STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 residents (Resident #25 and 83) reviewed for medications, the facility failed to ensure the resident and/or resident representative were offered to attend quarterly resident care plan conferences. The findings include: 1. Resident #25 was admitted to the facility in May 2017 with diagnoses that included dementia, schizophrenia, and Wernicke's encephalopathy. The quarterly MDS dated [DATE] identified Resident #25 had intact cognition, had hallucinations and delusions and that Resident #25 and legally authorized representative participates in the assessment process. Review of the clinical record dated 11/14/23 through 12/17/24 identified care conferences were held on 11/14/23 and 11/19/24. The clinical record failed to reflect care conferences were held February, May, and August of 2024. Interview with RN #4 (MDS coordinator) on 12/15/25 at 11:00 AM indicated that all residents were to have a quarterly care conference including the resident and/or the resident representative. RN #4 indicated that when a meeting is held, she was responsible or the social worker to have everyone in attendance sign in on a form. RN #4 indicated that she and the social worker had a pile of the sign in sheets, and they were not in the resident's clinical record. RN #4 indicated that she is aware that not all residents have had a quarterly care conference per requirement, but the other full time MDS coordinator had been out on leave. RN #4 indicated that she would look for the documentation for Resident #25. Interview with Resident #25 on 12/15/24 at 9:21 AM indicated that he/she does not recall going to care plan conference meetings with the staff to discuss his/her plan of care or being invited to go. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #5 conservator of person (COP) on 12/18/24 at 12:12 PM indicated that he/she doesn't consistently get a quarterly notice of when the care plan conferences will be held. Person #5 indicated that if he/she receives a notice it comes after the care plan conference was held. Person #5 indicated that he/she must call the facility and speak with the social worker to get updates. Person #5 indicated that Resident #25 can attend the care plan conferences with him/her if they were notified. Person #5 indicated that it had been quite a while since he/she had received a notice, so he/she could attend. Person #5 indicated that he/she had emailed the social worker stating he/she wanted to attend the care plan conferences but did not get a response or email back. Person #5 indicated that the notices for the care plan conferences were not consistent and not timely. Interview and clinical record review with RN #10 (MDS coordinator) on 12/18/24 at 9:21 AM indicated all residents must have a quarterly care plan conference with the quarterly MDS. RN #10 indicated that Resident #25 should have had a care plan conference within a few days of the MDS on 2/28/24, 5/28/24, and 8/28/24 and then 11/28/24. RN #10 indicated that the last care plan conference was held on 11/14/23 and not again until 11/20/24. RN #10 indicated that she did not know why there was not a care conference held in a year. 2. Resident #83 was admitted to the facility in June 2023 with diagnoses that included respiratory failure, diabetes, and renal failure with dialysis. The quarterly MDS dated [DATE] identified Resident #83 had intact cognition and required total assistance for personal hygiene, dressing, and transfers. The care plan dated 6/22/23 identified Resident #83 needed assistance with mobility and care needs. Interventions include to encourage resident to make choices and decisions. Review of the clinical record dated 1/1/24 through 12/17/24 identified care plan conferences were not held in March 2024 and June 2024. Interview and clinical record review with RN #4 (MDS coordinator) on 12/17/24 at 11:29 AM indicated that Resident #83 was cognitively intact and should be invited to all his/her quarterly care plan conferences. RN #4 indicated that she only sees documentation for one care plan conference in all of 2024. Interview and clinical record review with RN #10 (MDS coordinator) on 12/18/24 at 11:10 AM identified that Resident #83 had intact cognition and should have been invited to attend the quarterly care plan conferences. RN #10 identified from 1/1/24 until now she only saw a note that a care plan conference was held on 9/6/24. RN #10 indicated that for the 9/6/24 she could not find a sign in form to identify whether Resident #83 was invited and/or if he/she had attended. RN #10 indicated that she could not find any documentation that Resident #83 had a care plan conference in March and June of 2024. Review of the Resident Rights Policy identified Federal and state laws guarantee certain basic rights to all residents. Residents have the right to be informed of, and participate in, his/her care planning and treatment. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Planning - Interdisciplinary Team Policy identified that the resident, the resident's representative, and the resident's legal representative are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and resident representative.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 residents (Resident #31 and 87) reviewed for advance directives, the facility failed to ascertain the resident/representative wishes and the necessary documentation regarding Code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops). The findings include: 1. Resident #31 was admitted to the facility in [DATE] and readmitted in [DATE] with diagnoses that included dementia, stroke, cancer, and malnutrition. The hospital discharge summary dated [DATE] identified Resident #31 was a full code (full code directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency) and had altered mental status. A physician's order dated [DATE] directed for nursing to call the resident representative to obtain a formal directive on a code status post readmission. The physician's orders did not reflect a code status. Review of the nurses and social worker notes dated [DATE] to [DATE] failed to reflect an attempt to contact the resident representative to discuss code status wishes. Review of the census form identified Resident #31 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE]. The hospital discharge summary dated [DATE] identified Resident #31 was a full code. The admission physician orders dated [DATE] failed to reflect a code status. The nurse note dated [DATE] at 4:18 PM identified hospice to follow up per recommendations. APRN aware of resident's return. The admission MDS dated [DATE] identified Resident #31 had severely impaired cognition. The nurses note dated [DATE] at 3:16 PM identified the resident was admitted to hospice today and recommendations given to the supervisor. The significant change of condition MDS dated [DATE] identified Resident #31 had severely impaired cognition and hospice care while a resident. The monthly physician orders dated [DATE] to [DATE] failed to reflect a code status despite having been admitted to hospice services on [DATE]. Review of the resident health care instruction form dated [DATE] (69 days after admission) identified the resident representative made the decision that Resident #31 would be DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Corporate LPN #4 on [DATE] at 6:40 AM indicated that she had done an audit a month ago for all residents for their code status. LPN #4 indicated that she had noted Resident #31 returned from the hospital in [DATE] and was placed on hospice, but the last code status was for a full code and had not been signed since readmission, so she had informed the DNS to address it. Interview and review of the clinical record with the DNS on [DATE] at 9:50 AM indicated that when a resident is readmitted , the nurse was responsible to call the resident representative to address the code status within the first 24 hours. The DNS indicated that 2 nurses, one being an RN can sign the code status as a telephone order and the next visit the resident representative would sign the form. The DNS indicated that Resident #31 did not have a physician order for a code status or signed advance directives from the [DATE] readmission or the [DATE] readmission. The DNS indicated that on a hospice note dated [DATE] Resident #31 was a DNR so the DNS indicated that she would have expected the hospice nurse to make sure the advance directive form was signed by the resident representative. The DNS indicated that if Resident #31 had coded from readmission on [DATE] until now he/she would have been given CPR because there was not a signed code status form or a physician's order for a DNR. A physician order dated [DATE] at 8:06 AM (74 days after admission) directed that Resident #31 was a do not resuscitate. Review of the facility advance directives policy identified the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance directives - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated 2. Resident #87 was admitted to the facility in [DATE], with diagnoses that included vascular dementia with severe agitation, diabetes, and asthma. Review of the clinical record identified Resident #87 had a Power of Attorney (POA) for health care decisions. The health care instruction form dated [DATE] identified an X mark on withhold for Cardiopulmonary Resuscitation (which means Do Not Resuscitate - DNR no chest compressions) and Intubation (breathing tube). The health care form was signed by a facility representative but not signed by the resident or the resident POA. Review of physician's orders for [DATE] directed for Do Not Resuscitate, Do Not Intubate, and Registered Nurse to pronounce. Additional review of the clinical record from [DATE] - [DATE], 1 year and 7 months, failed to reflect documentation of a signed advance directive/code status from the POA. The nurse's notes and the social service notes dated [DATE] - [DATE], 1 year and 6 months, failed to reflect documentation addressing Resident #87 advance directives. The quarterly MDS dated [DATE] identified Resident #87 had severely impaired cognition. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated [DATE] identified Resident #87 has an advance directive of Do Not Resuscitate, Do Not Intubate (DNR/DNI). Feeding restrictions - no G-tube feeding. Restrictions - No artificial nutrition. Do not hospitalize, palliative care. Interventions included advised staff of my wishes. Respect my wishes. Provide me with written information regarding advanced directives as needed. Physician's orders for [DATE] directed for Do Not Resuscitate, Do Not Intubate, and Registered Nurse to pronounce. Interview and review of the clinical record with the DNS on [DATE] at 9:00 AM failed to provide documentation that an advance directive was addressed. The DNS identified she was not aware that Resident #87 advance directive was not completed. The DNS indicated it was the responsibility of the admission nurse and the floor nurse to address the advance directive with the resident or the resident responsible party and have them sign the form. Although attempted, an interview with APRN #1 was not obtained. Review of the facility advance directives policy identified the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance directives - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated 42117

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #50), reviewed for nutrition and weight loss, the facility failed to notify the physician and resident representative after a significant weight loss was identified, and for 1 of 2 residents (Resident #103) reviewed for opioid medications, the facility failed to notify the resident representative when a new medication was initiated. The findings include: 1. Resident #50 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), hypotension, and dementia. Review of the clinical record identified Resident #50 was hospitalized from 8/11/24 following a fall with fracture of the left femur. Resident #50 was readmitted to the facility on [DATE] and weighed 146.2 lbs. The physician's orders dated 8/20/24 directed a carbohydrate-controlled diet, dysphagia advanced with thin liquids and scoop plate with meals; obtain weights every Tuesday, Thursday, and Sunday (3 times weekly) related to CHF and report a gain of 5 or more lbs. to the MD/APRN; and administer Remeron (an antidepressant used to help appetite) 15 mg nightly at bedtime. A nutritional assessment dated [DATE] identified Resident #50 was seen following readmission to the facility. The note identified that Resident #11 was 128 lbs. on 8/11/24 prior to hospitalization and that Resident #50's had a history of variable weights due to fluid shifts related to CHF and a history of increased intake and snacking. The note further identified that no changes were made to the nutrition plan of care and continue to monitor weights. The 5-day MDS dated [DATE] identified Resident #50 had severely impaired cognition, was frequently incontinent of bowel and bladder and required substantial/maximal assistance with dressing, bathing, and toileting. Although requested, the facility failed to provide documentation related to Resident #50's care plans. The physician's order dated 8/30/24 directed to administer Furosemide 20 mg (a diuretic medication for fluid overload) twice daily for CHF. Review of the clinical record identified LPN #9 documented Resident #50 weighed 138.5 lbs. on 9/8/24, a 7.7 lb. or 5.47% loss since readmission on 8/20/24 (19 days prior). The clinical record failed to identify any additional documentation including any notification to the physician or resident representative, nursing assessments, reweights, on interventions initiated related to the documented weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified LPN #9 documented Resident #50 weighed 122 lbs. on 9/12/24, a 16. 5 lb. or 11.85% loss over 4 days. The clinical record failed to identify any additional documentation including notification to the physician or resident representative, nursing assessments, reweights, or interventions initiated following this significant weight loss. Review of the clinical record identified LPN #8 documented Resident #50 weighed 118.7 lbs. on 9/15/24, a 3. 3 lb. or 2.8 % loss over 3 days, and a total weight loss of 27.5 lbs. or 18.81% following readmission on 8/20/24 (26 days). Review of the clinical record identified LPN #9 documented Resident #50 weighed 117. 8 lbs. on 9/22/24. A physician's order dated 9/23/24 directed to administer Metoprolol XL (a blood pressure medication) 25 mg daily. Review of the clinical record identified on 9/29/24, LPN #8 documented Resident #50 had a weight of 112 lbs. , a 5.8 lb. or 4.92 % loss from one week prior, and a total weight loss of 34.2 lbs. or 23.71% following readmission on 8/20/24 (40 days). Review of the clinical record failed to reflect documentation related to notification to the physician or resident representative, nursing assessments, interventions initiated or implemented related to Resident #50's documented initial weight loss on 9/8/24, significant weight loss on 9/12/24, or continued weight losses on 9/15, 9/22, or 9/29/24. Review of all 24-hour report sheets for Resident #50 for 9/2024 failed to identify nursing documentation related to Resident #50's significant weight loss, including nursing assessments, physician/APRN notification, resident representative notification, or interventions. A nutrition note dated 10/4/24 identified Resident #50 had ongoing weight loss with a 26 lb./18% loss over the last month. The note further identified that Resident #50's weight loss had an unknown etiology, but the resident had a history of CHF, diuretics, fluid shifts, and multiple hospitalization s. Recommendations included to start 237 ml clear house supplement three times daily and monitor intakes, weights, labs, and skin integrity. An APRN note dated 10/4/24 by APRN # 1 identified Resident #50 had a recent weight loss per the dietitian, had been eating and drinking well, and historically had a baseline weight of 120 lbs. but had recently started Furosemide per Cardiology due to CHF. The note identified that the treatment plan included to continue Remeron, monitor percentages of meals consumed; start super cereal with breakfast, magic cup with lunch and dinner, and that while the dietitian recommended the clear house supplement three times daily, this was discontinued due to Resident #50's history of CHF. Review of the clinical record failed to identify documentation that Resident #50's representative was notified of the significant weight loss, interventions, or treatment plan on or after 10/4/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dietitian on 12/17/24 at 1:50 PM identified that Resident #50 was seen on 10/4/24, when the Dietitian was first notified of an issue with his/her weight. The Dietitian identified that this notification likely came from being notified by a nurse assigned to Resident #50 in person, however the specific nurse would not be typically documented anywhere, and that unless the nursing staff provided notification that a resident had an issue with weights, the dietitians did not review all weights for every resident in the building with every visit to the building. The Dietitian also identified she would be notified of any nutritional issues by text message from the ADNS, DNS, or the APRN, but would rely on nursing staff to notify her of nutritional issues. Review of Resident #50's clinical record and interview with the ADNS on 12/17/24 at 2:15 PM identified Resident #50's weights were flagged as red on multiple dates in the electronic clinical record. The ADNS identified that this would indicate to the nursing staff that there had been a change in Resident #50's weight, and this should have been investigated further, including an assessment and a reweight within a day of the initial flagged weight loss. The ADNS identified, upon review of the clinical record, that Resident #50 should have had a reweight done within a day of the initial weight loss to confirm it was a true weight loss, and then the APRN, resident representative, and Dietician should have been notified following Resident #50's initial weight loss on 9/8/24. Interview with APRN #1 on 12/18/24 at 8:24 AM identified that she was initially notified by the Dietitian on 10/4/24 that Resident #50 had an issue with weight loss, and that at that time she assessed Resident #50 related to the weight loss and ordered nutritional supplements with all meals. APRN #1 identified that while she was aware that Resident #50 had a documented weight loss, she was not aware that Resident #50 had a 16 lb. weight loss from 9/8/24 - 9/12/24. APRN #1 identified she would have expected the nursing staff to contact her regarding this as it would be a significant weight loss that may have impacted Resident #50's medications as Resident #50 had a significant history of being very sensitive to his/her cardiac and hypertensive medications. APRN #1 further identified Resident #50 had a history of hypotension which had resulted in severe hypotensive episodes with hospitalization s in the past. APRN #1 identified had she been notified, she may have decreased or even held Resident #50's Furosemide or metoprolol due to the large weight fluctuation as a rapid weight loss could have impacted the dosing of these medications. Interview with the DNS on 12/18/24 at 8:58 AM identified that she had discussed weight fluctuations with the Dietitian related to Resident #50 and that APRN #1 was aware there were issues as well. The DNS was unable to identify when she was first notified of any issues with Resident #50's weights, however it was over the course of several months due to a decline in Resident #50's health. The DNS identified she was not aware there had had been a significant weight loss for Resident #50 which initially started on 9/8/24, or that APRN #1 and the Dietitian were not aware of the continued significant weight loss until 10/4/24, approximately 26 days later. The DNS identified that she would have expected the nursing staff to obtain a reweight following the initial weight loss within a day, and if the weight loss was accurate, to assess the resident, then notify the APRN, resident representative, and Dietitian to determine what interventions would be needed. The DNS also identified that all documentation related to this should also be included in the clinical record. Although attempted, an interview with LPN #8 and LPN #9 were not obtained. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on weight assessment and intervention directed that the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for facility residents. The policy directed that any weight change of 5% or more would be retaken the next day for confirmation, and if the weight change was verified, nursing would immediately notify the Dietitian in writing, and any verbal notification must also be confirmed in writing. The policy further directed that the threshold for significant unplanned and undesired weight loss would be based on the following criteria: A) 1 month - 5% weight loss was significant; greater than 5% was severe weight loss. B) 3 months - 7.5% weight loss was significant; greater than 7.5% was severe weight loss. C) 6 months - 10% weight loss was significant; greater than 10% was severe weight loss. The policy also identified that care planning for weight loss or impaired nutrition would be a multidisciplinary effort and include the physician, nursing staff, Dietician, and the resident or resident legal surrogate, and that the care plan would be individualized and address to the extent possible, the identified cause of weight loss, goals and benchmarks for improvement, and timeframes and parameters for monitoring and reassessment. The facility policy on change of condition directed that the facility would promptly notify the resident, attending physician, and resident representative regarding a significant change to the resident's medical/mental condition and/or status. The policy further directed that a significant change of condition was a major decline in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention (would not be self-limiting); would impact more than one area of the resident's health status; and required interdisciplinary review and revision to the care plan. The policy also identified that prior to notifying the physician or healthcare provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider including information prompted by the SBAR (Situation/Background/Assessment/Recommendation) Communication form. The policy also directed that unless instructed by the resident, the nurse would notify the resident representative when there was a significant change to the resident's physical status, and that notifications would be made within 24 hours of the change in condition, except in medical emergencies. The policy further directed that the nurse would record in the resident's medical record relative to the changes in the resident's medical condition and status. 2. Resident #103 was admitted to the facility on [DATE] with diagnoses that included hypertension, dementia, and rheumatoid arthritis (RA). The admission MDS dated [DATE] identified Resident #103 had severely impaired cognition, required a moderate assist with sitting to standing, chair/bed-to-chair transfers, personal hygiene, and received a scheduled pain medication regimen. The care plan dated 8/9/24 identified Resident #103 had the potential for pain/discomfort related to general discomfort and diagnosis of RA. Interventions included reporting any changes/concerns to physician and resident representative as needed (prn). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 10/1/24 at 3:39 PM identified that Resident #103 complained that his/her lower left extremity was in pain. The resident representative asked about an order for Tramadol and the APRN was contacted, and an order was placed for Tramadol 50mg tablet every 8 hours, prn for 14 days. The resident representative was aware. A physician's order dated 10/1/24 directed to administer Oxycodone 2.5mg by mouth, every 8 hours prn for right knee pain. The nurse's note dated 10/5/24 identified that Resident #103 was seen in bed, Oxycodone 2.5mg administered prn with good relief. The nurse's note dated 10/5/24 identified the resident representative was at the bedside and had concerns regarding Resident #103 being more sleepy than usual and more lethargic. Upon assessment, Resident #103 was lying in bed with his/her eyes closed, responsive to tactile stimuli. Vital signs taken identified blood pressure: 132/71, oxygen saturation 95% on room air, heart rate 72, and respiratory rate 16. The resident representative stated that he/she requested a stronger pain medication, but if Oxycodone was going to leave Resident #103 in this state, he/she would like it discontinued. The APRN was updated and an order to discontinue the Oxycodone was obtained. The resident representative would like to request a meeting. Interview with Resident #103's representative (Person #2) on 12/16/24 at 1:00 PM identified that he/she was not notified of Resident #103's Oxycodone order. Person #2 indicated that he/she was very upset that the Oxycodone order was not discussed with him/her prior to administering the medication to Resident #103 because he/she would have refused it. Person #2 further indicated that when he/she came in to visit, Resident #103 was out of it, and that was when he/she learned of the Oxycodone order. Person #2 identified that he/she had been talking to the facility nurses about his/her concerns related to Resident #103's pain management regimen and that he/she had been asking them to arrange for Cortisone injections. Interview and review of the clinical record with the DNS on 12/18/24 at 9:50 AM failed to provide documentation that Person #2 was notified of the Oxycodone order before the medication was administered. The DNS indicated that Person #2 had expressed concerns that Resident #103's arthritis pain was getting worse; the APRN and Physiatrist were working with Resident #103 because of Person #2's pain management concerns, and Oxycodone was ordered, prn on 10/1/24 and was discontinued on 10/5/24. The DNS indicated that she only saw documentation about Person #2 being notified when the Tramadol was ordered but did not see a note indicating that Person #2 was notified when the Oxycodone was ordered/started. The DNS identified that she would have expected Person #2 to be notified of a new Oxycodone order, either by the charge nurse or the RN supervisor prior to administering the Oxycodone. Interview and review of the clinical record with the nurse supervisor (RN #1) on 12/18/24 at 11:54 AM failed to provide documentation that Person #2 was notified of Resident #103's Oxycodone order before the medication was administered. RN #1 identified that she remembered having a generalized conversation with Person #2 regarding Resident #103's pain management, but she could not recall if she was the one who took off the Oxycodone order or notified Person #2 and she would have to review her notes and review the original order. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Change in a Resident's Condition or Status policy directs the facility to promptly notify the resident, his/her attending physician, and the resident representative of changes to the resident's medical/mental condition and/or status. 47457

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15802 Based on review of the clinical record, facility documentation, and interview for 2 residents (Resident #53 and 78) who reside on a locked unit, the facility failed to identify the clinical criteria for placing the residents on the locked unit, failed to provide the method of opening doors independently to the residents, failed to involve the resident/representative in discussions regarding the decision for placement on a locked unit, and failed to ensure the clinical record included documentation according to 483.12(a)(1) to ensure the residents were free from involuntary seclusion. The findings include: According to S483.12(a)(1) Each resident has the right to be free from involuntary seclusion. Involuntary seclusion includes, but is not limited to, the following: A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. A resident who chooses to live in the secured/locked unit and does not meet the criteria for placement, must have access to the method of opening doors independently. 1. Resident #53 was readmitted to the facility in November 2023, to a locked unit, with diagnoses that included diabetes. The quarterly MDS dated [DATE] identified Resident #53 had intact cognition, utilized a manual wheelchair and once seated in the wheelchair could wheel at least 150 feet independently. The care plan dated 11/11/24 identified Resident #53 was independent while in the wheelchair. The care plan failed to reflect the resident resided on a locked unit, how the resident would be provided independent egress from the unit, and ongoing review and revision of the care plan regarding remaining on the locked unit. The clinical record failed to reflect initial or ongoing assessments regarding the clinical criteria for placing the resident on the locked unit, failed to reflect documentation of the resident/representative's involvement in the decision for placement on the locked unit and failed to reflect documentation whether placement on the locked unit was the least restrictive approach. 2. Resident #78 was readmitted to the facility in July 2024, to a locked unit, with diagnoses that included end stage renal disease. The annual MDS dated [DATE] identified Resident #78 had intact cognition, utilized a motorized wheelchair and once seated in the wheelchair could wheel at least 150 feet independently. The care plan dated 12/11/24 failed to reflect the resident resided on a locked unit, how the resident would be provided independent egress from the unit, and ongoing review and revision of the care plan regarding remaining on the locked unit. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record failed to reflect initial or ongoing assessments regarding the clinical criteria for placing the resident on the locked unit, failed to reflect documentation of the resident/representative's involvement in the decision for placement on the locked unit and failed to reflect documentation whether placement on the locked unit was the least restrictive approach. Interview with the Administrator, with the Regional Manager (RN #8) present, on 12/18/24 at 11:23 AM identified he has been the Administrator at this facility since September 2022, over 2 years. The Administrator identified he does not know how long the units have been locked but indicated they have been locked since he began his position here over 2 years ago. The Administrator identified that there are no policies or procedures that identify the clinical criteria for placing a resident on the locked units or ongoing assessments or requirements for discussions/notifications to the resident/representative regarding the locked units. Further, residents are not given independent egress and are required to ask staff to be let off the unit. The Administrator and RN #8 indicated that they recently began to address the locked units by speaking to a contractor regarding alternatives to allow independent egress to all residents except residents with a wander guard. Interview with the 3:00PM - 11:00 PM RN Supervisor, (RN #9) on 12/15/24 at 2:23 PM Identified she is from the agency and has been coming to this facility for a while. RN #9 indicated that if a resident is not an elopement risk a staff member will enter the code and let the resident off the unit. Residents who are an elopement risk are assisted with a staff member. No residents don't have the code to leave the unit, they have to ask staff to be coded out. If there is suspicion that a resident has the code staff will change the code, and the code is changed frequently (a few times a month) and staff members will stand in front of the keypad when entering the number so that the code cannot be seen by residents. Although requested, the facility did not have a policy on placement of residents on a locked unit.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 6 residents (Resident #13 and 96) reviewed for pre-admission screening and resident review (PASARR), the facility failed to ensure the residents, who had newly diagnosed mental disorder, or a related condition, were referred for rescreening. The findings include: 1. Resident #13 was readmitted to the facility in March 2023 with diagnoses that included depression and dementia. A PASARR dated 8/25/20 identified Resident #13 had a diagnosis of major depression and dementia but did not have corroborative testing or other information to verify presence or progression of dementia. Resident #13 did not have a dementia workup or a comprehensive mental status exam. Resident #13 was approved for long term care and the major depression was a single episode. Resident #13 was approved for long term care. A psychiatric APRN note dated 4/5/22 identified the Resident #13 had a diagnosis of depression, Alzheimer's dementia, and insomnia. A physician order dated 5/9/22 directed to obtain a psychiatric eval for signs of depression. A psychiatric APRN note dated 5/10/22 identified Resident #13 had a diagnosis of depression, Alzheimer's dementia, and schizoaffective disorder. A physician order dated 5/10/22 directed to administer Abilify (antipsychotic medication) 7 mg daily for schizoaffective disorder, check orthostatic blood pressure once a week for 4 weeks. Review of the residents list of diagnosis identified schizoaffective disorder was added 5/10/22. The annual MDS dated [DATE] identified Resident #13 had severely impaired cognition, had a diagnosis of depression but did not have a diagnosis of Schizophrenia or schizoaffective disorder. Resident #13 was on antipsychotics and antidepressants medications with in the last 7 days daily. The quarterly MDS dated [DATE] identified Resident #13 had severely impaired cognition and had an active diagnosis of schizoaffective disorder. Resident #13 was on antipsychotics and antidepressants medications with in the last 7 days daily. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 12/16/24 at 9:30 AM indicated she was responsible for the PASARR's for the facility. SW #1 indicated she was responsible to update the PASARR program when a resident received a new psychiatric diagnosis. SW #1 indicated that she had started at the facility in April 2024 and did not go back to see if the PASARR 's prior to her starting were accurate. After clinical record review, SW #1 indicated on admission Resident #13 was admitted with a diagnosis of major depression and dementia and did not need a level 2. SW #1 indicated that the only PASARR in the system was from 8/26/20 and it did not include the diagnosis of schizoaffective disorder. SW #1 indicated when Resident #13 had received the new diagnosis of schizoaffective disorder, the PASARR should have been updated with a new Level 1 for determination if a Level 2 was needed, which was not done. Review of the Behavioral Assessment, Interventions, and Monitoring Policy identified all residents will have a Level 1 PASARR screen prior to admission. If a Level 1 screen indicates that the resident may meet the criteria for a mental disorder, intellectual disability or related condition he/she will be referred to the state PASARR representative for a Level 2 evaluation and determination screening process. The Level 2 evaluation report will be used when conducting the resident assessment and developing the care plan. New onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or related disorder will be referred for a PASARR Level 2 evaluation. The facility's Preadmission Screening and Resident Review Procedures policy identifies the Preadmission Screening and Resident Review (PASARR) process is a federal requirement and the purpose of the PASARR is to ensure individuals who are being considered for placement in a Medicaid-certified nursing facility are evaluated for serious mental illness, intellectual disability, or related condition or both, offered the most appropriate setting for their long term care needs, and are able to receive the services they need in those settings, which may include specialized services or specialized rehabilitative services. The policy directs that a Level II PASARR be done whenever a new diagnosis indicating a serious mental illness or intellectual disability is identified. Review of the Admissions Policy identified all new admissions and readmissions will be screened for mental disorders, intellectual disabilities, or related disorders per the Medicaid Pre-Admissions Screening and Resident Review (PASARR) process. The facility conducts a Level 1 PASARR screen for all potential admissions to determine if the resident meets criteria for a mental illness, intellectual disability, or related condition or both. If the Level 1 screen indicates that the resident meets the criteria, he/she is referred to the state PASARR representative for a Level 2 evaluation and determination screening process. 47457 2. Resident #96 was admitted to the facility in February 2024 with diagnoses that included malignant neoplasm of the breast, cerebrovascular disease, and anxiety. Notice of PASARR Level I Screen Outcome dated 2/2/24 identified no Level II was required. The Level I screen did not identify the presence of a serious mental illness or an intellectual/developmental disability. No further Level I screening was required unless the resident was suspected of having a serious mental illness or an intellectual or developmental disability and exhibit a significant change in treatment. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE] identified Resident #96 had intact cognition and had the following psychiatric/mood disorder: anxiety. The psychiatric evaluation and consultation note dated 8/2/24 identified the following diagnoses: anxiety disorder and mild neurocognitive disorder. The APRN note dated 8/9/24 at 9:16 PM identified Resident #96 recently had increased anxiety and accusatory behaviors. The assessment and plan included referral to psychiatric services for a formal diagnosis and question of brain imaging to evaluate for metastasis due to increased behaviors and forgetfulness. The psychiatric evaluation and consultation note dated 8/14/24 identified the following diagnoses: anxiety disorder, mild neurocognitive disorder, and bipolar disorder. The significant change MDS dated [DATE] identified Resident #96 had the following psychiatric/mood disorder: anxiety and manic depression (bipolar disease). Interview and review of the clinical record with the Director of Social Services (SW #1) on 12/16/24 at 10:48 AM identified that although Resident #96's bipolar diagnosis was identified on 8/8/24, she had never been made aware. SW #1 further identified that during the timeframe of Resident #96's new bipolar diagnosis, the communication process between her and the psychiatric providers was completed via a form which included the resident's name, any changes in condition, plan of care, medication change, or new diagnoses. SW #1 indicated that also during that time there had been different psychiatric providers coming to the facility, and the forms were being utilized differently by each provider. SW #1 indicated that she was not provided a form for Resident #96, and as a result, she was not aware of the new diagnosis; if she had been aware then she would have submitted a new Level of Care screening. The Preadmission Screening and Resident Review Procedures policy identified the Preadmission Screening and Resident Review (PASARR) process is a federal requirement and the purpose of the PASARR is to ensure individuals who are being considered for placement in a Medicaid-certified nursing facility are evaluated for serious mental illness, intellectual disability, or related condition or both, offered the most appropriate setting for their long term care needs, and are able to receive the services they need in those settings, which may include specialized services or specialized rehabilitative services. The policy directs that a Level II PASARR be done whenever a new diagnosis indicating a serious mental illness or intellectual disability is identified.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #75) reviewed for PASARR, the facility failed to ensure that a PASARR rescreen was completed following admission to the facility for a resident who had documented major mental illness that required treatment. The findings include: A PASARR level I screening, completed prior to admission to the facility on [DATE], identified Resident #75 had no mental health diagnoses that were known or suspected, had not received any behavior health services in the past or currently and had not had any recent or current mental health symptoms. The PASARR level I screening also identified Resident #75 did not require a level II screening due to no history of serious mental health illnesses. Resident #75 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, anxiety disorder, and diffuse traumatic brain injury. The baseline care plan dated 10/1/21 identified Resident #75 had a potential for alteration of mood and behavior due to bipolar disorder. Interventions included psychiatric services as ordered. The physician's orders dated 10/1/21 directed for psychiatric evaluation, Clonidine (a blood pressure medication also used for anxiety) 0.1 mg 3 times daily as needed for agitation and trazadone (an antidepressant medication) 25 mg twice daily as needed for agitation. A 10/3/21 physician admission note identified Resident #75 had a history of bipolar disorder, polysubstance abuse, and anxiety and was admitted to the facility following a prolonged hospitalization for multiple facial fractures and traumatic brain injury. The admission MDS dated [DATE] identified Resident #75 had intact cognition, was always continent of bowel and bladder, required the assistance of one staff member with toileting, and was independent with dressing and bathing. The MDS also identified Resident #75 had active diagnoses that included anxiety and bipolar disorder and required daily antidepressant medication. A psychiatric note dated 10/22/24 identified Resident #75 was seen for bipolar disorder and anxiety disorder and had a history of symptoms that included anxiety and delusions. The note identified Resident #75 was seen and treated 1-5 times monthly for psychiatric services. A physician note dated 10/31/24 identified Resident #75 had a history of bipolar disorder and anxiety. The note further identified Resident #75 was under the care of psychiatry and required Depakote 250 mg (a psychotropic medication used as a mood stabilizer) daily for symptoms. Review of the clinical record failed to identify documentation related to a PASARR rescreen completed following Resident #75's admission to the facility in 2021, or that a PASARR level II was completed related to the resident diagnoses of bipolar disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Social Worker #1 on 12/18/24 at 9:15 AM identified that she was not aware Resident #75 did not have a level II PASARR on file as she recently began working at the facility but identified that Resident #75 should have had a PASARR rescreen done following admission to the facility in 2021 based on his/her history of bipolar disorder with need for psychiatric treatment and medication. Social Worker #1 identified, that after surveyor inquiry, she discovered issues related to PASARR rescreening not being completed for multiple residents and was working to rectifying the issue by completing a facility audit for all residents. The facility policy on behavior assessment and monitoring directed that as part of the initial assessment, the nursing staff and attending physician would identify individuals with a history of altered behavior, substance abuse disorder, or mental disorder. The policy further directed that residents identified with a possible serious mental disorder would be referred for a PASARR level II evaluation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 47457 Based on review of the clinical record, facility policy, and interviews for 1 of 6 residents (Resident #96) reviewed for PASARR, the facility failed to ensure a comprehensive care plan was developed for a new psychiatric diagnosis. The findings include: A PASARR Level I Screen Outcome dated 2/2/24 identified no Level II was required. The Level I screen did not reveal the presence of a serious mental illness or an intellectual/developmental disability. No further Level I screening was required unless the resident was suspected of having a serious mental illness or an intellectual or developmental disability and exhibit a significant change in treatment. Resident #96 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of central portion of the left breast, cerebrovascular disease, and anxiety. The quarterly MDS dated [DATE] identified Resident #96 had intact cognition and had the following psychiatric/mood disorder: anxiety. The psychiatric evaluation and consultation note dated 8/2/24 identified the following diagnoses: anxiety disorder and mild neurocognitive disorder. The APRN note dated 8/9/24 at 9:16 PM identified Resident # 96 recently had increased anxiety and accusatory behaviors. The assessment and plan included referral to psychiatric services for a formal diagnosis and question of brain imaging to evaluate for metastasis due to increased behaviors and forgetfulness. The psychiatric evaluation and consultation note dated 8/14/24 identified the following diagnoses: anxiety disorder, mild neurocognitive disorder, and bipolar disorder. The significant change MDS dated [DATE] identified Resident #96 had the following psychiatric/mood disorder: anxiety and manic depression (bipolar disease). The care plan dated 10/29/24 identified Resident #96 exhibited periods of anxiety related to cancer diagnosis. Interventions included to approach resident calmly and to allow resident to express anxiety and fears. The care plan failed to identify goals and interventions related to Resident #96's bipolar disorder diagnosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Director of Social Services (SW #1) on 12/16/24 at 10:48 AM identified that Resident #96's bipolar diagnosis was identified on 8/8/24, but she had never been made aware of the change. SW #1 further identified that during the timeframe of Resident #96's new bipolar diagnosis, the communication process between her and the psychiatric providers was completed via a form which would include the resident's name, any changes in condition, change to the plan of care, medication changes, or new diagnoses. SW #1 indicated that also during that time there had been different psychiatric providers coming to the facility, and the forms were being utilized differently by each provider. SW #1 indicated that she was not provided a form for Resident #96, and as a result, she was not aware of the new bipolar diagnosis; if she had been aware then she would have completed a care plan for the diagnosis, completed a Level II PASARR screen and created a care plan for Resident #96's based off the recommendations provided on the Level II PASARR report, as well. The Care Planning-Interdisciplinary Team policy directs that the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident.

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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** 47457 Based on review of the clinical record, facility documentation, facility policies, and interviews for 2 of 3 residents (Resident #47 and 89) reviewed for care planning, the facility failed to hold quarterly resident care conferences and failed to ensure the resident/resident representative were invited. The findings include: 1. Resident #47 was admitted to the facility in December 2023 with diagnoses that included peripheral vascular disease, type 2 diabetes mellitus, and hypertension. The Care Conference progress note dated 6/19/24 at 12:40 PM identified that social work reached out to Resident #47's representative by phone who could not attend the meeting due to working. Social work provided the resident representative with a quick update due to being busy. Review of the clinical record failed to identify that resident care conferences were held/completed before or after the 6/19/24 meeting. The annual MDS dated [DATE] identified Resident #47 had moderately impaired cognition. The care plan dated 9/25/24 identified Resident #47 was alert, oriented and aware of his/her situation, able to express ideas and wants, and had a history of depression and anxiety. Interventions included anticipating needs and encouraging Resident #47 to verbalize thoughts and feelings. Interview with Resident #47 on 12/15/24 at 10:40 AM identified that he/she could not recall attending a resident care conference with members of the facility's interdisciplinary team. Resident #47 identified that he/she would like to participate in meetings to discuss his/her care and goals. Interview and review of the clinical record with the Director of Social Services (SW #1) on 12/16/24 at 11:05 AM failed to identify documentation that resident care conferences were completed quarterly for Resident #47. SW #1 identified that she began working at the facility in April of 2024, after Resident #47's admission to the facility, and that the social worker is responsible for coordinating the 72-hour admission meetings and the discharge planning meetings. SW #1 further identified that while she does attend the quarterly care conference meetings, it is the responsibility of the MDS Coordinator to schedule and coordinate the quarterly care conference meetings. SW #1 indicated that residents that are conserved or have a resident representative should still be invited and encouraged to attend their care conferences, along with their resident representative. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the MDS Coordinator (RN #4) on 12/16/24 at 12:11 PM failed to identify documentation that resident care conferences were completed quarterly for Resident #47. RN #4 indicated that she was not the primary MDS Coordinator that was responsible for coordinating Resident #47's quarterly care conferences and the nurse that was responsible had been out on a leave of absence. RN #4 indicated that both social services and MDS share the responsibility of coordinating care conferences; social services arrange the 72 - hour meetings, discharge meetings, and as needed meetings while MDS coordinates the quarterly conferences. RN #4 identified that the goal is to coordinate resident care conferences following MDS updates, which is quarterly. RN #4 further identified that the MDS Coordinator will send care conferences letters, which includes the date of the upcoming care conference, to both the resident and/or resident representative notifying them of the upcoming care conference. Interview with the DNS on 12/18/24 at 9:38 AM identified that resident care conferences are scheduled based on protocol, 72 hours after admission, then quarterly thereafter, or following a change in condition. The DNS further identified that residents should be invited to participate in the care conferences, even if they are conserved or have an appointed resident representative. The Care Planning - Interdisciplinary Team policy directs that the resident, resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. The facility's Resident Participation in Care Planning policy directs the resident and his/her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan. The facility's Resident Participation in Care Planning policy directs the resident and his/her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The policy further directs that resident assessments are begun on the first day of admission and completed no later than 14 days after admission, a comprehensive care plan is developed within seven days of completing the resident assessment, and seven day advanced notice of the care plan conference is provided to the resident and his/ her representative, such notice may be made by mail and or telephone. The social services director or designee is responsible for notifying the resident or resident representative and for maintaining records of such notices. Notices include: the date time and location of the conference, the name of each person contacted, input from the resident or representative, if they were able to attend, refusal of participation, and the date and signature of the individual making the contact. 2. Resident #89 was admitted to the facility in June 2023 with diagnoses that included urinary retention, diabetes mellitus, and dislocation of the knee. The quarterly MDS dated [DATE] identified Resident #89 had intact cognition. The care plan dated 10/29/24 identified Resident #89 was alert, oriented and aware of his/her situation, able to express ideas and wants, and had a history of depression and anxiety. Interventions included anticipating needs and encouraging Resident #89 to verbalize thoughts and feelings. Review of the clinical record failed to identify resident care conferences were completed for Resident #89 from admission in June 2023 through 12/15/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #89 on 12/15/24 at 10:30 AM identified that he/she could recall attending one meeting after arriving at the facility with his/her mom and some facility staff members. Resident #89 indicated that he/she would like to participate in meetings to discuss his/her care and goals. Interview and review of the clinical record with the Director of Social Services (SW #1) on 12/16/24 at 11:05 AM failed to identify documentation that resident care conferences were completed quarterly for Resident #89. SW #1 identified that she began working at the facility in April of 2024, after Resident #89's admission to the facility, and that the social worker is responsible for coordinating the 72-hour admission meetings and the discharge planning meetings. SW #1 further identified that while she does attend the quarterly care conference meetings, it is the responsibility of the MDS Coordinator to schedule and coordinate the quarterly care conference meetings. SW #1 indicated that residents that have a conservator or have a resident representative should still be invited and encouraged to attend their care conferences, along with their resident representative. Interview and review of the clinical record with the MDS Coordinator (RN #4) on 12/16/24 at 12:11 PM failed to identify documentation that resident care conferences were completed quarterly for Resident #89. RN #4 indicated that she was not the primary MDS Coordinator that was responsible for coordinating Resident #89's quarterly care conferences and the nurse that was responsible had been out on a leave of absence. RN #4 indicated that both social services and MDS share the responsibility of coordinating care conferences; social services will arrange the 72 - hour meetings, discharge meetings, and as needed meetings and MDS coordinates the quarterly conferences. RN #4 identified that the goal was to coordinate resident care conferences following MDS updates, which would be quarterly. RN #4 further identified that the MDS Coordinator will send care conferences letters, which includes the date of the upcoming care conference, to both the resident and/or resident representative notifying them of the upcoming care conference. Interview with the DNS on 12/18/24 at 9:38 AM identified that resident care conferences are scheduled based on protocol, 72 hours after admission, then quarterly thereafter, or following a change in condition. The DNS further identified that residents should be invited to participate in the care conferences, even if they are conserved or have an appointed resident representative. The Care Planning - Interdisciplinary Team policy directs that the resident, resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. The facility's Resident Participation in Care Planning policy directs the resident and his/her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The policy further directs that resident assessments are begun on the first day of admission and completed no later than 14 days after admission, a comprehensive care plan is developed within seven days of completing the resident assessment, and seven day advanced notice of the care plan conference is provided to the resident and his/ her representative, such notice may be made by mail and or telephone. The social services director or designee is responsible for notifying the resident or resident representative and for maintaining records of such notices. Notices include: the date time and location of the conference, the name of each person contacted, input from the resident or representative, if they were able to attend, refusal of participation, and the date and signature of the individual making the contact.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy and interviews for 5 residents (Resident #25, 27, 47, 50 and 62) the facility failed to provide care in accordance with professional standards of practice, physician's orders and facility policy. For 2 of 5 residents (Resident #25 and 27) reviewed for unnecessary medications, the facility failed to ensure bloodwork was obtained per the physician order and failed to ensure that a medication was administered per the physician's order. For 1 of 5 residents (Resident #47) reviewed for hospitalization , the facility failed to ensure a resident was transferred to the appropriate hospital for a scheduled surgery. For 1 of 5 residents (Resident #50) reviewed for nutrition, the facility failed to ensure that an RN assessment was completed when the resident was identified with a significant weight loss. For 1 of 2 residents (Resident #62) reviewed for medication administration, the facility failed to ensure medications were administered within the prescribed timeframe. The findings include: 1. Resident #25 was admitted to the facility in April 2017 with diagnoses that included dementia, schizophrenia, and Wernicke's encephalopathy. A physician's order dated 7/18/23 directed to administer Valproic Acid 500 mg daily for schizophrenia and to check a Depakote level (Valproic Acid) every 6 months on the 18th day in January and June. Review of the lab report dated 1/18/24 identified valproic acid was low at 10.5ug/ml. The normal range was 50 - 100ug/ml. Review of the clinical record from 2/1/24 to 12/17/24 did not reflect a valproic acid level was obtained. The quarterly MDS dated [DATE] identified Resident #25 had intact cognition. The care plan dated 5/28/24 identified Resident #25 was at risk of adverse consequences related to the administration of psychotropic, antianxiety, and antidepressants. Interventions included to administer all medications and labs as ordered by the physician. Review of the nursing progress notes dated 6/1/24 to 9/1/24 did not reflect that Resident #25 had refused labs to be drawn. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 12/16/24 at 2:13 PM indicated the APRN puts the order for the labs in the computer and it will appear on the MAR for the charge nurse on the night shift the day it is due to fill out a lab slip. The DNS indicated that if a resident refuses a lab to be drawn the charge nurse must notify the APRN and the lab would try again on the next visit and if resident refused a second time the APRN would be notified again. The DNS indicated that the expectation was the nurse would document the refusals and notification to the APRN. The DNS indicated that she does not know why Resident #25 did not have the Valproic Acid level drawn in July 2024 according to the physician order. The DNS indicated that she did not see the lab ordered appear on the MAR and she did not see any progress notes regarding the lab. Interview with Lab Customer Service Person #6 on 12/17/24 at 12:35 PM indicated that after review between 4/1/24 to now, Resident #25 did not have a Valproic Acid level drawn, but did have other labs. Interview with APRN #1 on 12/17/24 at 1:57 PM indicated that Resident #25 was placed on Depakote and would need a Valproic Acid levels every 6 months. APRN #1 indicated that she had put in the order herself. APRN #1 indicated that the night nurse was responsible to fill out the lab slip the morning that the lab was due. APRN #1 indicated that the lab comes into the facility on Tuesdays, Wednesdays, and Fridays. Interview with the APRN #1 on 12/18/24 at 7:46 AM indicated that Resident #25's Valproic Acid level was low in January 2024, so she did not adjust the dose because Resident #25's behaviors were good but if the behaviors got worse, she would have made adjustments. APRN #1 indicated that the lab was ordered on the 18th of the month for January and July every year. APRN #1 indicated that she did not consider that the 18th may not fall on a lab day. APRN #1 indicated that after surveyor inquiry she will change the way she put the order into the computer so it will go by the day of the week not a set date. APRN #1 indicated that she did order a level to be drawn now in December and June on a Wednesday moving forward. APRN #1 indicated that her expectation was that nursing would have made sure that physician ordered labs were completed per the physician's order and if where not able to get the labs, then notify her as the APRN or the physician. Review of the facility Lab and Diagnostic Test Results Protocol identified the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory will report test results to the facility. The charge nurse or supervisor will notify the physician. 2. Resident #27 was admitted to the facility on [DATE] with diagnoses that included hypotension, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). The care plan dated 3/3/24 identified Resident #27 was at risk for cardio/pulmonary complications related to multiple diagnoses including CHF and COPD. Interventions included to obtain vital signs and administer medications as ordered. A physician's order dated 3/8/24 directed to administer Midodrine (a medication used to increase blood pressure) 5 mg tablet by mouth 3 times daily (8 AM, 12 PM, and 6 PM) with meals with additional directions to hold medication for SBP (systolic blood pressures) greater than 120/80. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS dated [DATE] identified Resident # 27 had moderately impaired cognition, was always incontinent of bowel and bladder and was dependent on staff assistance with eating, bathing, and toileting. A review of clinical record for Resident #27 identified the following related to Midodrine administration from 3/24-12/24: The MAR dated 3/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered when the blood pressure was above the hold parameters for a total of 13 out of 23 days, including: 3/9/24 all 3 doses given despite SBP greater than 120/80. 3/11/24 all 3 doses given despite SBP greater than 120/80. 3/12/24 8 AM and 12 PM doses held with no BPs documented. 3/16/24 12 PM dose held with no BP documented. 3/19/24 12 PM and 6 PM doses given despite SBP greater than 120/80. 3/20/24 6 PM dose despite SBP greater than 120/80. 3/21/24 6 PM dose given despite SBP greater than 120/80. 3/22/24 8 AM dose given despite SBP greater than 120/80. 3/24/24 8 AM and 12 PM doses despite SBP greater than 120/80. The MAR dated 4/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered when the blood pressure was above the hold parameters for a total 10 of 30 days, including: 4/1/24 6 PM dose given despite SBP greater than 120/80. 4/2/24 12 PM and 6 PM doses given despite SBP greater than 120/80. 4/6/24 12 PM dose held with no BP documented; 6 PM dose given despite SBP greater than 120/80. 4/14/24 8 AM dose given despite SBP greater than 120/80. 4/15/24 all 3 doses given despite SBP greater than 120/80. 4/16/24 6 PM dose given despite SBP greater than 120/80. 4/17/24 6 PM dose given despite SBP greater than 120/80. 4/23/24 8 AM dose held with no BP documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/24/24 12 PM dose held with no BP documented. 4/27/24 6 PM dose given despite SBP greater than 120/80. Review of the clinical record identified pharmacy recommendations completed for Resident #27 on 4/29/24 identified that Midodrine had been administered when within the hold parameters on 4/15/24 (all shifts), 4/16/24 at 6 PM, 4/24/24 at 6 PM and 4/27/24 at 6 PM and directed for the facility to review. Review of the clinical record failed to identify documentation related to any review completed by the facility related to the 4/29/24 pharmacy recommendations, or that the recommendations had been reviewed by any facility nursing staff or provider. The MAR dated 5/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 14 of 31 days. The MAR dated 6/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 13 of 30 days. The MAR dated 7/2024 identified that midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 23 of 31 days. The MAR dated 8/2024 identified that midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 16 of 31 days. Review of the clinical record identified pharmacy recommendations completed for Resident #27 8/29/24, which identified that Midodrine had been administered when within the hold parameters on 7/31, 8/1, 8/2 and 8/5 at 6:30 PM. The pharmacy recommendations were not signed off by any facility staff but had a handwritten circle over the area of the recommendations listed as follow up comments. Review of the clinical record failed to identify any documentation related to a review completed by the facility related to the 8/29/24 pharmacy recommendations, or that the recommendations had been reviewed by any facility nursing staff or provider. The MAR dated 9/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressure above the hold parameters for a total of 17 of 30 days. The MAR dated 10/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressure above the hold parameters for a total of 17 of 31 days. The MAR dated 11/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 16 of 30 days. The MAR dated 12/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 7 of 18 days reviewed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #4 (Regional Nurse Consultant) on 12/18/24 at 8:46 AM identified that if the provider placed a circle over the comments section of the pharmacy recommendations, it was a prompt used to notify the DNS that there was an issue related to the nursing staff and the medication, and it would be the responsibility of DNS to determine what the issue was, and after determining the issues, the DNS should have discussed with the APRN, including if the order for Midodrine needed to be changed related to the blood pressure parameters, etc. Interview with APRN #1 on 12/18/24 at 8:50 AM identified that Resident #27 had a history of hypotension with multiple hospitalization s. APRN #1 identified that while none of the nursing staff had discussed administering Midodrine outside of the hold parameters of blood pressures greater than 120/80, based on her discussions, Resident #27 often requested the medication be given even with blood pressures outside of the order. APRN #1 identified that she would order the medication without the hold parameter in place, but this was a pharmacy requirement. APRN #1 identified that if anyone from the facility had discussed issues with the parameters with her, she would have amended to allow for higher blood pressure readings prior to the medication being held. APRN #1 identified that the only pharmacy recommendations that she had been provided for Resident #27 related to Midodrine were from 8/29/24, and she placed a circle over the follow up comments area and provided the recommendations back to the DNS as it appeared to be an issue with nursing, and not with the current medication order. Review of the clinical record failed to identify documentation or care plans in place related to Resident #27's Midodrine administration, including requests to administer the medication outside of the hold parameters related to the resident's blood pressures. Interview with the DNS on 12/18/24 at 8:58 AM identified that she was not aware of any issues related to Resident #27's Midodrine order or blood pressure checks and was not aware of any pharmacy recommendations related to Resident #27's Midodrine administration. The DNS identified she relied on APRN #1 to review and address the recommendations and was unable to identify if her understanding related to the circled recommendations included the need for determining issues related to nursing staff and medication administration. The DNS identified that she expected the nursing staff to adhere to the hold parameters in place for any medication, and that she would also expect the nursing staff to contact the provider if there was an issue with the order. Although requested, the facility failed to provide a policy related to following the physician's orders. The facility policy on medication administration directed that if medication was not administered (omitted), the reason should be documented in the MAR. The facility policy on change of condition directed that notifications to the provider should be made within 24 hours for a change related to the resident's medical condition or status, and that prior to contacting the provider, the nurse should gather relevant and pertinent information related to the resident. The facility policy on physician's services directed following admission to the facility, the resident's immediate needs could be addressed by the APRN and included participation in the resident's assessment and care planning, prescribing medications and therapies, and overseeing the plan of care of the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on pharmacy services directed that the facility would accurately and safely provide pharmaceutical services, which included identifying, evaluating, and addressing medication related issues including the prevention and reporting of medication errors. 3. Resident #47 was admitted to the facility in December 2023 with diagnoses that included peripheral vascular disease (PVD), type 2 diabetes mellitus, and polyarthritis. The annual MDS dated [DATE] identified Resident #47 had moderately impaired cognition, utilized a walker and a wheelchair, and required a moderate assist sitting to standing and with chair/bed-to-chair transfers. The care plan dated 9/25/24 identified Resident #47 was at risk for pain/discomfort related to chronic pain syndrome, PVD, and diabetic neuropathy. Interventions included to determine factors that may precipitate, exacerbate, or alleviate pain. A progress note dated 10/21/24 at 11:24 AM identified Resident #47 was set for transportation on 10/23/24 for surgery, 5:00 AM pick-up, and he/she would be staying overnight. A nurse's note dated 10/22/24 at 2:50 PM identified Resident #47 will return from surgery with an abduction pillow and sling. The Resident Census identified on 10/23/24 at 5:20 AM, Resident #47 began a hospital leave and on 10/23/24 at 12:32 PM, Resident #47 returned from the hospital leave. Review of the clinical record dated 10/23/24 failed to identify documentation of Resident #47's hospital transfer and/or surgery status. Interview with the nurse supervisor (RN #1) on 12/16/24 at 2:52 PM identified that on 10/23/24 Resident #47 was originally scheduled for right should arthroscopy, but transportation took him/her to the wrong hospital, and the surgery was rescheduled for 11/27/24. RN #1 was unable to identify which hospital Resident #47 was brought to or the details of why he/she was brought to the wrong hospital, but that she would look into it and find out. Interview with the facility's Transportation Scheduler on 12/17/24 08:48 AM identified that she was originally the facility's receptionist and began filling in for the Scheduler, who was out on a leave at the end of September. The Transportation Scheduler indicated that she did not have a copy of the form, (which included the hospital that Resident #47 was to be brought to for surgery), that was provided to the driver on 10/23/24, but she did recall scheduling Resident #47's transportation to the address of Hospital #1, but the transportation driver brought Resident #47 to Hospital #2. Interview with the Receptionist from the transportation scheduling agency (Receptionist #4) on 12/17/24 at 9:20 AM identified that 2 trips were completed by a third-party transportation agency on 10/23/24 for Resident #47: 1. The address of Hospital #1, which was scheduled by the facility with a pick-up time of 5:30 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The address of Hospital #, return pick-up at 8:50 AM from Hospital #2. Receptionist #4 could not identify why Resident #47 was scheduled to be dropped off at Hospital #1 but was picked up later that morning at Hospital #2. Interview and review of the clinical record with the DNS on 12/18/2 4 at 9:23 AM failed to identify documentation of Resident #47's 10/23/24 hospital leave. The DNS identified that last minute the facility was waiting for hospital confirmation for the location of Resident #47's surgery and per Resident #47 there was confusion between Hospital #1 and Hospital #2, and the resident was dropped off at the wrong hospital. The DNS further indicated that she was unsure of the details surrounding the communication between the Transportation Scheduler, the 3:00 PM - 11:00 PM Nurse Supervisor (RN #2), and the 11:00 PM - 7:00 AM Nurse Supervisor (RN #6), but that Resident #47 safely returned to the facility and the surgery was rescheduled for 11/27/24. Resident #47 did not report pain or distress waiting for the surgery. The DNS indicated that human error can happen, but she would expect to see documentation in the clinical record identifying when Resident #47 left the facility and that he/she was dropped off at Hospital #2 not Hospital #1, resident representative notification, and interventions that were implemented. Although documentation of an investigation of the incident was requested, it was not provided. Interview with Resident #47's representative (Person #3) on 12/18/24 at 10:28 AM identified that Resident #47 was supposed to be transported to Hospital #1 around 5:30 AM on 10/23/24 for a 7:00 AM surgery, but the resident was brought to Hospital #2. Person #3 indicated that when he/she looked in Resident #47's online medical portal account on 10/23/24 around 8:00 AM, everything regarding the surgery had been deleted. Person #3 indicated that he/she immediately called Resident #47, who identified that he/she was brought to the wrong hospital. Person #3 identified that didn't make sense to him/her, and the facility told Person #3 that they would start an investigation, but Person #3 had not heard the outcome on the investigation. Interview with the 11:00 PM - 7:00 AM Nurse Supervisor (RN #6) on 12/18/24 at 10:37 AM identified that when she arrived for her shift on 10/22/24, RN #2 had told her that the Transportation Scheduler notified her that Resident #47 was not going to Hospital #1 but was instead was going Hospital #2. RN #6 indicated that when the driver showed up, he said Resident #47 is going to Hospital #1 and RN #6 told him to take the resident to Hospital #2, not Hospital #1. RN #6 indicated that she was made aware of the error when Hospital #1 called her saying Resident #47 hadn't arrived for his/her surgery and RN #6 told them that there was a change of locations, and they indicated there was no change and that the surgery was scheduled for Hospital #1. Although attempted, an interview with 3:00 PM - 11:00 PM Nurse Supervisor (RN #2) was not obtained. Follow-up interview with the Transportation Scheduler on 12/18/24 at 11:01 AM identified that on 10/22/24 she taped Resident #47's transportation sheet directing Resident #1 to be brought to the address of Hospital #1 at the nurse's station but when she got home she called RN #2 and asked her to please double check the address listed on the sheet to ensure that was the address of where the procedure was taking place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #47 on 12/18/24 at 1:22 PM identified that when he/she spoke with the facility's Transportation Scheduler the night before his/her scheduled shoulder surgery she said the surgery was scheduled at Hospital #1. Resident #47 further identified that when he/she woke up the day of the surgery around 4:00 AM, the nurse informed him/her that there was a change in hospitals. Resident #47 indicated the form he/she was given to hand to the driver had Hospital #1's address crossed out and Hospital #2's address written in. Resident #47 identified that he/she informed the driver that the Hospital #1 address was correct, and the change must have been an error. Resident #47 further identified that the driver informed him/her that he had to bring Resident #47 to the location listed on the form, Hospital #2, and the resident was dropped off at Hospital #2. Resident #47 indicated that he/she was assisted by staff members at Hospital #2 and it was identified that he/she was brought to the wrong hospital; a staff member assisted him/her with contacting Hospital #1 and he/she was told that it was too late to get to Hospital #1 in time as he/she was scheduled for their first OR case, and a staff member from Hospital #2 contacted the transportation agency and arranged to have Resident #47 brought back to the long term care facility. Resident #47 identified that his/her shoulder surgery was rescheduled and completed at the end of November. The facility's Treatment Services policy identified that residents and resident representatives have the right to request, refuse and or discontinue treatment. The center will work with the resident and representative to schedule transportation to and from the appointment, if needed, and staff will accompany the resident should the family and or resident representative be unable to attend, as deemed necessary by the provider or nursing supervisors. 4. Resident #50 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF), hypotension, and dementia. Review of the clinical record identified Resident #50 was hospitalized from 8/11/24 - 8/20/24 following a fall with fracture of the left femur and Resident #50 weighed 146.2 lbs. following readmission to the facility on [DATE]. The physician's orders dated 8/20/24 directed for a carbohydrate-controlled diet, dysphagia advanced with thin liquids and scoop plate with meals; obtain weights every Tuesday, Thursday, and Sunday (3 times weekly) related to CHF and report a gain of 5 or more lbs. to the MD/APRN; and Remeron (an antidepressant used to help appetite) 15 mg nightly at bedtime. A nutritional assessment note dated 8/20/24 identified Resident #50 was seen following admission to the facility. The note identified that Resident #50 was 128 lbs. on 8/11/24 prior to hospitalization and that Resident #50's had a history of variable weights due to fluid shifts related to CHF and a history of increased intake and snacking. The note further identified that no changes were made to the nutrition plan of care and continue to monitor weights. The 5-day MDS dated [DATE] identified Resident #50 had severely impaired cognition, was frequently incontinent of bowel and bladder and required substantial/maximal assistance with dressing, bathing, and toileting. Although requested, the facility failed to provide documentation related tot Resident #50's care plans. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order dated 8/30/24 directed to administer Furosemide 20 mg (a diuretic medication for fluid overload) twice daily for CHF. Review of the clinical record identified LPN #9 documented Resident #50 weighed 138.5 lbs. on 9/8/24, a 7.7 lb. or 5.47% loss since readmission on 8/20/24 (19 days prior). The clinical record failed to identify an RN assessment, reweight, or interventions initiated related to the documented weight loss. Review of the clinical record identified LPN #9 documented Resident #50 weighed 122 lbs. on 9/12/24, a 16. 5 lb. or 11.85% loss over 4 days. The clinical record failed to identify an RN assessment, reweight, or interventions initiated related to the documented weight loss. Review of the clinical record identified LPN #8 documented Resident #50 weighed 118.7 lbs. on 9/15/24, a 3. 3 lb. or 2.8 % loss over 3 days, and a total weight loss of 27.5 lbs. or 18.81% following readmission on 8/20/24 (26 days). Review of the clinical record identified LPN #9 documented Resident #50 weighed 117. 8 lbs. on 9/22/24. A physician's order dated 9/23/24 directed to administer Metoprolol XL (a blood pressure medication) 25 mg daily. Review of the clinical record identified on 9/29/24, LPN #8 documented Resident #50 had a weight of 112 lbs. , a 5.8 lb. or 4.92 % loss from one week prior, and a total weight loss of 34.2 lbs. or 23.71% following readmission on 8/20/24 (40 days). Review of the clinical record failed to reflect an RN assessment, reweight, or interventions initiated related to Resident #50's documented initial weight loss on 9/8/24, significant weight loss on 9/12/24, or continued weight losses on 9/15, 9/22, or 9/29/24. A nutrition note dated 10/4/24 identified Resident #50 had ongoing weight loss with a 26 lb./18% loss over the last month. The note further identified that Resident #50's weight loss had an unknown etiology but had a history of CHF, diuretics, fluid shifts, and multiple hospitalization s, and identified a recommendation to start 237 ml clear house supplement three times daily and monitor intakes, weights, labs, and skin integrity. An APRN note dated 10/4/24 by APRN # 1 identified Resident #50 had a recent weight loss per the Dietitian, had been eating and drinking well, and historically had a baseline weight of 120 lbs. but had recently started furosemide per Cardiology due to CHF. The note identified that the treatment plan included continue Remeron, monitor percentages of meals consumed; start super cereal with breakfast, magic cup with lunch and dinner, and that while the Dietitian recommended the clear house supplement three times daily, this was discontinued due to Resident #50's history of CHF. A quarterly nutrition note dated 11/15/24 identified that Resident #50 had weights monitored three times weekly and had no significant changes in the last 30 days with weights of 114.9 lbs. on 10/13/24 and 116.1 lbs. on 11/14/24. The note identified to continue with magic cups twice daily, super cereal with breakfast, and monitor intakes, weights, labs and skin integrity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietitian on 12/17/24 at 1:50 PM identified that Resident #50 was seen on 10/4/24, when the Dietitian was first notified of an issue with his/her weight. The Dietitian identified that this notification likely came from being notified by a nurse assigned to Resident #50 in person, however the specific nurse would not be typically documented anywhere, and that unless the nursing staff provided notification that a resident had an issue with weights, the Dietitians did not review all weights for every resident in the building with every visit to the building. The Dietitian also identified she would be notified of any nutritional issues by text message from the ADNS, DNS, or the APRN, but would rely on nursing staff to notify her of nutritional issues. The Dietitian identified that Resident #50 had multiple issues with fluid shifts, and had CHF and dementia, which contributed to the weight issues. Review of Resident #50's clinical record and interview with the ADNS on 12/17/24 at 2:15 PM identified Resident #50's weights were flagged as red on multiple dates in the electronic clinical record. The ADNS identified that this would indicate to the nursing staff that there had been a change in Resident #50's weight, and this should have been investigated further, including an RN assessment and a reweight within a day of the initial flagged weight loss. The ADNS identified, upon review of the clinical record, that Resident #50 should have had a reweight done within a day of the initial weight loss to confirm it was a true weight loss, and then the APRN, resident representative, and Dietitian should have been notified following Resident #50's initial weight loss on 9/8/24. The ADNS further identified since the electronic health record also flagged Resident #50's weights in red, this should have been a further indication to all the nursing staff caring for Resident #50 that there were issues with his/her weights. Interview with APRN #1 on 12/18/24 at 8:24 AM identified that she initially notified by the Dietitian on 10/4/24 that Resident #50 had an issue with weight loss, and that at that time she assessed Resident #50 related to the weight loss and ordered nutritional supplements with all meals. APRN #1 identified that while she was aware that Resident #50 had a documented weight loss, she was not aware that Resident #50 had a 16 lb. weight loss from 9/8/24 - 9/12/24. APRN #1 identified she would have expected the nursing staff to contact her regarding this as it would be a significant weight loss that may have impacted Resident #50's medications as Resident #50 had a significant history of being very sensitive to his/her cardiac and hypertensive medications. APRN #1 further identified Resident #50 had a history of hypotension which had resulted in severe hypotensive episodes with hospitalization s in the past. Interview with the DNS on 12/18/24 at 8:58 AM identified that she had discussed weight fluctuations with the Dietitian related to Resident #50 and that APRN #1 was aware there were issues as well. The DNS was unable to identify when she was first notified of any issues with Resident #50's weights, however it was over the course of several months due to a decline in Resident #50's health. The DNS identified she was not aware there had had been a significant weight loss for Resident #50 which initially started on 9/8/24, or that APRN #1 and the Dietitian were not aware of the weight loss until 10/4/24, approximately 26 days later. The DNS identified that she would have expected the nursing staff to obtain a reweight following the initial weight loss within a day, and if the weight loss was accurate, to conduct an assessment of the resident, then notify the APRN, resident representative, and Dietitian to determine what interventions would be needed. The DNS also identified that all documentation related to this should also be included in the clinical record. Although attempted, an interview with LPN #8 and LPN #9 was not obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on weight assessment and intervention directed that the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for facility residents. The policy directed that any weight change of 5% or more would be retaken the next day for confirmation, and if the weight change was verified, nursing would immediately notify the Dietitian in writing, and any verbal notification must also be confirmed in writing. The policy further directed that the threshold for significant unplanned and undesired weight loss would be based on the following criteria: A) 1 month - 5% weight loss was significant; greater than 5% was severe weight loss. B) 3 months - 7.5% weight loss was significant; greater than 7.5% was severe weight loss. C) 6 months - 10% weight loss was significant; greater than 10% was severe weight loss. The policy also identified that care planning for weight loss or impaired nutrition would be a multidisciplinary effort and include the physician, nursing staff, Dietitian, and the resident or resident legal surrogate, and that the care plan would be individualized and address to the extent possible, the identified cause of weight loss, goals and benchmarks for improvement, and timeframes and parameters for monitoring [TRUNCATED]

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 8 residents (Resident #265 and 104) reviewed for smoking, for Resident #265, the facility failed to put smoking interventions in place prior to the resident being found smoking in his/her room on 10/8/24 and failed to ensure every 15-minute checks were completed subsequent to the incident, and for Resident #104 the facility failed to ensure the resident was free of smoking contraband. The findings include: 1. Resident #265 was admitted to the facility in October 2024 with diagnoses that included moderate dementia, chronic obstructive pulmonary disease (COPD), hallucinations, disorientation with delusions, and Nicotine dependance. The hospital discharge summary dated 10/7/24 indicated that Resident #265 had a diagnosis of COPD, was dependent on oxygen at 5 liters of via nasal cannula and had a physician order for Nicotine patch 21mg to be applied daily. Further, Resident #265 was on Chantix for smoking cessation, but it had been discontinued upon discharge from the hospital. A physician order dated 10/7/24 directed to apply a Nicotine patch 21 mg daily, and oxygen at 5 liters via nasal cannula continuously. Review of the clinical record dated 10/7/24 to 10/28/24 did not identify a baseline care plan for a resident with a history of smoking or a resident on oxygen with interventions. The admission smoking assessment dated [DATE] at 7:01 PM identified Resident #265 had last smoked on 9/30/24, denied wanting to smoke now, indicated that he/she did not have any smoking materials on his/her person, and he/she understood the smoking policy. The nurses note dated 10/7/24 at 7:52 PM identified Resident #265 was admitted to facility on 6 liters of oxygen via nasal cannula for COPD exacerbation. Resident #265 indicated that he/she was on 6 liters of oxygen at home prior to admission. Further, Resident #265 is wearing a Nicotine patch. A reportable event form dated 10/8/24 at 8:30 PM indicated that Resident #265 was smoking inside his/her room, witnessed by NA #1. Intervention included to remove smoking materials. APRN #1 and the resident representative were notified. The nurses note dated 10/8/24 at 9:46 PM identified Resident #265 was alert and verbally responsive and persistently craving cigarettes. The smoking policies were reviewed with Resident #265 and the resident representative and both parties verbalized understanding. Resident has order in place for Nicotine patch. Will have psychiatry and the APRN evaluate during next visit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurses note dated 10/8/24 at 10:00 PM identified Resident #265 was observed smoking in his/her room by staff. Cigarette materials were immediately and safely confiscated from the resident, and he/she agreed with allowing two staff member present with him/her to conduct room search. The no-smoking policy was reviewed with the resident. APRN #1 was notified, and message left with resident representative by nursing supervisor. A smoking assessment, completed by the DNS dated 10/7/24 (a day prior to the incident) at 10:26 PM, identified Resident #265 did not wish to smoke now and indicated the last time he/she smoked was on 10/8/24. Resident #265 indicated that he/she did not have any smoking materials on him/her. The DNS during interview indicated that she did this assessment at home. The psychiatric APRN note dated 10/9/24 at 1:45 PM identified Resident #265 has depression, anxiety, dementia, Nicotine dependence and was seen per staff request for smoking in his/her room. Resident was found smoking in his/her room with oxygen tank in the room. Resident is alert and oriented and presents with anxious and depressed mood. Resident did not admit to smoking but admitted to turning oxygen tank off. Resident reports smoking is his/her business. Education provided related smoking safety in room with oxygen tank and smoking guidelines in building. Resident advised smoking in the room and especially with oxygen tank is a safety issue and that can lead to a fire hazard. Resident reports he/she was aware and continues to state that the oxygen tank was off. No new order. Collaborate with nursing staff. Continue with Nicotine patch for Nicotine dependence and Risperdal 0.5mg twice daily and 1mg daily for dementia with psychotic disturbance. Continue to provide education related to smoking policy. Smoking policy reviewed but resident was non receptive to education. Will continue to provide education related smoking policy. The APRN note dated 10/9/24 at 5:18 PM identified Resident #265 was on 4 liters of oxygen, is tobacco dependent and smoked while in his/her apartment while on oxygen prior to admission. Resident is alert and oriented but forgetful. Nursing found resident smoking yesterday 10/8/24 in his/her room, but resident had informed them at that time he/she had turned the oxygen off, so he/she thought was okay. The admission MDS dated [DATE] identified Resident #265 had intact cognition, had no wandering behaviors, did not currently use tobacco, was on continuous oxygen, required moderate assistance with toileting and dressing, and was independent for personal hygiene. Review of a social services note by SW #2 dated 10/14/24 at 12:40 PM indicated Resident #265 reported he/she lived in an apartment but was evicted due to smoking in his/her apartment while on oxygen. The admission physician note written on 10/15/24 at 9:30 PM identified the resident was at the hospital from 9/30/24 to 10/7/24 reportedly with altered mental status on initial presentation to emergency room and was evaluated by psychiatry and deemed stable. Resident admitted for rehab given oxygen requirement. Recently evicted from home due to smoking while on oxygen. Residents has COPD and on chronic oxygen. Resident #265 is on a Nicotine patch daily. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of the every 15 minute checks documentation, initiated on 10/8/24 at 10:30 PM (2 hours after incident) identified checks were not completed on 10/9/24 from 7:00 AM until 2:45 PM (missing 32 observations), were not completed on 10/10/24 from 7:15 AM to 7:45 AM and 3:15 PM until 10:45 PM (missing 34 observations), were not completed on 10/11/24 3:30 PM until 11:45 PM (missing 34 observations), and were not completed on 10/12/24 from 7:15 AM until 10:45 PM (missing 64 observations). The every 15 minute checks ended on 10/13/24 at 7:00 AM. The nurses note dated 10/13/24 at 4:30 AM and 7:56 PM identified Resident #265 continues on every 15-minute checks related to smoking in his/her room. The nurses noted dated 10/14/24 at 5:00 AM identified Resident #265 continues on every 15-minute checks related to smoking in his/her room. The nurses note dated 10/16/24 at 3:00 PM identified Resident #265 continues on every 15-minute checks related to smoking in his/her room. The care plan dated 10/29/24 identified on 10/8/24 Resident #265 was observed smoking in his/her room. Interventions included to educate resident on smoking policy, room search randomly, no smoking materials are to be kept in resident possession or room, and smoke detector in room as needed. The APRN note dated 11/18/24 identified Resident #265 was seen for tobacco dependance. Resident #265 has COPD on 4 liters of oxygen, tobacco dependent and smokes in apartment while on oxygen, moderate dementia and traumatic brain injury. Interview with NA #1 on 12/16/24 at 11:47 AM indicated that he was sitting at the nurse's station and could smell cigarette smoke so he went to investigate and as he entered Resident #265's room, the smell of cigarettes was strong, and he could see the room full of smoke. NA #1 indicated that Resident #265's roommate indicated he/she saw Resident #265 smoking the cigarette in their room. NA #1 indicated that he saw Resident #265 in bed next to the open window trying to hide the cigarette. Resident #265 initial refused to give the cigarette to NA #1, who could not tell if it was lit at that time. NA #1 indicated that he stayed with the resident and asked another staff member to call the supervisor. NA #1 noted Resident #265 had the oxygen concentrator on the left side of the bed and it was off. NA #1 indicated that eventually Resident #265 gave him what was left of the cigarette, which was about half left. NA #1 indicated that when they searched the room, Resident #265 had a pack of cigarettes and a lighter in the top of the nightstand. Interview RN #2 on 12/16/24 at 1:21 PM indicated she was the supervisor on 10/8/24 when Resident #265 was caught smoking in his/her room. RN #2 indicated that she did not see Resident #265 smoking but did see the half-smoked cigarette and could smell the cigarette smoke. RN #2 indicated she interviewed the roommate who was upset about seeing Resident #265 smoking in the room. RN #2 indicated that the staff informed her that during the incident the window was open, and the staff still could smell the cigarette smoke really strong. RN #2 indicated that she had asked permission to do the room search, and the resident agreed. RN #2 indicated that she notified the DNS, and the DNS indicated that she would do all the documentation and call corporate to see what to do. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 12/16/24 at 2:16 PM indicated that she received a call while she was at home that Resident #265 was smoking a cigarette in his/her room, and it was witnessed. The DNS indicated that the intervention was the room was searched at that time and that Resident #265 was placed on every 15-minute checks for 72 hours. The DNS indicated that the staff did a room search and found the cigarette and a lighter. The DNS indicated that on admission the charge nurse was responsible to start a baseline care plan and smoking and being on oxygen should have been done then MDS was responsible to do the comprehensive care plan within 14 days of admission. Review of the clinical record with the DNS on 12/16/24 at 2:58 PM indicated the nurse aides were responsible to physically go see the resident every 15-minutes and document the time, what the resident was doing at that time, and initial the paper. The DNS indicated that the charge nurse was responsible to make sure at the end of the shift that the nurse aides completed the every 15-minute checks form during their shift. The DNS indicated that at morning report, the IDT would discuss if Resident #265 would be safe to come off or stay on every 15-minute checks after the 72 hours. The DNS indicated that a physician's order should have been obtained for the 15-minute checks, so the nurse knows when it starts and when it ends. The DNS indicated that she does not know why the staff did not complete the every 15-minute checks. Interview with the DNS on 12/18/24 at 6:40 AM indicated that she should have done every 15-minute checks as a nursing measure in the computer and she should have put the stop date in the physician orders because that is the only way the nurses would have known when to stop doing the every 15-minute checks and she did not do that. The DNS indicated she did the smoking assessment for Resident #265 on 10/8/24 from home and indicated that she did not ask the questions to the resident she just went by what the supervisor had told her. The DNS indicated the supervisor was busy, so she wanted to help, so things did not get missed. The DNS indicated that the nurse should be physically present with the resident to perform and answer the smoking assessment questions. Interview with APRN #1 on 12/18/24 at 8:31 AM indicated that staff had called her and informed her that Resident #265 was smoking in his/her room and that's all she can remember. APRN #1 indicated that she told the nurse to do a room search and take the smoking materials away. APRN #1 was concerned because Resident #265 was on oxygen and indicated that when she had seen him/her on 10/9/24 after the incident Resident #265 had expressed the desire to continue to smoke and refused Nicotine gum. Interview and review of the clinical record with DNS on 12/18/24 at 9:00 AM failed to reflect that interventions had been put in place prior to the 10/8/24 smoking incident, failed to reflect the every 15 minute checks were completed after the smoking incident, and failed to ensure the smoking assessment had been completed accurately. Review of the facility Resident Smoking Protocol and Evidence of Education Policy identified to provide a supervised smoking program to resident's who desire to smoke. The resident will relinquish to staff any smoking materials. Smoking cessation treatment options will be reviewed with you during this evaluation. Smoking materials will be labeled with resident's name and then locked in the smoking cart. (continued on next page)

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Civita Care Center at Milford	2028 Bridgeport Ave Milford, CT 06460

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission packet identified the smoking policy identified that smoking was prohibits resident and visitor smoking in the facility or on the grounds. Smoking is only permitted for those residents who have been evaluated and provided a physician's order for such with supervision of staff. Noncompliance with smoking policy resident who are suspected of hold cigarettes lighters or matches will be asked to voluntarily relinquish all such objects. Additionally, a room search of the resident's room, person, and all belongings will be performed with the consent of the resident. Residents suspected or determined to be in violation of the policy will be provided a copy of the policy. Continued violations of the smoking policy may result in the following actions: education with random room and person searches, searches upon return from leaves of absences or appointments, initiate a discharge to alternate location, if resident has a desire to smoke will be provided smoking cessation program, any identification of smoking paraphernalia such as a cigarette but , etc. shall be investigated by the Administrator or designee to determine the source. Although requested, a facility policy for every 15-minute checks was not provided. 2. Resident #104 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, pain and diabetes type 2. The admission MDS date 8/17/24 identified had moderately impaired cognition and required supervision or touching assistance with walking greater than 10 feet. A physician's order dated 10/19/24 indicated that Resident #104 may smoke at scheduled time supervised by staff twice a day 11:00 AM and 4:30 PM. The care plan dated 10/29/24 identified a focus with smoking with interventions that included to consent to smoke as per protocol, and room searches/random searches by facility with resident present for smoking materials would be conducted as needed if observed or suspected. Observations on 12/17/24 at 11:10 AM during scheduled smoking session noted after Resident #104 was given a cigarette by NA #11, Resident #104 reached into his/her pocket and pulled out a book of matches and lit the cigarette themselves. The matchbook utilized had several matches missing with only 6 matches remaining. Resident #104 indicated the matches were obtained when he/she went to the gas station on Saturday with NA #6. Resident #104 gave the matches to NA #11 when requested. An interview with the DNS on 12/17/24 at 11:35AM identified she was not aware Resident #104 had matches and indicated she would secure authorization to conduct a room search. A nurse's note dated 12/17/24 at 12:30PM identified Social Worker #1 reviewed the smoking policy with Resident #104 and secured an updated signature of understanding of the smoking policy, and Resident #104 agreed to the room search. A secondary nurse's note dated 12/17/24 at 3:54 PM identified a room search was conducted and Resident #104 willingly gave an unused book of matches to LPN #1. Resident #104 was educated on smoking material policy and expressed understanding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #6 on 12/17/24 at 1:03 PM identified that he took Resident #104 to the gas station to secure cigarettes, with the authority of the Administrator. NA #6 indicated Resident #104 purchased a package of cigarettes and did not receive any matches and smoked a cigarette immediately upon exiting the gas station and NA #6 stated he used his personal lighter to light Resident #104 cigarette. Upon returning to the facility NA #6 indicated he sat with Resident #104 outside in the designated smoking area and Resident #104 smoked 2 additional cigarettes and NA #6 indicated both were lit by staff. 43032

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 residents (Resident #30, 265 and 89) reviewed for respiratory care, the facility failed to ensure oxygen tubing and humidifier were changed and dated per the physician order and that a physician's order for CPAP was followed. The findings include: 1. Resident #30 was readmitted to the facility in Aril 2024 with diagnoses that included pneumonia, heart failure, and dementia. The quarterly MDS dated [DATE] identified Resident #30 had severely impaired cognition, was receiving oxygen and had shortness of breath or trouble breathing when lying flat. The chest x-ray report dated 11/12/24 identified results were suggestive of CHF with bilateral pleural effusions. The care plan dated 11/16/24 identified Resident #30 has a respiratory infection. Interventions included to report signs of pneumonia. A physician's order dated 12/2/24 (original date 9/19/24) directed oxygen at 2 liters per minute continuous. Observation on 12/15/24 at 7:55 AM identified Resident #265 was lying in bed using oxygen via concentrator with oxygen tubing via nasal cannula not dated. Interview and observation with LPN #2 on 12/15/24 at 9:10 AM identified that Resident #30 was lying in bed on 2 liters of oxygen continuously via nasal cannula. Per LPN #2, the oxygen tubing is to be changed weekly and dated when changed. LPN #2 indicated that the oxygen tubing was not dated, and she did not know when it was last changed. LPN #2 indicated that she did not see the physician order for the oxygen tubing to be changed weekly and dated. LPN #2 indicated even without the physician order the oxygen tubing was to be changed weekly. Interview with the DNS on 12/16/24 at 7:10 AM indicated that all oxygen tubing was to be changed every Wednesday 11:00 PM to 7:00 AM by the charge nurses and the charge nurse must date the tubing when it is changed. 2. Resident #265 was admitted to the facility on [DATE] with diagnoses that included moderate dementia, chronic obstructive pulmonary disease (COPD), oxygen dependent, and nicotine dependance. Hospital discharge summary dated 10/7/24 indicated that Resident #265 had a diagnosis of COPD, was dependent on 5 liters of oxygen via nasal cannula. A physician's order dated 10/9/24 directed Resident #265 was to receive oxygen at 5 liters via nasal canula continuously, change oxygen tubing weekly and initial and date on Tuesdays 3:00 PM to 11:00 PM. Additionally, change humidifier water bottle when empty or no less than weekly on Tuesdays 3:00 PM to 11:00 PM shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS dated [DATE] identified Resident #265 had intact cognition was on continuous oxygen and required moderate assistance with toileting, and dressing. The physician's monthly orders for November and December 2024 directed Resident #265 was to receive oxygen at 5 liters via nasal canula continuously and change oxygen tubing weekly and initial and date on Tuesdays 3:00 PM to 11:00 PM. Additionally, change humidifier water bottle when empty or no less than weekly on Tuesdays 3:00 PM to 11:00 PM shift. Clean the concentrator and filters weekly on 3:00 PM to 11:00 PM shift on Sundays. Review of the MAR dated 11/1/24 to 12/18/24 identified the nurses were documenting that every Tuesday 3:00 PM to 11:00 PM they had changed the oxygen tubing and humidifier water bottle. Additionally, the nurses were documenting that every Sunday 3:00 PM to 11:00 PM they were cleaning the concentrator and replacing the filters. Observation on 12/15/24 at 8:00 AM identified Resident #265 was lying in bed with oxygen on via nasal cannula from a concentrator without the benefit of a humidifier. Further, the oxygen tubing was dated 10/30/24, 6 weeks prior. Interview and observation with LPN #2 on 12/15/24 at 9:15 AM identified that Resident #265 was lying in bed on 5 liters of oxygen continuously via nasal cannula and the oxygen tubing was to be changed weekly and dated when changed. LPN #2 indicated that the oxygen tubing was dated 10/30/24 (not changed for 6 weeks). LPN #2 indicated that Resident #265 did not have humidified air from a bubbler, and she was not sure if Resident #265 was supposed to have a bubbler for humidified air. Interview with the DNS on 12/16/24 at 7:10 AM indicated that all oxygen tubing was to be changed every Wednesday 11:00 PM to 7:00 AM by the charge nurses and the charge nurse must date the tubing when it is changed. The DNS indicated that Resident #265 must have a bubbler/humidifier attached to the concentrator because he/she was on 5 liters via nasal cannula. The DNS indicated that she was not sure how often the bubbler gets changed. Observation on 12/17/24 at 2:00 PM identified the oxygen concentrator did not have the humidified bubbler attached. Review of the Oxygen Administration Policy identified to provide safe oxygen administration. Verify physician order for oxygen administration. Review residents care plan to assess for any special needs of the resident. Ensure the oxygen tubing is changed weekly and dated with each change per the physician order. Humidifier water bottles on the concentrator as ordered by physician. Cleanse the concentrator and filters as ordered by the physician. 3. Resident #89 was admitted to the facility on [DATE] with diagnoses that obstructive sleep apnea, mild asthma, and obesity. A physician's order dated 7/23/24 directed for the administration of CPAP set @ 13 qHS at Bedtime 9:00 PM. The quarterly MDS dated [DATE] identified Resident #89 had intact cognition and did not require respiratory treatments such as intermittent or continuous oxygen therapy or CPAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 10/29/24 identified Resident #89 had potential for complications, discomfort related to sleep apnea. Interventions included nasal CPAP device per MD orders. The care plan further identified that Resident #89 was at risk for cardio/pulmonary complications secondary to the following diagnosis: HTN, HLD, history of OSA (obstructive sleep apnea), obesity, and persistent asthma. Interventions included ensuring the head of the bed was elevated to prevent shortness of breath when lying flat and to provide oxygen support as indicated. The care plan failed to identify that Resident #89 refused care or treatments, including refusals of CPAP. The nurse's note dated 7/23/24 through 12/15/24 failed to identify that Resident #89 had refused CPAP at bedtime. Observations on 12/15/24 at 7:10 AM identified Resident #89 sleeping in bed, with a nasal canula in his/her nostrils, no CPAP machine in the room. Interview with Resident #89 on 12/15/24 at 10:30 AM identified that his/her CPAP machine was not in the facility, it was at a family member's house, and that he/she had not used it in over a year. Resident #89 indicated that around the time that he/she was admitted to the facility the machine began displaying a code and a message indicating that the hose was not connected. Resident #89 indicated that he/she had reached out to the company multiple times and needed to schedule an appointment to have the machine serviced but was not able go to an appointment due an immobility issue. Resident #89 indicated that both the hospital and the long-term care facility had provided him oxygen as a precautionary measure. Resident #89 declined feeling any distress. Observations on 12/16/24 at 7:05 AM identified Resident #89 sleeping in bed, with a nasal canula in his/her nostrils, no CPAP machine in the room. Interview and clinical record review with LPN #6 on 12/16/24 at 7:07 AM identified that while there was an order for CPAP, the resident was alert and oriented and he/she doesn't want CPAP. LPN #6 indicated that she works 11:00 PM - 7:00 AM and the CPAP order would be completed before she arrives, by the 3:00 PM-11:00 PM nurse. LPN #6 further indicated that while there should be documentation of his/her refusals to wear CPAP, the resident has never wanted it and the APRN was aware. LPN #6 identified that Resident # 89 receives 2 liters of supplemental oxygen and has not been in distress. Follow-up interview with Resident #89 on 12/16/24 at 2:10 PM identified that he/she does not refuse CPAP at night, but he/she does receive oxygen via nasal cannula; Resident #89 indicated how can I refuse something that isn't here? Although the CPAP was not in the room, the MAR dated 11/1/24 through 12/16/24 identified Resident #89's CPAP was documented as (on) 26 of 46 nights. Interview with the ADNS on 12/17/24 at 12:24 PM identified that Resident #89 did not bring his/her CPAP machine to the facility and that when she discussed CPAP with Resident #89, on admission, the resident flat out refused, indicating that it would not help, and he/she would not use it if it was brought in or a new one was provided. The ADNS indicated that Resident #89 refused CPAP to her personally, and that she would look for her documentation of the refusal in her notes. A physician's order dated 12/17/24 directed to discontinue CPAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 12/18/24 at 8:51 AM identified that prior to admission Resident #89 had a sleep apnea work-up, had documented sleep apnea, and that she had ordered Resident #89 a CPAP machine. When the CPAP arrived, the resident felt that it was clunky, and the mask was uncomfortable. APRN #1 indicated that despite educating Resident #89, he/she continued to refuse the CPAP, so 2 liters of supplemental oxygen at bedtime was ordered. APRN #1 further indicated that she feels that in the long-term care setting, 2 liters of oxygen via nasal cannula is sufficient. APRN #1 indicated that Resident #89 had been bed-bound due to complications from multiple surgeries, and only recently has he/she been able to get out of bed into a wheelchair. APRN #1 further indicated that she would order a Pulmonology consult and then a sleep study, as soon as Resident #89 can be safely transported. Interview with the DNS on 12/18/24 at 1:56 PM identified that from her understanding Resident #89 was not using CPAP prior to admission, and that from her conversations with the nursing supervisor and the APRN, the resident had refused it, and he/she was educated. The DNS further identified that if there was an order for CPAP, but there was no CPAP in the room, then the charge nurse would notify the nursing supervisor, and she would notify the APRN and the oxygen company for the CPAP machine. Although requested, documentation identifying a CPAP machine being ordered/delivered to the facility was not provided. The facility's CPAP and BiPap Support policy directs that the physicians order is to be reviewed to determine the oxygen concentration and flow for the machine. CPAP is used when residents have not responded to attempts to increase PaO2 with other types of oxygen delivery systems, such as nasal cannula. The following documentation is included in the resident's medical record: general assessment prior to procedure, time CPAP was started and the duration of the therapy, mode and settings, oxygen concentration and flow, how the resident tolerated the procedure, and oxygen saturation during therapy. The policy further directs to notify the physician if the resident refuses the procedure. 47457

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43032 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to provide education on the use of a smoking blanket to staff responsible for monitoring the smoking process. The findings include: An observation on 12/17/24 at 11:10 AM during scheduled smoking session supervised by NA #11, NA #11 stated she had never heard of a smoking blanket and was unaware of its use. NA #8 who observed smoking as part of her assigned 1:1 assignment for Resident #104 identified she had no knowledge of a smoking blanket either. Both indicated they were only told of the use of the fire extinguisher during a fire associated with cigarette smoking. Interview on 12/17/24 at 11:55 with the DNS identified that 2 nurse aides who oversaw the most recent smoking session were unfamiliar with the smoking blanket. The DNS indicated she did not know why staff was unfamiliar with the smoking blanket and indicated the blanket is contained in the smoking lockbox which contains the resident's cigarettes and proceeded to secure the lockbox, removed the resident's cigarettes and identified the blanket in the manufacturer's plastic wrapped container on the bottom of the box. Interview with LPN #4 (Regional Nurse Consultant) on 12/17/24 at 1:40 PM identified the smoking training did not contain any content regarding the smoking blanket. The facility policy for smoking was requested but not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #27) reviewed for nutrition, the pharmacy failed to identified a medication irregularity, and failed to ensure that pharmacy recommendations were addressed per facility policy. The findings include: Resident #27 was admitted to the facility on [DATE] with diagnoses that included hypotension, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). The care plan dated 3/3/24 identified Resident #27 was at risk for cardio/pulmonary complications related to multiple diagnoses including CHF and COPD. Interventions included to obtain vital signs and administer medications as ordered. A physician's order dated 3/8/24 directed to administer Midodrine (a medication used to increase blood pressure) 5 mg tablet by mouth 3 times daily with meals with additional directions to hold medication for blood pressures greater than 120/80. The quarterly MDS dated [DATE] identified Resident # 27 had moderately impaired cognition, was always incontinent of bowel and bladder and was dependent on staff assistance with eating, bathing, and toileting. The MAR dated 3/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total of 13 out of 23 days. Review of the pharmacy recommendations for 3/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. The MAR dated 4/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 10 of 30 days. Review of the clinical record identified pharmacy recommendations completed for Resident #27 on 4/29/24, which identified that Midodrine had been administered when within the hold parameters on 4/15/24 (all shifts), 4/16/24 at 6 PM, 4/24/24 at 6 PM and 4/27/24 at 6 PM and directed for the facility to please review. Review of the clinical record failed to identify any documentation related to any review completed by the facility related to the 4/29/24 pharmacy recommendations, or that the recommendations had been reviewed by any facility nursing staff or provider. The MAR dated 5/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 14 of 31 days. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy recommendations for 5/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. The MAR dated 6/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 13 of 30 days. Review of the pharmacy recommendations for 6/2024 failed to identify the pharmacy had reported any irregularities related to Midodrine administration. The MAR dated 7/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 23 of 31 days. Review of the pharmacy recommendations for 7/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. The MAR dated 8/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 16 of 31 days. Review of the clinical record identified pharmacy recommendations completed for Resident #27 8/29/24, which identified that Midodrine had been administered when within the hold parameters on 7/31/24, 8/1/24, 8/2/24 and 8/5/24 at 6:30 PM. The pharmacy recommendations were not signed off by facility staff but had a handwritten circle over the area of the recommendations listed as follow up comments. Review of the clinical record failed to identify documentation related to review completed by the facility related to the 8/29/24 pharmacy recommendations, or that the recommendations had been reviewed by any facility nursing staff or provider. The MAR dated 9/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressure above the hold parameters for a total of 17 of 30 days. Review of the pharmacy recommendations for 9/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. The MAR dated 10/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressure above the hold parameters for a total of 17 of 31 days. Review of the pharmacy recommendations for 10/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. The MAR dated 11/2024 identified that Midodrine 5 mg was held without a documented blood pressure measurement or administered for blood pressures above the hold parameters for a total 16 of 30 days. Review of the pharmacy recommendations for 11/2024 failed to identify the pharmacy had reported any irregularities for Resident #27. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 (Regional Nurse Consultant) on 12/18/24 at 8:46 AM identified that if the provider placed a circle over the comments section of the pharmacy recommendations, it was a prompt used to notify the DNS that there was an issue related to the nursing staff and the medication, and it would be the responsibility of DNS to determine what the issue was, and after determining the issues, the DNS should have discussed with the APRN, including if the order for Midodrine needed to be changed related to the blood pressure parameters, etc. Interview with APRN #1 on 12/18/24 at 8:50 AM identified that Resident #27 had a history of hypotension with multiple hospitalization s. APRN #1 identified that while none of the nursing staff had discussed administering Midodrine outside of the hold parameters of blood pressures greater than 120/80, based on her discussions, Resident #27 often requested the medication be given even with blood pressures outside of the order. APRN #1 identified that she would order the medication without the hold parameter in place, but this was a pharmacy requirement. APRN #1 identified that if anyone from the facility had discussed issues with the parameters with her, she would have amended to allow for higher blood pressure readings prior to the medication being held. APRN #1 identified that the only pharmacy recommendations that she had been provided for Resident #27 related to Midodrine were from 8/29/24, and she placed a circle over the follow up comments area and provided the recommendations back to the DNS as it appeared to be an issue with nursing, and not with the current medication order. Interview with the DNS on 12/18/24 at 8:58 AM identified that she was not aware of any issues related to Resident #27's Midodrine order or blood pressure checks and was not aware of any pharmacy recommendations related to Resident #27's Midodrine administration. The DNS identified she relied on APRN #1 to review and address the recommendations and was unable to identify if her understanding related to the circled recommendations included the need for determining issues related to nursing staff and medication administration. The DNS identified that she expected the nursing staff to adhere to the hold parameters in place for any medication, and that she would also expect the nursing staff to contact the provider if there was an issue with the order. The facility policy on pharmacy services directed that the facility would accurately and safely provide pharmaceutical services, which included identifying, evaluating, and addressing medication related issues including the prevention and reporting of medication errors. The policy also directed that medications would be administered in accordance with all applicable laws and consistent with standards of practice. The policy further directed that the facility would contract with a licensed consultant pharmacist, who would work in collaboration with the dispensing pharmacy and the facility and oversee the development of procedures related to pharmacy services, including administration of medication. The facility policy on physician's services directed following admission to the facility, the resident's immediate needs could be addressed by the APRN and included participation in the resident's assessment and care planning, prescribing medications and therapies, and overseeing the plan of care of the resident. The policy further directed that consultative services were made available from community-based consultants.

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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. 43032 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure the medication cart was secured when unlocked and unattended and that expired medications were discarded. The findings include: Observation on 12/18/24 at 8:30AM identified the medication cart was unlocked, and the charge nurse was not in sight with a resident in the vicinity. LPN #13 emerged from the nourishment room and identified she was microwaving a resident's food and closed the door. She further identified she is responsible for securing the cart and failed to secure the cart prior to going into the nourishment room behind the closed door. Review of LPN #13 medication cart identified multiple medications beyond their expiration date. LPN #13 indicated she just takes the keys and does not review the cart for expired medications but indicated she is responsible for the cart and the cart's contents. The ADNS was on the floor and witnessed the unlocked cart and the review of its contents and indicated the cart is to be secure at all times, and the charge nurse has the responsibility of ensuring medication in the cart have not reached their date of expiration. Interview with the DNS on 12/18/23 at 9:40AM identified the medication carts are to be secured at all times and expired medications are to be discarded. The policy for Medication Storage identified compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #74) reviewed for dental, the facility failed to follow a recommendation from the APRN for dental services in a timely manner and failed to ensure routine dental services were rendered annually. The findings include: Resident #74 was admitted to the facility in September 2021 with diagnoses that included diabetes, anemia, and cough. The quarterly MDS dated [DATE] identified Resident #74 had moderately impaired cognition and was independent with eating. The care plan dated 6/29/23 identified Resident #74 had the potential for alteration in nutritional status related to history of compromised cardiac function, and diabetes. Interventions included to encourage compliance with dietary needs, assess nutritional status on admission and as needed. Physician's monthly orders dated 7/1/23 directed to provide a regular therapeutic lifestyle changes (TLC) diet. The reportable event form dated 7/27/23 at 12:50 PM identified Resident #74 had a choking event during lunch while in the main dining room. The Heimlich was successfully performed by staff present during the event which lasted under a minute. The DNS confirmed via the dietary slip that Resident #74 was served the correct diet which was a therapeutic lifestyle changes diet as ordered and thin liquids. The DNS interviewed Resident #74 who was alert and talking, indicated he/she was eating cornbread, it was so good, but he/she was eating too fast, and a piece went down the wrong pipe. RN assessment done, APRN was notified and new orders to downgrade diet to dysphagia puree until seen by speech therapist, monitor vital signs every shift for 72 hours, lung assessment every shift for 72 hours, notify the APRN/MD with any respiratory changes. The resident representative was notified of the event and the new orders. The care plan was reviewed and revised A physician's order dated 7/27/23 directed to provide a dysphagia puree therapeutic lifestyle changes (TLC) diet. The APRN note dated 7/29/23 at 12:00 PM identified status post chocking event. Resident #74 indicated he/she was eating corn bread, and did not drink enough water and the corn bread got lodged. The staff performed Heimlich with success, the corn bread was dislodged. Resident #74 had some rib and epigastric pain but overall feels well. Resident indicated he/she occasionally feels like the food has trouble passing through the esophagus. Resident #74 was edentulous and never wore dentures. Discontinue current diet. Pureed diet for now until seen by speech therapist. Refer to dentist regarding edentulous, would benefit from dentures. Will refer to gastrointestinal for evaluation for questionable esophagus stricture. Monitor vital signs every shift for 3 days. The speech therapy notes dated 7/29/23 - 8/25/23 identified Resident #74 was seen for 10 days for dysphagia, oral phase. Treatment of swallowing dysfunction and/or oral function for feeding. Resident #74 was discharged from speech therapy on 8/11/23 on a regular consistency diet, thin liquids. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #1 (Customer Service Care) at on 12/16/24 at 3:00 PM identified Resident #74 had never signed up for dental services with the dental provider. Person #1 indicated the dental provider had never received a written or verbal recommendation during the month of July 2023, and August 2023 from the facility for dental services. Review of the clinical record failed to reflect Resident #74 had a follow up dental appointment or prior dental appointments. Interview and clinical record review with the DNS on 12/18/24 at 7:45 AM failed to provide documentation that dental services were provided. The DNS identified she was not aware of the APRN recommendation for dental services, and Resident #74 did not have annual dental services since his/her admission. Although attempted, an interview with APRN #1 was not obtained. Review of the facility dental services policy identified routine, and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through: a contract agreement with a licensed dentist that comes to the facility monthly; referral to the resident's personal dentist; referral to community dentists; or referral to other health care organizations that provide dental services. All dental services provided are recorded in the residents medical records.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43032 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure food temperatures were logged prior to serving meals, temperatures were logged for refrigeration, beard restraints worn as appropriate, refrigerated and frozen items were dated when opened, and ensure the refrigerator, and food storage shelves were free of personal employee items. The findings include: Observation on 12/15/24 at 8:00 AM identified the Food Service Director (FSD) and a male employee had beards without the benefit of a beard guard. Observation of the refrigerator identified an employee's personal water bottle, undated opened container of almond milk, while the freezer identified and opened bag of ravioli, and pepperoni also undated and the December 2024 refrigerator log identified 2 dates without an afternoon temperature. Interview with the FSD on 12/15/24 at 8:00 AM identified he is new to the facility and working with staff to ensure that all protocols related to food service and kitchen protocols are adhered to and would continue to work with staff to ensure the desired outcome. On 12/18/24 at 9:40 AM observation identified the food temperature logs were incomplete for the following dates: 12/2/24 - dinner temperature missing. 12/5/24 - breakfast and lunch temperatures missing. 12/6/24 - dinner temperatures missing. 12/9/24 - dinner temperatures missing. 12/10/24 - dinner temperatures missing. 12/12/24 - breakfast temperatures contained only milk temperature. 12/14/24 - lunch temperatures missing. A policy for Kitchen Hygiene identified hair nets or caps and/or beard restraints must be worn by employees to keep hair from contacting exposed food, clean equipment, utensils and linens while in food preparation areas (e.g., kitchen), and the policy for Food Sanitation states the function of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #265) reviewed for quality of care, the facility failed to ensure a complete and accurate medical record for meal intake. The findings include: Resident #265 was admitted to the facility on [DATE] with diagnoses that included dementia, diabetic, and osteoarthrosis. The admission MDS dated [DATE] identified Resident #265 had intact cognition and required maximum assistance to sit upright but was able to eat independently. Additionally, Resident #265 was not on a restricted diet. The physician order dated 10/7/24 directed for a regular diet. The care plan dated 10/29/24 directed to report any concerns or changes to the physician and resident representative. Review of the Meal Intake Report dated 11/1/24 to 12/17/24 identified that breakfast and lunch were not recorded for 47 out of 47 days and dinner was not recorded for 38 out of 47 days. Interview and clinical record review with LPN #4 (corporate clinical nurse) on 12/18/24 at 8:55 AM indicated that Resident #265 did not have meals documented in the medical record from 11/1/24 to 12/17/24 except for about 9 dinners. LPN #4 indicated that the nurse's aides were responsible to document all the meals during their shift. LPN #4 indicated that it was the expectation that every meal be documented into the electronic medical record by the nurse's aides. Interview and clinical record review with the Dietitian on 12/18/24 at 10:03 AM indicated the nurse's aides were responsible to document all meals during their shifts. Review of the clinical record, the Dietitian indicated that the record did not reflect meal intake from 11/1/24 to 12/17/24 for breakfast or lunch and there were only a few dinners documented. The Dietitian indicated that the documentation of the meals was important to see if a resident loses or gains weight. The Dietitian indicated that she meets a resident at admission and unless there is a clinical change like a weight loss or a wound, she would only look at meal intakes quarterly. The Dietitian indicated that she has not looked at Resident #265's meal intakes since admission because the quarterly MDS was not due yet.

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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** 43032 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to provide appropriate education to its staff for Covid 19 during a recent outbreak, and for 1 of 5 residents (Resident #47) reviewed for hospitalization s, the facility failed to ensure infection control standards during lunch when staff placed a lunch tray on the residents overbed table next to 2 urinals containing urine. The findings include: 1a. Observation of NA #6 on 12/15/24 at 8:59 AM identified he entered a room of a resident who was Covid 1919 positive without donning (wearing) PPE and delivered the breakfast tray. NA #6 identified at that time he did not perform hand hygiene upon exiting the room, he did not don PPE because he did not provide care, and he did not perform hand hygiene because he was trying to pass trays in a timely manner. b. Observation of NA #7 on 12/15/24 at 9:02 AM identified she a room of a resident who was Covid 1919 positive without donning PPE and delivered the breakfast tray, emptied and replaced the urinal and then went through the shared bathroom into the adjoining room and exited from that room (both residents were Covid 1919 negative). NA #7 indicated that she washed her hands in the residents' shared bathroom, and she did not don PPE because she was not performing care, just putting the trays down. c. Observation with 12/15/24 at 10:40 AM identified a surgical mask discarded on a wet floor in the kitchen. Interview with the Food Service Director on 12/15/24 at 10:40AM identified it is his expectation that PPE is discarded appropriately in the trash after use. Interview and review of facility documentation on 12/16/24 at 10:00AM with LPN #1 (Infection Prevention Nurse), and LPN #4 (Regional Nurse Consultant) identified the facility is currently in the middle of a Covid 19 outbreak which began 11/21/24 with 2 residents and a staff member. LPN #1 identified that hand hygiene is generally done with annual competencies, and she had provided one hand hygiene in-service from earlier in the year dated 7/2/24, and an in service on masking 1/30/24. LPN #1 indicated she does not provide hand hygiene training with each outbreak, nor conduct hand hygiene observations, or monitor appropriate personal protective equipment (PPE) use with each outbreak. LPN #1 further identified that she does not instruct the supervisors to monitor hand hygiene or PPE use during outbreaks. LPN #1 identified a hand hygiene education was conducted on 9/26/23 - 10/7/23 for staff. LPN #1 also indicated she does not conduct rounds throughout the facility to monitor infection control, except for one time when she shadowed someone else's rounding and did not document any observations. LPN #1 indicated she does not request the date the residents are first identified as Covid 19 positive, and she did not know it was required as part of the line list. Interview RN #1 (RN Supervisor) on 12/15/24 at 9:44 AM identified the staff should fully gown-up and change PPE between each Covid19 positive resident, and a buddy system is encouraged when passing trays to residents in Covid19 positive rooms and hand hygiene should be performed prior to donning and after doffing PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with LPN #1 on 12/17/24 at 2:00 PM identified the wearing of PPE into the room of a Covid19 resident is required for staff and residents even if they're just dropping off a tray, and Covid19 positive residents' trays should be passed last and removed last. The facility's policy for Covid 19 precautions identified that the response to a current outbreak of coronavirus is based on the most current recommendations from health policy official, state agencies and the federal government. Infection prevention and control measures are based on established guidelines governing all communicable diseases. Any individual who enters the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH approved particulate respiration with N95 filters or higher, gown, gloves and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Anyone with even mild symptoms of Covid 19, regardless of vaccination status should receive a viral test for SARS-CoV-2 as soon as possible. 2. Resident #47 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease, type 2 diabetes mellitus, and hypertension. The annual MDS dated [DATE] identified Resident #47 had moderately impaired cognition, required a partial/moderate assist with toileting and personal hygiene, and was occasionally incontinent of urine. The care plan dated 9/25/24 identified Resident #47 required assistance with mobility and self-care needs. Interventions included allowing extra time to perform needed tasks and providing assistance and privacy to the extent needed. Interview with Resident #47 and observation of 2 urinals containing urine on the bedside table next to his/her lunch tray on 12/16/24 at 2:10 PM identified that when the nurse aide passed his/her lunch tray, it was placed on the bedside table next to the half-full urinals. Resident #47 further identified that while a lunch tray being placed next to his/her urinal did not happen often, he would prefer not to eat next to a urinal containing his/her urine. Interview and observation with NA #8 on 12/16/24 at 2:15 PM identified that she had placed Resident #47's lunch tray on the bedside table, next to the urinals. NA #8 further identified that she always removes urinals from the bedside table, prior to placing a food tray on the table, but today she had gotten distracted changing her PPE and began passing out other lunch trays and forgot to remove the urinals. Interview with the ADNS on 12/16/24 at 2:15 PM identified that she had educated the facility nursing staff not to place food down next to a resident's urinal, that the urinal should first be emptied and then placed within reach of the resident but not on a table with food. The ADNS indicated that intake and output should not be next to each other. Interview with the Infection Control Nurse (LPN #1) on 12/17/24 at 2:00 PM identified that her expectation is that urinals are removed from the bedside table and emptied, then the tabletop surface should be wiped with a sani-wipe, and the resident should be offered hand sanitizer. Interview with the DNS on 12/18/24 at 9:34 AM identified that she would expect a urinal to be removed and the tray table to be sanitized prior to serving a food tray. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Rights policy directs that federal and state laws guarantee certain basic rights to all residents of the facility, including the right to a dignified existence. 47457