STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075196	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Village North Health and Rehabilitation Cen	78 Viets St Extension New London, CT 06320

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical records, and facility policies, the facility failed to prevent, identify, assess, and treat pressure ulcers/injuries in accordance with resident's needs and facility policy for 2 of 3 sampled residents (Resident #3 and Resident #11). Specifically, the facility did not complete timely risk assessments or comprehensive skin assessments; failed to implement and ensure staff adherence to required offloading/turning interventions; did not measure and monitor wounds after onset; and did not follow physician orders (including heel offloading and catheter anchoring). These failures resulted in actual harm: Resident #3 developed an in-house deep tissue pressure injury to the right heel and a stage 2 sacral/coccyx ulcer that worsened, and Resident #11 developed a device associated stage 3 pressure ulcer of the penis and lacked heel offloading despite an existing stage 4 heel ulcer. The facility's systemic failures to implement, monitor, and revise interventions to prevent deterioration constitute noncompliance, which resulted in actual harm. The findings include: 1. Resident #3's diagnoses included chronic kidney disease, muscle weakness, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment, was dependent on staff for toileting and transfers, and required substantial/maximal assistance with changing positions in bed (rolling, lying and sitting). Additionally, the MDS identified Resident #3 was at risk for developing pressure ulcers, did not have any current unhealed pressure ulcers/injuries, and skin ulcer/injury treatments included a pressure reducing device for the bed, and application of ointments/medications. The Resident Care Plan in effect from 1/18/26 through 1/25/26 identified Resident #3 was at risk for developing a wound. Interventions directed to provide a pressure reducing device to the bed and chair and apply [NAME] lotion to the skin twice daily. The Resident Care Plan failed to include interventions for turning and positioning or to offload Resident #3's heels. Although physicians order dated 1/18/26 and in effect through 1/25/26 directed to apply a protective foam dressing to the resident's coccyx every shift and as needed, the orders failed to direct interventions for turning and positioning or to offload Resident #3's heels. a. A physician's order in effect from 1/18/26 through 1/25/26 directed to apply skin prep twice a day to Resident #3's heels. Review of the nurses note dated 1/25/26 at 10:14 PM identified a Nurse Aid (NA) noted redness on both of Resident #3's heels. On evaluation the shift nurse identified a possible pressure wound to the resident's bilateral heels. The skin appeared dark and dry with some scaling on the right heel. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the nurse's note dated 1/26/26 at 12:00 PM identified Resident #3's heels were assessed by the Assistant Director of Nursing Services (ADNS), who was also the wound nurse. Resident #3's bilateral heels were red and blanchable with calloused skin forming, skin was intact, pedal pulses were positive, and no pressure ulcer was identified. The APRN was updated and new orders were obtained to apply skin prep every shift (increased from twice daily) and apply bilateral foam boots when in bed. The Resident Care Plan was updated on 1/26/26 to include the intervention to provide bilateral offloading foam boots in bed, treatment as ordered and encourage the resident to reposition every 2 to 3 hours. A physician's order dated 1/26/26 directed foam boots when in bed every shift. The physician's order failed to include the new APRN order for skin prep every shift (increased from twice daily) as directed in the nurse's note dated 1/26/26 resulting in no change to the previous order. Review of the facility weekly wound rounds and clinical record from 1/26/26/26/26 through 2/16/26 failed to indicate that Resident #3's reddened heels had been assessed, monitored or measured for improvement or deterioration since initially identified in the nurse's note as blanchable on 1/26/26. Review of weekly skin assessments dated 2/1/26, 2/8/26, 2/22/26, and 3/1/26 failed to indicate Resident #3 had or did not have a skin alteration of the right heel. Review of the facility weekly wound evaluation and initial wound physician's visit note dated 2/17/26 identified Resident #3 had a new in-house acquired deep tissue pressure injury to the right heel with an onset date of 2/17/26 measuring 1.8 cm x 2.4 cm x 0 cm, intact skin, and with purple/maroon discoloration. The wound physician Plan of Care recommendations included floating heels in bed, elevating legs, offloading the wound, turning side to side in bed, repositioning per the facility protocol and obtain a Dietitian consultation. b. Review of a weekly skin check assessment dated [DATE] at 10:55 AM identified a new skin issue, purple discoloration to the sacrum/coccyx, wound acquired in house. Subsequent skin checks on 2/8/26, 2/22/26, and 3/1/26 described the sacrum/coccyx area as other, purple discoloration acquired in house. (The skin checks failed to identify measurements or any further wound assessment). Review of the nurses note dated 2/7/26 at 2:49 PM identified the sacrum/coccyx wound was nonblanchable. (The note failed to identify measurements or any further wound assessment). Review of the APRN progress note dated 2/9/26 at 12:00 PM identified Resident #3 was evaluated for a decline and was bedbound for the majority of the day. Additionally, he/she experienced a progressive functional decline over recent weeks with decreased mobility and increased time spent in bed. The APRN note failed to indicate that Resident #3 had any skin issues of the heels or sacrum/coccyx. Review of the clinical record and facility provided ADNS/wound nurse weekly wound evaluation rounds dated 2/12/26 at 1:32 PM identified Resident #3 had a new in-house acquired open area to the sacrum/coccyx with an initial onset date of 2/7/26. Although documentation in a nurse's note on 1/31/26 indicated discoloration remained present, on 2/1/26 a skin check assessment identified a new skin issue with purple discoloration to the sacrum/coccyx was acquired in house, and on 2/7/26 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	at 2:49 PM a nurse's note identified a non-blanchable sacrum/coccyx wound, the facility lacked documentation of a completed assessment or any measurements of the wound until the weekly wound evaluation rounds dated 2/12/26. On 2/12/26 (5 days after the recorded initial onset date) the wound was identified as a stage 2 pressure ulcer/injury and measured 1 centimeter (cm) x 0.5 cm x 0.1 cm with exposed dermis, light serous drainage, and blanchable redness to the peri (surrounding) skin. Review of nurse's notes and physician's orders failed to identify the implementation of any new interventions to aide in prevention of deterioration or to promote healing following the development of the sacral/coccyx wound on 2/7/26, until 2/12/26 (5 days later) when a treatment order was obtained. Although the Resident Care Plan included to encourage Resident #3, to turn and reposition every 2-3 hours the resident required substantial/maximal assistance with changing positions in bed (rolling, lying and sitting). A physician's order dated 2/12/26 directed to clean the sacral/coccyx wound with cleanser followed by calcium alginate with Ag (silver) to the wound bed followed by a dry clean dressing, to be changed daily and as needed. Review of the facility weekly wound evaluation and initial wound physician's visit note dated 2/17/26 identified Resident #3 had a sacral/coccyx stage 2 in house acquired pressure injury measuring 1.4 cm x 1 cm x 0.1 cm (an increase from 2/12/26, 5 days prior) with an onset date of 2/7/26. c. Review of the clinical record identified a Braden Scale evaluation (skin risk assessment) dated 2/12/26 indicated a very high risk for pressure ulcer development. The clinical record failed to identify any further Braden Scale or skin risk assessments had been completed upon or since Resident #3's admission date in February 2025. An observation on 2/25/26 at 10:17 AM identified Resident #3, alone, in the room, in bed without the benefit of heel boots. Observation and interview on 2/27/26 at 9:41 AM with Nurse Aid (NA) #1 identified Resident #3 in bed with heel boots applied. Upon removal of the heel boots by NA #1 noted that Resident #3 had a quarter sized dried brown area on the outside of his/her right sock as well as on the linen by the foot board. NA #1 identified the areas as dried blood, stating that Resident #3 regularly kicked off the heel boots. Observation and interview with Registered Nurse (RN) #4 on 2/27/26 at 9:43 AM identified he was the regular nurse for Resident #3, and he/she was noncompliant with the off-loading foam heel boots and removed the heel boots all the time by kicking them off. RN #4 proceeded to perform the treatment to the wounds per the physician's orders. RN #4 indicated that the ADNS/Wound nurse was previously made aware that Resident #3 often self-removed his/her heel boots. Interview and record review with the ADNS/Wound Nurse on 2/27/26 at 1:15 PM identified the facility policy directed residents as at risk for skin breakdown were to be turned and repositioned every 2-3 hours, provided with supplements and vitamins per registered Dietitian evaluation and recommendations, as well as other interventions like skin prep, lotions, heel boots and a low air loss mattress. She stated Resident #3's sacrum was initially identified on 1/31/26 as Moisture Associated Skin Damage (MASD) and was noted to progress to a stage 2 pressure injury on 2/7/26. The ADNS did not indicate during the interview why there was a lack of assessment or measurements on 2/7/26 for the sacral/coccyx stage 2 sacral pressure ulcer until 2/12/26. The ADNS identified that although the Resident Care Plan had been updated to encourage Resident #3 to turn and reposition on 1/26/26, the facility failed to obtain a physician order to alert the staff of the need to assist the resident until (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	2/12/26 (5 days after the sacral/coccyx pressure injury onset) but an order should have been obtained. Further, she was unable to identify documentation that Resident #3 had been turned and repositioned every 2-3 hours since the onset of the pressure ulcer on 2/7/26. The ADNS identified the area on Resident #3's heel was first identified on 1/26/26 as red, but blanchable, at which point skin prep and heel boot orders were initiated. Following the discovery of the red heels, monitoring occurred weekly during skin rounds performed by the unit nurses (previous review of the weekly skin check records dated 2/1/26, 2/8/26, 2/22/26, and 3/1/26 failed to identify Resident #3 had a skin alteration of the right heel). On 2/17/26 Resident #3's right heel was assessed by the wound MD and noted to be a deep tissue injury. Although the ADNS indicated she had been made aware that the resident kicked off the heel boots on 2/17/26 (10 days prior) she had not implemented any new measures to prevent further deterioration. Resident #3 had been followed by the Registered Dietitian who ordered Boost glucose control (supplemental drink for diabetics) but Resident #3 should have had additional nutritional supplements and vitamins to promote wound healing, adding that she thought about obtaining a pressure-reducing mattress for Resident #3 but that the wound doctor did not agree, however she was unable to provide documentation requesting or being denied an alternating pressure mattress by the wound MD. Interview and record review with the Regional Clinical Registered Nurse (RN) #3 on 2/27/26 at 1:30 PM identified in addition to the interventions already discussed by the ADNS that could have been implemented, residents, such as Resident #3, who were clinically compromised due to wounds, weight loss, and at risk for pressure ulcer development over bony prominences, should have an alternating pressure mattress/low air loss mattress put in place as a nursing measure, as well as being referred to Occupational Therapy for evaluation of positioning. RN #3 added once it was identified that Resident #3's was not compliant with the heel boots, new interventions such as placing the residents heels up on a wedge could have been implemented, adding that all interventions listed should have been instituted. RN #3 was unable to identify why no further measures had been put in place once it was known Resident #3 was kicked off the offloading foam heel boots. Additionally, RN #3 indicated that it was facility policy to perform Braden scale assessments upon admission/ readmission, quarterly, annually and with a change of condition. Review of Resident #3's clinical record with RN #3 failed to identify that Resident #3 had any Braden scale assessments conducted except for the assessment conducted on 2/12/26 which was completed upon determination that Resident #3 had a sacrum/coccyx pressure ulcer that had developed on 2/7/26 Interview and record review with the Registered Dietitian (RD) on 3/2/26 at 10:25 AM identified the facility policy to promote wound healing included adding extra protein, first assessing food then supplements and vitamins as well as calculating the resident's nutritional needs. The RD identified she was aware Resident #3 had wounds by attending the weekly at risk meetings, and he/she was discussed weekly. A review of Resident #3's clinical record with the RD identified a weight of 107 lbs. on 11/26/25 and a weight of 96 lbs. on 3/1/26, an 11 lbs. 10.28 % weight loss in 3 months which indicated a severe weight loss. Her intervention was put in place on 2/13/26 increasing the Boost glucose from 2 to 3 times daily and as needed if meals were refused, however, review of the clinical record failed to identify an order or documentation to alert staff to give Boost glucose if Resident #3 refused his/her meal. The RD identified that for a compromised resident who had severe weight loss and wounds there should have been additional interventions initiated such as high calorie protein shakes, vitamins, and Resident #3 should have been discussed with the team more thoroughly to promote wound healing. Subsequent to surveyor inquiry Resident #3's clinical record identified physician's orders directing to (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	turn and reposition the resident every 4 hours while awake, a Liquid Protein Supplement Sugar Free Oral Liquid (Nutritional supplement) give 30 ml in the morning daily, Pro-stat Advanced Wound Care oral liquid 30 ml once daily to promote wound healing, vitamin C 500 mg 2 times a day for wound healing, Zinc Sulfate 220 mg once daily to promote wound healing, and a pressure relieving mattress set to weight. 2. Resident #11's diagnoses included severe protein calorie malnutrition, diabetes with neuropathy, and retention of urine. The admission Minimum Data Set assessment dated [DATE] identified Resident #11 had a Brief Interview for Mental Status score of 14 indicating no cognitive impairment and was totally dependent on staff for hygiene, dressing, toileting, and bed mobility, and had lower extremity limitation in range of motion on one side. Resident #11 required an indwelling urinary catheter and had a stage 4 pressure ulcer (severe wound exposing muscle, tendon, and bone) and 2 unstageable (full thickness wounds of indeterminate depth due to obscuring by slough: non-viable tissue) and was at risk for developing further pressure ulcers. a. The Resident Care Plan dated 10/30/25 identified indwelling urinary catheter due to a recent history of urinary retention and placement of foley while in the hospital. Interventions included provide catheter care daily and as needed, observe for signs and symptoms of discomfort with urination and frequency, observe and document pain or discomfort due to catheter, change the urinary drainage bag monthly and as needed. The Resident Care plan failed to include anchoring the indwelling urinary catheter to prevent pulling. The NA care card (directs care) directed float heels, observe for any new areas of skin breakdown catheter care daily and as needed. A nurse's note dated 11/7/25 at 5:38 PM identified Resident #11 had an excoriated area to the tip of the penis, the catheter was noted to be pulling, a new physician order to schedule a follow up with urology was obtained. The nurse's note failed to include further assessment or measurement of the area. A nurse's note dated 11/7/25 at 7:04 PM identified notification by a NA that Resident #11 had a tear at the tip of his penis due to the catheter pulling. The supervisor was notified. The area was cleansed and Triad ointment was applied. A new leg clip (decreases pressure from pulling the urinary catheter tubing away from the insertion site) was applied, and slack given on tube to eliminate further injury. The nurse's not failed to include further assessment or measurement of the area. A nurse's note dated 11/8/25 at 11:51 PM identified Resident #11 had a laceration to the penis observed with the presence of pus. The provider on call was notified, and an order was obtained to send Resident #11 to the Emergency Room. The nurse's note failed to include further assessment or measurement of the area. A readmission Nursing Assessment and nurse's notes from readmission dated 11/14/25 at 4:53 PM and nurses notes dated 11/14/25 through 11/17/25 at 6:53 AM failed to identify Resident #11 had a wound on his/her penis. Review physician orders from readmission on [DATE] through 11/17/25 failed to direct a treatment for the penis skin alteration until on 11/17/25 a physician's order directed to cleanse tip of penis with (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	normal saline followed by Triad ointment every shift for excoriation and ensure that catheter was anchored to the thigh to prevent pulling and excoriation to the tip of the penis every shift for foley catheter care. A wound physician note dated 11/18/25 identified an initial evaluation of a stage 3 full thickness pressure wound to the penis measuring 1.2 cm length, 1 cm width, 0.5 cm depth and that the wound was a medical device (indwelling urinary catheter) associated pressure injury. A physician's order dated 11/20/25 directed mupirocin ointment 2% apply to tip of penis topically 2 times a day for open area to penis. A wound physician note dated 11/25/25 identified a stage 3 pressure wound to penis: full thickness 1 cm length, 0.8 cm width, 0.5 cm depth and treatment mupirocin 2% apply twice daily for 23 days. A nurse's note dated 11/27/25 at 11:18PM identified Resident #11 had redness and swelling to the tip of the penis. A wound physicians note dated 2/3/26 identified Resident #11's stage 3 pressure wound on the penis was resolved. Interview and record review with Assistant Director of Nursing (ADNS) on 2/26 at 2:00 PM identified she did not know how the pressure ulcer on the penis was first identified or how it would have developed. b. a. The Resident Care Plan dated 10/30/25 identified a left lateral plantar (sole) foot ulcer, stage 4, an unstageable left heel ulcer, a left plantar medial foot, diabetic ulcer, and a chronic left plantar foot ulcer had reopened. Interventions included keeping the skin clean and dry, offload the wound, wound physician visits as needed, report changes of discoloration to the area, pain, location, type, frequency and intensity, notify the physician of new, increased discoloration, pain, or if an intervention was ineffective. The NA care card (directs care) indicated to float (eliminate pressure) heels, observe for any new areas of skin breakdown. A wound physician note dated 11/5/25 identified Resident #11 had a left heel full thickness stage 4 pressure ulcer measuring 4.3 centimeters (cm) length, 4 cm width, 0.3 cm depth, and that the area had improved. A nurse's note dated 11/6/25 at 10:17 PM identified Resident #11 had a left heel pressure ulcer injury unstageable acquired in house, unknown how long it had been present, and was staged by the healthcare provider. A nurse's note dated 11/8/25 at 11:51 PM directed Resident #11 be sent to the Emergency Room. A nurse's notes dated 11/14/25 at 4:53 PM and nurse's notes through 11/17/25 at 6:53 AM failed to identify Resident #11 had any wounds. A physician's order dated 11/14/25 directed heel boots applied while in bed for protection, every shift, offload heels while in bed around the clock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of the facility weekly pressure injury report dated 2/17/26 identified Resident #11 with a community acquired stage 4 pressure ulcer to the left heel with an onset date of 9/30/25. Observation and interview with the ADNS and LPN #2 on 2/27/26 at 8:30 AM of Resident #11's left heel dressing change, identified his/her heels resting on the mattress without the benefit of heel boots or offloading. Resident #11's heel boots were approximately 5 to 6 feet from the resident's bed by the dresser. The ADNS indicated that Resident #11 kicked the heel boots off and LPN #2 indicated Resident #11 refused to wear the heel boots at times. Although both the ADNS and LPN #2 indicated kicking the boots off and refusals, they did not indicate why Resident #11 failed to have his/her heels offloaded off of the mattress and failed to have any alternate offloading device present in the bed or surrounding area. LPN #2 indicated that Resident #11 should have had his/her heels offloaded. Review of the clinical record, nursing notes and administration records from 11/8/25 through 2/27/26 failed to identify that Resident #11 had been refusing his/her heel boots. Interview with MD #1 on 2/27/26 at 3:00 PM identified that the pressure ulcer on the penis was a medical device pressure ulcer caused by the urinary catheter, likely from the weight of the drainage bag. Resident #11's urinary catheter tubing pulled on the penis and caused an opening. MD #1 further indicated that catheters should be anchored to the thigh for the prevention of pulling and/or pressure ulcer development but was unable to recall if Resident #11 had been using a urinary catheter leg anchor for prevention. MD #1 also indicated that Resident #11 should have been wearing heel boots or should have had his/her heels offloaded while in bed. Observation on 3/2/26 at 6:34 AM identified Resident #11 was without the benefit of heel boots or heels offloaded while in bed and heel boots remained on the floor beside the dresser. Observation on 3/2/26 at 6:59 AM identified Resident #11 was without the benefit of heel boots or heels offloaded while in bed. Resident #11 identified that the boots were not worn and heels were not offloaded. Interview and observation with LPN #2 on 3/2/26 at 7:15 AM identified that Resident # 11 was without the benefit of heel boots while in bed and the heels were against the mattress. LPN #2 could not explain why Resident #11 did not have the benefit of heel boots or offloading. Interview with RN #3 (Director of Clinical Services) on 3/2/26 at 11:35 AM identified that Resident #11's pressure ulcer to the penis should have been identified and documented on his/her readmission on [DATE]. Further, the facility had a system of chart checks upon admission/readmission that should have identified both the area of the penis and the left heel if the areas had not been noted on readmission. A review of Prevention of Pressure Ulcers/Injuries policy dated 2/26/2020 directed, in part, assesses the resident on admission within 8 hours for existing pressure ulcer/injury risk factors. Conduct a comprehensive skin assessment upon admission including skin integrity: any evidence of existing or developing pressure ulcers or injuries, tissue tolerance: the ability of the skin and supporting structures to endure the effects of pressure and areas of impaired circulation due to pressure from positioning or medical devices. Use pillows, wedges, or other off-loading devices to keep bony prominences such as knees or ankles from touching each other. When in bed, every attempt should be made to float heels (keep heels off bed) by placing a pillow from knee to ankle or with the devices as recommended by the physician. That skin should be kept free from moisture, nutritional supplements (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	should be included in the resident's diet to increase calories and protein, repositioning should occur at least every 2 hours, provide appropriate support services based on the resident's mobility, continence, skin moisture, body size, weight and overall risk factors. Review the interventions and strategies for effectiveness on an ongoing basis. A review of the Pressure Ulcer/Injury Risk Assessment policy, directed in part, if the resident refused the treatment, document the reason for the refusal and the resident's response to the explanation of the risk of refusing the procedure, and the benefits of accepting any available alternatives. Document family and physician notification of refusal. Observations of anything unusual exhibited by the resident. That certain risk factors increase a resident's susceptibility to develop and heal a pressure ulcer/injury but are not limited to under nutrition, malnutrition, impaired/decreased mobility, exposure of skin to urinary and fecal incontinence, comorbidities such as renal disease and diabetes, cognitive impairments and resident refusal of certain aspects of the treatment. A risk assessment should be completed immediately after admission then weekly for 4 weeks. According to the pressure ulcer/skin breakdown protocol the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, and the nurse shall describe and document a full assessment of the pressure sore (ulcer) including locations, stage, width, depth, and presence of exudate and necrosis. Review of the Skin Prevention Care Policy dated 12/15/16 directed in part it was policy to identify residents who were at risk of skin breakdown and provide interventions to prevent skin breakdown whenever possible. Additionally, residents will be assessed on admission, readmission, quarterly and with change of condition and nursing measures will be instituted based on the risk assessment. Review of the Nutritional Assessment policy directed, in part, that the dietitian estimates calorie, protein, nutrient and fluid needs. A review of the Catheter Associated Meatal Pressure Injury in men from the clinical leadership program identified a number of different terms used to describe meatal injuries including iatrogenic hypospadias, penile cleft, ulceration of penis, broken urethra and penile erosion. ([NAME] et al 2022) Iatrogenic hypospadias is described as a preventable injury to the ventral male urethra, produced by the downward pressure of an indwelling urethral catheter ([NAME] et al, 1998) [NAME] and colleagues (2018) classified iatrogenic hypospadias into 4 types. Munien and colleagues (2024) built on this and other work including that of Shenhar et al (2020) to develop one term- catheter associated meatal injuries and a grading system for both male and female pressure injuries. Male catheter associated meatal injuries are divided into 4 grades, defined by the most proximal anatomical extent of the pressure injury.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record and policy reviews for 1 of 4 sampled residents (Resident #3) reviewed for nutrition, the facility failed to initiate timely interventions to prevent ongoing significant weight loss. The findings include: Resident #3's diagnoses included muscle weakness, diabetes, and dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status (BIMS) of 4 indicating severe cognitive impairment and required set up help for eating and supervision with personal hygiene and toileting. Additionally, the MDS identified Resident #3 weighed 121 pounds (lbs.), with no known weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status of 5 indicating severe cognitive impairment, required set-up help for eating and was totally dependent on staff for personal hygiene, toileting and transfers. Additionally, the MDS identified Resident #3 weighed 99 pounds (lbs.), had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and was not on a physician prescribed weight loss regimen. The Resident Care Plan in effect from 7/14/25 through 2/25/26 identified Resident #3 had a nutritional problem or potential nutritional problem, and was at risk for malnutrition, due to dementia, diabetes, chronic kidney disease, congestive heart failure, poor intake. Interventions included Registered Dietician (RD) consultation and follow up, Occupational Therapy (OT) screen as needed, and supplements as ordered. Review of Resident #3's weight identified the following:113.8 lbs. on 7/14/25,111lbs on 8/4/25,109.5 lbs. on 9/1/25107.2 lbs. on 10/3/25,107 lbs. on 11/26/25,102.2 lbs. on 12/3/25,99.2 lbs.1/1/26,98.8 lbs. on 1/13/26 showing a weight loss of 15 lbs. (13.18%) in 6 months.98 lbs. on 2/3/26,96 lbs. on 3/1/26. (a 12.33%, 13.5 lb. weight loss in the last 6 months).Review of Dietitian #3's (previous dietitian) admission Nutritional assessment dated [DATE] at 9:57 AM identified Resident #3 was receiving Boost Glucose control (a nutritional diabetic supplement) 240 milliliters (ml) twice daily and nutritional interventions included continuing a regular texture diet, continue to monitor the need for a therapeutic diet related, continue Boost Glucose control 240 milliliters (ml) twice daily, add fortified cereal with breakfast and pudding with lunch and dinner. Resident #3 had poor intakes overall since admission, maybe related to acclimation to new environment and confusion related to dementia. Boost Glucose control 240 ml twice daily was added to promote adequacy, will also provide fortified pudding and cereal. A therapeutic diet was not indicated at this time related to quality of life.Review of Dietitian #3's quarterly Nutritional assessment dated [DATE] at 2:39 PM identified Resident #3 had fair intake of meals between 50 and 100%, nutritional interventions included continuing the regular diet, Boost Glucose twice a day, fortified pudding twice a day, fortified cereal once a day and deferring to the MD for blood sugar management. Review of Dietitian #1's (new dietitian) quarterly Nutritional assessment dated [DATE] at 10:33 AM identified Resident #3 had nutritional interventions, to discontinue the regular diet and provide a Consistent Carbohydrate diet (CCHO therapeutic diabetic) diet, monitor weights, intakes, medication and labs, defer to MD for blood sugar management, continue Oral Nutritional Supplement (ONS/Boost Glucose and fortified cereal). The note failed to indicate Resident #3 was still receiving fortified pudding twice daily.Review of Dietician #1's Comprehensive Nutritional assessment dated [DATE] at 4:10 PM identified Resident #3 had a current weight of 109.5 lbs. with a goal weight greater than 109.5 lbs., was receiving Boost Glucose twice a day and was independent for meals, weight trending down slightly but considered stable in 6 months, tolerating current diet order and eating sandwiches with some parts of the meal. Nutritional goals were identified as nutritional intake greater than or equal to 50% of meals and fluid and to remain free from significant weight loss. Nutritional interventions were to provide diet as ordered, monitor intake, diet tolerance, weights, labs and medications as ordered. The note failed to indicate Resident #3 was still receiving fortified pudding twice daily or fortified cereal once daily.Review of (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Dietitian #1's Comprehensive Nutritional assessment dated [DATE] at 4:10 PM identified Resident #3 had a current weight of 102.2 lbs. with a goal weight greater than 102 lbs., was receiving Boost Glucose 2 times a day and was independent for meals. Nutritional risk was identified as a weight loss of 12.8 lbs., (12.5%) in 6 months with occasional meal refusals, nutritional goal was to maintain adequate nutritional intake of meals and fluid and to remain free from significant weight loss, awaiting reweight for further interventions. Nutritional interventions were to provide diet as ordered, adjust order to finger foods as available, monitor intake, diet tolerance, weights, labs, and medications as ordered. (Resident #3's reweight was not repeated until the weekly weight was taken on 12/9/26) The note failed to indicate Resident #3 was still receiving fortified pudding twice daily or fortified cereal once daily.Review of the quarterly Nutrition Assessment and Nutrition progress note dated 1/15/26 identified Resident #3 was on a diabetic diet, receiving Boost Glucose 240 ml twice a day, independent with meals and nutritional interventions were to provide a diabetic diet for blood sugar management, monitor weights, intake, labs and medications as ordered with referral to the nutrition progress note for more information. Additionally, Resident#3 had been hospitalized on [DATE] to 11/26/25 and had a decline in intakes with a decrease of 15 lbs. from 7/14/25 with a change of 15.18% in 6 months. Weight had been maintained in the 98 to 99 lb. range for 1 month, weight gain would be beneficial, and the resident's current weight was 98.8 lbs. Resident #3 mostly consumed fluids with varied takes. Oral nutrition supplement order remained appropriate for adequacy, will continue to monitor weights, intakes, pertinent medications/labs. The note failed to indicate Resident #3 was still receiving fortified pudding twice daily or fortified cereal once daily.Review of physician's orders from 4/30/25 until 2/13/26 failed to identify any change in the residents nutritional supplements from Boost Glucose 240 ml twice daily and failed to direct Resident #3 was to receive fortified pudding or fortified cereal.Physician's order in effect from 7/31/25 to 2/27/26 directed a Consistent Carbohydrate Diet (CCHO, diabetic diet) regular consistency with thin liquids and to provide sandwiches and finger foods as needed. (Physician's orders were changed from receiving a regular diet to a therapeutic CCHO diabetic diet despite Dietitian #1's statement that a therapeutic diet was not indicated at this time related to quality of life.)A physician's order dated 2/13/26 directed to administer Boost Glucose control 240 ml 3 times a day for nutritional supplementation. (increased from twice daily).Observation on 2/27/26 at 12:06 PM identified Resident #3 in bed, with a lunch served consisting of kielbasa, carrots and roasted potatoes. Resident #3 did not attempt to eat independently and refused to eat when Nurse Aid (NA) #2 came to assist. Additionally, Resident #3 declined multiple offers to obtain a sandwich. Interview and meal ticket review with NA #2 on 2/27/26 at 12:11 PM identified Resident #3 was independent for meals but sometimes needed assistance due to lethargy and although she could eat the meal provided, she preferred sandwiches. Review of Resident #3's lunch meal ticket with NA #2 identified he/she was a regular texture and special instructions stating, likes ham and cheese sandwiches, provide sandwiches and finger food as needed, but failed to indicate Resident #3 should be provided with finger foods or sandwiches on a regular basis or with meals.Interview and meal ticket review with the Dietary Director on 2/27/26 at 1:45 PM identified staff picked the meals for residents that could not choose themselves, and any allergies, aversions and special preferences would be noted on the meal ticket. Review of Resident #3's meal ticket with the Dietary Director identified that Resident #3 was currently receiving a CCHO diet and failed to indicate the resident was receiving fortified cereal or fortified pudding. Although Resident #3's meal ticket indicated he/she likes ham and cheese sandwiches, provide sandwiches and finger food as needed, it did not specify to send sandwiches or finger foods as a replacement or in addition to a meal on a daily basis and staff had to call the kitchen to request sandwiches or finger foods for Resident #3 if needed.Interview and record review with the Registered Dietitian, Dietitian #1, on 3/2/26 at 10:25 AM identified the facility policy directed her to evaluate residents on admission, readmission, quarterly, if they had a significant change, and if she noticed anyone was struggling with nutrition or with eating. Dietitian #1indicated Resident #3's weight was 107 lbs. on 11/26/25 and 96 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	lbs. on 3/1/26, which indicated a significant weight loss of 11 lbs. (10.28 %) in 3 months. She stated she was aware of the weight loss through attending weekly at risk meetings. Dietitian #1 identified that she had first identified Resident #3's weight loss on 1/11/26 at which time the resident weighed 99 lbs. a significant weight loss of 8.0 lbs. (7.4%) in 1 month. After identifying Resident #3's significant weight loss on 1/11/26 she recommended interventions to provide finger foods/sandwiches, encourage the resident to eat meals out of bed, provide Boost Glucose supplement twice daily and as needed for meal refusals. Further, Resident #3 weighed 109.5 lbs. on 9/1/25 and 96 lbs. on 3/1/26 which was a 13.5 lb. (12.3%) significant weight loss in 6 months. Although the Dietitian indicated after determining Resident #3's weight loss on 1/11/26, she had placed Resident #3 on Boost Glucose twice daily, the resident had been given Boost Glucose twice daily since Dietitian #1's admission Nutritional assessment dated [DATE]. Additionally, Dietitian #1 indicated that she had also started sandwiches and finger foods in response to the identified weight loss on 1/11/26, however, the order for sandwiches and finger foods had been in place since 7/31/25. Interview and record review with Registered Nurse (RN) #4 on 3/2/26 at 12:19 PM identified Resident #3 was independent for meals, had eaten half a ham and cheese sandwich for lunch and had an order for Boost Glucose supplement 3 times per day. RN #4 was unable to find an order or nursing measure directing staff to provide a Boost Glucose supplement if his/her meal was refused (50 days after a recommendation had been given according to Dietitian #1).Interview and at-risk meeting minutes review with Dietitian #1 on 3/3/25 at 11:06 AM identified that although she was aware of Resident #3's weight loss, which was identified as significant, the only intervention put in place to prevent weight loss was an increase in Boost Glucose to 3 times a day on 2/13/26 (33 days after the significant weight loss was identified). Dietitian #1 could not identify why she did not institute more interventions for the prevention of further significant weight loss.Subsequent to surveyor inquiry Resident #3's clinical record identified physician's orders were put in place for LPS Sugar Free Oral Liquid (Nutritional supplement) give 30 ml in the morning daily, Pro-stat Advanced Wound Care Oral liquid 30 ml once a day, Vitamin C 500mg twice a day and , Zinc Sulfate 220 mg 1 cap once a day.Review of the undated facility RD assessment criteria for severe protein calorie nutrition identified it as an unplanned weight loss greater than 5% in 1 month, 7.5% in 3 months, 10 % in 6 months and 20% in 1 year.Review of the Nutritional Assessment Policy directed in part that the nutritional assessment will be a systemic, multidisciplinary process that includes gathering and interpreting data, and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition.Review of the Weight Measurement Policy dated 12/2/16 directed in part that a significant weight change of 5% in 30 days, 7.5% in 90 days, or 10 % in 90 days required a weight reweight in 24 hours. Additionally, a weight variance must be reported to the provider.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record, and policy reviews for 2 of 3 sampled residents (Resident #15 and Resident #40) reviewed for abuse, the facility failed to ensure a resident was free from physical abuse. The findings include:1. Resident #15's diagnoses included vascular dementia with behaviors, schizophrenia and paranoid personality disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 had a Brief Interview of Mental Status of 9 indicating moderate cognitive impairment and was independent for eating, transferring, and changing position. Additionally, the MDS identified Resident #15 had no potential indicators of psychosis.The Resident Care Plan dated 1/28/26 identified Resident #15 had a potential for behaviors related to a diagnosis of dementia, paranoia, delusions, a history of physical aggression and a resident to resident altercation (6/1/25). Interventions included approaching the resident in a calm manner, documenting behaviors and following up with psychiatry.Review of the psychiatry APRN progress note dated 2/10/26 identified Resident #15 was seen as a regular follow up due to a diagnosis of schizophrenia and dementia, presenting with a stable mood and no reports by nursing staff of behavioral disturbances, aggression, or unsafe behaviors.2. Resident #40's diagnoses included unspecified dementia, bipolar II disorder, and anxiety.The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and was independent for eating, changing position, and required partial/moderate assistance for transfers. Additionally, the MDS identified Resident #40 had no potential indicators of psychosis.The Resident Care Plan dated 11/19/25 identified Resident #40 was at risk for mood/behaviors due to a diagnosis of anxiety and depression, rummaging, anger, yelling at staff, increased delusions and confusion. Interventions included evaluations by psychiatry services, observation for changes in mood /depression and encouragement to talk about problems.Review of the Psychiatry APRN progress note dated 2/13/26 at 4:00 PM identified Resident #40 was seen due to increased agitation, demonstrating stability in mood and behavior with no delusions, hallucinations or safety concerns identified at the time.a. Review of a nurse's note dated 6/1/25 at 10:29 PM identified Resident #15 allegedly grabbed her roommate's arm after an exchange of words.Review of the Reportable Event investigation dated 6/1/25 identified that Resident #15 had a BIMS score of 1. Upon interview of both residents, they denied physical contact but indicated that words were exchanged. There were no other witnesses to the altercation, only statements that residents were agitated were immediately separated from each other. The social worker and psychiatric services followed up with both residents, and they expressed no harm/emotional distress. There were no injuries on initial or subsequent assessments.Review of the psychiatry Advanced Practice Registered Nurse (APRN) note dated 6/1/25 at 10:10 PM identified Resident #15 was seen due to an alleged interpersonal issue and presented in a calm pleasant and cooperative manner during the interview and was not a danger to self or others.Review of the nurse's note dated 6/2/25 at 9:00 AM identified Resident #15 was spoken to regarding a heated discussion he/she had with a roommate. At the time Resident #15 felt the roommate did not belong in the room but was agreeable to having another roommate.Review of nurse's notes dated 6/2/25 to 2/23/26 failed to identify any resident to resident altercations.b. Verbal notification by the Administrator to surveyors on 2/24/26 at 12:54 PM identified there was a report of a resident to resident altercation between Resident #15 and Resident #40.Review of the nurse's note dated 2/24/26 at 1:04 PM identified Resident #15 admitted to grabbing his/her roommate, Resident #40, around the neck.Review of the facility Reportable Event form dated 2/24/26 identified that on 2/24/26 Resident #40 reported to a Nurse Aide (NA) that Resident #15 grabbed him/her around the neck. The investigation identified Resident #40 rolled to the thermostat in his/her wheelchair and adjusted the temperature, which appeared to trigger an altercation. Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#40 stated that Resident #15 grabbed his/her neck. The NA reported that Resident #15 admitted to putting her hands on Resident #40 and justified it by stating the resident had a foul mouth and deserved it. The roommate, Resident #46 witnessed Resident #15 place his/her hands on Resident #40's shoulders and confirmed an altercation occurred. During the investigation, both roommates felt the room placement was not appropriate for Resident #40, and Resident #40 was moved out of the room. The residents involved received 72 hour follow-up, and each reported feeling safe in their new rooms, including the roommate, Resident #46. No further incidents or concerns were identified.Review of the Psychiatry APRN progress note dated 2/24/26 at 2:36 PM identified Resident #15 was seen for follow up of a negative interaction with another resident, presented as pleasant, calm and engaged and the previous dose of Seroquel (an antipsychotic medication) would be resumed, noting the attempted gradual dose reduction had failed.Interview with Registered Nurse (RN) #4 on 2/24/26 at 1:43 PM identified he was the charge nurse on the unit where the resident-to-resident incident occurred, stating that although Resident #40 gets mad, loud and unpleasant with other residents and staff, even to him at times, in this scenario he/she was not the aggressor. Additionally, RN #4 stated Resident #15 who is usually very quiet was the aggressor and grabbed Resident #40's neck when he/she came to change the temperature setting on the heater, adding maybe Resident #15 just had enough of listening to Resident #40. The residents were immediately separated, and both were put under 1:1 observation at the time.Interview with Social Worker (SW) #1 on 2/25/26 at 11:01 PM identified Resident #15 and Resident #40 had a verbal disagreement over the temperature of the room that led to Resident #15 grabbing Resident #40 by the neck. Additionally, SW #1 identified Resident #40 had a feisty personality and although no issues were reported in the past with Resident #15 and Resident #40, the personalities were not a good match with resident #40 verbally initiating the disagreement that led to Resident #15 becoming physically aggressive. Subsequently both Residents were on 1:1 for 24 hours, cleared by psych and Resident #40 was being monitored for adjustment to a room change while Resident #15 stayed in the original room.Interview with NA #2 on 2/25/26 at 11:30 AM identified that Resident #40 was usually mild mannered, and there were no prior altercations between the 2 residents, and no indicators that the altercation would have occurred.Review of the Psychiatry APRN progress note dated 2/26/26 at 6:06 PM identified Resident #40 was seen due to an alleged incident with a peer, presented as calm, cooperative and engaged appropriately in conversation. Additionally Resident #40 reported feeling safe and denying any concerns?Resident #15 and Resident #40 both had Resident Care Plans indicating behavioral issues. Resident #15 had a history, per a past Reportable Event, of becoming agitated with others. According to RN #4 Resident #40, was known to get mad, loud and unpleasant with other residents and staff, even to him at times and according to SW #1, Resident #40 was known to have a feisty personality, and not a good match with Resident #15. Despite this, Resident #15 and #40 were deemed appropriate roommates leading to the physical altercation of Resident #15 grabbing Resident #40 around the neck.Review of the Abuse and Prohibition Policy revised 10/7/24 directed in part to maintain a zero-tolerance policy for any form of abuse or neglect of a resident by maintaining an environment free from abuse (verbal, physical, mental, psychological, or sexual), neglect, corporal punishment, involuntary seclusion, or misappropriation of property.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. F812 Kitchen Harbor TW finalBased on observations, staff interviews and review of facility documents, the facility failed to ensure expired food items were identified and appropriately discarded. The findings included:Observation, interview and facility document review with the Food Service Director on 2/27/26 at 10:04 AM of kitchen food storage identified the following items were expired:Deluxe pulled chicken with broth 48 ounce (oz) can,12 cans, best by 10/17/25Ocean Spray Orange Juice 32 oz bottle, 24 bottles, best by 12/15/25Beef stew 48 oz can, 6 cans, best by 2/22/26The Food Service Director identified that it was his responsibility to ensure that items were checked for expiration dates and that checks should occur monthly or when new stock arrived. He indicated that he was newly hired and did not check the emergency food supply for expiration dates, as he should have because he was informed that it was good to go.Subsequent to surveyor inquiry, the expired items were discarded by the Food Service Director.Although requested from the facility, a food storage policy was not provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and facility documentation during a review of the Infection Control Program, the facility failed to ensure the Registered Nurse overseeing the Infection Prevention Licensed Practical Nurse had an Infection Preventionist specialized training certificate. The findings included:Interview and document review on 2/26/26 at 11:15 AM with the Infection Prevention Nurse LPN #3 identified that although she was the Infection Control Nurse, and had a Nursing Home Preventionist certificate dated 4/17/22, the Director of Nurses, who was an RN oversaw her Infection Control Nurse Prevention role, but the Director of Nurses was out of the facility on an extended leave.Interview and document review with Regional Clinical Registered Nurse (RN) #3 on 3/2/26 at 11:30 AM identified that she was certified as a Nursing Home Infection Preventionist as of 12/17/21, and although she oversaw the facility infection prevention program, she did not directly oversee the Infection Prevention Nurse currently in the role, LPN #3. Additionally, RN #3 stated the DNS could not locate her certificate, identifying she re-completed the Nursing Home Infection Preventionist Training course and identified a certificate for the DNS dated 3/1/26, however, she was still not overseeing LPN #3.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interviews, review of the clinical record, and facility policy for 1 of 3 sampled residents (Resident #97) reviewed for smoking, the facility failed to provide access to the smoking activity per the residents choice. The findings include:Resident #97's diagnoses included chronic obstructive pulmonary disease, hyperlipidemia, and atherosclerotic heart disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #97 had a Brief Interview for Mental Status score of 13 indicating intact cognition, exhibited no signs or symptoms of delirium, and required substantial/maximal assistance with lower body dressing, required partial/moderate assistance with lying to sitting on the side of the bed, and substantial/maximal assistance to transfer from sitting to standing and chair/bed to chair transfers. The Resident Care Plan (RCP) in effect from 1/7/26 through 3/3/26 failed to identify a preference for smoking. An interview with the resident on 2/25/26 at 10:32 AM identified he/she smoked cigars and hadn't been able to smoke since his admission to the facility 1/7/26. Resident #97 identified he/she was not allowed to smoke due to the use of oxygen. Resident #97 indicated that he/she would like to have a cigar and was upset over being denied the opportunity to smoke. An interview with Registered Nurse (RN #1) on 3/3/26 at 9:23 AM identified the facility's process for assessing a resident's ability to smoke was to first find out if the resident was a smoker, or if they wanted to smoke upon admission. RN #1 indicated he, or the RN supervisor working at the time of a resident's admission to the facility, would perform a smoking evaluation which would determine if adaptive equipment was required as well as if a staff member was needed to assist the resident to smoke. RN #1 stated that the only limitation that would preclude a resident from participating in smoking if they desired, was exhibiting adverse behaviors and considered to be a risk to other residents. RN #1 identified residents were not required to have a physician order to participate in smoking groups, per the facility smoking policy. He indicated that Resident #97 had never been identified as a smoker due to not being evaluated or asked on admission if he/she would like to participate in the facility smoking activity. RN #1 stated that he had just performed Resident #97's smoking assessment the previous day, but he/she should have been given the opportunity on admission. A review of the facility policy for smoking directs, in part, that upon admission, residents and family members/responsible parties will be educated on the smoking policy and will sign an acknowledgement to adhere to the smoking policy. The policy also directs that a smoking assessment will be completed on smokers to ensure the functional ability to smoke safely, that a smoking assessment will be completed upon admission, quarterly, when a resident chooses to change their smoking decision, and with a change in resident condition. The smoking policy further directs if the resident is receiving oxygen, staff members will assist with removal of all oxygen equipment prior to entering the designated smoking area. Once the smoking session is completed the staff (will) escort residents out of the smoking area and assist in reapplying all oxygen equipment as ordered.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record and policy for 1 of 4 sampled residents (Resident #3), reviewed for nutrition, the facility failed to notify the provider of a severe weight loss of 13.5 pounds in 6 months. The findings include:Resident #3's diagnoses included muscle weakness, diabetes, and dementia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status (BIMS) of 4 indicating severe cognitive impairment and required set up help for eating and supervision with personal hygiene and toileting. Additionally, the MDS identified Resident #3 weighed 121 pounds (lbs.), with no known weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment, required set up for eating and was totally dependent on staff for personal hygiene, toileting and transfers. Additionally, the MDS identified Resident #3 weighed 99 pounds (lbs.), had a significant weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and was not on a physician prescribed weight loss regimen. The Resident Care Plan in effect from 7/14/25 through 2/25/26 identified Resident #3 had a nutritional problem or potential nutritional problem, and was at risk for malnutrition, due to dementia, diabetes, chronic kidney disease, congestive heart failure, poor intake. Interventions included Registered Dietician (RD) consultation and follow up, Occupational Therapy (OT) screen as needed, and supplements as ordered. Review of the nutrition note dated 1/15/26 at 3:57 PM identified Resident #3 had recent weight loss post hospitalization 10/21/25 to 11/26/25 related to behaviors. Resident #3 had a decline in intakes with a decrease of 15 pounds (lbs.) since 7/14/25 with a change of 15.18% in 6 months. His/her weight was maintained in the 98 to 99 lb. range for 1 month. Weight gain would be beneficial with a current weight of 98.8 lbs., and Resident #3 mostly consumed fluids with varied intakes. Oral nutritional supplement order remains appropriate for adequacy, will continue to monitor weights, intakes, and pertinent medications/labs.Interview and record review with Regional Clinical Registered Nurse (RN) #3 on 2/27/26 at 1:12 PM identified that the nutrition progress note dated 1/15/26 indicating Resident #3 was noted to have a significant weight loss of 15 lbs., a 15.18 % in 6 month loss. RN #3 identified that although it was the facility policy to update the provider on a change in status such as a weight loss, no one was updated but should have been.Interview and record review with APRN #1 on 3/3/26 at 10:29 AM identified it was facility policy for her to be updated on resident changes by reviewing concerns written down in the APRN/MD book located at the supervisor's desk, including notification of weight loss. Review of Resident #3's clinical record with APRN #1 identified on 1/15/26 the resident had a decline in intake with a decrease of 15 lbs. in 6 months (15.18%). APRN #1 identified she had not been notified of the significant weight loss and if she had been she would have monitored weights more closely, recommended protein shakes, and initiated a conversation with the family due to Resident #3's overall decline.Interview and at-risk meeting minutes review with the Dietitian #1 on 3/3/25 at 11:06 AM identified that she had been tracking Resident #3's weight loss and noted on 12/2/25 he/she has a 12.8 lb. (12.5%) weight loss in 6 months, and on 1/15/26 noted Resident #3 had a 15 lb. (15.18%) weight loss in 6 months. Dietitian #1 failed to identify that she updated the provider, stating she was under the impression that the APRN attended the at-risk meetings. Review of the at-risk meeting minutes dated 1/13/26-1/19/26, 1/20/26-1/26/26,1/27/26-2/2/26, 2/3/26-2/9/26 failed to identify the APRN was an attendee.Review of the Resident Change in Condition Policy revised 9/4/18 directed in part that all staff will communicate any information about resident change in condition to appropriate personnel, and notification of physician time and date are to be documented in the progress note.Review of the Weight Measurement Policy dated 12/2/16 directed in part that a weight variance must be reported to the provider.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and policy for 1 of 3 sampled residents, (Resident #47) reviewed for abuse, the facility failed to report an injury of unknown origin to the State Agency. The findings include: Resident #47's diagnoses included dementia with agitation, cognitive communication deficit, Parkinson's Disease with dyskinesia with fluctuations.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment, required partial/moderate for transfers from sitting to lying and lying to sitting on the side of the bed. The MDS also identified the resident required substantial/maximal assistance for transferring to/from the toilet and was fully dependent on staff for upper and lower body dressing, rolling left and right in bed, and transferring from sitting to standing as well as chair/bed to chair transfers. The Resident Care Plan (RCP) in effect from 1/7/26 through 3/3/26 identified Resident #47 had an Activity of Daily Living (ADL)/Mobility deficit. Interventions included assistance of 2 for toileting, dressing, bathing, and assistance of 2 with a mechanical lift for all transfers. An interview with Person #1 on 2/26/26 at 12:43 PM identified Resident #47 had an unwitnessed injury to the left side of his/her forehead on the morning of 2/18/26 resulting in a hematoma (large, raised, painful, firm collection of clotted blood lasting longer than a bruise). When staff notified Person #1 they indicated it was believed Resident #47 had hit his/her head on the headboard of the bed, due to intermittent episodes of dyskinesia (increased involuntary movements).A Reportable Event dated 2/18/26 identified at 7:00 AM, while Resident #47 was seated in his/her wheelchair at the nurse's station, an LPN had noticed a hematoma to the left side of the resident's forehead. The cause of the hematoma was unknown as no one had witnessed what happened to cause the hematoma. Staff concluded the resident had hit his/her head on the headboard of his/her bed inside the room earlier in the morning. An interview with the Assistant Director of Nursing (ADNS) on 2/26/26 at 1:20 PM identified after conferring with the Regional Clinical Director, Registered Nurse (RN) #3, and indicating to her the cause of the injury was able to be explained by dyskinesia, RN #3 stated the facility was still within the 24 hour State Agency time reporting window, therefore the injury did not need to be reported as an injury of unknown origin. The ADNS indicated that although the policy directed her to go back 72 hours to interview staff with access to Resident #47 to determine the cause of the injury, she had not done so and interviewed only the 2 Nurse Aid (NA) staff who had cared for the resident the shift prior. She indicated that she had not spoken to the unit nurse who had interacted with the resident minutes prior the initial report of the hematoma stating she forgot and also did not feel it was necessary based on the 2 interviews obtained by the NAs.An interview with the Regional Director of Clinical Services Registered Nurse (RN) #3 on 2/26/26 at 1:31 PM identified that Resident #47's injury to his/her forehead was not reported to the State Agency as she was under the impression that a complete and thorough investigation had been performed with the cause being known and due to dyskinesia and bumping his/her head. RN #3 indicated had she known the investigation was incomplete, she would have had the ADNS report Resident #47's injury to the State Agency within the 24 hour time frame and classified it as an injury of unknown origin.A review of the facility policy for abuse directs, in part that an injury of unknown source is when both of the following conditions are met: 1) the source of the injury was not observed by any persons or the source of the injury could not be explained by the resident, and 2) the injury is suspicious because of the extent of the injury or the location of the injury. It also directs that the time periods for reporting reasonable suspicion of a crime depends on the seriousness of the event that leads to the reasonable suspicion, and that if there is a result of serious bodily injury or not, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and in CT to the Department of Social Services within 24 hours after forming the suspicion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 residents, (Resident #47) reviewed for abuse, the facility failed to thoroughly investigate an injury of unknown origin. The findings include:Resident #47's diagnoses included dementia with agitation, cognitive communication deficit, and Parkinson's disease with dyskinesia with fluctuations.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 had a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment, required partial/moderate for transfers from sitting to lying and lying to sitting on the side of the bed. The MDS also identified the resident required substantial/maximal assistance for transferring to/from the toilet and was fully dependent on staff for upper and lower body dressing, rolling left and right in bed, and transferring from sitting to standing as well as chair/bed to chair transfers. The Resident Care Plan (RCP) in effect from 1/7/26 through 3/3/26 identified Resident #47 had an Activity of Daily Living (ADL)/Mobility deficit. Interventions included assistance of 2 for toileting, dressing, bathing, and assistance of 2 with a mechanical lift for all transfers. An interview with Person #1 on 2/26/26 at 12:43 PM identified Resident #47 had an unwitnessed injury to the left side of his/her forehead on the morning of 2/18/26 resulting in a hematoma (large, raised, painful, firm collection of clotted blood lasting longer than a bruise). When staff notified Person #1 they indicated it was believed Resident #47 had hit his/her head on the headboard of the bed, due to intermittent episodes of dyskinesia (increased involuntary movements).A Reportable Event and investigation dated 2/18/26 identified at 7:00 AM, while Resident #47 was seated in his/her wheelchair at the nurse's station, an LPN noticed a hematoma to the left side of the resident's forehead. The cause of the hematoma was unknown as no one had witnessed what happened to cause the hematoma. The 2 NA statements were inconclusive, indicating an assumption Resident #47 had hit his/her head on the headboard of the bed inside the room earlier in the morning.An interview with the Assistant Director of Nursing (ADNS) on 2/26/26 at 1:20 PM identified after conferring with the Regional Clinical Director, Registered Nurse (RN) #3, and indicating to her the cause of the injury was able to be explained by dyskinesia, RN #3 stated the facility was still within the 24 hour State Agency time reporting window, therefore the injury did not need to be reported as an injury of unknown origin. The ADNS indicated that although the policy directed her to go back 72 hours to interview staff with access to Resident #47 to determine the cause of the injury, she had not done so and interviewed only the 2 Nurse Aid (NA) staff who had cared for the resident the shift prior. She indicated that she had not spoken to the unit nurse who had interacted with the resident minutes prior the initial report of the hematoma stating she forgot and also did not feel it was necessary based on the 2 interviews obtained by the NAs.An interview with the Regional Director of Clinical Services RN #3 on 2/26/26 at 1:31 PM identified that Resident #47's injury to his/her forehead was not reported to the State Agency as she was under the impression that a complete and thorough investigation had been performed with the cause being known and due to dyskinesia and bumping his/her head. RN #3 indicated had she known the investigation was incomplete, she would have had the ADNS report Resident #47's injury to the State Agency within the 24 hour time frame and classified it as an injury of unknown origin.Review of the abuse policy identified that a thorough investigation of alleged abuse or neglect would be conducted by the Administrator and/or Director of Nursing to determine if the conduct of the individual is in violation of any standard of care.

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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** Based on observations, interviews, record and policy reviews for 2 of 3 residents (Resident #40 and Resident #97) reviewed for smoking and 1 of 6 residents (Resident #51) reviewed for accidents, the facility failed to perform assessments per the facility policy. The findings include:1. Resident #40's diagnoses included unspecified dementia, Bipolar II Disorder, and anxiety. The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had a Brief Interview of Mental Status (BIMS) of 8 indicating moderate cognitive impairment and was independent for eating, changing position, requiring partial/moderate assistance for transfers, and currently used tobacco. The Resident Care Plan dated 2/25/24 identified Resident #40 was a current smoker. Interventions included observation of smoking safety and use of a smoking apron. A physician's order dated 9/8/25 directed that Resident #40 may participate in the supervised smoking program per the facility policy. Interview and record review with the Assistant Director of Nurses (ADNS) on 3/3/26 at 9:23 AM identified it was the facility policy for nurses to perform smoking evaluations on admission, readmission, quarterly, and with a change in condition. Review of resident #40's clinical record identified that he/she was currently a smoker, had smoking assessments completed on 7/4/24, 11/4/25, and 2/2/26 but was missing 4 smoking evaluations during that time period. The ADNS could not identify why the facility failed to perform smoking assessments on a resident who was currently allowed to smoke. 2. Resident #51's diagnoses included dementia with psychotic disturbances, delusional disorders and frontotemporal neurocognitive disorder. The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 had a Brief Interview of Mental Status (BIMS) of 6 indicating severe cognitive impairment, was independent for changing positions and transfers but did not exhibit wandering. The comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 had a Brief Interview of Mental Status of 00 indicating severe cognitive impairment, was independent for changing positions and transfers, and exhibited wandering behaviors daily, with the wandering identified as same compared to the prior assessment. The Resident Care Plan dated 6/3/24 through 2/27/26 identified Resident #51 was at risk for elopement, was cognitively impaired and was independently mobile. Interventions included verifying placement and function of an elopement device as ordered, monitor for tailgating when visitors were moving throughout facility, and use verbal cues to minimize exit seeking. A physician's order dated 9/2/25 directed staff to check the elopement device placement to the left wrist every shift. Observation of Resident #51 on 2/27/26 at 9:25 AM identified he/she had a wander guard applied on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the left wrist. Review of the undated Resident Care Card directed staff to check Resident #3 for elopement device placement to the left wrist, monitor for tailgating when visitors were in the facility and use verbal cues to minimize exit seeking. Interview and record review with Regional Clinical Registered Nurse (RN) #3 on 2/27/26 at 1:34 PM identified it was the facility policy for nurses to complete wander/elopement assessments on admission, quarterly, annually and with a change in condition. Review of Resident #51's clinical record with RN #3 identified he/she had elopement assessments completed on 7/8/24, 10/14/25 and 1/13/26. Additionally, RN #3 identified that an additional 4 elopement assessment should have been completed between 7/2024 and 10/2025 but could not identify why the elopement assessments were not completed for a resident who was identified as exhibiting wandering behaviors. Review of the Wandering/Unsafe Resident Policy directed in part that staff will assess individuals for possible correctible risk factors related to unsafe wandering. 3. Resident #97's was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, hyperlipidemia, and atherosclerotic heart disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #97 had a Brief Interview for Mental Status score of 13 indicating intact cognition, exhibited no signs or symptoms of delirium, and required substantial/maximal assistance with lower body dressing, required partial/moderate assistance with lying to sitting on the side of the bed, and substantial/maximal assistance to transfer from sitting to standing and chair/bed to chair transfers. Additionally, the MDS identified he/she was a non-smoker. The Resident Care Plan (RCP) in effect from 1/13/26 through 3/3/26 failed to identify Resident #97 currently smoked or desired to smoke. An interview with Resident #97 on 2/25/26 at 10:32 AM identified he/she smoked cigars and hadn't been allowed to smoke due to the use of oxygen while residing at the facility since his admission on [DATE] (55 days). Resident #97 indicated he/she was upset and would like to be able to enjoy a cigar stating he had told everyone but was unable to recall any staff names. An interview with Registered Nurse (RN #1) on 3/3/26 at 9:23 AM identified upon admission all residents were asked if smoking would be requested and had a smoking assessment completed per the facility process. RN #1 indicated he, or the RN supervisor working at the time of a resident's admission to the facility, would perform a smoking evaluation which would determine if adaptive equipment was required as well as if a staff member was needed to assist the resident to smoke. RN #1 indicated that Resident #97 had never been asked on admission or identified as a smoker due to never having a smoking assessment completed. RN #1 stated that he had just performed Resident #97's smoking assessment the previous day 3/2/26 (55 days after admission), but he/she should have been asked and given the opportunity to smoke on admission. Review of the Smoking Policy revised 10/11/23 directed in part that a smoking assessment will be completed upon admission, quarterly, when a resident chooses to change their smoking decision and with a change in condition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, review of clinical records and policy for 2 of 3 residents (Resident #8 and #93) reviewed for respiratory care, the facility failed to ensure a resident receiving oxygen had a physician's order for oxygen and failed to ensure oxygen administration was set according to the physician order. The findings include:1. Resident #8's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), acute pulmonary edema, and anxiety disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Interview of Mental Status score of 15 indicating normal cognitive function, and was independent for oral hygiene, personal hygiene and transfers.The Resident Care Plan (RCP) dated 1/8/26 identified Resident #8 had COPD related to smoking. Interventions included monitoring difficulty breathing and elevating the head of bed or assist to an upright position in a chair during episodes of difficulty breathing.Observation on 2/25/26 at 11:05 AM identified Resident #8 lying in bed wearing a nasal cannula with the head of the bed elevated and being administered oxygen at 2 liters per minute.Review of Resident #8's physician's orders failed to identify an order for oxygen administration.Observation on 2/26/26 at 11:30 AM identified Resident #8 was lying in bed with the head of bed elevated wearing a nasal cannula and being administered oxygen at 2 liters per minute.2. Resident #93's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and muscle weakness.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #93 had a Brief Interview of Mental Status score of 14 indicating normal cognitive function, and was independent for oral hygiene, personal hygiene and transfers.The Resident Care Plan (RCP) dated 3/5/26 identified Resident #93 had an altered respiratory status related to Chronic Obstructive Pulmonary Disease (COPD). Interventions included administering oxygen as ordered.A physician's order dated 1/14/25 for Resident #93 directed to administer continuous oxygen at 2 to 4 liters per minute via nasal canula to keep oxygen saturation level greater than 92 percent (%).Observation on 2/24/26 at 11:46 AM identified Resident #93 was lying in bed wearing a nasal canula with the head of the bed elevated being administered oxygen at 5 liters per minute.Observation on 2/26/26 at 11:11 AM identified Resident #93 was lying in bed with head of bed elevated wearing a nasal cannula and being administered oxygen at 5 liters per minute.Interview and observation with LPN #1 on 2/26/26 at 11:43 AM identified that oxygen administration should be set according to the physician's order and that it was the responsibility of the assigned nurse to ensure that it was set correctly. LPN #1 indicated that she checks the resident's oxygen administration setting numerous times a shift and that she had checked Resident #8's and Resident #93's when her shift started. LPN #1 identified that Resident #8 was lying in bed wearing a nasal canula on and his/her oxygen administration was set at 2 liters per minute, but he/she lacked a physician's order for oxygen indicating she was used to Resident #8 using oxygen prior to his/her being hospitalized . LPN #1 indicated that she should have checked the clinical record to ensure there was a physician order to administer Resident #8's oxygen. LPN #1 could not identify why Resident #93's oxygen administration was set incorrectly at 5, and adjusted the setting to 3 liters per minute.Subsequent to surveyor inquiry, a physician order was obtained for Resident #8 directing to administer oxygen via nasal canula at one (1) to four (4) liters per minute.Interview with Registered Nurse (RN) #1 on 3/2/26 at 11:02 AM identified that oxygen administration should be set according to the physician's order and that it was the responsibility of the assigned nurse to ensure that it was set correctly. RN #1 could not identify why Resident #8 was receiving oxygen without a physician's order or why Resident #93's oxygen was set incorrectly. RN #1 indicated that he would conduct training with the facility nurses on oxygen administration.Interview with the Assistant Director of Nurses (ADNS) on 3/2/26 at 1:50 PM identified oxygen administration should be set according to the physician's order and that it was the responsibility of the unit nurse. The interview failed to identify why Resident #8 was receiving oxygen without a physician's order or why Resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#93's oxygen was set incorrectly.Review of the facility's Oxygen Administration Policy dated October 2010 directed, in part for staff to verify that there is a physician's order for oxygen administration. Additionally, the policy directed staff to set the oxygen level to 2 to 3 liters per minute unless ordered otherwise.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, reviews of the clinical record, policy and interviews for the only sampled resident (Resident #1) reviewed for hemolytic treatment, the facility failed to ensure a physician ordered fluid restriction was maintained. The findings include:Resident #1?s diagnoses included end stage renal disease, diabetes and dependence on renal hemolytic treatment.The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status score of 15 indicating intact cognition and required set up assistance for eating and bed mobility, partial moderate assistance with dressing and toileting, supervision with hygiene and transfers.The Resident Care plan dated 1/27/26 identified hemolytic treatment related to renal failure. Interventions included hemolytic treatment on Tuesday, Thursday and Saturday, left chest catheter site, left arm Arteriovenous (AV) site (new), diet as ordered, and fluid restriction as ordered.A physician's order dated 1/29/26 directed a fluid restriction of 1500 milliliters (ml) per day.Review of the meal intakes on the documentation survey reports and review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for January 2026, February 2026, and March 2026, failed to identify fluid intakes recorded for any meals, failed to document fluid intake amounts to be given, and failed to indicate that Resident #1 was to maintain a fluid restriction.Review of the quarterly Nutrition assessment dated [DATE] identified a 1500 ml fluid restriction but failed to indicate compliance with or any non-compliance of the fluid restriction or fluid intake. Review of the hemolytic treatment communication forms dated 2/10/26, 2/17/26 and 2/24/26, (the only forms in the hemolytic treatment binder), failed to indicate any concerns or inability to follow the fluid restriction.Interview and record review with the supervisor, Registered Nurse (RN) #1 on 3/2/26 at 11:10 AM failed to identify Resident #1 had fluid intake amounts being monitored or documentation for staff to maintain a 1500 ml fluid restriction. RN #1 indicated Resident #1's fluid restriction was not and has not been monitored according to the physician order dated 1/29/26.Subsequent to surveyor inquiry, a physician's order dated 3/2/26 at 11:10 AM directed a fluid restriction of 1500 ml daily, due to hemolytic treatment, that the 3:00 PM to 11:00 PM nurse was to total fluid intakes every 24 hours, and that Resident #1 was to receive 300 ml of fluid with each meal, and 600 ml of free fluid to be given by the nursing staff.Interview and clinical record review with the Assistant Director of Nursing Services (ADNS) on 3/2/26 at 11:17 AM identified that although there was a physician order, there should have been written indication on the MAR and TAR directing staff to maintain the 1500 ml fluid restriction and to document the intake amounts of fluid Resident #1 was taking. Additionally, meal intake percentages should have been documented in the task section of the medical record. The RN supervisor's for the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts were responsible for reviewing fluid restrictions. The ADNS was unable to indicate why Resident #1's fluid intake was not being monitored, or how unit nurses would know to monitor fluid intakes/restriction since the information was not included on the MAR, TAR, and meals intake noted in the task section of the electronic record.In an interview and clinical record review with Dietitian #1 on 3/2/26 at 12:30 PM, the clinical record failed to reflect documentation breaking down the fluid restriction into increments to be given, per meal, per shift, or that the nutrition notes indicated a fluid restriction or monitoring. Dietitian #1 indicated that she communicated with Dietitian #2 (hemolytic treatment dietitian) and could not explain why the fluid restriction was not being monitored or why she or the nurses had not broken down the fluid restriction per shift and per meal.Interview with Dietitian #2 (the hemolytic treatment dietitian) on 3/2/26 at 1:47 PM indicated according to her records, she had spoken to the Dietitian #1 prior to Resident #1's hospital return on 1/29/26 to initiate a fluid restriction of 1000 ml daily. She indicated she had spoken with RN #1 on 1/9/26 to reinforce Resident #1's renal restrictions with the dietary staff. Dietitian #2 spoke with a facility RN on 1/29/26 following Resident #1's readmission, who had indicated that Resident #1 was on a renal diet without fluid restriction with (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Village North Health and Rehabilitation Cen	78 Viets St Extension New London, CT 06320

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugars ranging from 34 to 600 and Resident #1 was not eating well at meals and often asked for cookies. The fluid restriction of 1500 ml and carb-controlled diet was added to the diet order. On 2/10/26 the Dietitian #2 indicated Resident #1's weight was high and he/she was overloaded with fluid. Additionally, the Dietitian #2 spoke to RN #1 on 2/11/26 requesting a fluid restriction be reduced to 1000 ml and that RN #1 was to reinforce the fluid restriction. On 2/24/26 the Dietitian #2 indicated Resident #1 was heavy, over 1 kilogram (2.205 pounds) over the target weight and his/her treatment weight had to be adjusted. She further indicated that the ill effects of Resident #1 not following the fluid restriction could impact the heart long term, elevate blood pressures, cause difficulty breathing, and edema to the legs, feet, and face. Dietitian #2 reviewed with Dietitian #1 on 3/2/26 at 4:38 PM labs as well as the fluid status, target weight change, and reviewed the fluid restriction and intent for the facility to follow the 1000 ml restriction. Dietician #2 further indicated she spoke with RN #1 to confirm the 1000 ml fluid restriction.Interview with RN #3 (Corporate Nurse) on 3/2/26 at 3:08 PM identified that the clinical record failed to reflect documentation indicating a conversation with the hemolytic treatment dietitian on 1/29/26 or on 2/11/26 regarding the fluid restriction for Resident #1. RN #3 indicated she would expect documentation in a nurse's note identifying any changes in the fluid restriction, intake, and communication with the hemolytic treatment center and could not explain why the clinical record failed to reflect this.Interview with APRN #1 on 3/3/26 at 11:35 AM indicated if there was a physician's order for a fluid restriction, intake should be monitored and if the facility was unable to monitor the intake she would expect to be notified. APRN #1 indicated she was not notified of the fluid restriction not being monitored and if she had been notified, she would have contacted the conservator and the hemolytic treatment center.Review of the Encouraging or Restriction Fluids policy directed, in part, verify there is a physician's order, follow specific instruction concerning intake or restrictions, be accurate when recording fluid intake, record fluid intake on the intake side of the intake and output record, record fluid intake in milliliters, when resident has been placed on restricted fluids, remove water pitcher and cup from room. Be sure the intake and output record is maintained in the resident's room.Review of the Nutritional Assessment policy directed, in part, the dietitian estimates calorie, protein, nutrient and fluid needs.

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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. Based on observations, interviews and policy review, the facility failed to ensure medications were stored according to professional standards and that controlled substance narcotic medications were double locked per the requirement. The findings include:Observation on 2/27/26 10:01 AM identified the South-Central medication cart containing a singly locked narcotic box was stored in the hallway parallel to the front door, across the front lobby without the benefit of being locked, and without the benefit of a nurse in view of the medication cart. Additionally in the lobby, the ADNS was noted to walk by, and 3 residents were seated there, as well as 2 housekeeping staff and the receptionist. At 10:03 AM 4 Residents were identified to walk past the medication cart, along with the Dietary Director and a rehabilitation staff member. At 10:06 AM an APRN passed by, and at 10:07 AM a resident passed by as well as a visitor entered the lobby. At 10:09 AM the scheduler, and an LPN walked past, followed by the psychiatric APRN and a resident, and at 10:10 AM 2 Nurse Aids also passed by.Observation and interview with Licensed Practical Nurse (LPN) #3 on 2/27/26 at 10:12 AM identified that she was the nurse assigned to the South-Central medication unit and cart. LPN #3 stated the facility policy directed medication carts be locked when unattended, at which point she locked the medication cart. Additionally, LPN #3 identified she was responsible for locking the cart when walking away but got busy and then went on break.Interview with Registered Nurse Supervisor (RN) #1 on 2/27/26 at 11:16 AM identified it was the facility policy to lock medication carts when unattended or in the case of an emergency another nurse could keep watch if he or she was right next to the medication cart. Additionally, RN #1 identified that although he was at the nearest nurses' station, no one had asked him to watch over the cart nor would it be appropriate for him to watch an unlocked medication cart for a nurse taking her break, adding it should have been locked.Review of the Storage of Medications Policy directed in part the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Additionally, compartments containing drugs and biologicals are locked when not in use and unlocked medication carts are not left unattended.The Controlled Substances Policy directed in part that the facility complies with all law, regulations, and other requirements related to handling, storage, disposal and documentation of controlled substances.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, and policy for the only sampled resident, (Resident #10) reviewed for dental, the facility failed to follow up on a request for upper-level denture replacement for a resident with Medicaid insurance. The findings include:Resident #10's diagnoses included chronic obstructive pulmonary disease, anxiety disorder, and hypertension.The admission minimum data set assessment dated [DATE] identified Resident #10 had a Brief Interview of Mental Status score of 7 indicating moderate cognitive impairment, was independent for oral hygiene, and required supervision/touching assistance for transfers.The Resident Care Plan dated 3/25/26 identified Resident #10 had dental concerns related to broken and missing teeth. Interventions included dental consultation and treatment.A nurse progress note dated 3/21/25 at 9:03 PM identified that Resident #10 had lost upper dentures at the last facility to which he/she was previously admitted . Additionally, the note identified that Resident #10 would like the missing upper dentures replaced.A dental examination note dated 7/1/25 identified that Resident #10 would like to have a full maxillary (upper teeth) denture made.Interview and clinical record review with the Central Supply/Medical Records Manager on 3/2/26 at 10:52 AM identified that she was responsible for scheduling dental appointments for residents. She indicated that after she received the visit summary from a dental appointment, she would give them to the nurses for review. Additionally, she indicated that she does not review the notes from the appointment and that she was unaware that Resident #10 had requested new upper dentures.Interview with the dental provider representative on 3/2/26 at 11:01 AM identified that Resident #10 was seen for a dental appointment on 7/1/25 and that after that appointment they did not put a request in for the dentures because their clinical record for Resident #10 identified that he/she was not insured. After reviewing the documentation, the facility sent to the dental office prior to the appointment on 7/1/25, Person #3 identified that it was a data entry error on their part as the paperwork sent by the facility identified Resident #10 had Medicaid insurance. the dental provider representative indicated that he/she would submit a new request to the insurance for upper dentures for Resident #10.Interview and clinical record review with the Assistant Director of Nursing (ADNS) on 3/2/26 at 1:50 PM identified that Resident #10 had requested new upper dentures when he/she was admitted to the facility on [DATE] and at a dental appointment on 7/1/25. The ADNS indicated that the facility failed to follow up on the request which led to Resident #10 not receiving a new set of upper dentures. Additionally, the ADNS indicated that the facility started a new process for following up with vendors to prevent the mistake from happening again. The ADNS identified that although multiple staff were involved with the process, it was the overall responsibility of the ADNS and Director of Nursing (DNS) to ensure that follow up services with vendors were completed.Review of the facility's Dental Consultant Policy dated April 2007 directed, in part to provide necessary information regarding residents to appropriate staff, care planning conferences and/or committees.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #11) reviewed for pressure ulcers, the facility failed to perform hand hygiene while performing a dressing change and after cleaning a glucometer. The findings include:1. Resident #11?s diagnoses included severe protein calorie malnutrition, diabetes with neuropathy and retention of urine.The admission Minimum Data Set assessment dated [DATE] identified Resident #11 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment and was totally dependent on staff for dressing, toileting, and bed mobility. Additionally, Resident #11 currently had a stage 4 pressure injury/ulcer and 2 unstageable pressure injuries. The Resident Care Plan dated 10/30/25 identified an actual impairment to skin integrity related to a deep tissue injury, unstageable left heel. Interventions included keeping skin clean and dry, offload wound, and provide a wound physician as needed.The Resident Care Plan dated 10/30/25 identified indwelling catheter recent history of urinary retention and placement of foley while in the hospital. Interventions included provide catheter care daily and as needed, observe and document pain or discomfort due to the catheter, change the drainage bag monthly and as needed.Observation and interview of Resident #11's dressing change with the ADNS on 2/27/26 at 8:30 AM identified that the ADNS applied gloves and cleansed the penis area with normal saline, removed her gloves and applied new gloves without the benefit of cleansing or sanitizing her hands. When performing Resident #11's left heel dressing, she removed her gloves, performed hand hygiene and applied new gloves. The ADNS then removed the old dressing from the left heel, removed the dirty gloves and was stopped prior to applying new gloves as she had not performed hand hygiene. The ADNS indicated that she should perform hand sanitizing with each glove removal and prior to placing new gloves. The ADNS sanitized her hands, placed on new gloves and completed Resident #11's dressing change.2. Observation and interview during cleansing of the glucose testing device with LPN #3 on 3/2/26 at 7:44 AM with LPN #3 identified she applied gloves without sanitizing her hands, cleansed the glucose testing device and reapplied gloves without performing hand hygiene. LPN #3 indicated that she was distracted with another resident and did not perform hand hygiene but should have. Subsequent to surveyor inquiry LPN # 3 went to the bathroom and washed her hands.Review of the policy handwashing, hand hygiene directed in part, use of alcohol based handrub containing at least 62% alcohol or alternatively soap and water for the following situations: before handling clean or soiled dressings, gauze pads etc., before moving from a contaminated body site to a clean body site, during resident care, after contact with blood or body fluids, after handling dressings or contaminated equipment, after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and review of policy, the facility failed to ensure access to state survey results. The findings include:A Resident Council meeting on 2/27/26 at 11:00 AM identified that residents did not know where the previous state survey results were located or that it was their right to be able to review the results. Residents stated they would have reviewed previous state survey results had they known where the results were located.Observation on 2/27/26 at 12:43 PM of the facility entrance lobby failed to identify the previous state survey results.Observation and interview with the Administrator on 2/27/26 at 12:48 PM identified that the previous state survey results were in the main lobby, in a wall file holder approximately 4 feet off the ground, behind an artificial tree, not visible to the residents or visitors. The Administrator identified an artificial tree that was obscuring the state survey results binder. She subsequently moved the artificial tree to make the survey results visible. Additionally, she indicated that she was unaware that the residents were allowed access state survey results, would ensure the state survey results were in an area easily accessible to residents and visitors, and would let residents and staff know where the state survey results were located.Observation and Interview with the Administrator on 3/2/26 at 12:38 PM identified that no change to the area or visibility of the state survey results had occurred and that the artificial tree continued to block the area. The Administrator indicated that she did not know why the artificial tree was placed back in the same are again inhibiting view and accessibility of the state survey results. Additionally, the Administrator indicated she would move the state survey results to a more accessible location and inform the residents and staff of that location. Subsequent to surveyor inquiry, the Administrator moved the state survey results to the facility main lobby desk and placed a label indicating the previous state survey results location.Review of the facilities Resident Rights policy dated 10/26/22 directed in part that federal and state laws guarantee certain basic rights to all residents of the facility. Additionally, it identified that the rights included the residents' right to examine survey results.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews during the Resident Council meeting, and review of facility policy, the facility failed to consistently deliver mail on Saturdays. The findings include: F565 - Harbor Village - DHBased on interviews, and review of facility policy reviewed for a concern discussed during resident council, the facility failed to consistently provide mail to residents on Saturdays. The findings include: A Resident Council meeting on 2/27/26 at 11:00 AM identified that residents were not consistently receiving their mail on Saturdays. It also identified that the residents were not aware that they were supposed to receive their mail each Saturday. Interview with the Recreation Director on 2/27/26 at 11:30 AM identified that he personally delivered mail to the residents when he worked on Saturdays but stated that he would follow up with his staff to instruct them to deliver mail to the residents on Saturdays. The Recreation Director identified that he never formally received a complaint from the residents that they were not getting their mail on Saturdays. The residents identified that they were unaware they were able to/supposed to be able to get their mail on Saturdays. A review of the facility policy for mail, in part directed that residents' mail and packages will be delivered within twenty-four hours of delivery on premises or to the facility's post office box (including Saturday deliveries). Facility [NAME], [NAME] (53085) - Resident Council 03/03/2026 3:39 PM - facility failed to provide mail services consistently on Saturdays to residents. F576 Facility failed to provide privacy for residents during Resident council meetings.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 5 of 5 sampled residents (Resident #8, Resident #16, Resident #23, Resident #30 and Resident #62) reviewed for Preadmission Screening and Resident Reviews (PASRR) the facility failed to code the Minimum Data Set (MDS) assessment correctly. The findings include:1. Resident #8's diagnoses included paranoid schizophrenia, major depressive disorder and anxiety.Review of an Ascend PASSR level 2 form dated 5/11/17 indicated schizophrenia, major depression and anxiety disorder. The level of services needed could be provided in the nursing facility and no specialized services for mental illness were needed. Long term approval was received.The annual Minimum Data Set assessment dated [DATE] failed to identify Resident #8's section A1500, PASSR level 2 section of the annual MDS was coded as no serious mental illness.2. Resident #16's diagnoses included schizophrenia, anxiety disorder and auditory hallucinations.Review of the Ascend PASSR level 2 form dated 9/14/20 indicated schizoaffective disorder and anxiety disorder. The level of services needed can be provided in a nursing facility and no specialized services for mental illness are needed. Long term approval was received.The significant change Minimum Data Set, dated [DATE] failed to identify Resident #16's section A1500, PASSR level 2 section of the annual MDS was coded as no serious mental illness. 3. Resident #23's diagnosis included schizophrenia disorder, bipolar type, anxiety disorder and extrapyramidal and movement disorder (EPS).Review of the Maximus PASRR level 2 form dated 9/30/25 indicated schizoaffective disorder, anxiety disorder and dementia. The level of services can be provided in a nursing facility setting because of dementia, ongoing medical conditions and required assistance from others with care. The nursing facility staff are able to provide the medical care and support required as well as any plan management and can meet your mental health needs. Long term nursing facility care has been approved, and mental health needs have been identified.The admission Minimum Data Set, dated [DATE] failed to identify Resident #23's section A1500, PASSR level 2 section of the annual MDS was coded as no serious mental illness. 4. Resident #30's diagnosis included paranoid personality disorder, depression and schizophrenia.The annual Minimum Data Set assessment dated [DATE] failed to identify Resident #30's section A1500, PASSR level 2 section of the annual MDS was coded as no serious mental illness. Review of the Maximus PASSR level 2 form dated 8/5/25 identified paranoid schizophrenia and depression. The level of services can be provided in a nursing facility with medical care and to make sure the mental health needs are met and pain is well managed, medications are taken as prescribed and daily activities are completed. Approval of 180 days from effective date of 2/6/25. The facility failed to complete a subsequent PASSR level 2.5. Resident #62's diagnosis included bipolar disorder, anxiety disorders and adjustment disorder with mixed anxiety and depressed mood.Review of the Maximus PASRR level 2 form dated 10/11/24 identified bipolar disorder and dementia. The level of services can be provided in a nursing facility with medical care; mental health needs are met and pain managed. Long term nursing facility care has been approved.The annual Minimum Data Set assessment dated [DATE] failed to identify Resident #62's section A1500, PASSR level 2 section of the annual MDS was coded as no serious mental illness. Interview with LPN #5 (MDS Coordinator) on 2/24/26 at 2:50 PM identified that the MDS assessments for residents with level 2 PASSR were coded incorrectly. LPN #5 indicated that the social worker was responsible for coding section A1500. Interview with Social Worker (SW) #2 on 3/3/26 at 9:16 AM identified that she was responsible for coding the A1500 PASRR section of the MDS assessments. She indicated that she and the Administrator were made aware of incorrect PASRR coding by staff. Subsequent to surveyor inquiry, SW #2 indicated that a sweep of the building for PASSR was completed and a Quality Assurance and Performance Improvement plan was developed. SW #2 indicated that modifications were completed for the inaccurate MDS assessments to correct the coding for PASSR and that 11 modifications of MDS assessments had been (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	completed.Review of the PASSR policy dated revised 1/25/25 directed, in part, every resident coming to the center requires a PASRR level 1 or level 2. The PASRR will need to be reviewed and kept on the chart as well as uploaded to the electronic medical record. The admissions will notify social services who will pull up the PASRR and review it for approval and forward this to admissions. Admissions or designee will upload in the documents section of the electronic medical record and place a hard copy in the front of the medical record. If the resident is level 2, ensure that recommendations are reviewed and develop a care plan with the recommendations by nursing and social services. Social services will maintain a current list of level 2 PASRR residents and should be reviewed with the quarterly, the annual and significant change assessments to ensure the care plan is specific to address the residents' needs.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #30) reviewed for Preadmission Screening and Resident Reviews (PASRR), the facility failed to complete a level 2 PASSR after 180-day exemption was expired. The findings include:Resident #30's diagnosis included paranoid personality disorder, depression and schizophrenia.The annual Minimum Data Set assessment dated [DATE] identified Resident #30 had a Brief Interview for Mental Status score of 11 indicating moderate cognitive impairment, required set-up assistance with hygiene, and was independent with dressing, bed mobility, and transfer.The Resident Care Plan revised [DATE] identified a psychosocial wellbeing problem related to recent admission, positive PASSR. Interventions included allow time to answer questions and verbalize feelings, perceptions and fears, support, encourage assistance with setting realistic goals, determine expectations and discuss in realistic terms, allow opportunity to communicate feelings regarding placement. The Maximus PASSR level 2 form dated [DATE] identified paranoid schizophrenia and depression. The level of services can be provided in a nursing facility with medical care and to make sure the mental health needs are met and pain is well managed, medications are taken as prescribed and daily activities are completed. Approval of 180 days was granted from an effective date of [DATE] (expiration date of [DATE]).Interview with Social Worker #2 (SW) on [DATE] at 9:16 AM (210 days after approval expired) identified that she was responsible for ensuring a level of care was completed prior to expiration and could not explain why another level of care was not requested, other than it was an oversite.Review of the PASSR policy dated revised [DATE] directed, in part, every resident coming to the center requires a PASRR level 1 or level 2. The PASRR will need to be reviewed and kept on the chart as well as uploaded to the electronic medical record. The admissions will notify social services who will pull up the PASRR and review it for approval and forward this to admissions. Admissions or designee will upload in the documents section of the electronic medical record and place a hard copy in the front of the medical record. If the resident is level 2, ensure that recommendations are reviewed and develop a care plan with the recommendations by nursing and social services. Social services will maintain a current list of level 2 PASRR residents and should be reviewed with the quarterly, annual, and significant change assessments to ensure the care plan is specific to address the residents' needs.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, review of the clinical record, and facility policy for 1 of 6 residents (Resident #7) reviewed for accidents, the facility failed to implement a fall risk care plan intervention. The findings include:F656 R7 Harbor TW finalBased on observations, staff interviews, review of the clinical record, and facility policy for 1 of 6 residents (Resident #7) reviewed for accidents, the facility failed to implement a fall risk care plan intervention. The findings include:Resident #7 ?s diagnoses included difficulty in walking, muscle weakness, and extrapyramidal movement disorder.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status score of 6 indicating severe cognitive impairment and was dependent on staff for putting on/taking off footwear, sitting to standing, and transfers.The Resident Care Plan in effect from 2/5/26 to 3/2/26 identified Resident #7 was at a moderate risk for falls. Interventions included a floor mat to be applied on the right side when the resident was in bed.Observations on 2/24/26 at 10:01 AM and 3/2/26 at 9:31 AM identified Resident #7 lying in bed without the benefit of the floor mat located on the right side of the bed.Interview, clinical record review, and observation with the supervisor, Registered Nurse (RN) #1 on 3/2/26 at 9:34 AM identified that Resident Care Plan intervention implementation was the responsibility of the unit nurse per the facility policy. On observation Resident #7 was observed in bed without the benefit of a floor mat to the right side of the bed per the Resident Care Plan. RN #1 indicated that he did not know why the floor mat was not present but would ensure that one would be placed.Interview, clinical record review, and observation with the Licensed Practical Nurse (LPN) #2 on 3/2/26 at 9:39 AM identified that Nurse Aids (NA) could implement Resident Care Plan interventions depending on the instructions, but that it was the responsibility of the unit nurse to ensure implementation. LPN #2 identified that Resident #7 had a Resident Care Plan intervention for a floor mat to be placed on the right side of the bed when in bed. LPN #2 identified that Resident #7 was lying in bed without the benefit of a floor mat on the right side of the bed. LPN #2 indicated that information for floor mat placement was located on the NA care card (directs care), and that NAs usually implemented floor mats for fall risk residents. A review of the NA care card failed to include the use of a floor mat to the right side of the bed. LPN #2 indicated that she would call maintenance to provide a floor mat to be placed on the right side of Resident #7's bed.Interview with the Assistant Director of Nursing (ADNS) on 3/2/26 at 1:48 PM identified that it was the responsibility of the unit nurse to ensure Resident Care Plan interventions had been implemented according to the facility policy. The ADNS could not identify why the Resident Care Plan intervention for Resident #7 was not implemented and she would educate staff on the facility policy regarding Resident Care Plan interventions. Subsequent to survey inquiry, a Resident Care Plan intervention for a floor mat to the right side of bed while resident was in bed was added to Resident #7's NA care card and a floor mat was placed on the right side of Resident #7's bed. Although requested, a policy for Resident Care Plan interventions was not provided.