STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075202	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Geer Nursing and Rehabilitation	99 South Canaan Rd Canaan, CT 06018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, facility policy review and interviews for 1 of 3 sampled residents (Resident #21) reviewed for dementia care, the facility failed develop a care plan that identified a resident with dementia and individualized care needs and for (Resident #4) reviewed for nutrition, the facility failed to ensure daily weights were implemented according to the plan of care for a resident at risk for fluid overload and for 2 of 2 residents, (Resident #47 and # 278)) reviewed for medication administration, the facility failed to ensure medications were administered in accordance to the plan of care and for for 1 of 5 residents, (Resident #7) reviewed for unnecessary medications, the facility failed to report a significant change in blood pressure per plan of care and for 1 of 1 resident (Resident # 60 reviewed for Hospice/ End of Life Services, the facility failed to ensure staff transcribed special diet instructions for a resident with dysphagia upon admission to the facility per plan of care The findings included: 1.Resident #21's diagnoses included Parkinson's disease and dementia without behavioral disturbance. The Minimum Data Set (MDS)assessment dated [DATE] identified Resident #21 as cognitively intact, independent/required set up assist with activities of daily living and noted a diagnosis that included dementia. The Resident Care Plan dated 6/26/24 identified Resident #21 had Parkinson's disease. Interventions included to monitor/document and report signs of Parkinson's disease complications such as tremors, mood changes and decline in cognitive function. The Resident Care Plan failed to identify Resident #21 had a diagnosis of dementia or any interventions that would support h/her individualized care needs. An interview with the Director of Nursing Services (DNS) on 8/27/24 at 12:10 PM identified the care plan should have been individualized to reflect Resident #21's diagnosis of dementia and h/her care needs. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Care Plans dated 3/2024 notes a resident care plan is a communication tool that guides all members of the healthcare team on how to meet each resident's needs. Developed and implemented within the first 48 hours of admission, the care plan should focus on preventing avoidable decline, managing risks factors, preserving resident strengths, evaluating progress towards goals and respecting a resident right to decline treatment. 2.Resident #4 's diagnoses included chronic atrial fibrillation and chronic diastolic congestive heart failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 as cognitively intact and required extensive two-person assist with activities of daily living, supervision with eating. The physician orders 5/23/24 directed daily weights. The Resident Care Plan 5/29/24 identified Resident #4 had altered cardiac status, was at risk for fluid overload related to CHF and had a potential for a nutritional problem related to heart disease. Interventions directed to monitor/document/report any signs and symptoms of coronary artery disease and to obtain weight according to facility guidelines. A review of the weight log dated 7/2/24 through 8/26/24 identified Resident #4's weight was recorded 11 out of 30 days in July 2024 and 19 out of 26 days in August. An interview with the Director of Nursing Services (DNS) on 8/27/24 at 1:22 PM identified that weights should have been obtained in accordance with physician orders. An interview with Nurse Practitioner, NP #1 on 8/27/24 at 1:41 PM identified monitoring weights assisted in evaluating how a resident with CHF was doing clinically as there were risks for fluid overload and abnormal laboratory. NP #1 identified the weights should be done in accordance with physician orders. Although requested, a facility policy for monitoring weights for a resident with CHF was not provided. 3. Resident #47's diagnoses that included asthma and hyperlipidemia (elevated cholesterol). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 as cognitively intact and independent with activities of daily living (ADL). The Resident Care Plan dated 7/18/24 identified Resident #47 had a communication deficit related to hearing loss and an ADL deficit related to gait imbalance and history of seizures. Interventions directed to provide a white board for communication and maintain a clutter free environment. The physician's orders dated 7/22/24 directed Atorvastatin 40 Milligrams (MG) one time a day for hyperlipidemia and Cetirizine hydrochloride (HCL) 10mg one time a day for dry skin. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 8/26/24 at 10:02 AM identified Licensed Practical Nurse, LPN #1 retrieved a blister pack from the medication cart. Instructions directed Atorvastatin 40mg one time a day at bedtime. The medication administration record (MAR) directed to administer the medication at 8:30 AM LPN #1 retrieved a second blister pack with instructions that directed Cetirizine hydrochloride (HCL) 10mg one time a day at bedtime. The MAR directed the medication at 8:30 AM. LPN #1 placed both medication blister packs aside and contacted the pharmacy to address the discrepancy and received clarification that both medications were ordered to be given at bedtime. The medications were subsequently held, and Resident #47 received the remainder of h/her prescribed medications. A review of the physician orders dated 6/1/24 through 8/22/24 identified that physician prescription renewal orders dated 6/10/24 directed Atorvastatin 40mg one time a day at bedtime for hyperlipidemia. Additionally, physician prescription renewal orders dated 6/12/24 directed Cetirizine hydrochloride (HCL) 10mg one time a day at bedtime for dry skin. A review of the Medication Administration Record (MAR) dated 6/11/24 through 7/22/24 identified the Atorvastatin was administered at 8:30 AM instead of bedtime as prescribed. A review of the Medication Administration Record (MAR) dated 6/13/24 through 7/22/24 identified the Cetirizine HCL was administered at 8:30 AM instead of bedtime as prescribed. An interview and facility documentation review with the facility Pharmacist on 8/22/24 at 1:15 PM identified he reached out to the provider directly for any medication renewals. The prescriptions for renewals were stored in a separate system used by the pharmacy and were not integrated with the facility MAR. The Pharmacist obtained a medication renewal for Atorvastatin on 6/10/24 once daily at bedtime and Cetirizine HCL10 mg at bedtime on 6/12/24. The Pharmacist filled the prescriptions and sent the medication with instructions to the unit. The Pharmacist further identified Resident #47 was readmitted to the facility on [DATE]. However, no orders were sent following that readmission with any medication changes. An interview and clinical record review with the Director of Nursing Services (DNS) on 8/26/24 at 9:49 AM identified the Pharmacist reaches out to the provider independently for medication renewals. The system utilized by the Pharmacist was not integrated into the electronic medical record. However, any discrepancies between the administration instructions on the blister packs and the MAR should have been clarified by nursing staff and changed according to the most accurate order. A review of the facility policy for Medication Orders dated 7/2023 directed that Medications are administered only upon clear, complete, and signed orders of a person lawfully authorized to prescribe. Elements of the medication order and specify the name of the medication, strength, dose, time and frequency of administration and route, duration and indication for use. 4. Resident #278 was admitted to the facility on [DATE]. The resident diagnosis includes Parkinson's disease. The admission MDS assessment dated [DATE] identified Resident #278 as cognitively intact and required extensive assistance with bed mobility, toileting, and personal hygiene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital discharge instructions dated 7/25/2023 directed Resident #278 to continue taking carbidopa-levodopa (a medication to treat Parkinson's disease) 25-100 milligrams (mg) three times a day but did not indicate the number of tablets to be taken. The hospital discharge instructions also indicated Resident #278 would continue taking one tablet of carbidopa-levodopa 25-100mg extended release (a version designed to release medication gradually in the body) twice daily at 1:00 PM and noon. A nursing note dated 7/25/2023 indicated the nursing supervisor Registered Nurse (RN#5) had spoken to Resident #278's family member regarding the resident's medications, including the preferred schedule. The preferred schedule was observed to be handwritten over the hospital discharge instructions and indicated the resident was to have one and a half tablets of carbidopa-levodopa 25-100mg at 6;00 AM, 9:00 AM, 3:00 PM, 6:00 PM, and 9:00 PM. The handwritten note also indicated the resident was to have one tablet of carbidopa-levodopa 25-100mg extended release at noon and at bedtime. A physician's order dated 7/26/2023 directed to administer one and a half tablets of carbidopa-levodopa 25-100mg five times a day. Additionally, a physician's order dated 7/27/2023 directed to administer one tablet of carbidopa-levodopa 25-100mg extended release once in the day and once before bed. A nursing note dated 8/4/2023 written by RN #3 identified Resident #278's family member had indicated Resident #278 should have been receiving one tablet of carbidopa-levodopa 25-100mg at noon along with one tablet of carbidopa-levodopa 25-100mg extended-release. A physician's note dated 8/4/2023 identified the physician clarified with the resident's family member the medication and ordered carbidopa-levodopa 25-100mg to be administered at noon. A physician's order dated 8/5/2023 directed to administer one tablet of carbidopa-levodopa 25-100mg with the noon dose of carbidopa-levodopa 25-100mg extended release. A review of the medication administration record (MAR) from 7/25/23 through 8/15/23 failed to provide evidence that one and a half tablets of carbidopa-levodopa 25-100mg were administered as ordered for the following dates and times: 7/26/2023 at 2:30 PM, 7/28/2023 at 2:30 PM, 7/31/2023 at 2:30 PM, 8/3/2023 at 2:30 PM, 8/6/2023 at 2:30 PM, 8/13/2023 at 6:00 AM and 8/14/2023 at 2:30 PM. A review of nursing progress notes from 7/25/23 through 8/15/23 did not identify any reason for the not administering carbidopa-levodopa 25-100mg. In an interview on 8/26/2024 at 1:57 PM, RN #3 indicated s/he could not recall how the conversation with Resident #278 family member came about but identified the family member had requested that carbidopa-levodopa 25-100mg be administered as per the resident's home schedule including the doses for noon. RN#3 indicated s/he notified the physician and had the noon dose ordered. Additionally, RN#3 indicated on admission to the facility, the hospital Intra-Agency Report (W10), discharge instructions, and discussion with the resident or family are used to determine what medications a resident should be ordered. RN #3 indicated s/he was not aware of any complaints prior to or after her/his conversation with Resident #278's family member. In an interview on 8/27/2024 at 11:15 AM, APRN #2 indicated s/he could not recall specifics regarding the conversation with the resident's spouse. APRN #2 also indicated s/he placed an order for carbidopa-levodopa but could not recall the dose or the scheduled time and referred to her/his note and physician's orders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/2024 at 11:45 AM, a record review and interview with the DNS identified the discharge paperwork from the hospital was not always accurate regarding specific regimens, especially with Parkinson's medications. The DNS indicated that verifying a resident's particular medication regimen with the family was important. Additionally, the DNS was unable to identify why there were blanks in the MAR for carbidopa-levodopa 25-100mg for the scheduled times of 7/26/2023 at 2:30 PM, 7/28/2023 at 2:30 PM, 7/31/2023 at 2:30 PM, 8/3/2023 at 2:30 PM, 8/6/2023 at 2:30 PM, 8/13/2023 at 6:00 AM and 8/14/2023 at 2:30 PM. The DNS further indicated that if a dose of medication was not given or was held, s/he would expect a nursing note. On 8/27/2024 at 12:13PM an interview with RN#5 identified s/he had spoken to Resident #278's family member and verified the schedule of the residents Parkinson medications. In an interview and record review on 8/27/2024 at 1:57 PM, LPN #3 indicated that based on his/her documentation in the MAR, the resident did not receive the 2:30 PM dose of carbidopa-levodopa on 7/26/2023 because the medication was not available. LPN #3 could not recall why the medication was not available at the time. Additionally, LPN #3 could not identify a reason why the MAR had blanks on 7/31/2023 at 2:30 PM, 8/3/2023 at 2:30 PM, and 8/14/2023 at 2:30 PM (times on which s/he was on duty). LPN #3 indicated that s/he most likely gave the medications but was not sure since s/he could not recall the resident. A review of the facility policy for medication administration identified the individual who administers the medication records the administration on the resident's MAR directly after it is given. Additionally, the facility policy indicated an individual who administered medications should not report off-duty without first recording the administration of any medications. 5. Resident #7's diagnoses included Alzheimer's disease, insomnia, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #7 as severely cognitively impaired and required extensive assistance for transfers, toileting, and supervision for eating. The Resident Care Plan dated 7/1/24 identified Resident #7 has a diagnosis of anxiety. Interventions included mood assessment and provision of supportive care through one-on-one visits. A physician's order dated 7/18/24 directed to obtain orthostatic blood pressures monthly for postural hypotension. Report a decrease in systolic blood pressure of 20mmHg or more and decrease in diastolic blood pressure of 10 mmHg or more with change in position. A nursing note written by LPN #5 dated 7/2724 at 3:00 PM identified Resident # 7's orthostatic blood pressures as 146/69 (120/80 Normal Range) lying, 177/68 sitting, and 95/71 standing. The pharmacy reports dated 6/14/24, and 8/18/24 recommend monitoring orthostatic blood pressures at least monthly to monitor for postural hypotension. The report also directed to report a decrease in systolic blood pressure of 20mmHg or more and decrease in diastolic blood pressure of 10 mmHg or more with change in position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and clinical record review with the DNS on 8/28/24 at 11:00 AM identified the clinical record failed to reflect documentation that the decrease in blood pressure on 7/27/24 was reported to the Medical Doctor (MD)/APRN. The parameters state to report a decrease in BP greater than 20 mmHg systolic or 10 mmHg diastolic with position change to the MD/APRN. Resident # 7's BP on 7/27/24 indicated a pressure of 146/69 Lying, 177/68 sitting, and 95/71 standing. The systolic pressure decreased by 82 mmHg from sitting to standing. When asked, the DNS identified the decrease from sitting to standing should have been reported to the MD/APRN. The DNS also stated staff should be documenting in the nursing notes any notification to the MD/APRN. The DNS indicated s/he could not provide evidence of the notification to the MD/APRN on 7/27/24 per physician's parameters for blood pressure monitoring. Review of the Orthostatic Blood Pressure Monitoring policy 3/07 directed, in part, to report newly or unexpectedly abnormal orthostatic changes as follows: systolic BP is decreased by 20 or more, with or without change in diastolic BP. 6. Resident #60's diagnoses included pneumonitis, dysphagia (difficulty swallowing), a progressive neurogenerative disorder and palliative care. The hospital discharge summary dated 7/17/2024 at 11:34 AM directed to provide an easy to chew diet cut into bite sized pieces with discharge special instruction to provide Strict Aspiration Precautions with upright posture while eating. A physician's order dated 7/17/2024 directed to provide a puree texture diet with nectar thick liquids. A physician's order dated 7/18/2024 directed to provide a regular chopped texture diet with nectar thick liquids due to Resident #60 and family preferring a more palatable texture. The RCP dated 7/19/2024 indicated Resident #60 had a swallowing problem related to couching, choking during meals or swallowing medications and difficulty with thin liquids. Interventions included in part for all staff to be informed of Resident #60's special dietary and safety needs, instruct resident to eat in an upright position, eat slowly and chew each bite thoroughly and to provide food for comfort. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 as cognitively intact and noted coughing or choking during meals and or with medications and indicated the resident was on a mechanically altered diet. A facility Reported Incident dated 8/23/2024 at 8:30 AM identified Resident #60 required the successful application of the Heimlich Maneuver after choking on a piece of fruit provided at breakfast. The physician's orders obtained post episode of choking dated 8/23/2024 at 3:00 PM directed to provide supervision with eating with aspiration precautions every shift and provide a regular diet, puree consistency. The RCP was updated on 8/23/2024 indicated Resident #60 was to eat only with supervision with aspiration precautions (37 days after admission) and to mash banana. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review on 8/26/2024 at 1:20 PM with RN #3 indicated on part The admission discharge summary from the hospital indicated strict aspiration precautions which was not transcribed onto the admission orders and did not mention in the plan of care but indicated supervision while eating and cleanse mouth before and after eating and to have head of bed elevated. An interview on 8/26/2034 at 1:40PM with the DNS indicated if strict aspiration precautions was on the discharge summary it should have been transcribed as an order. The facility policy labeled Aspiration Precautions indicated in part the facility was to provide guidelines in the policy when ordered by a physician to reduce the risk of aspiration: clear oral cavity of residual food and fluid following all oral intake including medications and to position to approximately 90 degrees for all oral intakes including fluids. However, the facility policy makes no indication if staff must remain present when a resident is taking food and or fluids.

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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** 49100 Based on clinical record reviews, facility policy review and interviews for 1 of 3 sampled residents reviewed for care planning for(Resident # 71), the facility failed to conduct a Resident Care Conference (RCC) within the appropriate timeframe and invite the resident's responsible party/ family and for 1 of 1 resident (Resident # 60), reviewed for End of Life Services, the facility failed to revise the care plan to address the resident's wishes to received non prescribe foods for comfort. The findings included: 1. Resident #71 's diagnoses included unspecified dementia, cognitive communication deficit and aphasia. A review of the admission record identified Resident #71 was admitted on [DATE] The admission Minimum Data Set assessment dated [DATE] identified Resident #71 was cognitively impaired and required one person assistance in bed mobility and transfers and requires set up for food. The RCP dated 7/18/24 identified the need for long-term care. Interventions included collaborating with residents, family and Interdisciplinary Team (IDT) to determine emotional needs and to maintain quality of care. A review of progress notes dated 7/17/24 through 8/26/24 failed to indicate that RCC was held for Resident # 71. Interview with Person #1 on 8/22/24 at 11:54 AM indicated s/he has not been invited to a care plan meeting for Resident # 71. Person #1 also indicated it has been over 4 weeks since Resident # 71 was admitted . On 8/28/24 at 10: 37 AM a review of the RCC sign off sheet was requested; however, the facility was unable to provide the requested document. Interview Social Worker (SW #1) on 8/28/24 at 10:43 AM indicated residents on long term units care plan completed quarterly. For new residents the care plan is completed with in 2.5 months of admission. SW#1 further indicated Resident #71 has an upcoming MDS assessment and care plan review in October 2024. SW #1 further indicated care conference is done after the MDS assessment. When asked about MDS completed on 7/22/24, SW #1 indicated s/he was not aware the RCC could have been completed based on the MDS assessment completed on 7/22/24. 2. Resident #60's diagnoses included pneumonitis, dysphagia (difficulty swallowing), a progressive neurogenerative disorder and palliative care. Resident #60 elected Hospice services on 7/19/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 7/24/2024 indicated Resident #60 was receiving End of Life Services. Interventions included collaboration between End-of-Life Services and the Skilled Nursing Facility and directed the social worker to provide support to the resident and family. An interview on 8/26/2024 at 1:24 PM with Hospice Agency Nurse (RN #6) identified eating food for comfort in the consistency Resident # 60 preferred though not recommended by physician due to progressive dysphagia diagnosis, was one of the most important needs expressed by the resident and family while on Hospice/ End of Life Services. An interview and record review with the Director of Nursing Services (DNS) on 8/28/2024 indicated Resident #60's care plan would need to be updated/ revised to reflect Resident # 60's choice to eat food in a consistency not recommended by physician. Interventions to assist the resident by providing the safest eating experience while providing food for comfort and to prevent further choking episodes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observations and staff interviews for 1 of 5 Residents (#60) reviewed for accidents, the facility failed to ensure the resident's discharge summary physician's orders for aspiration precautions were transcribed to meet professional standards of practice. The findings include. Resident #60's diagnoses included pneumonitis, dysphagia (difficulty swallowing), a progressive neurogenerative disorder and palliative care. The hospital discharge summary dated 7/17/2024 at 11:34 AM directed to provide an easy to chew diet cut into bite sized pieces with discharge special instruction to provide Strict Aspiration Precautions with upright posture while eating. A physician's order dated 7/17/2024 directed to provide a puree texture diet with nectar thick liquids. A physician's order dated 7/18/2024 directed to provide a regular chopped texture diet with nectar thick liquids due to Resident #60 and family preferring a more palatable texture. Resident #60 elected Hospice services on 7/19/2024. The admitting note indicated Resident #60 and family were made aware of risks of recurring aspiration due to disease progression by choosing not to follow a recommended diet consistency of puree and opting for a chopped consistency diet. The RCP dated 7/19/2024 indicated Resident #60 had a swallowing problem related to couching, choking during meals or swallowing medications and difficulty with thin liquids. Interventions included in part for all staff to be informed of Resident #60's special dietary and safety needs, instruct resident to eat in an upright position, eat slowly and chew each bite thoroughly and to provide food for comfort. Additionally, the care further indicated Resident #60 had a self-care deficit related to activity intolerance related to aspiration pneumonia and a progressive neurodegenerative disorder. Interventions included in part for staff to provide supervision for eating, to cleanse mouth with wet swabs prior to and post eating and to position plate or bowl in lap, use an inner lip plate at all meals and to keep drinks on right hand side of the table. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 as cognitively intact and noted coughing or choking during meals and or with medications and indicated the resident was on a mechanically altered diet. A facility Reported Incident dated 8/23/2024 at 8:30 AM identified Resident #60 required the successful application of the Heimlich Maneuver after choking on a piece of fruit provided at breakfast. The physician's orders obtained post episode of choking dated 8/23/2024 at 3:00 PM directed to provide supervision with eating with aspiration precautions every shift and provide a regular diet, puree consistency. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP was updated on 8/23/2024 indicated Resident #60 was to eat only with supervision with aspiration precautions (37 days after admission) and to mash banana. A physician's order dated 8/24/2024 at 6:48 PM directed to provide a regular diet, ground texture, with nectar thick liquids and mashed bananas aspiration precautions. Resident #60 had declined the puree consistency as it did not meet his/her comfort needs while on hospice. An observation on 8/25/2024 at 12:38 PM found Resident #60 sitting upright in bed alone and without supervision, the tray table was noted in front of the resident with two full beverages within reach. On 8/25/2024 at 12:40 PM an interview with NA #1 who was sitting at the nurse's station at the end of hallway 2 rooms down from Resident #60's indicated s/he supervises Resident #60 while eating by walking up and down the hall, looking in and checking on the resident, s/he sometimes sits with the resident, but Resident # 60 does not always like someone sitting with him/her. NA #1 further indicated Resident#60's diet required food to be cut into small pieces, was not on duty the day Resident #60 choked and further indicated Resident # 60 had not received a banana for breakfast this am. NA #1 indicated s/he thought the kitchen would mash the banana before sending the tray up from the kitchen. On 8/25/2024 at 12:45 PM and interview with the unit charge nurse LPN #3 indicated s/he supervises Resident #60 while eating by walking up and down the hallway looking in the room, sometimes staying with the resident and sometimes observing from the doorway. LPN #3 indicated Resident #60 did not like to be watched. LPN #3 further indicated staff is not required to stay with Resident #60 while eating or drinking, just to supervise and check in on the resident and instructed the surveyor to talk with the unit manager RN #3. On 8/25/2024 at 12:48 PM an interview with the Unit Manager, RN#3 indicated a staff member is expected to stay with Resident #60 while eating and drinking. However, hospice election notes Resident #60 chooses to eat for comfort despite the consistency recommended. RN #3 acknowledged a difference in interpretation of what supervision requires staff members caring for Resident #60 to do and indicated s/he would find a copy of the facility policy. On 8/25/2024 12:48 PM during interview, record review with RN #3 at nurses' station and direct observation with charge nurse LPN #3, LPN #3 indicated aspiration precautions was put in place and updated on the care card. Observation of Resident #60 with charge nurse LPN #3 found Resident # 60 alone in room in bed without supervision with the tray table pulled up to the chest and two beverage cups upright and empty and the contents of one spilled on the tray table. LPN #3 checked on Resident #60 and cleaned the spill. LPN #3 provided the NA care card updated on 8/23/24 which indicated supervision with meals, aspiration precautions and to provide mashed bananas. An interview and record review on 8/26/2024 at 1:20 PM with RN #3 indicated in part the admission discharge summary from the hospital indicated strict aspiration precautions which were not transcribed onto the admission orders but was not noted in the plan of care. However, the plan of care indicated supervision while eating and cleanse mouth before and after eating and to have head of bed elevated. (continued on next page)

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Geer Nursing and Rehabilitation	99 South Canaan Rd Canaan, CT 06018

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 8/26/2034 at 1:40PM with the DNS indicated if strict aspiration precautions were noted on the discharge summary the strict aspiration precautions should have been transcribed as an physician's order.

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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** 46046 Based on clinical record review, review of facility policy and staff interview for 1 of 2 residents (Resident #32) reviewed for Pressure Ulcer, the facility failed to ensure weekly skin assessments were completed per plan of care for a resident who developed a pressure ulcer. The findings include. Resident #32's diagnoses included Stage 2 pressure ulcer and Alzheimer's disease. A physician's order dated 5/9/2024 directed to complete a weekly skin check for skin assessment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #32 as severely cognitively impaired and at risk for pressure ulcer and noted no pressure ulcers. The clinical record on 8/16/24 identified the wound physician identified a Stage 2 pressure ulcer on 8/16/2024 on the resident's right buttocks. The RCP for potential for development of a pressure ulcer care plan revised on 8/21/2024 indicated Resident #32 had a stage 2 pressure ulcer on the right buttock. Interventions included to follow up with the wound Advanced Practice Registered Nurse (APRN) weekly, to maintain enhanced barrier precautions while wound is open. An interview and record review with the unit manager RN #3 on 8/26/2024 at 10:45 AM identified weekly skin checks were not documented on 7/10/24 and 8/7/2024. RN # 3 unit manager indicated s/he would expect the Treatment Administration Record (TAR) to have signatures to note completion of weekly skin checks assessment along with documentation of findings. RN #3 further indicated s/he could not find any weekly nursing skin assessment completed for 7/10/24 or 8/7/2024 or any documentation in the nurses' notes on 7/10/24 and 8/7/24 regarding a skin assessment. The facility policy labeled pressure ulcers given on survey indicated in part, all residents will have a total body skin check at least weekly by the licensed professional nurse and results will be documented.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observation, review of facility policy and interviews for 1 of 5 Residents (#60) reviewed for accidents, the facility failed to ensure a resident with at risk for aspiration while eating and drinking provided necessary supervision to ensure the resident did not have access to fluids not on recommended and failed to ensure all staff were educated and demonstrated the understanding of a resident's need for supervision while eating and drinking. The findings include. Resident #60's diagnoses included pneumonitis, dysphagia (difficulty swallowing), a progressive neurogenerative disorder and palliative care. a. The hospital discharge summary dated 7/17/2024 at 11:34 AM directed to provide an easy to chew diet cut into bite sized pieces with discharge special instruction to provide Strict Aspiration Precautions with upright posture while eating. A physician's order dated 7/17/2024 directed to provide a puree texture diet with nectar thick liquids. A physician's order dated 7/18/2024 directed to provide a regular chopped texture diet with nectar thick liquids due to Resident #60 and family preferring a more palatable texture. Resident #60 elected Hospice services on 7/19/2024. The admitting note indicated Resident #60, and family were made aware of risks of recurring aspiration due to disease progression by choosing not to follow a recommended diet consistency of puree and opting for a chopped consistency diet. The RCP dated 7/19/2024 indicated Resident #60 had a swallowing problem related to couching, choking during meals or swallowing medications and difficulty with thin liquids. Interventions included in part for all staff to be informed of Resident #60's special dietary and safety needs, instruct resident to eat in an upright position, eat slowly and chew each bite thoroughly and to provide food for comfort. Additionally, the care further indicated Resident #60 had a self-care deficit related to activity intolerance related to aspiration pneumonia and a progressive neurodegenerative disorder. Interventions included in part for staff to provide supervision for eating, to cleanse mouth with wet swabs prior to and post eating and to position plate or bowl in lap, use an inner lip plate at all meals and to keep drinks on right hand side of the table. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #60 as cognitively intact and noted coughing or choking during meals and or with medications and indicated the resident was on a mechanically altered diet. A facility Reported Incident dated 8/23/2024 at 8:30 AM identified Resident #60 required the successful application of the Heimlich Maneuver after choking on a piece of fruit provided at breakfast. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders obtained post episode of choking dated 8/23/2024 at 3:00 PM directed to provide supervision with eating with aspiration precautions every shift and provide a regular diet, puree consistency. The RCP was updated on 8/23/2024 indicated Resident #60 was to eat only with supervision with aspiration precautions (37 days after admission) and to mash banana. A physician's order dated 8/24/2024 at 6:48 PM directed to provide a regular diet, ground texture, with nectar thick liquids and mashed bananas aspiration precautions. Resident #60 had declined the puree consistency as it did not meet his/her comfort needs while on hospice. An observation on 8/25/2024 at 12:38 PM found Resident #60 sitting upright in bed alone and without supervision, the tray table was noted in front of the resident with two full beverages within reach. On 8/25/2024 at 12:40 PM an interview with NA #1 who was sitting at the nurse's station at the end of hallway 2 rooms down from Resident #60's indicated s/he supervises Resident #60 while eating by walking up and down the hall, looking in and checking on the resident, s/he sometimes sits with the resident, but Resident # 60 does not always like someone sitting with him/her. NA #1 further indicated Resident#60's diet required food to be cut into small pieces, was not on duty the day Resident #60 choked and further indicated Resident # 60 had not received a banana for breakfast this am. NA #1 indicated s/he thought the kitchen would mash the banana before sending the tray up from the kitchen. On 8/25/2024 at 12:45 PM and interview with the unit charge nurse LPN #3 indicated s/he supervises Resident #60 while eating by walking up and down the hallway looking in the room, sometimes staying with the resident and sometimes observing from the doorway. LPN #3 indicated Resident #60 did not like to be watched. LPN #3 further indicated staff is not required to stay with Resident #60 while eating or drinking, just to supervise and check in on the resident and instructed the surveyor to talk with the unit manager RN #3. On 8/25/2024 at 12:48 PM an interview with the Unit Manager, RN#3 indicated a staff member is expected to stay with Resident #60 while eating and drinking. However, hospice election notes Resident #60 chooses to eat for comfort despite the consistency recommended. RN #3 acknowledged a difference in interpretation of what supervision requires staff members caring for Resident #60 to do and indicated s/he would find a copy of the facility policy. On 8/25/2024 12:48 PM during interview, record review with RN #3 at nurses' station and direct observation with charge nurse LPN #3, LPN #3 indicated aspiration precautions was put in place and updated on the care card. Observation of Resident #60 with charge nurse LPN #3 found Resident # 60 alone in room in bed without supervision with the tray table pulled up to the chest and two beverage cups upright and empty and the contents of one spilled on the tray table. LPN #3 checked on Resident #60 and cleaned the spill. LPN #3 provided the NA care card updated on 8/23/24 which indicated supervision with meals, aspiration precautions and to provide mashed bananas. An interview with the DNS on 8/25/2024 at 1:30 PM indicated h/she would expect staff to stay with a resident while eating of there was an order for supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the primary physician Medical Doctor (MD #2) on 8/27/2024 at 8:42 AM indicated s/he would expect a resident with an order for supervision at mealtime and a history of aspiration to have a staff member with the resident while eating and drinking and when staff is not able to stay with the resident food and drink should be out of resident's reach. Interview on 8/27/2024 at 10:07 AM with MD #1 indicated s/he would expect staff to be with a resident at all times while eating and drinking if there is an order for supervision with meals and staff should not leave the food or drinks with the resident when unable to supervise. The facility's mechanically soft chopped diet: National Dysphagia Diet level 3 provides foods that are moist, in bite sized pieces and nearly regular in texture. Hard, sticky and crunchy foods are excluded. Fruits allowed include, ripe banana, melon peeled peaches and pears, cooked or frozen fruit soft berries with small seeds(strawberries). The facility policy labeled Aspiration Precautions indicated in part the facility directs to follow guidelines in the policy when ordered by a physician to reduce the risk of aspiration: clear oral cavity of residual food and fluid following all oral intake including medications and to position approximately 90 degrees for all oral intakes including fluids. However, the facility policy makes no indication if staff must remain present when a resident is taking food and or fluids b. An observation on 8/28/2024 at 9:50 AM found Resident #60 alone in room without the benefit of supervision sitting upright in bed with the tray table across lap with beverages placed on table within resident's reach. NA#3 and NA#4 were noted sitting at the nurses' station 2 doors down from Resident #60's room. NA#3 and NA#4 indicated Resident #60 was supervised while eating food, but they were not aware Resident # 60 could not be left alone. Interview with Charge Nurse LPN #3 on 8/28/2024 at 9:52 AM indicated s/he informed the nurse aides on duty to stay with Resident #60 while eating and felt the resident could be left alone with the fluids. On 8/28/2024 at 10:05AM an interview with the DNS indicated s/he verbally quizzed and reviewed supervision at meals with staff members on 8/27/2024 but did not have staff sign an in-service sheet. The DNS indicated LPN#3 was in-serviced and should have known, NA#3 and 4 were not on duty on 8/27/24. The DNS further indicated the need to provide in-servicing today for safety and the unit manager would assist the DNS in completing the task. The facility policy labeled, Following the Occurrence of a Resident Choking Requiring the Heimlich Maneuver indicated in part the diet would be downgraded to ground or puree and in the event of the resident refusing a downgrade, the resident would be educated regarding the risks and benefits and the care plan and care card would be updated following the incident to include potential for choking. Although requested, the facility was unable to produce a policy and procedure that defined staff members responsibility while supervising residents during meals for residents requiring this safety measure.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37721 Based on review of facility documentation, facility policy and interview, the facility failed to ensure staff education was completed and competencies up to date for the provision of Intravenous Therapy (IV) services. The findings include: An interview and review of staff education for the initiation of intravenous therapy and competencies for intravenous services with the Director of Nursing Services on 8/27/24 at 9:44 AM failed to identify licensed staff were certified in the implementation of IV therapy and when staff competencies were last evaluated. The DNS further identified s/he was responsible for ensuring the completion of the education and competencies which were to be completed on an annual basis. A review of the Facility Assessment Tool identified the facility assessment is to be updated at least annually or as needed and includes staff training, education and competencies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48950 Based on observations, interviews, and review of the facility policies, the facility failed to keep refrigerators at the appropriate temperatures for maintaining medications and for 2 of 2 medication rooms, the facility failed to dispose of expired medications. The Findings included: 1. Observation of the Harmany Lane medication room with LPN #3 on 8/24/24 around 10:00 AM identified the Medication Room refrigerator Temperature Log was found to be below 36 degrees on 9 days out of 27 days logged, the dates included 8/1/24, 8/2/24, 8/3/24, 8/19/24, 8/20/24, 8/21/24, 8/22/24, 8/23/24, and 8/24/24. The refrigerator contained the following: A package of Humalog containing 100 per milliliters 3 Flex pens of insulin 1 package of Lantus insulin 3 packages of Lorazepam (Anti-Anxiety) containing 30cc each LPN #2 identified that none of the medications were being used and the medications were for emergency only and that 3-11 PM shift was responsible for logging the refrigerator temperatures. Observation of the Cardinal Court medication room with LPN #2 on 8/24/24 at 10:30 AM identified the Medication Room refrigerator Temperature Log was found to be below 36 degrees on 27 days of the month of July which include 7/2/24, 7/3/24, 7/5/24, 7/6/24, 7/7/24, 7/8/24, 7/9/24, 7/10/24, 7/11/24, 7/12/24, 7/13/24, 7/14/24, 7/15/24, 7/16/24, 7/18/24, 7/19/24, 7/20/24, 7/21/24, 7/22/24, 7/23/24, 7/24/24,7/25/24, 7/26/24, 7/27/24, 7/28/24, 7/29/24 and 7/30/24 and missing temperatures from 4 of the days for July 2024 which include 7/1/24, 7/4/24, 7/17/24, and 7/31/24. Review of the August 2024 Refrigerator Temperature Log identified 7 days were logged below 36 degrees which included 8/1/24,8/2/24, 8/3/24, 8/5/24, and 8/22/24. Further observations also identified missing temperature logged for 8/15/24, and 8/16/24. The refrigerator contained the following: 2.2 packages of influenza vaccine 5 milliliter dose with an expiration date of 6/24. 2 packages of lorazepam 30cc. A box of 8 influenza high dose which contained 7 vials of 0.7 milliliters with an expiration date of 6/24, and it was noted 1 dose was missing. 1 Package of Levemir insulin flex pen. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/24/24 at 10:50 AM interview with LPN #2 identified s/he was unsure of when the last time the influenza vaccine was given, and s/he would find out. LPN #2 also identified s/he had planned to give the supervisor the expired medication but just had not had the time. LPN #2 also identified that s/he will give the refrigerated medications to the supervisor and order replacements. On 08/27/24 at 11:09 AM an interview with RN#3 identified if the medication refrigerator temperatures are below 36 degrees the supervisor and maintenance should have been notified. RN#3 provided evidence that no one was given expired influenza, and the last time an influenza vaccine was given was 2/24. On 08/27/24 at 11:18 AM an interview with the DNS identified that the 11:00 -7:00 AM shift was responsible to monitor the Medication Refrigerator Temperature Logs and to report any issues to maintenance. The DNS also identified the facility policy for Medication Refrigerator Temperatures noted not between 36-46 degrees directs that the supervisor and maintenance be notified. The DNS also indicated monthly audits are performed for the Medication Refrigerator Temperature Logs. The DNS Identified that the policy for expired medication was for the unit nurse to notify the supervisor who then collects the medication, and a double signed destruction sheet was to be filled out. After that a company comes to the facility to pick up the expired medications. On 8/2/4/24 at 12:00 PM an interview with the Director of Maintenance identified s/he was unaware the refrigerators had issues with the temperatures, and no one had placed a ticket. The Director of Maintenance further identified that a ticket should have been placed and staff should have notified her/ him of the policy. Review of the facility policy dated 7/23 for Refrigerator in Kitchenettes, Unit Lounges and Medication Rooms, temperature was to be between 36-46 degrees, that the temperatures will be checked and logged in daily by the 11:00 PM-7:00 AM by shift Nursing Aide staff. If temperatures were outside of the acceptable ranges a maintenance work ticket needs to be entered and the Nursing Supervisor needs to be notified. If the temperature is more than 5 degrees off, the medication needs to be replaced by the pharmacy. Review of the facility policy for Medication Storage in the Facility identified that outdated medications were to be immediately removed from the stock, disposed of according to procedures for supplies and reordered from the pharmacy. Medications are to be stored in a clean, well-lit, free from clutter, and extreme temperatures. Medications storage containers are monitored monthly and corrective action was to be taken if any problems were identified.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 3 of 5 sampled residents (Residents #4, #14 and #71) reviewed for immunizations, the facility failed to ensure pneumococcal vaccines were administered after obtaining consent. The findings included: A clinical record review of the pneumococcal immunization record identified the following: 1.For Resident #4, a Pneumococcal Vaccine Informed Consent/Declination Form dated 5/29/24 identified consent was obtained from Resident #4 to receive the Pneumovax vaccine with no documented history of administration following consent. An interview with the Director of Nursing Services (DNS) on 8/27/24 at 9:44 AM identified availability for the vaccine was inconsistent. An alternate vaccination could have been offered to Resident #4 but was not. Additionally, there was a community pharmacy that offered pneumococcal vaccinations that could have been utilized but were not. Resident #4 was scheduled to receive the Pneumovax vaccine after surveyor inquiry. 2. For Resident #14, a Pneumococcal Vaccine Informed Consent/Declination Form dated 2/17/23 identified consent was obtained from the responsible party to receive the Pneumovax vaccine with no documented history of administration following consent. An interview with the DNS on 8/27/24 at 9:44 AM identified availability for the vaccine was inconsistent. An alternate vaccination could have been offered to Resident #14 but was not. Additionally, the was a community pharmacy that offered pneumococcal vaccinations that could have been utilized but were not. Resident #14 received Prevnar 20 on 7/23/24. 3. For Resident #71, a Pneumococcal Vaccine Informed Consent/Declination Form dated 7/17/24 identified consent was obtained from the responsible party to receive the Prevnar 20 vaccine with no documented history of administration following consent. An interview with the DNS on 8/27/24 at 9:44 AM identified availability for the vaccine was inconsistent. An alternate vaccination could have been offered to Resident #71 but was not. Additionally, there was a community pharmacy that offered pneumococcal vaccinations that could have been utilized but were not. Resident #71 was scheduled to receive the Prevnar 20 vaccine after surveyor inquiry. Review of the facility policy for Pneumonia Vaccine Administration Guidelines dated 2/2023 directed pneumococcal vaccines will be administered in accordance with best practice immunization guidelines. Vaccine information Sheets (VIS) will be reviewed and informed consent must be obtained.