STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075208	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on staff and resident interviews and observations within the secured unit, the facility failed to ensure state survey results were available and accessible on the secured unit for those residents who resided there. The findings include: During a resident council interview conducted on 4/29/25 at 9:55 AM, 5 residents who resided on the secured unit identified that they were not aware of where to find the state survey results. Observations during a tour of the facility on 4/30/25 at 2:25 PM identified that although the most recent state survey results from 2023 were available in the lobby of the facility, they were not available on the locked unit (3rd floor). Observation of an orange binder on the wall behind the nurse's desk marked State Survey, identified that it had dust on the binder and contained State Survey results from 2019 and was missing results from 2021 and 2023 re-certification surveys. Interview with the Administrator on 4/30/25 at 2:05 PM identified that management had been informed by the Ombudsman recently that the survey results needed to be on each wing as well as the lobby, believed that they recently put the survey results on each unit and was surprised they were not found and to ask the recreation director. Interview with the Recreation Director on 4/30/25 at 2:10 PM identified that he had been working here for only 8 months and did not know if the survey results were on each floor or if they were required to be. Interview with the Director of Nurses on 4/30/25 at 2:15 PM identified that she thought the survey results were placed on each floor however, was not sure where they would be and the scheduler might know where to find them. Interview and observation with the Scheduler on 4/30/25 at 2:20 PM identified that she wasn't sure where the survey results were located on each floor and she could not locate them.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation(s), review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #286) reviewed for non-pressure skin conditions, the facility failed to obtain wound treatment orders upon admission for a resident with a surgical wound and a venous stasis ulcer. The findings include: Resident #286 was admitted to the facility in April 2025 with diagnoses that included chronic venous hypertension with inflammation, cellulitis of the lower limbs, and cutaneous abscess of left foot. Review of the hospital discharge records dated 4/26/25 identified Resident #286 had a left leg cellulitis and abscess with surgical debridement and a right lower extremity cellulitis and venous ulcer. The discharge records directed to continue daily dressing changes with Betadine and dry sterile dressing as well as Sodium Hypochlorite topical solution applied to foot ulcers daily with a dressing of gauze and gauze roll bandage twice daily. Although the discharge records further indicated see instructions with regards to treatments for the left and right lower extremity areas, they failed to identify wound treatment/dressing change orders and instructions for those areas. The admission nursing assessment dated [DATE] identified Resident #286 required assistance with transfers and activities of daily living. The admission skin assessment identified a right lower extremity venous ulcer and cellulitis on bilateral lower extremities with a surgical wound (abscess debridement) on the left foot. The admission physician's orders dated 4/26/25 directed Sodium Hypochlorite External Solution 0.125%, apply topically to foot ulcers daily every shift for wounds but failed to identify wound treatment/dressing change orders for Resident #286's bilateral lower extremities (venous ulcers/cellulits and surgical wound). The Resident Care Plan dated 4/28/25 identified cellulitis, a left foot abscess debridement, and chronic venous ulcers. Interventions included to provide treatments as ordered and provide wound care. An admission nursing note written by Registered Nurse (RN) #4 and dated 4/26/25 at 4:14 PM identified Resident #286's discharge medications and orders were reviewed to ensure a safe transition of care and hospital discharge orders were reviewed and updated as appropriate with the on-call provider. Observation on 4/28/25 at 11:10 AM identified Resident #286 was seated at the bedside in his/her wheelchair with his/her left lower extremity elevated and resting on the bed. Resident #286 had gauze dressings in place to his/her bilateral lower extremities and the dressing to the left lower extremity had red/brown colored drainage coming through the dressing and onto the bed sheet. Both lower extremity dressings were labeled and dated 4/28/25. (continued on next page)

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission APRN note written by APRN #1 and dated 4/28/25 at 11:15 AM identified Resident #286 had chronic venous leg ulcers and an incision and drainage of a left foot abscess on 4/19/25. Although the progress note indicated to continue wound care with Sodium Hypochlorite 0.125% solution daily, the progress note failed to identify comprehensive wound treatment/dressing change orders for Resident #286's right lower extremity cellulitis and left foot surgical wound. The progress note further identified Resident #286 was to receive continued wound care and antibiotic therapy while at the facility with wound consult, treatment and assessment per protocol. The Treatment Administration Record (TAR) for April 2025 directed Sodium Hypochlorite External Solutions 0.125%, apply to foot ulcers daily topically every day shift for wounds. The TAR failed to identify wound treatment or dressing application directives for the resident's bilateral lower extremities. Interview and review of the clinical record with the Infection Preventionist (RN #3) on 5/1/25 at 2:45 PM identified Resident #286's wound treatment/dressing change orders were not obtained and incomplete to Resident #286's bilateral lower extremities since his/her admission on [DATE]. RN #3 indicated the hospital discharge orders were unclear and should have been clarified on admission by the nursing supervisor. RN #3 identified that since Resident #286's admission on [DATE], the nurses were putting dressings on Resident #286 without orders in place but she was unsure what was the dressing treatments consisted of. RN #3 indicated nursing should have clarified and obtained orders with the on-call provider on admission or subsequently with the APRN or Medical Director, and she was unsure why that was not done. RN #3 stated she had placed a call to Resident #286's podiatrist and infectious disease physician today and was awaiting a call back. Interview and review of the clinical record with the DNS on 5/1/25 at 3:12 PM indicated although, on admission, the nursing supervisor did assess and document Resident #286's wounds, she failed to clarify and obtain complete treatment/dressing orders. Review of the clinical record with the DNS identified that directives (site, frequency, dressing/gauze type) for how to dress the resident's wounds were not in place and nurses should not have been completing dressing changes on Resident #286 without wound treatment orders in place. The DNS indicated the nurses should have reached out and obtained the needed orders for Resident #286 and she was unsure why that was not done but would make sure it was addressed. Subsequent to surveyor inquiry, review of the physician's orders for 5/1/25 indicated new physician's orders for wound care were obtained for Resident #286 as follows: 1. Sodium Hypochlorite External Solution 0.125 % Apply to Right lateral calf topically every day shift for vascular, cleanse with Sodium Hypochlorite external solution 0.125% solution and pat dry. Apply Betadine moistened gauze and bordered foam daily and as needed (prn) AND apply to Right lateral calf topically as needed for vascular, cleanse with sodium Hypochlorite external solution 0.125% solution and pat dry. Apply Betadine moistened gauze and bordered foam prn if dressing missing, dislodged or soiled. 2. Sodium Hypochlorite External Solution 0.125 % (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply to Left medial foot surgical topically every day shift for wounds, cleanse with Sodium Hypochlorite 0. 125 % and pat dry. Apply Betadine moistened gauze, ABD pad followed by gauze wrap daily and prn AND apply to Left medial foot topically as needed for surgical if dressing missing, dislodged or soiled. Interview with APRN #1 on 5/5/25 at 10:27 AM identified treatments and dressing changes should have been clear and updated and if wound care orders were vague or there was a discrepancy on the hospital discharge paperwork, the nursing staff should have called the hospital to clarify the orders. APRN #1 indicated the medical director was at the facility over the weekend when Resident #286 was admitted on [DATE], and it could have been addressed with him at that time as well. APRN #1 identified the nurses should not have been completing dressing changes on Resident #286 without comprehensive wound treatment orders in place and she was unsure why it was missed and was unaware of the issue when she saw the resident on 4/28/25. Attempts to contact RN #4 (the admitting RN Supervisor) were unsuccessful. Review of facility policy, Transcription of Orders, dated 01/2024, directed the facility was to establish guidelines for accepting and reviewing orders and orders were considered but not limited to medications, labs, diagnostics, or consultations. The policy further directed that orders are accepted by a registered nurse or a licensed practical nurse and can be obtained over the phone or from discharge and transfer paperwork from the hospital.

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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 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** Based on interviews, clinical record review, and facility policy for one of three residents (Resident #22) reviewed for advanced directives, the facility failed to ensure the Resident Care Plan accurately reflected Resident #22's code status. The findings include: Resident #22 was admitted to the facility in April 2025 with diagnosis that included chronic obstructive pulmonary disease, diabetes, and falls. A Social Service initial assessment dated [DATE] identified that Resident #22 was a full code. There were no physician orders on admission directing Resident #22's code status. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 was moderately cognitively impaired, required set up assistance for eating, maximal assistance for toileting, showering, and dressing. Also identified was Resident #22 required moderate assistance with transfers. The Resident Care Plan (RCP) dated 4/15/25 identified that Resident #22's code status was cardiopulmonary resuscitation with interventions directed to review advanced directives with resident/responsible party on admission and at least quarterly, and honor advanced directives as directed by the resident/responsible party for guidance. Review of the signed advanced directive consent/acknowledgement release form dated 4/15/25 identified that Resident #22 wishes were to be a Do Not Resuscitate (DNR). An interview and review of the RCP on 4/28/25 at 2:22 PM with RN #1 identified that the RCP was incorrect, and that Resident #22 was a DNR, but the current care plan had Resident #22 identified as a full code. Further identifying that any nurse can update the care plan when the code status was changed, and it should have been updated to the correct code status. Review of the facility policy for Advanced Care Planning Code status identified that orders not to attempt cardiopulmonary resuscitation of a resident will be in writing, after consent has been obtained. This procedure will clarify the rights and obligations of residents, families, and other health care providers. Every resident admitted to the facility was presumed to consent to the administration of cardiopulmonary resuscitation in the event of cardiac/respiratory arrest unless there was a consent to a Do Not Resuscitate order. Further identified that upon admission the option of choosing to resuscitate or not to resuscitate will be offered and reviewed with the resident/family representative. A physician's order must be written accordingly. Also, identified documentation of the resident's choice to opt for resuscitation or not to resuscitate shall be maintained in the medical record. Subsequent to surveyor inquiry the physician orders were updated to reflect DNR on 4/29/25 and the RCP was updated on 4/30/25 to the correct code status of DNR.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #53) reviewed for accidents, the facility failed to ensure orthostatic blood pressures were monitored per the physician's order for a resident with postural hypotension and history of repeated falls. The findings include: Resident #53's diagnoses included unspecified dementia, orthostatic hypotension, and repeated falls. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #53 was cognitively intact and required setup or clean up assistance with transfers and toileting and was independent with bed mobility. The Resident Care Plan dated 4/1/25 identified recurrent falls, a fall with rupture of the globe of the right eye and orthostatic hypotension. Interventions included to monitor vital signs and monitor for signs and symptoms of orthostatic hypotension. A physician's order dated 4/5/25 identified Resident #53 had a history of postural hypotension and directed to take orthostatic blood pressures daily. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2025 failed to indicate an order for daily orthostatic blood pressures had been transcribed and therefor orthostatic blood pressures were not taken. Interview and review of the clinical record with Licensed Practical Nurse (LPN #3) on 5/1/25 at 10:28 AM identified that although Resident #53 had a current order for daily orthostatic blood pressures, she was unable to locate in the clinical record where the orthostatic blood pressure results were documented. LPN #3 indicated it would be the nurse who would obtain the orthostatic blood pressures and document the results in the clinical record. After review of the MAR and the TAR for Resident #53, LPN #3 identified that the orthostatic blood pressure order was not there, and she did not know the reason. LPN #3 further indicated that she had not taken orthostatic blood pressures on Resident #53 before and would need to check with her nursing supervisor. Interview and review of the clinical record with the Nursing Supervisor (RN #1) on 5/1/25 at 12:25 PM identified that the nurse that transcribed the order for daily orthostatic blood pressures (when the order was originally placed on 9/20/24) did so incorrectly in the electronic health record (EHR) and the order was not shared onto the MAR or TAR. RN #1 indicated the error with the order should have been discovered by nursing when an audit was done, but it appeared that had also been missed. RN #1 identified the mistake was due to a transcription error and oversight by nursing and that the daily orthostatic blood pressures had never been completed on Resident #53. RN #1 indicated it would have been her expectation that the order was appropriately placed in the MAR and the daily orthostatic blood pressures would have been monitored per the physicians order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 5/1/25 at 3:20 PM identified the order for Resident #53 to have daily orthostatic blood pressures was not transcribed correctly and if the nurse did not indicate an area to put the order in the electronic health record, then it would not automatically go onto the MAR or TAR. The DNS indicated that although Resident #53 had repeated falls prior to his/her admission to the facility, daily orthostatic blood pressures were not monitored for Resident #53 since the order was placed (on 9/20/24). The DNS identified that order audits done by the nurse on the 11:00 PM to 7:00 AM shift should have discovered the order and corrected the transcription error and she was unsure of the reason that did not occur. Subsequent to surveyor inquiry, on 5/1/25, the order for daily orthostatic blood pressures for Resident #53 was discontinued by APRN #1. Interview with APRN #1 on 5/5/25 at 10:19 AM identified the order for Resident #53 to have daily orthostatic blood pressures was initially placed upon admission and she was not aware that it was not correctly transcribed or completed since then. The APRN indicated she would expect the order would have been correctly transcribed, daily orthostatic blood pressures would have been monitored and the nurse would have been responsible. APRN #1 identified that although Resident #53 was admitted to the facility with repeated falls and postural hypotension, since the resident has not had any recent falls and has a steady gait, she discontinued the order for daily orthostatic blood pressures on 5/1/25, after it was brought to her attention. Review of facility policy, Transcription of Orders, dated 01/2024, directed the facility was to establish guidelines for accepting, transcribing, and reviewing orders. The policy directed that transcribing is the recording of orders by a registered nurse or a licensed practical nurse and accuracy of orders must be reviewed and verified. Additionally, the policy directed the EHR process for the transcription of orders was to be followed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 5 residents (Resident #24) reviewed for falls, the facility failed to provide a transfer according to physician orders which resulted in a fall with injury and failed ensure all appropriate doors were secured on the locked memory care unit. The findings include: 1. Resident #24's diagnoses included transient cerebral ischemic attack, morbid obesity, and difficulty in walking. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was moderately cognitively impaired, had no falls since the previous assessment (5/18/23), had received physical therapy services from 6/2/23 through 7/4/23, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility, and was dependent for transfers. A physician order dated 8/23/23 directed to provide extensive assistance of 1 staff member for bed mobility, Resident #24 required the use of a Sarita lift for transfers, was non-ambulatory, required limited assistance for upper extremity dressing, required extensive assistance with lower body dressing, and was independent with eating. The Resident Care Plan (RCP) dated 8/28/23 identified Resident #24 was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, and a prior fall without injury on 5/29/23. Interventions included every shift must ensure Resident #24 was wearing non-skid socks while in bed and physical therapy to evaluate as ordered or as needed. Additionally, the RCP dated 8/28/23 identified Resident #24 had an activities of daily living (ADL) deficit related to generalized weakness especially to the lower extremities. Interventions included Resident #24 required extensive assistance by 1 staff member to turn and reposition in bed and required the use of a Sarita (mechanical lift) with assistance by 2 staff members for transfers. The Nurse Aide (NA) care card for Resident #24 dated 9/1/23 identified to transfer Resident #24 assist out of bed (OOB) to the chair/wheelchair as tolerated with assistance of 1 staff member (a discrepancy with physician orders and RCP in effect at that time directing to utilize a Sarita lift for transfers) and Resident #24 was to be transferred using the Sarita with the assistance of 2 staff members. A nursing note written by Registered Nurse (RN) #3 on 9/8/23 at 10:26 AM identified she had been requested to assess Resident #24 following a fall. The note identified that upon RN #3 entering the room, Resident #24 was observed sitting on the floor next the bed with his/her legs outstretched. The note identified Resident #24 verbalized pain to the right ankle with and without manipulation of the ankle. Additionally, the nursing note identified NA #1 reported Resident #24's leg appeared to twist as NA #1 lowered Resident #24 to the floor during a transfer. The note identified no bruising or swelling was observed to the right ankle, Resident #24 was assisted back to bed using a mechanical lift, and the Advanced Practice Registered Nurse (APRN) #1 and Resident #24's responsible party were updated. The note further identified an x-ray was ordered to rule out injury to the right ankle. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility Reportable Event form identified on 9/8/23 at 10:00 AM Resident #24 was lowered to the floor by NA #1 during a transfer after which Resident #24 verbalized pain to the right ankle. The report identified x-rays were performed and identified 2 fractures: the base of the medial malleolus (inner side of the ankle) and distal fibular (end of leg bone near the ankle) fracture. The report identified Resident #24 was sent to the hospital ED for evaluation and treatment. The RE identified Resident #24's physical status before the event was to transfer with extensive assistance of 1 staff member (a discrepancy with the physician order dated 8/23/23 which directed Resident #24 required extensive assistance of 1 staff member for bed mobility, required use of a Sarita for transfers and was non-ambulatory), and Resident #24's physical status after the event was transfer with mechanical lift and assistance of 2 staff members. A nursing note written by Licensed Practical Nurse (LPN) #8 and dated 9/9/23 at 2:33 AM identified x-rays of the right ankle were completed at 12:30 AM. A radiology report dated 9/9/23 at 4:40 AM identified 3-view right ankle x-rays had been completed for Resident #24 on 9/8/23 with findings of an acute nondisplaced fracture at the base of the medial malleolus (inner side of the ankle) with an acute comminuted nondisplaced distal fibular (end of leg bone near the ankle) fracture. Diffuse osteopenia (decreased bone density) was seen. A nursing note written by RN #8 on 9/9/23 at 6:48 AM identified Resident #24 was status post a fall with complaints of pain to the right ankle, the x-ray results were positive for fractures to the medial malleolus and distal fibula, and the on-call Advanced Practice Registered Nurse was updated and directed to send Resident #24 to the hospital emergency department (ED). A nursing note written by LPN #8 on 9/9/23 at 7:44 AM identified Resident #24 was transferred to the hospital ED at 7:40 AM with all required paperwork. The note identified Resident #24's right leg and ankle were swollen with no bruising noted, Resident #24 complained of knee pain and Tramadol (pain medication) was administered at 7:00 AM. A nursing note written by RN #7 on 9/9/23 at 5:08 PM identified Resident #24 returned to the facility from the hospital emergency department at 3:30 PM with a diagnosis of a right ankle fracture, a soft cast in place to the right lower extremity and the on-call medical doctor was updated on Resident #24's return. Interview with NA #1 on 5/5/25 at 2:15 PM identified she was the NA caring for Resident #24 on 9/8/23 and indicated the NA care card in the computer was confusing and directed that Resident #24 could either be transferred by a stand/pivot transfer and the assistance of 2 staff members or by a Sarita lift. NA #1 identified she was unable to locate another staff member to assist her with the transfer and thought she would be fine to complete the transfer by herself. NA #1 identified as she was transferring Resident #24 from the bed to the wheelchair by herself when Resident #24's legs buckled and as NA #1 lowered Resident #24 to the floor, Resident #24's ankle went backwards and twisted. NA #1 identified that the instructions on the NA care card were confusing and she did not ask a staff member for clarification regarding if Resident #24 transfer status. NA #1 further noted if Resident #24 needed to be transferred by the Sarita lift, she still should have had a second staff member with her for Resident #24's transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 5/5/25 at 2:30 PM identified the policy for any mechanical lift including the Sarita was that 2 staff members were required for the transfer with the mechanical lift without exception. The DNS identified NA #1 should have completed the transfer using a Sarita lift, should have had a second staff member with her for the transfer and did not follow facility policy for use of the Sarita lift. Review of the Mechanical Lift policy directed, in part, 2 staff members must be involved in the transfer of a resident with a mechanical lift, when lifting a resident from the floor, two staff members including a licensed nurse must be present while operating the mechanical lift, and documentation of need for a mechanical lift was in the care plan and NA care card. 2. Review of the Resident Listing Report dated 4/28/25 indicated there were 30 residents living on the facility's secured/locked memory care unit. An observation on the secured /locked memory care unit with the Director of Maintenance on 4/28/25 at 12:45 PM identified the shower room contained a metal nail clipper and a bottle with a white liquid in it (soap). Additionally, the door to the room labeled dentist office was propped open with a garbage can, and the door to the room labeled soiled utility, which was equipped with a key pad locking mechanism (the mechanism had been bypassed), was not locked/secured. The soiled utility room contained two bottles of cleaning solution with liquid in them. Interview with the Maintenance Director on 4/28/25 at 12:49 PM while on the secured locked memory care unit identified he was not aware the dentist office and soiled utility room doors were not locked/secured. The Maintenance Director indicated the soiled utility room should have been locked/secured and staff should have only used the keypad code to gain access to the room. He demonstrated how the keypad code could be bypassed, resecured the keypad lock and stated he would plan to install a different lock on the door that could no longer be bypassed. Observation and interview with LPN #2 on 4/28/25 at 1:05 PM identified the door to the room labeled dentist office was found propped open and not locked/secured as it should have been. LPN #2 indicated she was not sure why the door was not locked/secured but sometimes nursing staff used the room for charting. LPN #2 identified the nursing station was also equipped with a retractable plastic barrier that could be pulled to deter access to the area behind the nurse's station (where the dentist office was located) but that it was not pulled/secured and should have been. Subsequent to surveyor inquiry, on 4/28/25 at 1:08 PM the retractable barrier was pulled/secured by LPN #2. Interview with the Administrator on 4/28/25 at 1:20 PM identified all doors on the secured locked memory care unit should have been locked/secured for the safety of the residents. The Administrator indicated he would have expected the soiled utility and dentist office doors to always be locked/secured. The Administrator identified he would speak to the nursing supervisor about providing staff further education and oversight on keeping all doors locked/secured on the unit. Subsequent to surveyor inquiry, on 4/29/25 at 10:00 AM the door to the shower room on the secured locked memory care unit was now equipped with a keypad locking mechanism. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy, Living Legacy Memory Care Unit, undated, directed the unit provided a secure environment where the safety and well-being of residents is maintained. The policy further directed the unit was a safe, secured physical environment which allowed maximum freedom, safety, and a sense of security for residents and families.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy and interview for 2 of the 2 residents reviewed for infection control, the facility failed to ensure the peripheral lines had appropriate physician orders in place to rotate access site every 96 hours and as needed or the site was to be removed. 1. Resident #19's diagnosis included Covid 19, myocardial infarction, and hyponatremia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 was cognitively intact, required maximal assistance for toileting, set up assistance for oral hygiene and eating. Also identified that Resident #19 was dependent on showering and transfers. Further identifying Resident #19 was not receiving intravenous therapy. A nursing note dated 4/16/25 at 11:42 AM written by Registered Nurse (RN) #1 identified a urine culture was obtained with sensitivities which the Advance Practice Registered Nurse (APRN) reviewed, and intravenous (IV) was to be started with a new order for IV Ceftriaxone. The Resident Care Plan (RCP) dated 4/16/25 identified IV medication of Ceftriaxone related to a urinary tract infection with intervention to rotate the peripheral site per protocol, observe/document/report as needed signs and symptoms of leaking at the IV site, and observe the IV dressing routinely for signs and symptoms of leakage/bleeding. Additionally, the RCP included to monitor site for placement, signs and symptoms of infection every shift and to change the dressing and site every 96 hours for peripheral lines. The Medication admission Record (MAR) dated 4/17/25 identified Ceftriaxone (an antibiotic) 2 grams daily, one time for a day for urinary tract infection for 5 days. Review of the physician orders and interview on 5/01/25 at 6:51 AM with the Director of Nursing services failed to identify a physician order that corresponded with the MAR dated 4/17/25 directing Ceftriaxone 2 grams daily. A nursing note dated 4/17/25 at 12:11 AM identified that Resident #19 was started on IV Ceftriaxone via left arm heplock due to a urinary tract infection. A nursing note dated 4/18/25 at 12:23 PM written by RN #1 identified the IV company was called to replace the peripheral IV and to continue with antibiotic treatment. A nursing note dated 4/18/25 at 9:39 PM identified Resident #19 peripheral IV was removed from his/her left arm and a new peripheral line was placed in his/her right hand, and the dressing was clean, dry, and intact. A nursing note dated 4/19/25 at 2:19 PM identified that Resident #19's IV to his/her right arm was flushed without difficulties, no infiltration noted, and no redness or swelling noted. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR dated 4/28/25 directed to flush the peripheral catheter with 10 cubic centimeters (cc) of Normal Saline every 8 hours while not in use (although there were no physician orders to correspond with the MAR instructions to flush the peripheral catheter). On 4/29/25 at 9:37 AM, interview with Resident #19 identified that he/she was receiving IV medications to his/her right arm. Observations at that time identified the dressing covering the IV insertion site was labeled 4/18/25 (11 days old). Interview on 4/29/25 at 9:50 AM with RN #1 identified that Resident # 19's peripheral line dressing should be changed one time a week and the last time it was changed was 4/18/25. Further, identifying the IV was last used on 4/22/25, had not been replaced/removed yet and the facility was waiting for lab results before removing it (the RCP interventions directed to change the IV site every 96 hours). RN #1 also identified a batch order set (a template type document that identifies routine IV orders for maintenance of the site) was to be put in place every time a resident was started on a peripheral IV which contained parameters to follow. Resident #19 did not have the batch order set in place when he/she was started on peripheral IVs and therefore the site wasn't rotated every 96 hours and the dressing not changed. RN #1 provided a copy of the batch order set which should have included the following: 1) Change IV tubing used for intermittent administration of fluids or medication every 24 hours for prophylaxis and as need prophylaxis. 2) Normal saline flush solution use 10 ml intravenously three times a day for infection. Flush before and after each medication administration, no flushing required with continuous infusions. 3) Monitor IV site for redness, swelling, drainage, any signs and symptoms of infection every shift for prophylaxis and as needed. 4) Rotate access site every 96 hours and as needed. Review of the nursing notes dated 4/29/25 at 11:47 AM identified the peripheral IV was discontinued. An interview on 5/1/25 at 6:51 AM with DNS identified that an IV peripheral line can stay in for 96 hours (Resident #19 was in place for 11 days), Resident #19 site should have been changed on 4/22/25 and IV parameters per the batch order set were not in place until 4/28/25. Also identifying that orders should have been put in place for each resident that was started on a peripheral IV and that she was responsible for this. Also identifying that it was an oversight. 2. Resident #236's diagnosis included sepsis, fracture of right femur, and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #236 was moderately cognitively impaired, dependent on toileting and showering. and transfers. Also identified Resident #236 required moderate assist for eating, personal hygiene, and oral hygiene. Further identifying Resident #236 was receiving antibiotic therapy not through intravenous (IV) therapy. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note dated 4/24/24 at 10:27 AM identified that Resident #236 was seen by the Advance Practice Registered Nurse (APRN) for right face cheek swelling, new orders in place for Prednisone 40 milligrams (mg) times 1, give now, then give 20 mg daily times 4 days, start a peripheral IV and give Ceftriaxone (an antibiotic) 1 gram x 5 days. The Resident Care Plan (RCP) dated 4/24/25 identified Resident #236 was on antibiotic therapy related to cellulitis to the right cheek with interventions to administer antibiotic medications as ordered by physician and monitor/document/report as needed adverse reactions to antibiotic therapy. The Medication Administration Record (MAR) dated 4/24/25 identified Ceftriaxone 1 gram IV every 24 hours for oral cellulitis for 5 days. A nursing note dated 4/29/25 at 1:22 PM identified Resident #236 was a day post IV of Ceftriaxone, no adverse reactions noted due to IV antibiotics. APRN notified, new orders given to discontinue the peripheral IV. An interview on 4/29/25 at 9:50 AM with RN #1 identified a batch order set was to be put in place every time a resident was started on a peripheral IV which contained perimeters to follow. Resident #19 and #236 did not have the batch order set in place when started on peripheral IV's. RN #1 provided a copy of the batch order set which included the following: 1) Change IV tubing used for intermittent administration of fluids or medication every 24 hours for prophylaxis and as need prophylaxis. 2)Normal saline flush solution use 10 ml intravenously three times a day for infection. Flush before and after each medication administration, no flushing required with continuous infusions. 3)Monitor IV site for redness, swelling, drainage, any signs and symptoms of infection every shift for prophylaxis and as needed. 4)Rotate access site every 96 hours and as needed. Subsequent to surveyor inquiry the MAR was updated on 4/29/25 to include parameters which directed to provide normal saline flush, use 10 milliliters intravenously one time a day for cellulitis, flush before and after each medication administration. Also, to monitor peripheral site for redness, swelling, drainage, any sign of infection every shift for prophylaxis. Review of the physician orders and interview on 5/1/25 at 6:51 AM with the DNS failed to identify a physician order was written that corresponded with the MAR directing Ceftriaxone 1 grams daily for 5 days. An interview on 5/1/25 at 6:51 AM with the DNS identified that an IV peripheral line can stay in for 96 hours and an order should have been put in place for each resident started on a peripheral IV. Also, identifying Resident #236 IV should have been pulled out on 4/28/25 not 4/29/25 and it was not pulled on time, it was an oversight. Further, identifying she was responsible over seeing this. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a written facility policy for maintaining a peripheral intravenous site was not provided, however the DNS identified that the facility uses the batch order set to direct the maintenance/treatment of a peripheral line.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Deficiency Text Not Available

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of facility policy for two of three medication storage rooms, the facility failed to ensure expired medication was disposed of and supplies and medications were stored properly. The findings include: a. Interview and observation of the 4th floor medication room with Licensed Practical Nurse (LPN) #2 on [DATE] at 10:40 AM identified 20 hemoccult cards were observed that had an expiration date of 8/2023 and a bottle of hemoccult developer that expired in 8/2021 in the cabinet drawer. Further observation identified 6 full unopened tubes of Collagen Hydrogel (3 ounce each) with an expiration date of 3/31/ 25 and a 24-French 8.0 millimeter (mm) indwelling catheter with an expiration date of [DATE]. b. Interview and observation of the 3rd floor medication room with LPN #7 on [DATE] at 11:45 AM identified an unopened box of Lorazepam (a Schedule IV controlled medication) 30 milliliters (ml) oral concentrate on the bottom shelf in the medication refrigerator (not stored in a locked, affixed box) with other non-controlled medications stored with it (Insulins). The lock box that was present in the refrigerator was marked DO NOT USE. LPN #7 did not know the reason it was marked DO NOT USE and did not have a key to open it. The lock box was affixed to the inside of the refrigerator. Interview with the DNS on [DATE] at 2:15 PM identified she was not aware the lock box in the 3rd floor refrigerator was not being utilized for controlled medications such as the Lorazepam, or that it was marked DO NOT USE. A review of the maintenance log did not identify an entry regarding the 3rd floor lock box being broken in 2025. Interview with the DNS on [DATE] at 2:15 PM indicated that the Pharmacy representative did a monthly review of all the medication rooms and carts and a monthly summary report for each unit/floor was provided to the DNS. The date of the last pharmacy inspection was [DATE] for all three units but did not identify the failure of Lorazepam being in a locked box and affixed to the shelf. Additionally in the 3rd floor medication room, there was one box of COVID-19 tests in the overhead cabinet above the sink with an expiration date of [DATE], one pouch of COVID-19 rapid tests on the counter with an expiration date of [DATE] and a large cardboard box in a gray upright cabinet with 6 boxes of COVID-19 tests containing 4 tests each with an expiration date of [DATE]. Lastly, a two-thirds full gallon of distilled vinegar with a use by date written on it, [DATE] was identified to be in the medication room. Interview with the Regional Pharmacy Consultant on [DATE] at 2:00 PM identified the pharmacy consultant would not normally pick up on non-medication items. The Regional Consultant could not confirm the Lorazepam located in the 3rd floor medication room refrigerator was present at the time of the last pharmacy inspection on [DATE] as it was not identified on the summary report. Additionally, the Regional Consultant identified that Lorazepam locked in the medication refrigerator in the locked medication room would be sufficient. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated Medication Storage policy (PHNE132) identified Schedule II-V medications must be maintained in a separately locked, permanently affixed compartment or cabinet. The access system used to lock these medications cannot be the same access system used to lock other non-scheduled medications (i. e. two separate keys).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 2 residents (Resident #33) reviewed for dental services, the facility failed to ensure timely dental services were provided related to non-restorable teeth. The findings include: Resident #33's diagnoses included weakness and partial paralysis affecting the left side following a stroke, dementia, and depression. The face sheet identified Resident #33's payor source was Medicaid. The Resident Care Plan (RCP) dated 2/14/23 and currently in effect identified Resident #33 had oral/dental health problems related to poor dentition. Interventions included monitor/document/report any signs and symptoms of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, teething missing/loose/broken/eroded/decayed and report pain, bleeding, broken teeth to the nurse. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #33 had intact cognition and required set up assistance with eating and oral hygiene. Additionally, the MDS identified Resident #33 required partial assistance with personal hygiene. A dental hygienist (RDH) note dated 11/2/23 at 4:18 PM and written by RDH #1 identified Resident #33 was seen for a comprehensive oral examination, routine oral cleaning, and fluoride treatment. The note identified Resident #33 expressed his/her concern again regarding the desire to have his/her teeth repaired. The nursing supervisor was informed of the dentist (DMD) #1's previous recommendation for Resident #33 to see a dentist in the community, and that a referral letter and x-rays were located in Resident #33's electronic medical record (EMR). A letter by DMD #1 and dated 1/31/24 identified Resident #33 was referred for dental services for evaluation and treatment regarding full mouth rehabilitation. The consult identified Resident #33 was asymptomatic at that time, however he/she had multiple non-restorable teeth with potential for developing acute episodes. The consult identified Resident #33 had expressed desire for dental implants. The consult further identified the facility staff would provide whatever additional medical information was required and dental radiographs would also be made available. A dental hygienist note written by RDH #1 and dated 2/2/24 at 5:04 PM as a late entry for 1/31/24 identified Resident #33's oral exam revealed poor oral hygiene and multiple teeth in various stages of failure. The note identified Resident #33 again asked about having implant retained dentures. The note identified Resident #33 was reminded that a referral to a dental provider in the community was indicated for this type of dental care. The note identified the nursing supervisor was informed of Resident #33's request and that a referral letter had been updated and made available in Resident #33's EMR. A dental hygienist note written by RDH #1 and dated 7/26/24 at 10:06 PM identified Registered Nurse (RN) #1 had been informed of the dental concerns regarding Resident #33. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A dental hygienist note written by RDH #1 and dated 11/22/24 at 9:11 PM identified the nurse on duty notified RDH #1 that Resident #33 had requested to be seen by the dentist and that Resident #33 wanted to do something about his/her teeth and had changed his/her mind about implants. The note identified Resident #33 just wants to get the bad ones removed and partial dentures made. The note further identified Resident #33 would be seen by DMD #1 for further evaluation. A dental hygienist note written by RDH #1 and dated 12/6/24 at 9:57 PM identified Resident #33 was seen for exam and consultation regarding treatment options. The note identified Resident #33 was previously referred to a dental provider in the community for dental care as he/she had specifically asked for dental implants. The note identified the referral was not carried out and the reason was unknown. The note identified Resident #33's exam revealed complete fracture of almost all of his/her remaining teeth with only retained roots remaining. Additionally, RDH #1's note identified treatment options were discussed and Resident #33 indicated he/she was ready to have all remaining teeth removed and dentures fabricated. The note identified implants were discussed and if possible, Resident #33 wanted to have implants to assist in retaining the dentures. The note identified RN #1 was informed of Resident #33 wishes, and arrangements would be made for referral to an oral surgeon for full mouth tooth removal. The note further identified a dental referral letter would be made available in the EMR and once complete healing occurred, arrangements would be made for consultation and treatment regarding denture fabrication. A letter by DMD #1 dated 12/6/24 identified Resident #33 was referred for dental services for removal of all remaining teeth and alveoloplasty in preparation for fabrication of full dentures. The letter identified facility staff would provide whatever additional information was required. The letter further identified a request to forward a copy of the consultation to the fax number indicated on the letter. A dental hygienist note dated 3/14/25 at 9:57 PM identified Resident #33 was seen for an oral exam and Resident #33 inquired when his/her teeth would be removed so he/she could have dentures made. The note identified the social worker was consulted about DMD #1's referral to an oral surgeon for removal of all remaining teeth and recommendation of dentures and that Resident #33 had inquired about the treatment and wanted to proceed. The note identified the social worker requested nursing staff be informed. The note identified RN #3 was informed of the referral to an oral surgeon for removal of all remaining teeth and recommendation of dentures and that Resident #33 had inquired about the treatment and wanted to proceed. Observation on 4/28/25 at 1:25 PM identified Resident #33 was missing several teeth on both the top and bottom, and Resident #33 had visible tooth fragments along the top of the bottom gums and the gums were red. Interview with Resident #33 on 4/28/25 at 1:25 PM identified his/her teeth could be painful at times, and that his/her teeth were falling out. Resident #33 identified the meals provided look like they had been through a ricer because of the condition of his/her teeth, and that the meals were not very appealing because of that. Resident #33 identified that he/she was supposed to be getting his/her teeth fixed, but didn't know how or when that was going to happen. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Registered Nurse (RN) #3 on 4/30/25 at 11:15 AM identified on 3/14/25 when she received a referral for Resident #33 to be seen by an oral surgeon for removal of teeth, she had given a slip to the receptionist who makes resident appointments. RN #3 identified she had notified RN #1 of the referral so that she could keep track of the appointment(s), and that she had not heard anything additional since that date of 3/14/25. Interview with Reception #1 on 4/30/25 at 11:20 AM identified she was responsible for making resident appointments and that Resident #33 was scheduled to go out to the dental health clinic for a consult with the oral surgeon 5/1/25 at 11:00 AM. Reception #1 identified Resident #33 had an appointment scheduled 4/11/25, but that transportation had not shown up, so the appointment needed to be rescheduled. Interview with Resident #33 on 5/5/25 at 9:15 AM identified he/she was seen by the dentist at the facility and was supposed to get dentures but he/she doesn't know when because first the rest of his/her teeth needed to be removed. Resident #33 identified that when he/she eats it is uncomfortable because the food rubs against some of the broken teeth, but that the discomfort is only momentary and goes away quickly so he/she doesn't ask for medication. Resident #33 identified that the facility had not helped to his/her satisfaction with getting an appointment in the community for dental services, that he/she does not know what the delay is with getting an appointment to get his/her remaining teeth pulled. Interview with RN #1 on 5/5/25 at 10:15 AM identified referrals from DMD #1 are uploaded into the EMR, then the referral was approved by the Medical Doctor/Advanced Practice Registered Nurse (MD/APRN) and then it goes to the front desk for the appointment to be made. RN #1 identified it was the responsibility of the charge nurse and/or the Supervisor to ensure recommendations from DMD #1 are followed up on and that appointments or follow-up visits are made. RN #1 identified that when an appointment needed to be rescheduled the receptionist would reschedule the appointment and then let the nurses know of the new appointment date. Interview with DMD #1 on 5/5/2025 at 10:49 AM identified Resident #33 had initially requested to get something permanent like implants to replace his/her missing and broken teeth which required a referral. DMD #1 identified she had written a letter and uploaded it into the EMR and then spoke with nursing to explain what Resident #33's wishes were. DMD #1 identified that she had written multiple referral letters for Resident #33. DMD #1 identified she and RDH #1 had followed up with the facility and followed through with reminding the nursing staff many times of the referral letter(s) in Resident #33's EMR. DMD #1 identified there was a delay in Resident #33 receiving outside services to facilitate his/her acquiring implants/dentures, and DMD #1 did not know the reason for the delay. DMD #1 identified communication from the facility wasn't ideal as nursing staff did not communicate changes or delays to DMD#1. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Reception #1 on 5/5/25 at 11:50 AM identified she did not recall receiving a referral for Resident #33 for dental services from an outside resource until recently (this year). Reception #1 identified she did not retain the referral sheets/forms she received from the nursing staff for longer than 3 to 4 months after making an appointment. Reception #1 identified the excel spreadsheet she used on her computer for resident appointment scheduling went back to at least 2023 and identified she had searched through all resident appointments since January 2023 and she had located only 3 appointments for Resident #33 for dental services outside of the facility. All 3 appointments were with Resident #33's oral surgeon's office, and it was Resident #33's initial consultation with the oral surgeon which needed to be rescheduled 2 times. The original appointment was scheduled for 4/11/25 but the wheelchair transport did not arrive to pick Resident #33 up and the appointment was rescheduled for 5/1/25. On 4/30/25 Resident #33 was positive for COVID requiring the appointment on 5/1/25 to be rescheduled for 5/15/25 (but failed to identify dental services had been scheduled from her recommendations on 11/2/23, 2/2/24, and 12/6/24) when RDH #1 initially requested Resident #33 be seen by a dentist in the community related to a desire to have his/her teeth repaired. Interview with Director of Nursing Services (DNS) on 5/5/2025 at 12:05 PM identified she was unaware of referrals for dental services for Resident #33 prior to December 2024. After being informed the first referral letter from DMD #1 for Resident #33 was 2/16/23, the DNS was unable to identify reasons for the delay in Resident #33 receiving dental services from an outside resource. DNS further identified the nursing staff did not typically write notes in the EMR to document barriers or difficulties for the scheduling of appointments for residents. Review of the Dental Services policy directed, in part, the facility is responsible to provide an outside resource, routine, and emergency dental services to meet the needs of each resident, assistance for dental care upon the resident's request, and the facility will also assist with providing transportation as needed. The policy further directed in the event there is a delay in obtaining a dental appointment, the facility will document the reason for the delay.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on the tour of the Dietary Department and Nourishment Rooms, staff interviews, and review of facility policies, the facility failed to ensure opened items were labeled and dated when opened, food that was expired was discarded and the 3 of 3 nourishment refrigerator/freezer/ice makers were sanitary. The findings included: Tour of the Dietary Department on 4/28/25 at 10:40 AM during the initial walk through with the Dietary Director identified the following: a. 16 hot dog buns were in an opened package and not dated when opened b. 1 loaf of French bread, opened and not dated when opened c. 2 slices of French toast on a plate, covered with plastic wrap and located in the walk in refrigerator and not dated when opened d. 8 donuts in a box that was opened and not dated when opened e. 1 package (5 lb) egg noodles with an expiration date of 4/2023 f. 1 (48 ounces) plastic container of honey that was ¾ full, opened and not dated when opened g. 1 bag of peas located in the walk in refrigerator was opened and not dated, with a hole in the packaging h. 1 (5 pound) bag of egg noodles was opened and not dated when opened, located in the dry storage room i. 1 (5 pound) package of elbow macaroni that was ½ full, was opened and not dated when opened, located in the dry storage room j. 1 (25 pound) bag of rice that was ½ full and opened located in the dry storage room, was not dated when opened k. 4 (28 ounce) cans of pinto beans with an expiration date on 10/19/23 An observation made with the Dietary Director on 4/30/25 at 9:30 AM of the walk in refrigerator identified the following: a. 4 loaves of cooked meatloaf, on a tray uncovered and undated b. 1 loaf package of white American cheese that was ½ full, opened and not dated when opened c. tomato juice in a 1-gallon plastic container approximately ¾ full, opened and not dated when opened (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. prepared soup in a plastic container that was approximately ½ full dated 4/23/25 (7 days old) e. sliced beef with prepared gravy in a metal container dated 4/23/25 (7 days old) f. a small chaffing metal container approximately ½ full of cooked egg noodles was dated 4/23/25 (7 days old) g. 1 package of Tortellini with an expiration date of 3/23/24 h. 1 plastic container of beef broth approximately 1/3 full, not labeled, and not dated On 4/30/25 at 10:35 AM a tour of the nourishment rooms with Dietary Director identified the following: 2nd floor nourishment room: a. The coffee maker was soiled with a heavy accumulation of coffee grounds on the machine and staining covering the machine. b. a single serving size box of cereal with an expiration of dated 4/7/25 was located on the counter c. 2 chocolate cookies on a plate, loose, and uncovered were located on the counter d. 2 slices of bread not dated on a plate, uncovered, not dated located on the counter e. the refrigerator was observed to have brownish drip marks on multiple shelves on the inside The 3rd floor nourishment room was identified with the following: a. The ice maker was observed with a brown substance in the ice scoop container located attached to the side of the ice maker b. The wall was coming away with noted debris behind the ice maker toward the floor c. 1 package (approximately 1 lb) of brown sugar was opened and not dated d. 1 foil wrapped item not dated (unable to determine what the item was without unwrapping) e. The nourishment room refrigerator was noted to be tacky to touch with brown substance located along the inside door, bottom of the refrigerator, plastic shelving 4th floor nourishment room: a. The ice maker was noted to have a heavy accumulation of a brown and white substance on front grate and along the side. The ice scoop container which also had a brown substance at the bottom of the holder (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. 1 container (32 ounce) of mayo that was almost full, opened and not dated when opened c. 1 container (24 ounce) of salsa that was ¾ full, opened and not dated when opened Interview on 4/30/25 at 11:00 AM with the Dietary Director identified that he was unsure of the policy on items to be labeled with the date and going through inventory for expired food items. He also identified that the nourishment room refrigerator/freezer/ice makers needed to be cleaned on all 3 units, Further, identifying that the dietary department was responsible for maintaining the cleanliness of the nourishment rooms, and that he makes round to check on the cleanliness but apparently not often enough. Review of the facility policy for Storage of food and supplies food, non-food items, and supplies used in food preparation and service shall be stored in such manner as to maintain safety and sanitation of the food or supply for human consumption at outline in the federal drug administration food code, state regulation, and city/county health codes. Identified labeling and rotating food supply, food products that are opened and not completely used, transferred from its original container package to another storage container, or prepared at the facility and stored should be labeled as its contents and used by dates. Also identified was food removed from its original container must be labeled with the common name of the food. Further identifying that refrigerator time/temperature safety, ready-to-eat food that was opened but not completely used and was held for longer than 24 hours should be labeled with the common names and use by day, with day 1 counted as the day the item was opened. Rotate food product (dry, refrigerated, or frozen) to ensure the oldest inventory was used first. Discard food that exceeds their used by date or expiration date, was damaged, spoiled, has the time/temperature danger zone requirements, or was incorrectly stored such that it was unsafe, or its safety was uncertain.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on staff interview, observation and facility policy of the dumpster area, the facility failed to properly dispose of garbage and refuse. The findings include: On 4/30/25 at 9:15 AM observation of the dumpster area with the Dietary Director noted a heavy accumulation of debris alongside the dumpsters consisting of 1 discarded mattress, 2 bedside tables, 2 wheelchairs, leg rest for wheelchairs, 2 pink cloth large garbage containers, a green blanket, flowered curtains, window blinds, and a piece of therapy equipment. An interview with the Dietary Director on 4/30/25 at 9:20 AM identified that the area was not well kept or cleaned. He stated that the items were from maintenance and not dietary related items and that a pickup would be later that week or the following week. An interview, observation of the dumpsters and surrounding areas with the Maintenance Director on 4/30/25 at 9:30 AM identified that the items listed above had been outside the dumpsters for over a week. The Maintenance Director further identified that he usually does not call for a pickup of the debris until the pile was larger and more significant. Also, identifying he did not know the policy and did not think the area was clean and tidy. Subsequent to surveyors inquiry, the items were removed by the Maintenance Director who brought the items to a sister facility who had more room in their dumpster to accommodate the durable equipment. Review of the policy for Environmental Management identifies that a process was in place to inspect, maintain and clean grounds, parking lots and sidewalks. Further, identified a schedule plan to maintain areas free of debris, to empty/clean trash containers and maintain areas where compactors, dumpsters or collection containers are located.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, review of the clinical record and facility policy for 6 residents (Resident #4/Resident #36 (roommates), Resident #13/Resident #25 (roommates)and Resident #33/Resident #37 (roommates) on isolation precautions, the facility failed to ensure the nursing staff donned the appropriate Personal Protective Equipment (PPE) and for 1 of 6 sampled residents (Resident #36) reviewed for infection control documentation, the facility failed to ensure documentation was accurate and consistent regarding the type of precautions Resident #36 required. The findings include: 1a. Resident #4 was admitted in April 2021 with diagnoses that included Alzheimer's disease and dementia (was roommates with Resident #36). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a short/long term memory problem and had severely impaired cognitive skills for tasks of daily living. Additionally, the MDS identified Resident #4 required substantial/maximal assistance with upper body dressing and was totally dependent for lower body dressing and personal hygiene. Nursing notes dated 4/28/25 and 4/30/25 identified Resident #4 was tested for Covid-19 with negative results on both days. Observation during a tour of the facility on 4/29/25 at 9:50 AM, identified Licensed Practical Nurse (LPN) #3 was preparing medications at the medication cart in the hall on the 3rd floor in front of Residents #4/Resident #36's room. The room had a sign posted on the door frame stating that room was on transmission-based precautions for droplets (related to Resident #4's roommate/Resident #36 testing positive for Covid-19) and required staff to don a gown, eye protection, an N95 face mask and gloves. Further observation identified LPN #3 entered the room to pass medications to Resident #4, wearing only a surgical mask (and failed to apply a gown, eye protection, an N95 mask or don gloves) . Interview with LPN #3 on 4/30/25 at 12:45 PM identified that she did not don a gown, gloves, eye protection or an N95 mask when going into Resident #4/Resident #36's room on 4/29/25 at 9:50 AM and she was only wearing a surgical mask because she was administering medications to Resident #4 who tested negative for Covid-19 on 4/28/25. Further interview with LPN #3 identified she should have donned a gown, eye protection, gloves and N95 face mask which were located outside of the room and she should don the proper PPE to go into any residents room that was labeled as droplet precautions regardless of the residents' roommates status of infection. b. Resident #36 was admitted to the facility in April 2024 (was roommates with Resident #4) with diagnoses that included Alzheimer's disease, malignant neoplasm of the breast, immunodeficiency due to drugs and tested positive for Covid-19 on 4/27/25. A physician's order dated 4/28/25 identified Resident #36 was put on contact and droplet precautions every shift for 10 days, ending on 5/8/25 due to Covid-19. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], identified Resident #36 was severely cognitively impaired and required partial/moderate assistance with toilet hygiene and required supervision with upper/lower body dressing and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing notes dated 4/28/25 through 5/2/25 identified Resident #36 was showing symptoms of dry cough, stuffy nasal passages, weakness and increased difficulty in walking on 4/27/25 then tested positive for Covid-19 on 4/28/25 at 6:48 AM. Further review identified implementation of precautions were documented; however, the type of precautions implemented were inconsistent and differed with each day/different shifts: on 4/28/25 at 6:48 AM the nurse documented transmission- based precautions (TBP) then on the same day 4/28/25 at 2:00 PM, a different nurse documented Resident #36 was on enhanced-barrier precautions (EBP). On 4/29/25 at 6:48 AM and 9:42 PM and 4/30/25 at 5:54 AM TBP was documented, but on 4/30/25 at 6:38 PM, EBP was documented. Further review of the nursing notes identified inconsistent documentation of the type of precautions documented for Resident #36 continued through 5/5/25. 2a. Resident #13 had diagnoses that included asthma, anxiety, and chronic peripheral venous insufficiency. (was roommate with Resident #25) The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired, was up-to-date with COVID-19 vaccinations, was independent with eating and personal hygiene, and required setup or clean-up assistance with bed/chair transfers. The Resident Care Plan (RCP) dated 4/16/25 identified Resident #13 was at risk for complications of asthma related to seasonal allergies. Interventions included to assist Resident #13 in identifying asthma triggers and strategies for prevention, encourage prompt treatment of any respiratory infection, and give medications as ordered. b. Resident #25's diagnoses included being positive for Covid-19, pleural effusion, and dementia. (Resident #25's roommate was Resident #13). A physician's order dated 4/25/25 directed for isolation related to being positive for Covid-19, every shift for infection control measures for 10 days. The Resident Care Plan (RCP) dated 4/25/25 identified that Resident #25 was confirmed Covid-19 positive with interventions that included contact/droplets precautions, assist resident with the application of face mask as needed, and assist resident with hand hygiene as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #25 was moderately cognitively impaired, required supervision for bed mobility, transfers, eating, and toilet use. Additionally, the MDS identified Resident #25 was up to date with Covid-19 vaccinations. i. Observation on 4/29/25 at 9:50 AM identified signage posted on the door frame of the room that indicated Resident #25 was on contact/droplet precautions and staff and/or visitors entering the room were required to don the following personal protective equipment (PPE) prior to entering the room: gown, N95 mask, eye protection/shield, and gloves. Observation at that time noted Licensed Practical Nurse (LPN) #1 in the room wearing a blue surgical mask (not an N95 mask), failed to don a gown, eye shield and gloves and standing in front of the bed conversing with Resident #25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #1 on 4/29/25 at 9:53 AM identified Resident #25 was on contact/droplet transmission-based precautions, and the signage posted on the doorframe of Resident #25's room directed staff/visitors to don the PPE listed on the signage prior to entering the room. LPN #1 identified that while she was wearing a surgical mask, she should have been wearing an N95 mask, gown, eye shield and gloves. LPN #1 identified she had been in a rush and had not put on the required PPE before entering the room. Interview with the Infection Preventionist (RN #3) on 4/30/25 at 12:20 PM identified prior to entering a room with signage posted that indicated one or both the residents in that room were on contact/droplet precautions, all staff were required to don the appropriate PPE (gown, N95 mask, eye shield, and gloves) before entering the room. RN #3 identified that even if a staff member was entering the room to assist the resident who was not on contact/droplet precautions, the staff were still expected to don the required PPE prior to entering the room. RN #3 identified wearing the required PPE was part of infection prevention. ii. An observation made outside of Resident #25's room on 5/1/25 at 7:50 AM identified signage was posted outside the room, that the resident's were on enhanced barrier precautions (EBP) which directed that isolation droplet/contact precautions were in place and that staff must wear gloves, a gown, N95 mask and eye protection upon entering the room. A cart containing isolations gowns and other personal protective equipment (PPE) was observed outside of Resident #13's/Resident #25's room. Additionally, Nurse Aide (NA) #6 was observed to don gloves, a gown, an N95 mask but failed to don eye protection upon bringing a breakfast tray into the room. An interview on 5/1/25 at 7:59 AM with NA #6 once she exited Resident #25's room the cart outside the room did not contain any eye protection, that she needed to request more be brought up to the unit and NA #6 knew the policy for wearing eye protectors in a room with droplet/contact precautions but she went in the room anyway without wearing. An observation of the unit on 5/1/25 at 8:00 AM identified that other EBP carts were placed in the hallway with one cart containing 3 eye protectors not far from Resident #13's/Resident #25's room. An interview on 5/1/25 at 8:20 AM with the Director of Nursing (DNS) identified that full PPE was to be worn when entering Resident #25's room which included eye protectors. Also, identifying that was the policy and what the signage was outside the doorway of the room. 3a. Resident #33 had diagnoses that included COVID-19, dementia, and depression.(Resident #33 was roommates with Resident #37). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 was cognitively intact, was up-to-date with COVID-19 vaccinations, required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 1/30/25 identified Resident #33 was at risk for altered respiratory status/difficulty breathing. Interventions included administer medication as ordered, oxygen per medical doctor (MD) orders, and monitor for signs and symptoms of respiratory distress and report to MD as needed: increased respirations, decreased pulse oximetry, increased heart rate, restlessness, lethargy, and confusion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 4/25/25 directed isolation for positive COVID-19 every shift for 10 days. b. Resident #37 had diagnoses that included lymphedema, epilepsy, and stroke. (Resident #37 was roommates with Resident #33). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 was cognitively intact, was not up-to-date with COVID-19 vaccination, required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and substantial/maximal assistance with transfers. The Resident Care Plan (RCP) dated 4/2/25 identified Resident #37 had a Multi-Drug Resistant Organism (MDRO) infection/colonization of a wound to the right leg. Interventions included enhanced barrier precautions: don gown and gloves when performing high contact care activities, and private room or cohort with appropriate roommate. Observation on 4/29/25 at 10:04 AM identified signage posted on the door frame of the room that indicated Resident #33 was on contact/droplet precautions and staff and/or visitors entering the room were required to don the following personal protective equipment (PPE) prior to entering the room: gown, N95 mask, eye protection/shield, and gloves. Nurse Aide (NA) #1 was observed in the room, walked away from the foot of Resident #33's bed and stopped at the disposal receptacles and removed her gown and gloves and placed the used gown in the laundry receptacle and the gloves in the trash can. The observation identified NA #1 was wearing a blue surgical mask (and not an N95 mask) that she did not take off prior to exiting the room and going into the hallway. Interview with NA #1 on 4/29/25 at 10:05 AM identified Resident #33 was on contact/droplet transmission-based precautions, and the signage posted on the doorframe of Resident #25's room directed staff/visitors to don the PPE listed on the signage prior to entering the room. NA #1 identified that although she was wearing a surgical mask, gown and gloves inside the room, she should have been wearing an N95 mask instead of the surgical mask and an eye shield also. NA #1 identified she had not donned all the required PPE because she had rushed into the room because she heard Resident #33's roommate (Resident #37) crying. Interview with the Infection Preventionist (RN #3) on 4/30/25 at 12:20 PM identified prior to entering a room with signage posted that indicated one or both the residents in that room were on contact/droplet precautions, all staff were required to don the appropriate PPE (gown, N95 mask, eye shield, and gloves) before entering the room. RN #3 identified that even if a staff member was entering the room to assist the resident who was not on contact/droplet precautions, the staff were still expected to don the required PPE prior to entering the room. RN #3 identified wearing the required PPE was part of infection prevention. Review of the COVID-19 policy directed, in part, under the section for PPE, upon entry to a COVID-19 positive resident room all healthcare workers are to wear an N95 mask, eye protection, gown and gloves which is to be removed prior to exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy for Precautions to prevent infection identified that there are two tiers of precautions to prevent infectious agents, Standard Precautions and Transmission -Based Precautions. Transmission-Based Precautions are for patients who are known or suspected to be infected or colonized with infectious agents, including certain epidemiological important pathogens, which require additional control measures to effectively prevent transmission. Further, identified to make PPE, including gowns, and gloves available immediately outside the resident's room when on Transmission-Based precautions. Also, identified for Standard and Enhance Barrier Precautions PPE was always readily available to all staff. Gloves are in each resident room, gowns are available in/on linen carts, eye protection and face mask are available in the clean utility room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075208	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 1 of 5 residents (Resident #33) reviewed for vaccinations, the facility failed to ensure the appropriate time was provided between COVID-19 vaccination administration. The findings include: Resident #33 had diagnoses that included weakness and partial paralysis affecting the left side following a stroke, dementia, and COVID-19. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 was cognitively intact, used a wheelchair, required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 8/6/24 identified Resident #33 was immunized against COVID-19, influenza, and pneumonia. Interventions included refer to the immunizations tab in Resident #33's chart for dates of vaccine administration. Review of the Immunization Report dated 4/30/25 identified Resident #33 received administration of the (Pfizer) COVID-19 2024-2025 on 10/9/24 in the left deltoid while in the facility and received administration of the (Pfizer) COVID-19 2024-2025 on 10/18/24 in the left deltoid (9 days after receiving a COVID-19 vaccine on 10/9/24) while in the facility. Interview with Registered Nurse (RN) #3 on 5/5/25 at 11:00 AM identified her process for administering vaccines was to obtain the consent signed by the resident/responsible party, provide the Vaccination Information Sheet (VIS), and after the vaccination was completed to enter the vaccine under the vaccination tab in the electronic medical record (EMR). RN #3 identified she administered most of the vaccinations, but sometimes she put an order in the EMR and scheduled the vaccine to be administered by the charge nurse. RN #3 identified per the Centers for Disease Control and Prevention (CDC) the COVID-19 vaccine for 2024 through 2025 was recommended to be given twice in the year, 6 months apart for residents who were immunocompromised. RN #3 identified in the EMR documentation of administration of a 2024 through 2025 COVID-19 vaccine given on 10/9/24. RN #3 identified she had documented administration of the 2024 through 2025 COVID-19 on 10/18/24. RN #3 identified that she was not aware a COVID-19 vaccine was administered on 10/9/24, and if she had seen the vaccine documentation, she would not have administered the 2024 through 2025 COVID-19 vaccine on 10/18/24 (9 days later). RN#3 was unable to identify the reason she had not seen the documentation for the 2024 through 2025 COVID-19 vaccination that was administered on 10/9/24 when she was administering the same 2024-2025 COVID-19 vaccination on 10/18/24. RN #3 identified vaccination administration was passed on in shift to shift report by the nurse who administered the vaccination. RN #3 identified she did not write progress notes after vaccine administration, and only documented the administration in the vaccination section of the EMR and that she did not think it was written policy to document vaccination administration in progress notes in the EMR. (continued on next page)

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	075208	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Infection Prevention and Control Program policy directed, in part, documentation for each resident who receives an immunization from facility staff would be in the resident's medical record and would include the date, site of administration, type of vaccine, dose, manufacturer, lot number, education provided, reactions if any, and the name of the person administering the vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on observations, interviews and review of facility policy for two of three medication storage rooms, the facility failed to ensure the medication rooms were clean. a. Interview and observation of the 4th floor medication room with Licensed Practical Nurse (LPN) #2 on [DATE] at 10:40 AM identified the medication room floor was dirty with dried spilled liquids and debris. Additionally, 20 hemoccult cards were observed that had an expiration date of 8/2023 and a bottle of hemoccult developer that expired in 8/2021 in the cabinet drawer. LPN #2 identified that it was housekeeping's responsibility to clean the medication room floor, but the floor was not cleaned often. An interview with the Director of Facilities Housekeeping on [DATE] at 12:30 PM identified it was the responsibility of housekeeping staff to dust and mop the floors and clean other areas in the medication rooms daily. The housekeeping staff report directly to the Director of Facilities Housekeeping. b. Interview and observation of the 3rd floor medication room with LPN #7 on [DATE] at 11:45 AM identified the medication room tile floor was soiled, with a build-up of dust and debris around the floor. The were several tiles (6) in the room near where the medication cart was stored that were broken, crumbling and cracked. The sink around the faucet and the faucet had white build-up surrounding it. The base of the sink was also dirty with splashes of liquid and debris noted. Interview and observation of the 3rd floor medication room with Director of Facilities Housekeeping on [DATE] at 12:30 PM identified the broken tiles on the floor and the status of the sink. The Director of Facilities Housekeeping could not identify how long the sink and floor had been in disrepair, but had been aware of both issues ad noted he would change the tiles and the faucet. The unit maintenance book for the current year, 2025, did not identify the tiles and faucet had been reported and LPN #7 wasn't able to identify when it occurred or if this had been reported to the Director of Facilities Housekeeping A review of the housekeeping policy for Medication Rooms identified the medication room floors must be dust mopped and then damp mopped daily and stainless-steel fixtures and bright metal must be cleaned and polished with dry cloth and stainless-steel polish daily. A review of the Engineering Management Plan and Procedure identified furnishings, equipment and accessories shall be maintained in good order.