STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075198	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bristol Rehabilitation and Healthcare Center	23 Fair Street Forestville, CT 06010

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on clinical record review, observation and interviews for 1 of 2 residents (Resident #26) reviewed for dignity, the facility failed to ensure a resident urinary collecting device was handled in a dignified manner. The findings include: Resident #26 's diagnoses included obstructive and reflux uropathy, unspecified, benign prostatic hyperplasia with lower urinary tract symptoms and history of fall. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was cognitive impaired and required moderate assistance with toileting hygiene, maximal assistance in personal hygiene and toilet transfer. The care plan dated 1/28/25 identified Resident #26 was incontinent of urine. Interventions included utilizing appropriate continent products, monitoring output for odor, color, consistency and amount and completing an incontinent assessment at intervals according to policy and procedure. A physician's order dated 2/13/25 directed to urinary drainage one time per day for Foley management. Remove leg bag and once a day Foley management apply leg bag. Observation on 3/10/25 at 8:35AM identified Resident#26 indwelling catheter bag was visible from the hallway. Resident #26 expresses frustration that her/his urinary bag was located by his/her ankle and visible. Resident#26 reported I asked, and they did not do anything. Resident #26 expressed his/her only concern at this time ws that his Foley bag was not covered by his/her pants. Interview with Licensed Practical Nurse (LPN #2) on 3/10/25 at 8:45 AM identified it should not be like that, she also indicated she was unsure why Resident # 26's Foley was loosely fitted to his/her leg and visible. LPN #2 after surveyor inquiry, instructed the Nurse Aide (NA) to adjust Resident #26's Foley.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record review, observations, review of facility documents and staff interviews for 1 of 5 residents (Resident #62) reviewed for the Environment, the facility failed to ensure the floor in the resident's room was kept clean and sanitary. The findings include: Resident #62 was admitted on [DATE] with diagnoses that included a neurological disorder and chronic respiratory failure. The quarterly MDS assessment identified Resident #62 was cognitively intact, had a tracheostomy, and was dependent for Activities of Daily Living (ADL). A care plan dated 9/19/2024 indicated the resident had an enteral feeding tube and a urinary catheter. On 3/9/2025 at 1:49 PM, an interview with Resident #62's family member indicated that housekeeping does not come often and can take several days for someone from housekeeping to disinfect the floor when there is a spill. An observation of the floor with the resident's family member identified a pink stain on the floor by the foot of the bed. Additionally, it was observed that there were several plastic caps by the legs of the nightstand: three caps were for tube feeding tubing, one cap was for an irrigation syringe (used to administer medication through a gastric tube), and one small grey-colored cap. There was also an orange cap under the bed. On 3/11/2025 at 11:12 AM, an observation with the Housekeeping Director identified the pink stain by the foot of the bed was gone, but the plastic caps by the nightstand were still present. There were three tube-feeding tubing caps, one irrigation syringe cap, and one small grey-colored cap. An interview with the Housekeeping Director identified rooms are cleaned daily. During the daytime, between 7:00 AM and 3:00 PM, the daily cleaning included dust mopping and wet mopping. The Housekeeping Director also indicated that if there was debris or items a dust mop cannot pick up, staff would sweep up the items and discard them. A review of facility documentation on 3/11/25 with the Housekeeping Director and the Housekeeping District Manager identified that each resident's room is deep cleaned and disinfected monthly. Resident #62's room was due for a deep cleaning on 3/11/2025. The documentation identified the Housekeeping Director performs quality control inspections after the deep cleanings; however, the facility did not maintain quality control documentation for daily room cleanings, including dust mopping. Although requested, the facility did not provide a policy on housekeeping or daily room cleaning.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. 46046 Based on review of the clinical record, observation, review of facility policy and interviews for 1 of 3 residents (Residents #41) reviewed for smoking, the facility failed to ensure a resident's personal cigarette lighters were not used for other residents. The findings include. Resident #41's diagnosis includes personal history of nicotine dependence The 1/11/2025 quarterly Minimum Data Set (MDS) assessment identified Resident #41 as moderately cognitive impairment, required assistance for eating. The resident also required assistance with oral hygiene, personal hygiene and upper body dressing. The care plan dated 1/14/2025 indicated in part Resident #41 may smoke with supervision and lighter. Additionally, noted smoking materials must be maintained by center staff, to ensure supervision while smoking and to ensure no oxygen is in the smoking area. A physician's order dated 7/12/2024 directs to apply oxygen at 2 liter every evening at bedtime. The physician's order dated 11/13/2024 directs to apply CPAP (continuous positive airway pressure) at bedtime. A smoking evaluation dated 2/5/2025 at 3:19 PM indicated Resident #41 had a poor memory, does not have the ability to light a cigarette, does not require a smoking apron, can safely hold a cigarette and dispose of ashes and butts. The resident also utilized oxygen. The evaluation summary indicated Resident #41 required supervision for smoking. An observation of supervised smoking of Resident #125 at 5:55 PM identified (Nurse Aide) NA #8 had a lighter to light Resident #125's cigarette. Smoking ended at 6:00 PM and NA#8 brought the lighter to the charge nurse on the unit. An observation on 3/11/25 at 6:05 PM with the administrator and Licensed Practical Nurse (LPN #9) identified cigarettes for all resident smokers except Resident #16, in the smoking bin in the locked medication room. Two lighters were also inside the bin, both with a piece of tape and written on each was Resident #41's last name. No lighters for the other smokers. An interview with Social Worker (SW #1) with the administrator present indicated cartons for cigarettes were kept locked in the social service office and packs are distributed to the Trach unit medication room where the smoking bin is located. SW #1 further indicated she/he would purchase lighters and label them Facility for the residents to use. An interview with LPN #9 at 6:45 PM with the Administrator present (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	indicated providing an independent smoker (Resident #28) earlier on the shift with his/her cigarettes from the smoking bin in the medication room along with one of the lighters. LPN #9 further indicated there were two lighters with another resident's names on them (Resident #41) gave Resident #28 one of them to use as she/he does not have his/her own lighter. LPN # 9 also indicated when the resident brought the lighter back she/he indicated wiping the lighter down with a bleach wipe then placed it back in the bin. The Facility policy labeled Abuse Prohibition dated last reviewed 3/14/2025, indicated in part, misappropriation of patient property is defined as the deliberate temporary use of a patient's belongings without the patient's consent.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical record, facility policy and interviews for 1 of 2 residents (Residents #224) reviewed for hospitalization , the facility failed to ensure the responsible party was notified of the bed hold policy when a transfer to another facility occurred. The findings include: Resident #224's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), pneumonia, acute respiratory failure. A physician's order dated 1/14/2025 directed to provide Oxygen at 3 liters per minute via a trach mask (a mask that covers and provides oxygen through Resident #224's tracheostomy stoma site located in the neck area) with 28% humidification at bedtime ,off in the AM and as needed. The care plan dated 1/17/2025 indicated Resident #224 was at risk for Multiple Drug-Resistant Organisms (MDRO) due to having a tracheostomy. An intervention was put in place to maintain Enhanced Barrier precautions. A nursing progress note date 2/20/2025 at 11:34 AM indicated Resident #224 was transferred to the hospital at 11:30 AM due to increased respiratory secretions and to refer to S-BAR transfer summary documentation which indicated APRN #1, and the responsible party were notified. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact required oxygen therapy, no suctioning and no tracheostomy care. Resident #224 was readmitted to the facility on Thursday 3/06/2025. An interview with the Administrator on 3/11/2025 at 3:30 PM indicated Resident #224's bed was for 14 days, and the facility had an infection control issue with another (Resident #274) due to admission to the facility on day 14 and at the time Resident #224's bed was the only one available to use that met the infection control criteria. The maintenance staff had packed all Resident #224's belongings in a box in preparation for the new admission The Administrator further indicated on day 14 the hospital called the facility to indicate Resident #224 was ready to return to the facility. The hospital was asked to hold the discharge until the next day when another resident was planning to be discharged and Resident #274 could be placed in the discharging resident's room at which time Resident #224 could be admitted directly to the room occupied prior to the hospitalization . Over the weekend the nursing supervisor left a message for the social worker regarding Resident #224 and his/ her responsible party's concern about how Resident #224's belongings were handled. The responsible party was encouraged to file a grievance. The Social Worker once finding the note Monday morning 3/10/2025 followed up with the party responsible. An interview on 3/12/2025 at 8:45 AM with RN #1 (Infection Preventionist) indicated having called the state agency infection control nurse to ask if a bed of a resident in the hospital could be used for another resident with an infection control need. RN #1 indicated being told it was not an issue and informed the administrative staff. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview and record review with SW#1 on 3/12/2025 8:45 AM identified she/he could not find any progress note or notification of the bed hold policy. However, the responsible party is called to see if they want to hold the bed and SW #1 was unsure if any notification should have been given in writing, but the bed hold policy was located in the Admission Agreement packet. The facility policy labeled Attachment A: Bed Hold Policy dated 4/15/2024 for Medicaid covered Residents Regulation, Connecticut State Agencies Section 17-134 d-79 indicated in part requirements for Medicaid covered residents in a nursing home, nursing homes are required to inform residents who are recipients of medical assistance and their relatives or other responsible person upon admission to the nursing home and upon transfer to a hospital of the conditions under which the nursing home is required to reserve a bed for the resident. The bed of a hospitalized resident shall not be made available for use by any other person unless the nursing home documents in the resident's medical record the medical or administrative reasons for justifying the changes in the resident's bed and a consultation with the Medical Director or nursing staff of the nursing home and the treating physician had determined the change in the bed assignment would not anticipate to result in serious harm to the resident. The policy further indicated before the resident may be transferred to the hospital the facility is required to provide the facility's bed hold policy to the resident and a family member or legal representative which includes any state Medicaid bed hold requirements and information of how Medicare, Private Pay residents and, if applicable, Veterans may request and obtain a bed hold.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 1 sampled resident (Resident #1) reviewed for Preadmission Screening and Resident Review (PASRR), failed to ensure the accurate coding of an MDS assessment for a resident identified with a serious mental illness. The findings include: Resident #1 had diagnoses that included schizoaffective disorder bipolar type. Preadmission Screening and Resident Review Summary of Findings Report dated 12/11/18 identified Resident #1 was determined to meet PASRR assessment requirements for a serious mental illness. The annual MDS assessment dated [DATE] identified Resident #1 was coded as '0' meaning s/he did not meet PASRR requirements as having a diagnosis of a serious mental illness was cognitively intact. The care plan dated 11/27/24 identified at risk for complications related to the use of psychotropic drugs. Interventions directed to monitor and report changes to mental status and obtain a psychiatric evaluation as ordered. An interview with the Director of Social Services dated 3/12/25 at 10:42 AM identified she was responsible for the coding of the MDS related to PASRR criteria and did not code accurately as an oversight. A review of the (MDS) 3.0 Resident Assessment Instrument (RAI) Manual directs to code 1, yes if the PASRR level II screening determined that the resident had a serious mental illness.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations, review of policy and interviews for 2 of 4 residents (Resident #224 and #274) reviewed for Respiratory Care, the facility failed to develop a baseline care plan to meet the essential needs of the resident. The findings included: 1. Resident #224's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), pneumonia, acute respiratory failure. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact required oxygen therapy, no suctioning and no tracheostomy care. A physician's order dated 1/14/2025 directed to provide Oxygen at 3 liters per minute via a trach mask (a mask that covers and provides oxygen through Resident #224's tracheostomy stoma site located in the neck area) with 28% humidification at bedtime and off in the AM. The care plan dated 1/17/2025 indicated Resident #224 was at risk for Multiple Drug-Resistant Organisms (MDRO) due to having a tracheostomy. An intervention was put in place to maintain Enhanced Barrier precautions. The care plan conference note dated 1/17/2025 at 3:32 PM indicated Resident #224's stay was expected to be Long Term and a copy of the baseline care plan was provided to the resident or/representative. On 03/12/25 at 11:18 AM an interview and record review with RN #4 found no evidence a respiratory care plan had been initiated for resident #224 during the stay at the facility and should have been. The facility policy labeled Person Centered Care Plan dated 04/15/2025 indicated in part the facility must develop and implement a baseline person centered care plan within 48 hours of admission/readmission for each Resident that includes instructions needed to provide effective and person-centered care that meets professional standards of care. 2. Resident #274's diagnoses included Acute and Chronic Respiratory Failure with hypoxia, acute and chronic respiratory failure with hypercapnia, and Chronic Obstructive Pulmonary Disease (COPD). A physician's order dated 3/4/25 directed to maintain target volumes for AVAPS: PC of 350 MAX IPAP 24 MinIPAP14, EPAP 8 back up rate/set rate every day and evening shift for Respiratory. Review of a respiratory therapy note dated 3/4/25 at 6:10 PM identified that CPAP machine was brought to patient's room, therapy applied to ensure it was working. The Baseline Resident Care Plan dated 3/5/25 identified the resident was at risk for skin infection, had an ADL/Self Care Deficit, had a nutritional problem, and was at the facility for a short-term stay. Interventions included monitoring weight, assisting with ADL, and to administer antibiotic therapy as prescribed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Admission Note written by APRN #1 on 3/6/25 identified the resident has a past medical history of chronic, hypoxemic respiratory failure and is on AVAPS. A Hospital Transfer form dated 3/9/25 at 2:03 PM identified the resident was alert and oriented and needed assistance with bathing, dressing and transfers. Record review and an interview on 3/10/25 at 1:50 PM with the MDS Coordinator identified the baseline care plan would be completed by her, the DNS, or the supervisor. The care plan should contain skin, pain, transfers, and mobility. When asked, she identified that the resident's respiratory care should have been on the care plan and she did not see that it was included. The MDS Coordinator further stated on average the comprehensive care plan is completed by day 8 and she is certain, she would have included the resident's respiratory needs. Additionally, she indicated the nursing supervisor, and the DNS completes baseline care plans. Review of the facility policy, Person-Centered Care Plans, dated 10/24/22 and presently in effect, directed in part, the center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/resident which includes the instructions needed to provide effective and person-centered care and one that meets professional standards of quality care. When asked for a copy of the Admission Nursing Assessment one was not provided. As per MDS they were not completed on this resident. Resident #274 was admitted on [DATE] and was transferred back to the hospital on 3/9/25. 48792

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37721 Based on clinical record reviews, review of policy and staff interviews for 1 of 1 resident (Resident # 2) reviewed for elopement, the facility failed to conduct elopement evaluations per facility policy and for 1 of 7 residents (Resident #124) reviewed for accidents, the facility failed to ensure a comprehensive care plan was in place for a resident with a history of seizures and for 1 of 4 for residents (Resident # 224) reviewed for Respiratory Care, the facility failed to ensure a comprehensive care plan for resident requiring respiratory care was develop. The findings included : 1. Resident #2's diagnosis included dementia with behavioral disturbances. An eMAR-Administration note dated 9/22/2023 at 2:50 PM directed to check the placement of the resident's Wander guard bracelet on the left ankle (a bracelet that alarms if a resident seeks to exit through a door that is equipped to detect the alarm). The documentation further indicated the wander guard was discontinued. An elopement evaluation dated 9/22/2023 at 3:09 PM indicated Resident #2 was able to walk and self-propel in wheelchair independently and has a history of wandering and elopement. Additionally, the evaluation noted the resident does not show one or more emotional states or behaviors that may result in exit seeking behavior. A general progress note dated 9/22/2023 at 3:21 PM indicated in part Resident #2 did not exhibit any elopement behaviors or made any verbal statement of wanting to leave the facility and per conversations with the nurse aides and other staff members Resident #2 had made no attempts to leave. The physician was updated, and an order was received to discontinue the use of the Wander guard bracelet alarm. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated in part Resident #2 was severely cognitive impairment, requires partial/moderate assistance of staff to ambulate 10 feet, uses a manual wheelchair requiring partial/moderate assistance to wheel 50-150 feet and no behaviors of wandering were exhibited. The care plan dated 2/18/2025, indicated in part, Resident #2 was at risk for elopement related to dementia. Interventions included to utilize and monitor code alert to left ankle, divert resident by giving alternative objects or activities. An interview and record review on 3/12/2025 at 10:56 AM with RN #4 the acting Director of Nursing Services (DNS) indicated not knowing why the elopement evaluation dated 9/22/2023 did not indicate a score to determine the level of risk for elopement and she/he was unsure how the risk of elopement is determined using the evaluation once completed. RN# 4 further indicates she/he was aware elopement evaluation is completed on admission but unsure of its frequency after. RN #4 verified the last elopement evaluation was completed on 9/22/2023 indicating a history of elopement, having a wander guard but it was discontinued due to Resident #2 made no attempts to leave the facility. RN #4 further indicated Resident #2 was no longer at risk as h/she got out of bed in an adaptive type of wheelchair and could not wheel self in the wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy labeled Elopement of Patient dated 4/15/2025 indicated in part a Resident's elopement risk would be determined on admission, re-admission, quarterly and with a significant change in condition. 2. Resident #124 had diagnoses that included a history of epilepsy. The admission MDS assessment dated [DATE] identified Resident #124 was severely cognitively impaired with a BIMS of 4, required assistance of one with bed mobility, total assistance of two for transfers and toileting. The care plan dated 5/13/24 identified Resident #124 had impaired cognitive function, required assistance with ADL care and was at risk for falls. Interventions included : monitoring changes in cognitive function, providing assistance of one with ADL, assistance of two with transfers and to ensure the call bell was within reach. The care plan did not include a problem related to a history of seizure and interventions to reduce accident risks. A Reportable Event Summary dated 6/17/24 identified NA #7 reported during care the resident's body started to flop a lot. NA #7 checked to make sure the resident was receiving oxygen when his/her leg was noted off the side of the bed. NA #7 was unable to catch the resident's leg. The care plan was revised to include an air mattress/bed with bolsters. An interview with Nurse Practitioner (NP #1) on 3/11/25 at 8:43 AM identified her/her documentation occasionally noted Resident #124 was placed on seizure precautions and included padded rail when in use. NP #1 further identified that although she did not suspect a seizure at the time Resident #124 fell out of bed, a seizure protocol should be followed for any resident with a history of seizure activity. An interview with the DNS on 3/11/25 at 10:58 AM identified a care plan should have been in place that included padded while in bed. An interview with RN #4 identified she/he was responsible for completing the MDS assessments and participated in the development of resident care plans. RN #4 further identified any seizure protocol would be included in an individualized care plan and Resident #124 should have had a care plan in place for seizures given his/her history. A review of the facility policy for Person- Centered Care Plans dated 10/24/22 directed the facility develops and implement care plans to provide effective person centered care. The care plan should include services to be furnished, goals and expected outcomes, type, amount and frequency of care and any other factor related to the effectiveness of the care plan. 3. Resident #224's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), pneumonia, acute respiratory failure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/14/2025 directed to provide oxygen at 3 liters per minute via a trach mask (a mask that covers and provides oxygen through Resident #224's tracheostomy stoma site located in the neck area) with 28% humidification at bedtime and off in the AM and as needed. A physician's order dated 1/14/2025 directed to change the orange stoma (trach stoma) button every day and to change the blue stoma button at every bedtime. A physician's order dated 1/14/2025 directed to cleanse around the stoma site with peroxide and sterile water before replacing the adhesive dressing every other day and as needed. The resident may do self-care of the stoma site with monitoring or assistance and provided supplies as needed. The care plan dated 1/17/2025 indicated Resident #224 was at risk for Multiple Drug-Resistant Organisms (MDRO) due to having a tracheostomy. An intervention was put into place to maintain Enhanced Barrier Precautions. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact required oxygen therapy, no suctioning and no tracheostomy care. On 3/12/25 at 11:18 AM an interview and record review with RN #4 identified no evidence of a respiratory care plan initiated for Resident #224 during the resident's stay at the facility. RN#4 further indicated there should have been a care plan. The facility policy labeled Person Centered Care Plan dated 4/15/2025 indicated the facility would develop a comprehensive individualized care plan within seven days after the completion of the comprehensive assessment on admission and no more than 21 days after admission. The care plan would be revised as needed to reflect the changing needs of the resident. 46046

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations, review of facility policy and staff interviews for 1 of 3 residents(Resident #24) reviewed for pressure ulcers and for the only resident (Resident #38) reviewed for specialized treatment and for the only resident resident (Resident #324) reviewed for range of motion, the facility failed to revise the resident's care plans. The findings included : 1. Resident #24's diagnosis included type 2 diabetes mellitus and vascular dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #24 was moderately cognitively impaired, had no pressure ulcers but was at risk for developing a pressure ulcer. Resident #24's care plan revised dated 3/1/2025 indicated Resident #24 was at risk for skin breakdown due to fragile skin, impaired cognition and impaired sensation. Interventions included in part to float heels as resident tolerates, and to offload or reposition Resident #24 four times per shift. A weekly wound evaluation completed on paper dated 3/6/2025 indicated the identification of an in-house pressure ulcer 0.5 Centimeter (CM) circular stage 1 (non-blanchable redness) with a treatment order dated 3/6/2025 to apply skin prep to the left heel and interventions to elevate heels. An interview and record review with the wound nurse (RN #1) on 3/11/2025 at 3:15 PM identified she/he was not not able to find Resident #24's care plan updated with the development of a new stage 1 pressure ulcer of the left heel and new orders. RN #1 indicated over the past months there were problems with the assessments not populating in the electronic record, the loss of Wi FI connectivity caused the facility to convert to paper documentation. RN#1 further indicated she/he completed weekly skin assessments for every resident in the building buit may have forgotten to check to see if Resident # 24's care plan had been updated. The facility policy labeled Person Centered Care Plan dated 4/15/2025 indicated in part the care plans will be reviewed and revised by the interdisciplinary team after each assessment and as needed to reflect the response to care and changing needs and goals for each resident. In addition, the facility policy labeled Skin Integrity and Wound Management indicated in part the resident care plan will be reviewed and revised as indicated. 2. Resident #38's diagnoses included encephalopathy, chronic systolic Congestive Heart Failure (CHF), and end stage renal disease. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #38 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. The assessment noted the resident was independent for eating, chair/bed-to-chair transfers, and toilet transfer. The Resident Care plan dated 3/6/24 for Resident #38 identified the resident was at risk for heart issues related to CHF. Interventions included: to conduct vital signs every shift and with change of condition, evaluate for edema, and to weight daily, notify physician of increase in weight of greater than two (2) pounds a day and increase of weight greater than five (5) pounds a week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders dated 3/7/24 for Resident #38 directed to only put in weights obtained after specialized treatment, document as post specialized treatment weight, and do not weigh patient in house. The physician's orders dated 4/10/24 for Resident #38 directed daily weight and to notify provider for increase in weight greater than three (3) pounds a day or increase in weight greater than five (5) pounds in a week. The Summary Report dated 3/12/25 for Resident #38 identified the physician's orders dated 4/10/24 directed daily weight and to notify provider for increase in weight greater than three (3) pounds a day or increase in weight greater than five (5) pounds in a week noted the order had been discontinued. Additionally, the report identified the physician's orders dated 3/7/24 which directed to only put in weights obtained after specialized treatment, document as post specialized treatment weight, and do not weigh patient in house had an order status as active. Interview and record review with MDS Coordinator/Registered Nurse (RN) #4 on 3/11/25 at 1:58 P.M. identified a care plan intervention for Resident #38's congestive heart failure was daily weights. Additionally, the care plan identified an active order which directed to only put in weights obtained after specialized treatment, document as post specialized treatment weight, and do not weigh patient in house. She also identified the care plan should have been revised after the new physician's order was placed per facility policy and indicated it was her responsibility to do so. The interview failed to identify why the resident's care was not revised. After surveyor inquiry, the care plan was revised. 3. Resident #324 was admitted to the facility with diagnoses that included a cervical spine injury. The quarterly MDS assessment dated [DATE] indicated Resident #324 was cognitively intact and was dependent on staff for activities of daily living (ADL). A care plan revised on 3/01/2025 indicated Resident #324 was dependent with ADL care, and interventions included placing left and right splints on with morning care and removing them during evening care. On 3/9/2025 at 11:24 AM, an observation identified signage in Resident #324's room directing the resident to wear hand splints during the day and at night. A review of the Nurse Aide Care card dated 3/10/2025 indicated Resident #324 used right and left-hand splints, which were applied with morning care and removed with evening care. On 3/10/2025 at 2:58 PM, an interview with NA#6 indicated the resident did not currently wear splints and may have worn splints in the past, but she was unsure. On 3/10/2025 at 3:00 PM an interview with LPN#6 indicated Resident #324 wore splints a while back prior to her/his hospitalization . LPN#6 further indicated the care plan and NA care card noted the resident utilized splints could have been on a care plan prior to the resident's hospitalization . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/2025 at 3:13 PM, a record review with the Director of Rehabilitation identified a care plan for splints. However, there was no active physician's orders for the utilization of splints. The Director of Rehabilitation indicated that although Resident #324 had been screened for therapy needs, therapy had not yet fully evaluated the resident due to her/his medical condition after the resident's rehospitalization . The Director of Rehabilitation indicated that she would have to review the medical record further to identify if the resident required hand splints. On 3/11/2025 at 11:00 AM, a record review and follow-up interview with the Director of Rehabilitation identified Resident #324 was originally ordered splints on 6/10/2024 that were later discontinued on 1/3/2025 due to the resident's hospitalization . Resident #324 arrived back at the facility on 1/17/25 and was hospitalized again on 1/30/2025 and 2/20/2025. The most recent admission back to the facility was on 3/3/2025. A therapy screening dated 3/6/2025 indicated the resident would benefit from Occupational Therapy (OT) and would be evaluated when stable. The Director of Rehabilitation indicated splints would not be ordered until the resident had been evaluated and she did not expect the resident's prior splints to be placed by nursing staff without an physician's order since the resident's condition may have changed due to the various rehospitalization . The Director of Rehabilitation was unable to indicate why the resident's care plan and NA care card still reflected the use of hand splints. On 3/11/2025 at 2:30 PM an interview with the MDS Coordinator indicated that when there is a change in a resident's physician's order for splints or other orthotic device, therapy would be notified of the changes and she would update the care plan. The MDS Coordinator indicated she did not recall being notified of the change in orthotic use for Resident #324 but indicated the care plan should have been reviewed and updated to reflect the discontinuation of the orthotic device. . 48880 51101

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on review of the clinical record and interviews for the only resident reviewed for Rehabilitation and Restorative Care (Resident #8), the facility failed to ensure the resident was ambulated according to the plan of care. The findings include: Resident #8 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and anxiety. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitively intact and required maximal assistance with personal care and supervision/ touching assistance with bed mobility and transfers. The care plan dated 1/17/25 identified Resident #8 requires assistance for Activities of Daily Living (ADL) care, Interventions included assistance of one for stand pivot transfers, assist of one with ambulation and rolling walkers. A physician's order dated 2/25/25 directed transfer and ambulate with wheelchair walker and assist of one every shift. Review of the Treatment Administration Records (TAR) identified four shifts where Resident # 8 did not ambulate. For the month of March 2025 during two shifts. Interview on 3/09/25 at 10:50 AM with Resident #8 identified he/she did not believe there was enough staff to walk him/her. Resident #8 further stated I'm always in my chair or bed. Resident #8 believes there is a decline in his/her mobility due to not being ambulated. In person interview on 3/11/25 9:06 AM with NA#7 identified nursing was responsible for ensuring residents ambulates, however, stated she/he believes the nurses (LPN/RN) would be able to explain where this information is documented once task is done. She also indicated she has personally never ambulated Resident #8 Interview on 3/11/25 at 9:09 AM with LPN #5 identified ambulation schedules are documented in the resident's electronic chart and are posted on the inside of residents closet on a paper. Observation (with assistance of LPN#5) of Resident #8 ambulation scheduled (physician's order) in his/her closet. LPN #5 further indicated staff from therapy are also responsible for ambulating residents. Interview on 3/11/25 at 9:26 AM with the Director or Rehabilitation Services indicated Rehabilitation, nursing and NAs can assist with ambulation, whenever Resident #8 wants to get up or need to go to bathroom. She also indicated staff is expected to assist with ambulation and if not not done document and explain why not. The Director of Rehabilitation was unable to explain why Resident 8 was missing ambulation in March 2025. A review of the nurse's notes for March 2025 failed to reflect any refusal from Resident #8 to ambulate. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility Transcription of orders indicated in part Documentation of ADL care is recorded in the medical record and is reflective of the care provided by nursing staff. ADL care will be documented in real time, as close to the time as possible.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, review of facility policy and interviews for 2 of 3 residents (Residents #24 and # 47) reviewed for pressure ulcers, the facility failed to ensure weekly skin checks were consistently completed, skin risk assessments were completed quarterly and with change in condition and ensure physician notification. The findings include: 1. Resident #24's diagnosis included type 2 diabetes mellitus, and vascular dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicted Resident #24 had moderate cognitive impairment had no pressure ulcers but was at risk of developing a pressure ulcer. Resident #24's care plan revised on 8/02/2024 indicated Resident #24 was at risk for skin breakdown due to fragile skin, impaired cognition and impaired sensation. Intervention included in part to float heels as resident tolerates, and to offload or reposition Resident #24 four times per shift. A Skin Check was completed on 8/2/2024 identified no skin injuries or wounds. However, no skin checks were identified for the weeks of 8/09/2024 and 8/16/2024, 8/23/2024, 8/30/2025, 9/6/24, 9/13/24 and 9/20/25. A Skin Check was completed weekly from 9/23/2024 through 10/23/2024. The quarterly MDS assessment dated [DATE] indicated Resident #24 had moderate cognitive impairment, had no pressure ulcers but was at risk for developing a pressure ulcer. A weekly skin check was completed on 11/02/2024 through 11/09/2024. No weekly Skin Checks were identiified for the week of 11/16/2024 through 12/14/2024. A Braden Scale for Predicting Pressure Sore Risk (a skin Risk assessment) was completed on 3/6/2025 at 10:19 AM and noted a score of 17 indicating Resident #24 was at low risk. A Skin Check was completed weekly from 12/22/2024 through 2/20/2024. No weekly Skin Checks were identified for the week of 2/27/2025. A skin check was completed weekly from 3/4/2024 through 03/10/2024. A weekly wound evaluation completed on paper dated 3/6/2025 indicated the identification of an in-house pressure ulcer 0.5 Centimeter (CM) circular stage one (non-blanchable redness) with a treatment order dated 3/6/2025 to apply skin prep to the left heel and interventions to elevate heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review with RN #1 (Wound Nurse) on 3/11/2025 at 3:15 PM indicated she/he could not locate skin checks for Resident #24 for the weeks omitted due to ongoing problems with the electronic scheduler for the assessment for Braden and weekly skin checks over many months. She/he also indicated the previous IT group could not find a permanent fix to the find the missing information. RN #1 indicted intermittent loss of Wi FI connectivity caused documentation to be done on paper, the assessments were not getting done and RN#1 indicated he/she began tracking and completing the weekly skin check for every resident. She/he believes now the new owner of the facility's leadership will be able to improve the situation. The facility policy labeled Skin Integrity and Wound Management dated 4/15/2025 indicated in part, a complete risk evaluation would be completed on admission/readmission, weekly for the first month, quarterly and with a significant change in condition, 2) Resident #47 had diagnoses that included Type II diabetes and neoplasm of the colon. The quarterly MDS assessment dated [DATE] identified Resident #47 was cognitively intact with a BIMS of 15 and required assist of one with bed mobility, two with transfers. The care plan dated 11/18/24 identified Resident #47 was at risk for skin breakdown related to chronic anemia and limited mobility and required assistance with ADL skills. Interventions included assist of one with bed mobility, repositioning, and weekly skin checks by a licensed nurse. a) A review of the weekly skin assessments dated 11/19/24 through 12/31/25 identified no recorded weekly skin checks for December 2024, a total of 4 missed weekly skin checks. An interview with RN #1 on 3/12/25 at 9:53 AM and 3/12/25 at 9:53 AM identified she was responsible for wound management at the facility including conducting weekly skin assessments alongside nursing staff. At some point, RN #1 noted the completion in the weekly skin assessments was inconsistent and difficulties linking them in the electronic clinical record. RN #1 indicated that although she started completing assessments on paper, she was unable to provide any of the (4) weekly skin assessments in December 2024 for Resident #47. An interview with the Administrator on 03/12/25 12:54 PM identified she would expect wound management to be completed in accordance with facility policy. Although requested a policy for weekly skin checks was not provided. The National Pressure Injury Advisory Panel (NPIAD) recommends conducting a head-to-to-toe skin assessment at least weekly for the prevention of pressure ulcers. Although requested, a copy of the physician orders was not provided. b) The admission nursing progress note dated 1/22/24 identified Resident #47 was readmitted with a stage II pressure injury to the sacral region. The assessment did not include the size, color, type and description of the wound bed, the presence of drainage/exudate and any associated pain. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c)Further review of the clinical record identified no skin risk assessment was completed on readmission and weekly thereafter for the first month. An interview with RN #1 on 3/11/25 at 2:50 PM and 3/12/25 at 9:53 AM identified she was responsible for wound management at the facility. RN #1 indicated the admission assessment of the wound should have included a full description of the wound including measurements. RN #1 identified the Braden Risk Assessment [a skin risk evaluation tool utilized by the facility] was not completed on admission and weekly thereafter for the first month and should have been. An interview with the Administrator on 03/12/25 12:54 PM identified she would expect wound management to be completed in accordance with facility policy. A review of the facility policy for Skin Integrity and Wound management dated 10/15/24 directs a complete comprehensive evaluation of the patient to be completed upon admission/readmission. Additionally, a risk evaluation is to be completed on admission and weekly thereafter for the first month, quarterly and with any significant change. _ Resident #47 Pressure Ulcer/Injury 46046 Resident #24 Pressure Ulcer/Injury F686 Based on clinical record review interviews and facility policy for 1 of 6 Residents reviewed for Pressure ulcer (#24), the facility failed to ensure staff completed weekly skin checks consistently, completed skin risk assessments quarterly or with change of condition and documented notification of the physician and responsible party with a new change in skin status. The findings include: _____ F657 No care plan update with development of the stage 1 heel pressure ulcer. _____ 03/10/25 10:22 AM has an [NAME] on left heel 03/10/25 01:10 PM Observation of the left outer heel with the wound nurse shows intact pink skin left outer heel. tender staff say due to neuropathy, wearing not skid socks no bootie or pressure relief. resident was repositioned by charge and wound nurses. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/11/25 03:07 PM - MDs quarterly 2/1/2025- no pressure ulcer at risk for pressure ulcer, had a clinical assessment diagnosis- Cerebral infarction, type 2 diabetes, dementia, Treatment orders- apply skin prep to left heel q shift every shift for wound care Other Active 3/6/2025 15:00 Pressure-redistribution mattress to bed No directions specified for order. Other Active 7/26/2024 Non skid footwear for safety No directions specified for order. Other Active Weekly skin checks Atlas 3/10/25 3/4/25 2/25 2/20/25 2/13/25 genesis 2/6/2025 1/2 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/9 1/16 1/23 1/30 9/23/2024 10/3/24 10/10/24 10/13/24 10/19/24 11/2/14 11/9/24 8/2/24 genesis Nursing notes 3/10/2025 10:06 Nurses Note (Structured Progress Note) Nurses Note: [NAME] had a scheduled skin check. The resident has no new skin alterations. Left heel - pressure 1 resolving treatment in place, Coccyx - masd resolved Interview with the wound nurse [NAME] and [NAME] the regional RN 3:50 PM on 3/11/2025 Care Plan- not updated with develoment of stage 1 left heel pressure ulcer- air matress not on care plan Resident at risk for skin breakdown related to_____ Type:_____ Location_____ decreased activity , frail fragile skin, impaired Cognition , impaired sensation has BLE scattered bruising H At Risk Goal: The resident will not show signs of skin breakdown x __90__ days H float heels as resident allows [Nsg] + H offload or reposition four times a shift (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Nsg] + H Pat (do not rub) skin when drying [Nsg] H [NAME], [NAME] (48792) (additional information recieved and no longer moving forward) Based on Resident Record Review, Facility documentation, Facility Policy, and Staff Interviews for the only resident (Resident #46) reviewed for skin conditions, the facility failed to follow their policy for pressure risk assessment frequency. _____ 03/09/25 01:20 PM Toes on right foot had a hematoma and it is now an open area. No EBP. Observed RN entering room without gowning. Did have gloves on. No signage for EBP Interview with RN #2 Supervisor: Q Should this resident be on EBP as he has an open area on his toes? A: I don't know. I only work here every other Sunday. Q: Would you expect that any resident requiring dressing changes for open areas to be on EBP? A: I don't know. 3/10/25 8:30 observation made and resident has EBP signage on door subsequent to surveyor inquiry 3/9/25 Interview with Wound RN #1 Q: yesterday there was no signage for EBP on the door and I noticed you went into the room without gowning. Should he be EBP? A: I do not know I didn't think so. I will ask the IP. 8:45 AM Wound RN stated that he should have been on EBP and he hasn't been . Resident at risk for skin breakdown related to actual skin breakdown Type: __lesion_____ Location_right dorsal foot_____ decreased activity , frail fragile skin, impaired sensation, incontinence, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited mobility, poor safety awareness, skin lesion Date Initiated: 02/17/2025 Revision on: 02/17/2025 At risk Goal: Resident will remain free of skin tear and/or bruising x_____90_____days Date Initiated: 02/17/2025 Revision on: 03/04/2025 Target Date: 05/22/2025 At Risk Goal: The resident will not show signs of skin breakdown x __90__ days Date Initiated: 02/17/2025 Revision on: 03/04/2025 Target Date: 05/22/2025 Healing Goal: The resident's wound /skin impairment will heal as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation X_____90_____days Date Initiated: 02/17/2025 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 03/04/2025 Target Date: 05/22/2025 encourage / assist in repositioning/off loading 4xshift as patient allows/tolerates Date Initiated: 02/17/2025 Revision on: 03/01/2025 Nsg encourage/assist in off loading/heels up 4xshift as patient allows/tolerates Date Initiated: 02/17/2025 Revision on: 03/01/2025 Nsg Pat (do not rub) skin when drying Date Initiated: 02/17/2025 Nsg Provide patient and/or healthcare decision maker education regarding risk factors and interventions Date Initiated: 02/17/2025 Nsg Provide preventative skin care i.e. lotions, barrier creams as ordered Date Initiated: 02/17/2025 Nsg Apply barrier cream with each cleansing Date Initiated: 02/17/2025 Nsg Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blistering, decrease sensation, and skin that does not blanche easily Date Initiated: 02/17/2025 Nsg Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation Date Initiated: 02/17/2025 Nsg Observe skin condition daily with ADL care and report abnormalities Date Initiated: 02/17/2025 Nsg Off Load/Float heels while in bed Date Initiated: 02/17/2025 Revision on: 03/04/2025 LPN CNA Weekly skin check by license nurs Enhanced barreir precautions rlt wound every shift Other Active 3/9/2025 15:00 Open area on toes 2/17/25. Braden Scale completed on 2/13, 2/20, no further assessments found. Per policy should be completed on admission and weekly for the first month. Subsequent to Surveyor Inquiry Braden Scales 2/27 and 3/6 were documented on paper. (computer system down on those days and staff documented on paper) Weekly skin checks completed 2/20, 2/21, 3/11. Missing 2/28 skin check. No wound deterioration noted. Wound is healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Has appointment with Podiatry 3/12/25. 3/12/25 9:15 AM Interview with Wound nurse Q: What is your policy for Braden scales related to frequency? A: I am not sure I would have to check. Q: I reviewed the policy and it says weekly x 1 month. How about your policy for skin checks? A: They should be weekly on shower day. Q; Resident has had a Braden on 2/13 and 2/20. Were any other Braden Scales completed or risk for pressure ulcer assessments? A: I do not see that there are any other assessment in the record. Q: How do you track when these assessments are due? A: When we were owned by Genesis the MDS would auto-populate to schedule them. Since we became Atlas, they assessments are not auto-populated. I have to talk to the MDS to see if they can be auto-populated again so that we do not miss them. 3/12/25 9:30 AM interview with MDS coordinator. Q: Do you auto-populate Bradens and skin assessments? A: not since we became Atlas. When we were Genesis we did auto populate but we do not now. I am going to talk to the regional to find out if we can start doing that again. I have yet to meet with the Regional MDS person.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, observation, facility documentation, review of facility policy and interviews for 1 of 7 sampled residents (Resident #124) reviewed for accidents, the facility failed to ensure necessary care and services were immediately sought and provided to ensure Resident # 124 safety and prevent a fall with major injury, when Resident # 124 exhibited a change in condition, subsequently fell out of bed and sustained an eyelid laceration and fracture to the face and failed to ensure the area designated for smoking was free from accident hazards. The findings included: 1. Resident #124's diagnoses included a history of Cerebrovascular Accident (CVA) with right sided hemiparesis/hemiplegia (weakness and paralysis), epilepsy and chronic respiratory failure with tracheostomy (trach). The admission MDS assessment dated [DATE] identified Resident #124 was severely cognitively impaired with a BIMS of 4, required assistance of one with bed mobility, total assistance of two for transfers and toileting. The care plan dated 5/13/24 identified Resident #124 had impaired cognitive function, required assistance with ADL care, was at risk for falls and at risk for respiratory complications related to the tracheostomy. Interventions included: monitoring changes in cognitive function, providing assist of one with ADL, assistance with two with transfers, to ensure the call bell was within reach, observe/report increased wheezing and lower activity tolerance. The care card for 6/2024 directed assistance of one for care and for dressing maximal assistance. The resident required partial assistance with mobility. A Physical Therapy Evaluation and Resident Plan of Care dated 6/13/24 identified Resident #124 was hospitalized [DATE] through 6/12/24 for encephalopathy, SIRS (systemic inflammatory response syndrome) and urinary tract infection. Resident #124's functional capacity was determined as moderate assistance of one for rolling (in bed) and maximum (two people) for transfers. The physician's orders dated 6/14/24 directed to cap the trach as tolerated 8:00 AM to 8:00 PM and add nasal cannula to keep oxygen saturation above 90% every day and evening shift. A respiratory progress noted dated 6/14/24 identified Resident #124 was stable, capped and placed on nasal cannula 2 l PM (liters per minute) and tolerating well new orders for patient to be capped from 8:00 AM to 8:00 PM as tolerated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Nurse Practitioner (NP #1) note dated 6/14/24 at 00:00 identified Resident #124 rolled out of bed to ground, and the incident was witnessed by nursing staff. Resident #1 was alert and responded to commands and noted with bleeding from nose and right lower eyelid, with no other visible injury/ bleeding. Oxygen via trach/ mask was 94-97% range (within normal limits), moving upper and lower extremities within baseline and no loss of consciousness. Resident #124 had a previous history of left frontal hemorrhagic stroke resulting in right sided hemiparesis, has a trach, and history of seizure disorder (nursing reported s/he was flapping hands prior to incident). Resident #124 was sent to the emergency department (ED) for a Computed Tomography CAT(CT) scan, evaluation to rule out an acute injury or fracture complication. A nurse's note dated 6/14/2024 at 1:25 PM (written by RN #6) identified Resident #124 fell out of bed, sustaining a bloody nose and right cheek bone bleeding was stopped with ice. The NP was aware and completed an assessment. Resident #124 was transferred to the ED for evaluation/ CT scan of the head. The Inter-Agency Patient Referral Report dated 6/14/24 at 8:57 PM identified Resident #124 was evaluated following a fall. Per Emergency Medical Services (EMS), staff were turning the resident when s/he rolled out of bed. A CT scan dated 6/14/24 of the facial bones identified severe comminuted fracture or the right maxillary sinus and orbital floor fracture and corneal abrasion. Resident #124 returned to the facility on [DATE] with 2 sutures in the right lower eye with instructions that directed follow-up with the primary care physician and Oral and Maxillofacial Surgery in one week and to continue erythromycin for treatment of the corneal abrasion. A Safety Report (no date) identified on 6/14/24 after 12:00 PM, a request was made for NA #9 to change Resident #124's brief , gown and bed (while in bed).NA #9 recalled from previous interactions, Resident #124 moved around a lot but was able to turn h/her side to side without difficulty until the last turn when Resident #124 started to flop h/her body around a lot NA #9 went to check if Resident #124 was receiving oxygen when h/her legs began to fall off the bed. NA 9 ran to catch Resident #124 but was too late. Resident #124 fell flat on h/her face. NA #9 then ran out of the room and yelled for help later returning with the nurse. A Reportable Event Summary dated 6/17/24 identified NA #9 reported during care the resident's body started to flop a lot. NA #9 checked to make sure the resident was receiving oxygen when his/her leg was noted off the side of the bed. NA #9 was unable to catch the resident's leg. The respiratory therapist had previously capped the resident around 12:30 PM. Resident # 124 was transferred to the hospital and later identified with a maxillary sinus fracture and right orbital fracture. The resident received two sutures on the right eye lid. The care plan was revised to include assistance of two staff who received education on to suspend care if resident anxious or agitated and to ensure the resident is calm before continuing with care, air mattress/bed with bolsters and fracture management. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with RN #6 on 3/11/25 at 9:24 AM identified h/she was the assigned nursing supervisor on 6/14/25 during the 7:00 AM to 3:00 PM shift at the time RN #6 was called to Resident #124's room with a report of a fall out of bed. Although unclear of all the details, RN #6 indicated Resident #124 was new to having h/her trach capped and started moving around a lot in bed while NA #9 who was finishing a complete bed change. The RN# 6 identified Resident # 124 was moving around a lot, perhaps in discomfort from being new to capping. NA #9, who was on the other side of the bed, left the side of the bed to check Resident #124's oxygen on the opposite side. During that moment Resident #124's legs started falling off the side of the bed and gravity took over and Resident #124 fell out of bed. RN #6 further identified Resident #124 used enable rails to assist with positioning and normally would have been able to assist with positioning. An interview with the Director of Nursing Services (DNS) on 3/11/25 at 10:58 AM identified NA #9 was at the top of the bed between the wall and head of bed completing a bed change for Resident #124 when s/he observed Resident #124 moving around a lot and in questionable distress. The DNS identified the root cause of the fall was NA #9 not calling for help when Resident #124 began moving around and showing questionable signs of distress and being unable to intervene when his/her legs began to fall off the side of the bed while focusing her attention on oxygen equipment. Education was subsequently provided to stop and call for the nurse for a questionable change of condition. An interview with the Medical Director on 3/11/25 at 12:09 PM identified the nurse aide should have called for help for any change of condition and focused on the resident while providing care. An interview with the Director of Rehabilitation on 3/14/25 at 10:19 AM identified while Resident #124 could normally assist with positioning side to side with the use of enabler bars, any change of condition could compromise h/her ability to do so. The nurse aides should be calling for help if a resident was experiencing a questionable change of condition. Additionally, the Director of Rehabilitation indicated the nurse aides should not be at the head of the bed between the wall and bed when providing care and instead at the side of the bed. NA #9 would not have been able to effectively intervene to prevent a fall if she was at the head of the bed. Although requested, a policy for nurse aide reporting of a change of condition was not provided. Attempts to interview NA #9, who is no longer employed at the facility, were unsuccessful. 2. A review of the facility smoking list identified (4) residents, Resident # 16, Resident #18, Resident #41 and Resident #125 actively smoked. An observation on 3/11/25 at 9:04 AM identified a canopy set up in the designated smoking area. The top of the canopy cover was made up of cloth like material. The label directed to keep away from all flames. An interview with the Director of Maintenance on 3/11/25 at 9:14 AM identified the canopy was placed the evening before as a replacement to the previous canopy damaged in the storm. The canopy was subsequently removed after surveyor inquiry with a plan to research adequate accommodations for the designated smoking area. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the manufacturer guidelines related to safety directed to keep all flame and heat sources away from the tent fabric. The tent may burn if left in continuous contact with any flame source. Although requested, a facility policy for ensuring a safe environment was not provided. 46046

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and interviews for the only resident reviewed for tube feeding (Resident #224), the facility failed to ensure staff obtained a treatment order indicating the location where the treatment should be applied. The findings include: Resident #224's diagnoses included dysphagia and gastrostomy (G-tube) status. A physician's order dated 1/14/2025 directed to cleanse site daily with normal saline, pat dry, apply Bacitracin and cover with a dressing every day and as needed. However, the physician's order failed to identify the location or site for the application of the treatment. The care plan dated 1/17/2025 indicated Resident #224 had an enteral feeding tube. Interventions included: to keep the head of the bed elevated 30-45 degrees during feeding, to monitor for changed in the gastrointestinal status, to monitor the skin surrounding the gastrostomy tube site and provide skin care and dressing change as ordered. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact and had a mechanically altered diet. A clinical record review and interview with RN #4 (DNS) on 3/12/25 at 12:24 PM indicated the order was missing the location of the treatment and staff should not assume the location is the G-tube site. The DNS further indicated she/he would clarify the order. After surveyor inquiry, a physician's order dated 3/13/2025 indicated to apply Bactroban external ointment 2% to the G tube site after cleansing with normal saline, applying calcium alginate and a split gauze dressing every evening and as needed if soiled or dislodged.

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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** 46046 Based on observations, review of facility policy and interviews for 1 of 4 residents (Resident # 224) reviewed for Respiratory Care, the facility failed to ensure staff notified the physician with a change of condition and obtained orders for an invasive procedure and failed to maintain an easily accessible, organized emergency equipment area at the resident's bedside. The findings included: Resident #224's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), pneumonia and acute respiratory failure and neoplasm of the larynx. 1. a. A physician's order dated 1/14/2025 directed to provide Oxygen at 3 liters per minute via a trach mask (a mask that covers and provides oxygen through Resident #224's tracheostomy stoma site located in the neck area) with 28% humidification at bedtime and off in the AM. The care plan dated 1/17/2025 indicated Resident #224 was at risk for Multiple Drug-Resistant Organisms (MDRO) due to having a tracheostomy. An intervention directed to maintain Enhanced Barrier precautions. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact required oxygen therapy, no suctioning and no tracheostomy care. An after hours encounter document dated 2/16/2025 with no time indicated Resident #224 had rhonchi sounds in the lungs and the plan was to obtain a stat chest x-ray and laboratory work had already been ordered for the morning. A nursing progress note dated 2/16/2025 at 9:07 PM indicated Resident #224 was complaining of a new cough with breath sounds decreased in the based and congestion was noted in the upper lobes. The on-call provider was notified and an ordered was obtained for a stat chest x-ray and indicated the responsible party was notified of the change. An after-hours telehealth consult dated 2/17/2025 at 1:00 AM indicated in part the encounter was for a follow up on the resident's chest x-ray results which showed a mild left lower lobe infiltrate improved from moderate infiltrates on 12/29/2024. The plan directed follow up with the day provider/team for antibiotic selection, continue monitoring and follow up as needed and notify physician with any changes or problems. A nursing progress note dated 2/17/2025 at 6:52 PM indicated Resident #224 complained of having difficulty breathing, had heavy secretions, and the respiratory therapist suction the resident and provided Resident#224 with a respiratory treatment. A nursing progress note dated 2/17/2025 at 10:23 PM identified spoke with responsible party concerning vital signs, chest x-ray, laboratory work, and overall status. The responsible party initially indicated wanting resident to be sent to the hospital but after further discussion agreed to the provider decision to treat within the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provider note dated 2/18/2025 at 00:00 indicated in part Resident #224 was being seen for increased congestion and respiratory secretions, laboratory work (white blood cells normal) the repeat chest x-ray showed improvement from prior chest x-ray in December 2024. Having completed intravenous antibiotics on 2/4/2025 for a Multi Drug Resistant Bacteremia. Additionally, the provider noted identified observation of the skin at the trach site was noted with moisture associated skin disorder and thick yellowish phlegm. The assessment and plan indicated the congestion, and increased secretion was stable and to continue supportive care. The plan of care was discussed with the responsible party who was in agreement. A nursing progress note dated 2/19/2025 at 2:08 PM indicated Resident #224 was suctioned once for thick green mucous. A social service note dated 2/20/2025 at 11:47 AM indicated the repsonsible party/ family came to the facility and spoke with (APRN #1) and the charge nurse(LPN #11) and requested Resident #224 be sent to the hospital. A Transfer to Hospital Summary Note dated 2/20/2025 at 11:34 AM indicated Resident #224 was transferred to the hospital at 11:30 AM. A physician order dated 3/10/2025 directed to suction resident as needed for increased secretions. An interview on 3/12/2025 at 12:13 PM with APRN #1 identified s/he had seen Resident #224 on Tuesday 2/18/2025 and the note had indicated thick yellowish phlegm and was notified by staff Resident #224 needed to be suctioned on 2/19/2025 secondary to thick green mucous (phlegm). APRN #1 indicated she/he was not working Wednesday but would have expected nursing to have notified the physician with a change of condition per protocol. APRN #1 further indicated she/he did not examine Resident #224 on 2/20/2025 but was notified of the change, and the responsible party wanting to send to the resident to the hospital which she/he was in agreement to transfer to the hospital. The facility policy labeled Change in condition: Notification date 4/15/2024 indicated the facility staff immediately inform the resident, consult with the resident's provider and notify the responsible party when the following, in part occurs; a deterioration in the resident's physical, mental, or psychological status that is a life-threatening condition or clinical complications, or a need to alter treatment. b. An interview with LPN #11 on 3/12/2025 at 2:18 PM identified not being aware there was no physician's order to suction Resident #224 on 2/19/2025. She/he, may have updated the nursing supervisor of the need to suction Resident #224 for thick green mucous and indicated everyone knew Resident #224 was sick. An interview and record review on 3/11/2025 at 11:18 AM with RN #4 Director of Nursing Services (DNS), indicated on 2/19/2025 there was no physician's order to suction Resident #224 found in the medical record. The DNS further indicated if the resident required suctioning and the color of the sputum changed the nursing supervisor, and the physician should have been notified of the change in condition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/19/2025 at 2:12 PM with the nursing supervisor, RN # 8 on duty 2/19/2025 7-3 PM shift identified she/he was not asked by LPN #11 to see Resident #224. RN # 8 indicated she/he did not notify the physician of any changes during the shift. The facility policy and procedure labeled Tracheostomy Suctioning dated 4/15/2025 indicated in part to verify the provider order for suctioning and to notify provider of abnormally thick, copious, malodorous, or blood-tinged secretions. 2. An observation on 3/9/2025 at 10:45 AM identified an open cardboard box of treatment supplies that had another open box both containing treatment supplies, was on the floor next to Resident #224's right side of the bed. Behind the boxes on the floor was a table with one shelf area. The tabletop had a suction machine on its top along with an open undated bottle of sterile water and a green hospital belongings bag which had an opened trach mask with attached tubing. Two containers of a topical moisturizing cream were on the tabletop in front of the suction machine, an open box to its right contained one suctioning kit. The shelf under the tabletop had various items and behind them was another Ambu bag. The bedside chair next to the table had a bag containing another Ambu bag. While reviewing the physician's orders no order for suctioning was noted. An observation and interview with RN #7 on 3/11/2025 at 3:55 with the Administrator and SW #1 present identified an adaptive type of wheelchair and a walker in front of two open cardboard boxes on the floor which were in front of a table with a suction machine on top and other items on the tabletop and the shelf below and a bedside chair to its right in disarray. RN #7 indicated s/he would move the chair and walker to gain access to the emergency equipment, and at which time identified the open boxes on the floor were treatment supplies for Resident #224 that should not be on the floor and indicated she/he would obtain a bin to organize them. RN #7 further indicated upon opening a green hospital bag on the shelf of the table that contained an open trach mask attached to some tubing which required disposal. RN #7 further indicated another item on the back of the shelf was an Ambu bag (Used to provide breaths in the event of an emergency requiring breathing to be conducted manually) and another Ambu bag. The administrator indicated RN #7 would arrange the supplies and table for ease of use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of facility documentation, facility policy review and interview for 4 of 4 Nurse Aides(NA) (Nurse Aides #1, # 2 # 3 and # 4), the facility failed to ensure that annual competencies were completed for nurse aide staff for 2023 and 2024. The findings include: Review of a facility employee listing provided to the survey team upon entrance to the facility as part of an annual recertification survey identified NA #3 had a hire date of 10/2/2000, NA #4 had a hire date of 7/3/12, and NA #2 had a hire date of 12/12/23. During a review of annual competencies for facility nurse aide staff for 2023, the facility failed to provide any documentation of annual competencies for 2023 completed for NA #3. Further review of the annual competencies for 2024 failed to identify any competencies for NA #2 and NA #4. Interview with LPN #1 (Infection Control Nurse) on 3/12/25 at 12:00 PM identified the facility did not have a dedicated staff development nurse and the DNS, who was unavailable to speak with during the survey, was responsible for ensuring that all nursing staff completed annual in services, education clinical competencies. LPN #1 identified she was unable to locate any documentation or tracking sheets to show the dates and years nurse aides completed annual competencies but was in the process of attempting to locate documentation. LPN #1 also identified the facility was in the process of changing ownership, and that a regional staff development nurse from the new owner would be taking over education and competencies until a permanent staff development nurse was hired. LPN #1 identified that all nursing staff, including nurse aides, were expected to complete in services and clinical competencies at least annually. The facility clinical competency validation checklist for 2023/2024 directed that nurse aide competencies included hand hygiene, personal protective equipment (PPE) donning and doffing, Foley care, intake and output monitoring, gait belt use, peri care, oral care, and oral vent care. The Facility assessment dated ,d+[DATE] directed that education, in services, mandatory inservices, and vital learning would be used for staff competencies and education, and topics would include infection control protocols, hand hygiene competencies, Covid signs/symptoms, cleaning of equipment and PPE donning and doffing. The Facility Assessment also directed that staff training and competencies were necessary to provide the level and types of care needed for the facility resident population.

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Bristol Rehabilitation and Healthcare Center	23 Fair Street Forestville, CT 06010

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46040 Based on review of employee files, facility documentation review, and facility policy review and interviews, the facility failed to ensure annual performance evaluations were completed for nurse aide staff for 2023 and 2024. The findings included: Review of a facility employee listing provided to the survey team upon entrance to the facility as part of an annual recertification survey identified NA #3 had a hire date of 10/2/2000, NA #4 had a hire date of 7/3/12, and NA #2 had a hire date of 12/12/23. A review of annual performance evaluations for facility nurse aide staff for 2023, the facility failed to provide any documentation of annual performance evaluations for completed for NA #3 and NA #4. A review of annual performance evaluations for facility nurse aide staff for 2024, the facility failed to provide any documentation of annual performance evaluations for completed for NA #2 and NA #4. Interview with the Director of HR on 3/12/25 at 11:05 AM identified she was responsible for notifying the DNS of the facility when nursing staff had performance evaluations that were due to be done. The Director of HR identified she kept this information on an excel document which she saved to her computer and that when she did a monthly review of the document, she would then provide the DNS the names and performance evaluation paperwork to complete for each employee. Following a request to see the document to determine when the evaluations for NA #2, NA #3 and NA #4 were due, the Director of HR then identified she had gotten behind in updating the document due to her workload and declined to provide any documentation. The Director of HR identified that the DNS did not keep any track of evaluations that were due and it was her responsibility to notify the DNS. The Director of HR identified that performance evaluations were to be done at 30 days, 90 days, and then annually thereafter. Although requested, the facility failed to provide any polices related to annual performance evaluations.

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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** 46046 Based on review of the clinical record, observation, facility policy and interviews for the only resident reviewed for skin conditions (Resident #46) and the only resident (Resident #224) reviewed for tube feeding, the facility failed to follow the Enhanced Barrier Precautions guidelines. The findings include: 1. Resident #46's diagnoses included Venous Insufficiency, edema, essential hypertension. The Resident Care Plan dated 2/17/25 identified the resident had a lesion on his/her right dorsal foot. Interventions included weekly skin checks by licensed nurses, and floating heels while in bed. The admission Minimum Data Set assessment dated [DATE] identified Resident #46 was cognitively intact and required maximum assistance with showering, toileting, and required moderate assistance with personal hygiene. A physician's order dated 3/9/2025 directed to place resident on enhanced barrier precautions every shift secondary to a wound. A physician's note dated 2/14/25 at 7:56 AM written by Medical Doctor (MD #2) identified Resident #46 had an abscess like lesion to foot and needed a follow up with a podiatrist for possible identification. Observation and interview with RN #2 (supervisor) on 3/9/25 at 1:20 PM identified there was no EBP signage on the resident's door and the Wound Care Nurse was completing a dressing change. RN #2 identified that there was no signage on the door and further stated she was unsure if the resident should be on EBP as she only works every other Sunday. When asked if she would expect a resident with an open wound to be on EBP, RN # 2 indicated she did not know. Observation on 3/10/25 at 8:30 AM identified EBP signage on the resident's door After surveyor inquiry. In an interview with Wound Care Nurse on 3/10/25 at 8:30 AM indicated she was unsure if the resident should be on EBP, and she would speak to the Infection Control Preventionist (ICP). At 8:45 AM the Wound Nurses confirmed that the resident should have been on EBP and has not been as per the ICP. Review of the facility policy, Enhanced Barrier Precautions, dated 1/8/24 presently in effect, directed, in part the purpose was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. 2. Resident #224's diagnoses included dysphagia and gastrostomy status. A physician's order dated 1/14/2025 directed to provide enhanced barrier precautions. A physician's order dated 1/14/2025 directed to cleanse site daily with normal saline, pat dry, apply Bacitracin and cover with a dressing every day and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 1/17/2025 indicated Resident #224 had an enteral feeding tube. Interventions included : to keep the head of the bed elevated 30-45 degrees during feeding, to monitor for changed in the gastrointestinal status, to monitor the skin surrounding the gastrostomy tube site and provide skin care and dressing change as ordered. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact and had a mechanically altered diet. An interview with LPN #11 on 3/10/2025 at 1:19 PM indicated Resident #224 had yet to change the gastrostomy tube dressing. LPN #11 further indicated Resident #224 may refuse to have the dressing changed since it was changed on 3/9/3035 at 10:00 PM. The surveyor went in to see Resident # 224 and the state Ombudsman Person was present. Resident #224 agreed to having the dressing changed, the surveyor was to observe process after the resident visit with the Ombudsman . An observation and interview with LPN #11 on 3/10/25 at 01:30 PM for the daily gastrostomy tube (G-tube) site care and dressing change. LPN #11 (charge nurse) on the unit, entered Resident #224's room bringing a box of gloves and treatment supplies. After applying the gloves, the bedside table was cleansed with a bleach wipe, a clean protective covering was placed on the table along with the supplies ordered and a trash bag, the gloves were removed, and hand hygiene was conducted before applying clean gloves. The old dressing dated 2025 at 10:00 PM was removed from around the G-tube site noting a small to moderate amount of tan drainage, no surrounding redness and skin intact, LPN #11 indicated it was tube feeding on the dressing and placed it into a trash bag, the gloves were removed, hand hygiene conducted, new gloves applied, and the G-tube site care and dressing was conducted as ordered. The new dressing was dated with the date and time. Resident #224 indicated the drainage had increased over time and the area surrounding area has increased tenderness. LPN #11 indicated s/he would notify the APRN to evaluate Resident #224's concern. After all items were bagged and the tabletop cleansed with a bleach wipe and resident items placed within reach LPN #11 and the surveyor exited the room and noted a large, opened box sitting on a white bin with drawers next to a tall cart with items on the right side of Resident #224's room. Behind the open boxed lid was a sign labeled Enhanced Barrier Precautions. When asked which resident did this apply to and should LPN #11 have donned a gown in addition to wearing gloves while providing a dressing change to Resident #224. LPN #11 indicated s/he should have worn a gown during the dressing change. An interview and observation of the blocked enhanced barrier signage with RN #4(Director of Nursing Services) outside Resident #224's room on 3/11 2025 at 2:00 PM identified LPN #11 should have worn a gown and RN #4 would ensure the signage and the personal protective equipment bin was visible. The facility policy labeled Enhanced Barrier Precautions dated 4/15/2025 indicated in part the purpose of Enhanced Barrier Precautions is to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. 48792

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record reviews, observations, review of facility policy and interviews for 2 of 5 (Residents # 40 and # 325) reviewed for the environment,, the facility did not ensure that residents call bell were within reach. The findings included: 1. Resident #40 was admitted to the facility on [DATE] with diagnoses that included a neurological disorder and dependence on a ventilator. A care plan dated [DATE] indicated Resident #40 was at risk for alteration in comfort related to chronic pain. Interventions included advising the resident to request pain medication before the pain becomes severe. The care plan also indicated the resident had an Advanced Directive to perform Cardio CPR during an emergency. The quarterly MDS assessment dated [DATE] indicated the resident had severe cognitive impairment, usually understood others. The MDS assessment further indicated the resident required substantial/maximal assistance with mobility and was dependent on personal hygiene and toileting. An observation in Resident #40's room on [DATE] at 11:48 AM identified Resident #40 was connected to a ventilator and the call bell was not within the resident's reach. The call bell was on the tray table next to the bed two feet away. The resident was observed to not be able to move arms up. During the observation, Resident #40 was mouthing words and asked the surveyor for pain medication for his/her neck. LPN #7 was called in to assist. An interview with LPN#7 indicated Resident #40 was able to use the call bell and the bell should have been within the resident's reach. 2. Resident #325 was admitted to the facility on [DATE] with diagnoses that included dependence on a ventilator and muscle weakness. An Admission Assessment by recreation identified Resident #325 was alert and was able to make their needs known to staff. The assessment also indicated the resident was able to answer yes/no questions, write some words, and mouth words. An observation in Resident #325's room on [DATE] at 12:50 PM identified the resident was connected to a ventilator and Resident # 325's call bell was on the floor next to the bed. NA#4 was called in to assist. An interview with NA#4 indicated she was not familiar with the resident's ability to call since the resident was new to the facility. NA#4 also indicated the resident should have had the call bell clipped to his/her sheets. NA#4 then proceeded to clip the call bell to the sheets, and Resident #325 was asked to test the button. Although Resident #325 held the call bell in his/her hand and attempted to push the button with his/her thumb, the resident was unable to push the button fully to activate the call bell. NA#4 further indicated the resident might benefit from a blue call bell, which is an adaptive call bell that is easier to push. The facility policy for call lights identified that all residents would have a call light or alternative communication device within their reach at all times when unattended.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations, review of facility documents, review of policy and interviews, the facility failed to ensure 2 therapeutic modality machines in the Therapy Department had been evaluated annually for safety in 2022 and 2023 and for 1 of 4 residents (Resident # 8) reviewed for Respiratory Care, the facility failed to ensure signage was on a resident's door to indicate oxygen was in use. The findings included: 1. An observation on 3/11/2025 starting at 2:00PM and ending at 3:15 PM of the Therapy Department that uses the same room and equipment for residents in the facility and for outpatient physical therapy. Further observations identified the therapy modality machines was without stickers to indicated when was the last time the machine had been evaluated for safety. An interview with the Maintenance Director on 3/11/2025 at 3:15 PM indicated she/he could not find stickers on either modality machine of when the last safety evaluation was conducted and indicated she/he would look at the service documents and provide an update to the surveyor. An interview and document review with the Maintenance Director on 3/11/2025 at 4:15 PM indicated she/he could provide service documents for the evaluation of the modality machines for 2023 or 2024. After surveyor inquiry, the Maintenance Director called the equipment servicing company who indicated they would be out in the following week to service the two machines. The Maintenance Director removed both machines were locked up and out of the area until they could be serviced. 2. Resident #8 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure and anxiety. The care plan dated 1/17/25 identified Congestive Heart Failure. Interventions included to administer Oxygen as ordered. A physician's order dated 1/17/25 directed Oxygen to be set at 3-5 liters via Nasal Cannula continuously. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was cognitive intact and required maximal assistance with personal care and supervision/ touching assistance with bed mobility and transfers. The MDS also indicated Resident #8 experiences shortness of breath or trouble breathing with exertion and shortness of breath when lying flat. Observations on 3/9/25 at 10:50 AM, identified Resident #8 in his/her room using Oxygen. There was no sign posted outside of the resident's room indicating oxygen was in use. Interview with LPN #3 on 3/9/25 at 11:15 AM identifed she is unsure why the oxygen in use sign was not up and stated the maintenance is usually responsible for putting up signs. LPN #3 further indicated she would bring this matter to maintenance attention. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Maintenance Director on 3/9/25 at 11:17 AM identified nursing staff typically handles ensuring resident who require signs are put up. After surveyor inquiry, on 3/9/25 at 1:30 PM LPN #3 identifed that an oxygen in use sign has been placed outside resident's room. Per facilities Oxygen High Pressure Cylinders (reviewed 12/16/24) section 1.3 in part indicated A No smoking- Oxygen in use sign must be posted in any area where high pressure cylinders are stored. 49100