. She further noted on her wound consult dated 9/2/24 that Resident #101 pressure wound to the coccyx had worsened because the measurement of the wound became larger from the previous wound assessment and the wound bed continued to be covered with 100% slough. She further identified that a pressure ulcer/injury could worsen quickly without a timely assessment and appropriate treatments and interventions provided. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Rehabilitation and Healthcare Center	55 Grand Street New Britain, CT 06052

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 9/10/24 at 11:20 AM identified that he would expect the nurse to assess the wound promptly and call the physician to obtain and implement the treatment immediately. He also was aware that any pressure wound and/or injury could worsen without immediate intervention and treatment. He identified that the weekly skin check needed to be documented under the evaluation of weekly skin monitoring and done weekly. He was not made aware that Resident #101 had a new open wound to the coccyx on 8/2/24. He further identified the coccyx wound should have been assessed by a nurse and documented in a nurse's note that included the wound measurement, description and/or pressure wound stage, call to the physician and obtain and implement treatment, and the wound should have been monitored weekly from the time it developed. Interview with RN #2 (interim ADNS) on 9/10/24 at 11:50 AM identified that she assessed the coccyx wound with LPN #2 on 8/16/24. She identified that she was newly hired and was not aware that the wound nurse was an LPN. She further identified that she agreed with LPN #2's documentation of the wound. The Prevention and Management of Wounds policy identified that residents receive appropriate treatment for skin issues based on the type of wound. The policy noted that staff provides treatments and interventions for skin issues. Review of the policy for procedures noted the nurse would identify the impairment and stage when applicable and is responsible for identifying the appropriate treatment and interventions through collaboration with the wound specialist and wound nurse. The policy directs staff to document physician's orders and transcribe them into the treatment administration record in the electronic medical record, indicate interventions on the resident care plan and recognize factors contributing to pressure, resident needs and behaviors.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record reviews, facility documentation, facility policy and interviews for two of three residents (Resident #68 and #22) reviewed for accidents, the facility failed to ensure residents on 1:1 observation did not have possession of smoking paraphernalia. The findings include: A. Resident #68's diagnoses included end stage renal disease, psychoactive substance abuse, and major depressive disorder. Record review identified Resident #68 had a court appointed Conservator of Person (COP). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 was alert and oriented, required assistance for transfers and supervision for mobility with a wheelchair. The Resident Care Plan (RCP) dated 7/23/2024 identified Resident #68 as at risk for injury to self and others secondary to unsafe smoking practices and had stored smoking supplies on his/her person and/or in his/her room. Interventions directed to provide one-to-one (1:1) staff for supervision, assigned a companion to go on all (outpatient) dialysis outings to ensure no vapes are acquired, search room/belongings search as needed, review facility smoking policy, have resident re-sign smoking contract. Further the COP makes all purchases for Resident #68 (to avoid purchase of smoking supplies), and COP provided list of approved visitors. Record review identified the following: 1. On 8/17/2024 at 11:00 AM, Resident #68 was observed vaping in his/her room. The corrective action plan was to continue 1:1 observation and encourage Resident #68 to comply with facility rules. Smoking policy was re-signed by Resident #68. 2. On 8/22/2024 at 2:00 PM, staff observed Resident with two vape pens in his/her pocket. The corrective action plan was to continue on 1:1 observation, remind visitors to not bring smoking/vaping materials to Resident #68. 3. On 8/30/2024 at 3:30 PM, Resident #68 was observed receiving a vape pen from another resident. The corrective action plan identified Social Services (SS) spoke with Resident #68 regarding facility smoking and vaping polices (re-education). Resident #68 verbalized understanding and re-signed the smoking policy. 4. On 9/5/2024 at 9:15 AM, the NA providing 1:1 observation observed Resident #68 with a vape pen. The DON and Social Services responded to the room and observed a yellow vape pen on the seat of the wheelchair. The corrective action plan directed to continue to encourage Resident #68 to comply with the smoking policy of the facility and maintain 1:1 observation. 5. On 9/5/2024 at 1:45 PM, Resident #68 was observed with a vape pen by the staff providing 1:1 observation, and Resident #68 tucked the vape into his/her brief. The corrective action plan directed facility staff will continue to encourage Resident #68 to comply with the smoking policy and to maintain 1:1 observation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. On 9/7/2024 at 10:30 AM, Resident #68 was observed with a vape pen in his/her possession. The corrective action plan directed facility staff will continue to encourage Resident #68 to comply with the smoking policy and to maintain 1:1 observation. Interview with DON on 9/16/2024 at 2:40 PM identified Resident #68 was alert and oriented, was offered smoking cessation interventions but declined them, and was noncompliant with the smoking policy. The interview identified although Resident #68 was on 1:1 observation, the interview failed to identify how Resident #68 continued to obtain smoking paraphernalia while on 1:1 staff observation. B. Resident #22's diagnoses included chronic kidney disease stage 3, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 was alert and oriented, and was independent with transfers and wheelchair mobility. The Resident Care Plan (RCP) dated 7/12/2024 identified Resident #22 as at risk for injury to self and others secondary to unsafe smoking practices, shared smoking supplies (lighters, cigarettes, vapes, e-cigs) with other residents and stored smoking supplies on his/her person and/or in his/her room. Interventions directed provide smoking education, staff to be present when opening deliveries, and room/belongings search as needed. Record review identified the following: 1. On 8/25/2024 at 12:00 PM, Resident #22 was observed with a vape pen. The corrective action plan identified vape pen was removed, and immediate education was provided. Resident #22 stated he/she purchased the vape while out on his/her last LOA (leave of absence). Resident verbalized understanding facility smoking policy and re-signed the policy. 2. On 8/29/2024 at 1:00 PM, staff observed a vape pen on Resident #22's power chair and removed the pen. The corrective action plan identified Resident #22 was reminded that having vape pens were not permitted and Social Services (SS) follow up was provided. 3. On 8/29/2024 at 10:00 PM, staff discovered five (5) vape cartridges in Resident #22's room. The corrective action plan identified Resident #22 was re-educated on the smoking and vaping policy and re-signed the smoking. 4. On 9/9/2024 at 9:0 AM, while receiving ADL care, the NA observed two (2) vape pens in Resident #22's possession, and the pens were given to staff. The corrective action plan identified Resident #22 was re-educated regarding facility smoking policy, re-signed the smoking policy, and was placed on 1:1 observation. 5. On 9/10/2024 at 7:50 AM, while the NA observed two (2) vape pens in Resident #22's possession, and the pens were given to staff. The corrective action plan identified Resident #22 was provided with re-education, re-signed the smoking policy, and continued on 1:1 observation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 9/16/2024 at 2:40 PM identified Resident #22 was alert and oriented, and noncompliant with the smoking policy. DON stated Resident #22 may have obtained the smoking paraphernalia from items ordered and delivered to the facility, or when out of the facility on an LOA. The interview identified although Resident #22 was placed on 1:1 observation on 9/9/2024, the interview failed to identify how Resident #22 continued to obtain smoking paraphernalia while on 1:1 staff observation. Review of the Smoking Policy identified under smoking rules, residents are not permitted to carry any smoking materials, such as: cigarettes, cigars, vapes, pipes, and lighting devices (matches, lighter). Anyone in violation of this rule will be reassessed, and re-educated. If non-compliance continues, the resident could receive an involuntary discharge notice.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47489 Based on review of facility documentation, review of facility policy and interviews, the facility failed to ensure that controlled medications were safe guarded and periodically reconciled to ensure against diversion of medication. The findings include: Interview with the DNS on 9/12/24 at 1:40 PM identified the Controlled Substance Disposition Records (CSDR) come in duplicate form with the controlled medications. The CSDR yellow form is placed in a box in the supervisor's office, and after the medication is completed, the CSDR white forms, with the administration forms get paired with the yellow form and the medication is reconciled. The DNS indicated that job was part of the ADNS duties and, since the ADNS left over a month ago, no one had been assigned to complete the task of narcotic reconciliation. Interview with the DNS on 9/13/2024 at 12:40 PM identified the facility had not conducted a facility narcotic audit for an undisclosed amount of time. The DNS indicated that the ADNS who left in August of 2024 was responsible for maintaining the narcotic reconciliations, and no one had been assigned to complete the task since he left employment. The DNS further indicated that he was not able to find any paperwork to prove that audits were completed and was not able to provide the date of the last audit for 2024 nor 2023. The DNS described step by step what happened once the pharmacy delivered a controlled medication. He indicated the delivery person obtains a signature from the supervisor who checks the medication being delivered against the packing slip. The supervisor signs and dates the packing slip, and the facility receives a copy of the packing slip. The DNS further identified that until the current survey, it was not the facility's practice to maintain the packing slips. The Controlled Substance Disposition Records (CSDR) are a duplicate form. One is yellow and one is white. The yellow form goes to the nursing supervisor's office and is placed in a binder (post surveyor inquiry and established during survey) and the white copy goes to the units to the controlled medication binders on the medication carts for the nurses to sign out the controlled medications along with the controlled medication that matches the specified medication on the form (CSDR). Interview with RN#6 on 9/13/24 at 12:50 PM identified that she and the DNS did a house wide narcotic audit the previous night and identified the following CSDRs (yellow copies) that did not have a corresponding CSDR (white copy), nor a corresponding bubble pack of medication in the building: 1. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 3/28/24 2. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 4/16/24 3. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 4/25/24 4. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 5/7/24 5. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 5/25/24 6. Oxycontin ER 10 mg tablets, 28 delivered from the pharmacy on 5/29/24 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 6/11/24 8. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 7/11/24 9. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 7/25/24 10. Oxycodone IR 5mg tablets, 30 delivered from the pharmacy on 8/14/24 11. Tramadol 50 mg tablets, 30 delivered from the pharmacy on 3/18/2024 12. Lorazepam 0.5 mg tablets, 30 delivered from the pharmacy on 8/27/24 13. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 5/24/24 14. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 6/6/24 15. Oxycontin ER 10 mg tablets, 28 delivered from the pharmacy on 6/12/24, 16. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 6/12/24 17. Xtampza ER 13.5mg caps, 28 delivered from the pharmacy on 7/6/2024 18. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 7/17/24 19. Hydromorphone 2mg tablets, 30 delivered from the pharmacy on 6/14/24 20. Oxycodone IR 20mg tablets, 30 delivered from the pharmacy on 6/15/24 21. Oxycodone IR 30mg tablets, 30, delivered from the pharmacy on 6/15/24 22. Oxycodone-APAP 5-325 mg tablets, 30 delivered from the pharmacy on 11/29/23 23. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 3/14/24 24. Hydromorphone 2 mg tablets, 30 delivered from the pharmacy on 8/1/24 25. Hydromorphone 4 mg tablets, 30 delivered from the pharmacy on 7/6/24 26. Hydromorphone 4 mg tablets, 30 delivered from the pharmacy on 8/14/24 27. Lacosamide 200mg tablets, 30 delivered from the pharmacy on 7/4/24 28. Clonazepam 0.5 mg tablets, 15 delivered from the pharmacy on 5/22/24 29. Clonazepam 0.5 mg tablets, 30 delivered from the pharmacy on 6/14/24, 30. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 6/27/24 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	31. Morphine Sulfate IR 15 mg tablets, 28 delivered from the pharmacy on 7/17/24 32. Morphine Sulfate IR 15 mg tablets, 30 delivered from the pharmacy on 8/6/24 33. Oxycodone IR 10 mg tablets, 30 delivered from the pharmacy on 8/8/24, 34. Oxycodone IR 5mg tablets, 15 delivered from the pharmacy on 2/6/24 35. Zolpidem 10 mg tablets, 30 delivered from the pharmacy on 5/31/24 36. Tramadol 50 mg tablets, 30 delivered from the pharmacy on 6/21/24 37. Tramadol 50 mg tablets, 30 delivered from the pharmacy on 6/14/24 38. Hydromorphone 2 mg tablets, 30 delivered from the pharmacy on 6/28/24 39. Oxycodone IR 5 mg tablets, 12 delivered from the pharmacy on 9/6/24 40. Oxycodone-APAP 5-325 mg tablets, 10 delivered from the pharmacy on 5/4/24 41. Oxycodone-APAP 5-325 mg tablets, 30 delivered from the pharmacy on 6/11/24 42. Oxycodone-APAP 5-325 mg tablets, 30 delivered from the pharmacy on 6/25/24 43. Oxycodone-APAP 5-325 mg tablets, 30 delivered from the pharmacy on 6/7/24 44. Tramadol 50 mg tablets, 30 delivered from the pharmacy on 8/13/24 45. Oxycodone-APAP 5-325 mg tablets, 30 delivered from the pharmacy on 8/20/24 46. Lorazepam 0.5 mg tablets, 30 delivered from the pharmacy on 8/21/24 47. Oxycodone IR 5 mg tablets, 30 delivered from the pharmacy on 8/1/24 48. Oxycodone IR 5 mg tablets, 8 delivered from the pharmacy on 9/1/24 Interview on 9/16/24 at 12:22 PM with the former ADNS (employed 1/2023 through 8/7/24) identified he was responsible for investigating missing narcotics but could not recall an instance where the white CSDR and the bubble pack of medication were both reported missing. The ADNS identified that he was taught to conduct narcotic audits and had a binder to log them in but lost the binder and was not able to conduct the audits due to other duties. The ADNS could not recall when the last audit was completed. Additionally, he identified that he had witnessed destruction of narcotics with the DNS but did not recall specific dates. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the DNS, Administrator, and RN#6 on 9/16/24 at 3:10 PM identified that a second in house narcotic audit was conducted that morning and additional medications were found missing bringing the total to 49 medications that were unaccounted for. The DNS indicated that he is uncertain where all of the narcotic medications could have gone and that he and RN#6 would continue to review the medication administration records (MAR) of the residents and that he thinks it could be possible that the white CSDR sheets could have been thrown out before they were reconciled. Interview with the Medical Director on 9/17/24 at 11:25 AM identified that narcotic disposition is a nursing procedure. When shown the CSDR sheets for the unaccounted-for controlled medications, the Medical Director denied being aware. The Medical Director indicated he would expect a thorough investigation. Additionally, he indicated he had never been informed that residents were not receiving their medications. The Handling of Controlled Substances policy indicated that any discrepancy in controlled drug counts should be reported to the Director of Nursing as soon as possible and the DNS will notify the administrator and the consultant pharmacist immediately and the Administrator and Pharmacist will consult concerning possible notification of police or other enforcement actions. Although requested, the facility did not provide a narcotic requisition/disposition/destruction/audit policy.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

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

Based on observations, review of clinical records, review of facility policy, review of facility documentation, and interviews during a review of the Infection Control Program, the facility failed to have the appropriate signage posted for a resident on transmission-based precaution (TBP) and the facility failed to utilize personal protective equipment (PPE) when entering a transmission-based precaution resident's room.

Resident #58's diagnoses included type 2 diabetes mellitus, anxiety and polyneuropathy.

The annual MDS assessment dated [DATE] identified Resident #58 was cognitively intact, required limited assistance with toileting hygiene, personal hygiene, and dressing. The assessment further identified that the resident was ambulatory, utilized a walker and wheelchair.

The physician's order dated 9/6/2024 directed contact precautions secondary to stool for Clostridium difficile (C. diff) ordered and pending every shift.

The nurse's note dated 9/9/24 at 6:32 AM identified that Resident #58 remained on contact precautions for a possible C. diff.

The nurse's note dated 9/10/24 2:45 PM identified that Resident #58 remained on contact precautions and awaiting to collect stool for C. diff secondary to loosen stool on 9/6/24.

Intermittent observation of Resident #58's room door entrance on 9/9/24 failed to identify posted signage that identified the need for contact precautions which would have noted the need for everyone to clean hands before entering and leaving the room, providers and staff must also wear gloves and gown before room entry and discard gown before room exit. Further observation identified a bin that was placed on the outside of Resident #58's room containing gown, gloves, face shield, surgical mask and a bottle of hand sanitizer on the top of the bin and a white bin located inside the room, just before the door exit for PPE disposal.

Observation on 9/10/24 at 12:10 PM failed to identify posted signage that identified the need for contact precautions which would have noted the need for everyone to clean hands before entering and leaving the room, providers and staff must also wear gloves and gown before room entry and discard gown before room exit. Further observation identified a bin that was placed on the outside of Resident # 58's room containing gown, gloves, face shield, surgical mask and 2 bottle of hand sanitizer on the top of the bin and a white bin located inside the room, just before the door exit for PPE disposal.

Interview with the Charge Nurse (LPN #13), NA #3 and NA #4 on 9/10/24 at 12:15 PM identified that staff knew when a resident is on precautions based on the signage posted on the outside of the room, which notes the type of transmission-based precautions, the type of PPE to be worn and when to wear the PPE, along with a bin on the outside of the room containing the appropriate PPE supplies. The staff also identified that the facility had provided education on transmission-based precautions which included, the type of precautions and how to don ad doff PPE.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/10/24 at 12:20 PM identified NA #4 entered Resident #58's room without the use of PPE and spoke with the resident regarding when to have a shower. Interview with NA #4 on 9/10/24 at 12:23 PM identified that she did not need to utilize PPE as she was not providing care to the resident. Observation on 9/10/24 at 12:30 PM identified NA #4 entering Resident #58's room with his/her lunch meal tray without the use of PPE. Observation on 9/10/24 at 12:45 PM identified NA #3 entering Resident #58's room without the use of PPE to remove the resident's lunch meal tray and place the tray inside of the food meal cart, then proceeded to pick-up the other meal trays from other resident's room. Interview and observation with LPN #13 on 9/10/24 at 1:20 PM identified that Resident #58's room entrance failed to have signage on the outside of the room identifying the type of transmission-based precaution and the appropriate PPE to be worn and when to wear the PPE for the staff to follow. She then identified that Resident #58 was on contact precautions, which was a part of the physician's orders, which required PPE to be worn upon entering the resident's room. LPN #13 identified that the signage needed to have had been posted on the outside of the room as it was the responsibility of the Infection Preventionist and the supervisor to place the signage on the outside of the room. In addition, as additional signs are kept at the nurses' station in the drawer, LPN #13 indicated that she had not been working for the past couple of days and shift-to-shift reports are not always thorough. She then notified the Infection Preventionist (LPN #3) about the lack of signage on Resident #58's room and on the unit. Interview with NA #3 on 9/10/24 at 1:20 PM identified he did not utilized PPE when he removed the tray from Resident #58's room as there weren't any signage outside of the room, however based on the cart on the outside of the room knew the resident was on some type of precaution. Interview with NA #4 on 9/10/24 at 1:20 PM identified she knew the resident was on an isolation precaution but failed to ask the type of transmission-based precaution to be followed. She indicated that she did not think that PPE was to be worn when entering the room, when asking a question or delivering the resident's meal tray. Observation with the Infection Preventionist (LPN #3) on 9/10/24 at 1:25 PM identified a bin containing gowns, masks, face shield, gloves, and 2 containers of the hand sanitizer on the top of the bin, a white bin was located inside the room, just before the door exit for PPE disposal and there was not a posted signage that would have had identified the need for contact precautions which would note the appropriate PPE to be worn and when to wear the PPE for the staff to follow. Interview with LPN #3 on 9/10/24 at 1:25 PM identified she had placed the contact precaution signage and the bin containing the PPE supplies outside of the room on 9/6/24, as the resident was experiencing loose stool. LPN #3 identified that the hand sanitizers should not have been placed on the cart as hand washing is required for a resident with or suspected of C. diff, as well as a signage should have been outside of the room. She identified that staff needed to wear PPE upon entering the room, wash hands with soap and water after exiting the room, and bleach wipes was required to clean any reusable equipment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor's inquiry LPN #3 posted a contact precaution signage outside of the room on the wall, which noted the need for everyone to clean hands before entering and leaving the room, providers and staff must also wear gloves and gown before room entry and discard gown before room exit. Review of the Transmission-Based (Isolation) Precautions policy identified that contact precautions are intended to prevent the transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment, and PPE to be donned upon room entry and discarded before existing the room. The policy further identified that the nursing staff may place a resident on transmission-based precaution/isolation with suspected or confirmed infectious diarrhea, or symptoms consistent with a communicable disease by obtaining an order for transmission-based precautions /isolation that specifies the type of precaution, reason for the precautions. The policy further identified that a signage that included instructions for the use of specific PPE and the transmission-based precautions such as contact, droplet or airborne, would be placed in a conspicuous location outside the resident's room with PPE readily available near the entrance of the resident's room.