STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075222	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Cheshire	745 Highland Avenue Cheshire, CT 06410

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review of the clinical record, facility documentation, facility policy and interviews for 1of 3 residents (Resident #39) reviewed for abuse, the facility failed to ensure a resident was treated in a respectful and dignified manner. The findings include: Resident #39 had diagnoses that included hemiplegia/hemiparesis (weakness and paralysis) affecting the left, non-dominant side following a cerebral infarction (stroke) and history of seizures. The baseline care plan dated 12/23/24 identified Resident #39 had a functional rehabilitation potential and was at risk for falls. Interventions included to provide the necessary set up cueing support/assistance to carry out activities of daily living. The admission MDS dated [DATE] identified Resident #39 was cognitively intact, required substantial one person assist with bed mobility, two-person assist with transfers using a mechanical lift and set up assist with eating. Interview with Resident #39 on 1/12/25 at 9:07 AM identified he/she was finishing up an afternoon meal recently and asked a nurse aide (NA #12), for a food item. NA #12 told the resident he/she was not from an African American [NAME] and therefore did not understand food deprivation and that Americans get whatever they want. Resident #39 felt NA #12 was disrespectful. Interview with NA #12 on 1/13/25 at 10:59 AM identified that although he denied making the specific statement to Resident #39 and was only speaking of his own chartable work, he did recall that at one time, Resident #39 requested various food items while he was providing the resident his/her meal tray. NA #12 asked Resident #39 why he/she doesn't eat the meal tray first before eating cookies. NA #12 returned sometime later after the meal and provided one food item and that nothing else was mentioned. Interview with the DNS on 1/13/25 at 3:16 PM identified NA #12 informed the DNS that he told the resident to eat the food first before getting cookies as the meal was more filling. Verbal education was provided to NA #12 regarding customer service as the resident had the right to have preferences regarding what he/she ate. NA #12 was removed from providing any further care to Resident #39. A review of the facility policy for Resident Rights directed that employees shall treat all residents with kindness, respect and dignity including self-determination.

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

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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 1 resident (Resident #45) reviewed for care planning, the facility failed to consistently hold interdisciplinary resident care conferences and invite the resident to participate. The findings include: Resident #45 was admitted to the facility in November 2020 with diagnoses that included chronic embolism and thrombosis of deep veins of left lower extremity, history of falls, major depression, poly neuropathy and seizures. The quarterly MDS dated [DATE] identified Resident #45 had intact cognition, was independent for dressing, toileting, and personal hygiene. Additionally Resident #45 participated in assessment. The care plan dated 3/26/23 identified code status with interventions to review quarterly and as needed with Resident #45. Review of the clinical record 4/13/23 to 10/10/24 identified the last quarterly interdisciplinary care conference was held on 4/13/23, over a year and a half ago, which included a recreation person, a social worker, and Resident #45. Six quarterly interdisciplinary care conferences were not held. Interview with Resident #45 on 1/12/25 at 10:20 AM indicated that he/she has not meet with the interdisciplinary team for a care conference in about 2 years. Resident #45 indicated that the facility used to have those meetings but did not know why the facility stopped having them. Resident #45 indicated that if they had the quarterly interdisciplinary care conference, he/she would want to attend, again. Interview with RN #7 (MDS coordinator) on 1/13/25 at 8:54 AM indicated that she had worked at the facility as the MDS coordinator for the last 9 years. RN #7 indicated that she creates the MDS schedule every month for the quarterly, annual, and significant change in condition MDS's. RN #7 indicated that the quarterly and annual interdisciplinary care conferences were scheduled by the social worker based off the MDS calendar each month. RN #7 indicated that the social worker must call or see each resident and resident representative to schedule that month's interdisciplinary care conference that are due. RN #7 indicated that the social worker must schedule the care conference at a time that is convenient for the resident and resident's representative so they can attend. RN #7 indicated that she was aware that she was expected to attend the care conferences, but she rarely attends any of the care conferences because she does not have the time to attend them. RN #7 indicated that the last couple of years she has not had the time to attend those meetings. RN #7 indicated that she has asked the Administrator many times over the last couple of years for a second person in her department so she would be able to attend the meetings, but that has not occurred. RN #7 indicated that the whole team should attend the quarterly interdisciplinary care conferences including the social worker, a floor RN, therapy if resident is on therapy, the dietitian (but she is only in the facility 2 days a week), and the MDS person. RN #7 indicated that she had to cut something out to get everything done so she stopped attending about 2 years ago. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 1/13/25 at 9:10 AM indicated that the MDS coordinator was responsible to make the monthly calendar for who was due for a care conference. SW #1 indicated that it was her responsibility and her part time social worker to speak with residents and call resident representative to schedule each month's care conferences based on their schedules. SW #1 indicated that the resident care conference should include the resident, resident representative, social worker, MDS coordinator, recreation, dietitian, and the nurse responsible for that unit the resident is on. SW #1 indicated that the social worker attending the meeting was responsible to have all attendees sign in and then write a note in the electronic medical record of who attended and what was discussed. SW #1 indicated that the nurse's aide assigned to the resident does not get invited to attend. SW #1 indicated that she did not have any sign in sheets for Resident #45 for his/her resident care conferences. After review of the clinical record, SW #1 indicated that for each quarterly and annual meeting scheduled for Resident #45 since 4/13/23, only the social worker attended and no one else attended and that does not meet the requirement of a quarterly or annual interdisciplinary resident care conference. SW #1 indicated that Resident #45 was scheduled on 1/9/25 for a interdisciplinary resident care conference, but only she had meet with Resident #45, not the interdisciplinary team. SW #1 indicated she had brought to the attention of the Administrator and DNS during a morning report with all management present that all staff that should be attending were not. SW #1 indicated that the last time she brought this to their attention was October 2024. SW #1 indicated she was documenting that the interdisciplinary resident care conferences were being conducted but it was only a one-on-one meeting with her or the other social worker. Review of the Care Plans, Comprehensive Person-Centered Policy identified a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team in conjunction with the resident or resident representative develops and implements a comprehensive, person-centered care plan for each resident. The interdisciplinary team includes the attending physician, a registered nurse, a nurse's aide who is responsible for that resident, a member of the dietary services staff, the resident and resident representative, and other appropriate staff or professionals as determined by the resident's needs or requested by the resident. The resident has the right to participate in his/her plan of care. , including the right to participate in the planning process, identify individuals or roles to be included in meetings, request meetings, request revision of the plan of care, participate in establishing the expected goals and outcomes of care, participate in determining type, amount, frequency, and duration of care. Resident has the right to see the care plan and sign it after significant changes are made. The care plan process will facilitate resident and/or resident representative involvement. The interdisciplinary team must at least quarterly review and update the care plan. The resident has the right to participate in this development of his/her care plan. (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 identified the interdisciplinary team was responsible for the development of a resident's individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment and is developed by a care planning interdisciplinary team which includes: the attending physician, the registered nurse who is responsible for the resident, the dietitian or dietary manager, the social worker, the activities director, therapies if applicable, consultants as appropriate, the DNS if appropriate, the charge nurse responsible for the resident, the nurses aide responsible for the residents care. The resident, resident's representative are encouraged to participate in the development 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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15802 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #44) reviewed for advance directives, the facility failed to inform the resident/resident representative of their rights upon admission. The findings include: Resident #44 was admitted to the facility in September 2024 with diagnoses that included stroke, gastrostomy placement, and dysphagia. The care plan dated 10/1/24 identified Resident #44 had impaired cognition related to a stroke, including being nonverbal. Interventions included to report any concerns or changes to the resident representative. A social work admission note dated 10/3/24 at 11:03 AM identified an admission care conference meeting was held with Person #1 (resident representative) related to the admission and included a review of medical and psychiatric history, current status, care plan, and goals of treatment. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff assistance with bathing, Interview with Person #1 on 1/12/25 at 9:49 AM identified the facility had not reviewed any documentation related to Resident #44's admission to the facility. Person #1 identified that upon Resident #44's admission, and with all subsequent communication with facility staff following admission, the facility at no time reviewed or requested a review of any documents related to admission. Person #1 identified they hadn't asked him/her to sign any paperwork since admission and questioned if they had any paperwork on file and how they were being paid if no one signed paperwork. Review of the clinical record on 1/12/25 identified blank admission documents including a consent to treatment, authorizing medical treatment by providers, a personal item inventory list, a consent for use of side rails, leave of absence policy no smoking policy; consent and request for audiology services including billing, payment criteria, authorization to share protected health care information, consent and request for supportive care services including billing, payment criteria, and authorization to share protected health care information, and consent and education for pneumococcal and influenza vaccinations. Further the record did not have a signed admission agreement. The Admission Agreement was in the clinical record and included Resident #44's name. Further, admission agreement documentation was in the clinical record, unsigned, undated and blank, and included the following. Review of treatment and services. General provisions for payment. Compliance with facility policies. Resident charge rates for services and charges for non-covered services. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medicare pay rates and authorizations. Privacy waivers, privacy consents. Right to refuse treatment. Medications obtained and administered by the facility. Involuntary discharge, emergency discharge, alternate placements. Bed hold. Facility liability related to the resident's care and services. Facility's right to change, amend, or alter the admission agreement at any time with 30 days written notice to the resident or resident representative. Interview with the Admissions Director on 1/15/25 at 8:52 AM identified that she was responsible for reviewing the admission agreement documentation with all newly admitted residents or the resident representative upon admission to the facility. The Admissions Director identified she wrote notes on the admission documents indicating her attempts to reach Person #1 on 9/28, 10/2, and 10/14 but did not speak with him/her and did not make any additional attempts. The Admission Director identified she did not speak with the DNS or Administrator to notify them that she did not reach Person #1 to review the admission agreement and identified since she reached out via phone with no return calls, she did not make any additional attempts. The Admission Director identified that the admission agreement document reviewed the specifics related to admission and care at the facility, including administrative processes related to billing, bed holds, and charges incurred outside of insurance paid services. Interview with the DNS on 1/15/25 at 9:38 AM identified that it was the responsibility of the admitting nurse to ensure that the clinical admission paperwork was completed within 48 hours of a resident's admission to the facility. The DNS identified that the timeframe for completion was based on when a resident was admitted to the facility (i.e. nights, weekends, etc.) and if the admitting nurse was unable to complete the paperwork with the resident or a resident representative, the nurse was responsible to report off to the next oncoming nurse to ensure that the paperwork was completed. The DNS identified that she had been able to reach and speak with Person #1 multiple times since Resident #44's admission and Person #1 had also been in the facility to visit Resident #44 so the admission paperwork should have been done. The facility admission agreement directed that the agreement was a legally binding contract between and amongst the resident and resident parties, and the resident parties acknowledged that they wanted the residents to be admitted and receive services provided by the facility. The agreement further directed that by signing, the facility and resident parties were legally bound by it. The facility policy on resident rights directed that residents of the facility were guaranteed certain basic rights that included the right to be informed of rights and responsibilities, be informed of, and participate in treatment.

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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** 46040 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 4 residents (Resident #16 and 41) reviewed for advance directives, the facility failed to obtain a physician's order for code status after the residents' wishes were communicated and identified on the Advance Directives-Clarification of Wishes document, and for 1 resident (Resident #44) reviewed for advance directives, the facility failed to review advance directives upon admission. The findings include: 1. Resident #16 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, Alzheimer's disease, and malignant neoplasm of an unspecified part of bronchus or lung. An Advance Directives-Clarification of Wishes document dated [DATE] identified Resident #16's wishes regarding care and treatment in the event that the resident was incapacitated and unable to direct his/her physician or if it was determined that the resident would be permanently unconscious were as follows: Do Not Resuscitate (DNR), IV therapy for hydration, antibiotic therapy, and no intubation (DNI). The care plan dated [DATE] identified Resident #16 wishes for advance directives were DNR. Interventions included honoring the Advance Directive for 90 days and no respirator. Review of the clinical record identified a physician's order honoring the residents request of DNR/DNI was not written until [DATE], 11 months after the Advance Directives-Clarification of Wishes document dated [DATE]. Interview and review of the clinical record with the DNS on [DATE] at 2:37 PM identified it was her expectation that the advance directive would be addressed with the resident by the RN supervisor and a signed physician's/APRN's order would be obtained within 48 hours of admission. The DNS further identified that while Resident #16's Advance Directives-Clarification of Wishes document was signed by the medical provider, she was unable to locate a physician or APRN's signed order until 2025. The DNS indicated that she was unable to identify where the breakdown occurred, and that the facility was working on a house wide audit for Advance Directives with QAPI. 2. Resident #41 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, Epilepsy, and schizoaffective disorders. An Advance Directives-Clarification of Wishes document dated [DATE] identified Resident #41's wishes regarding care and treatment in the event that the resident was incapacitated and unable to direct his/her physician or if it was determined that the resident would be permanently unconscious were as follows: Full Code (CPR), IV therapy for hydration, and antibiotic therapy. The care plan dated [DATE] failed to identify Advance Directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders failed to identify Advance Directives or code status. Interview and review of the clinical record with the DNS on [DATE] at 2:37 PM failed to identify a physician's order for Resident 41's advance directive. The DNS indicated that it was her expectation that within 48 hours of admission a resident's advance directive would be addressed by the RN supervisor and a signed medical provider order would be obtained. The DNS further identified that while Resident #41's Advance Directives-Clarification of Wishes document was signed by the medical provider, she was unable to locate a physician or APRN's signed order in the clinical record. The DNS indicated that she was unable to identify where the breakdown occurred, and that the facility was working on a house wide audit for Advance Directives with QAPI. Subsequent to surveyor inquiry, a physician's order dated [DATE] directed Resident #41 as a full code. The facility's Advance Directives policy directs the Director of Nursing Services or designee will notify the Attending Physician of advance directives so the appropriate orders can be documented in the resident's medical record and plan of care. 3. Resident #44 was admitted to the facility in [DATE] with diagnoses that included stroke, gastrostomy placement, and dysphagia. A physician's order dated [DATE] directed for DNR (do not resuscitate). The care plan dated [DATE] identified Resident #44 had an established advance directive of DNR/DNI. Interventions included discussing advance directives with the resident or legal representative on admission, annually and with a change of condition. A social work admission note dated [DATE] at 11:03 AM identified an admission care conference meeting was held on that date with Person #1 related to Resident #44's admission, however, the note failed to identify documentation that the resident's advance directives had been discussed. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition. Review of an Advance Directives-Clarification of Wishes form, undated and unsigned identified wishes included DNR, nurse may pronounce, use of feeding tubes, IV therapy for hydration, antibiotic therapy, and intubation in the event of a major respiratory event or infection. The form identified a handwritten note by the DNS which identified (verbal discussion with Person #1 on [DATE] consent for above wishes). The form failed to identify the signature of Person #1 or a witness. Review of the clinical record failed to identify that facility staff had provided the resident/resident representative with written information concerning the right to accept or refuse medical or surgical treatment and formulate advance directives on admission. Interview with Person #1 on [DATE] at 9:49 AM identified the facility had not reviewed and he/she had not signed any documentation related to Resident #44's admission to the facility, including advance directives. (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 the DNS on [DATE] at 9:38 AM identified that it was the responsibility of the admitting nurse to complete the advance directives paperwork with the resident or resident representative within 48 hours of admission to the facility, but that she had identified through audits of resident charts done ,d+[DATE] that there were multiple residents who did not have signed advance directives in the clinical record. The DNS identified that Resident #44 was one of the charts she completed an audit on, and she called Person #1 to review the advance directive choices on [DATE]. The DNS identified that due to the number of charts that had issues, she contacted Person #1 and wrote the note on Resident #44's paperwork, but did not have a witness present to cosign the document, and did not follow up with Person #1 regarding signing the document and she should have done both to ensure that the advance directive paperwork was completed per policy. The policy on Advance Directives directed that the resident would be provided with written information concerning the right to accept or refuse medical or surgical treatment and formulate advance directives if he/she wished to do so on admission to the facility and nursing would offer and document any assistance in the resident's clinical record.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 1 of 8 residents (Resident #44) reviewed for hospitalization s, the facility failed to ensure that the resident representative was notified following the resident's transfers to the hospital. The findings include: Resident #44 was admitted to the facility in September 2024 with diagnoses that included stroke, gastrostomy placement, and dysphagia. A physician's order directed to administer Osmolite (a liquid nutritional supplement used for gastrostomy tube feedings) to run continuously at 75 cc/hour and Clopidogrel (a medication used to help prevent blood clots) 75 mg daily via gastrostomy tube for history of stroke. The care plan dated 10/1/24 identified Resident #44 was dependent on tube feeding and was at risk for aspiration and other complications related to tube feeding. Interventions included to check placement and patency before each feeding or medication administration. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition and was dependent on staff assistance with bathing, dressing, and toileting. A nurse's note dated 10/11/24 at 5:39 AM by RN #1 identified that staff observed that Resident #44 had inadvertently pulled out his/her gastrotomy tube with scant blood noted at the insertion site. The note further identified following an attempt to insert a new gastrostomy tube, Resident #44 exhibited discomfort and pain, that the attempt was unsuccessful, and after contacting the APRN, Resident #44 was sent to the hospital for reinsertion of the gastrostomy tube. Review of the clinical record failed to identify Person #1 (Resident Representative) had been notified of the resident's change of condition or transfer to the hospital. Review of the clinical record identified that Resident #44 was hospitalized [DATE] - 10/16/24 for gastrostomy displacement and reinsertion. A nurse's note dated 10/24/24 at 12:34 AM by RN #1 identified that staff observed Resident #44 had inadvertently pulled out his/her gastrotomy tube with a small amount of blood noted at the insertion site. The note further identified that due to the blood observed, RN #1 contacted the APRN and Resident #44 was sent to the hospital to reinsert the gastrostomy tube. Review of the clinical record failed to identify Person #1 had been notified of the resident's change of condition or transfer to the hospital. A nurse's note dated 10/24/24 at 6:18 AM by RN #1 identified after discussion with the hospital, the resident's gastrostomy tube had been successfully reinserted without difficulty and the resident was being transferred back to the facility. RN #1 identified following the call, he notified the APRN and Person #1 that Resident #44 was being readmitted to the facility. (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 Person #1 on 1/12/25 at 9:49 AM identified he/she had issues with the facility not contacting him/her related to changes in the residents condition and hospital transfers. Person #1 identified that on at least 2 occasions after Resident #44 was transferred to the hospital he/she was not notified. Person #1 identified that on 10/11/24, he/she received a call from hospital staff related after Resident #44's admission to the hospital because the resident needed a GI specialist to reinsert the feeding tube. Person #1 identified he/she had no idea that Resident #44 had even left the facility and he/she was very upset that it was the hospital staff who contacted him/her with the information instead of the facility. Person #1 identified that another time, facility staff called to notify him/her that Resident #44 was being readmitted to the facility, however, Person #1 had not been notified the resident had been sent back to the hospital (10/24/24). Person #1 identified he/she the communication from the facility needed significant improvement and that he/she should be contacted with any changes that would impact Resident #44's care or require a hospital transfer. Interview with RN #1 on 1/14/25 at 7:14 AM identified he was the nurse who provided care and transferred Resident #44 to the hospital on 10/11/24 and 10/24/24. RN #1 identified that when he had to transfer a resident to the hospital, he documents a detailed note and would chart that he contacted resident representative. RN #1 identified that he remembered contacting Person #1 related to the 10/11/24 transfer but may have documented it in a facility accident and incident (A&I) report that he believed he filled out related to the tube dislodgement. RN #1 identified he also remembered speaking with Person #1 after the 10/24/24 tube dislodgement but again was unsure where he would have documented it. RN #1 identified he did remember one of the times the resident was transferred to the hospital, [NAME] #1 called the facility and was upset because he had not been contacted about the transfer and found out when the hospital had called him/her. RN #1 identified that while he did routinely contact the resident representatives related to change of conditions and transfers, he did not always call right away because he works in the middle of the night, and doesn't like to call and scare people. Interview with the DNS on 1/15/25 at 9:38 AM identified that the facility did not complete accident and incident (A&I) reports when Resident #44's gastrostomy tube dislodged. The DNS identified that when a resident has a change of condition or requires transfer to the hospital, the expectation is that the RN completes a change of condition assessment, notifies the provider (MD/APRN) and the resident's representative or emergency contact. The DNS identified that the notification to the provider and representative should occur right away. The facility policy on change on condition directed that the facility nurse would notify the resident representative promptly when the resident had a significant change in physical status and when it was necessary to transfer the resident to the hospital.

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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** 46040 Based on review of the clinical record, facility policy, and interviews for 2 of 2 residents (Resident #37 and 44) reviewed for tube feeding, the facility failed to ensure the comprehensive care plan was updated following multiple displacements of a feeding tube. The findings include: 1. Resident #37 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia, neuromuscular dysfunction of the bladder, neurogenic bowel, and a gastrostomy-jejunostomy (GJ) tube. The care plan dated 3/28/24 (last revised 11/12/24) identified Resident #37's GJ tube was at risk for coming out. The intervention was an abdominal binder. The quarterly MDS dated [DATE] identified Resident #37 had severely impaired cognition, had functional limitation in range of motion to both the upper and lower extremities, required maximal assistance for rolling left to right, and had a feeding tube. The nurse's note dated 11/4/24 at 10:34 AM identified that the writer was called into Resident #37's room by the charge nurse, resident's significant other at the bedside, Resident #37's g-tube noted to be dislodged. The medical provider was updated, and a new order was obtained to send Resident #37 to the ED for replacement of the GJ tube. The Interagency Patient Referral Report dated 11/4/24 identified Resident #37 underwent the following procedure: Interventional Radiology (IR) GJ tube change with guidance. The nurse's note dated 12/13/24 at 6:24 PM identified that at 5:00 PM during the medication pass, this writer noticed Resident #37's GJ tube was dislodged completely. The RN supervisor was notified, and Resident #37 was sent to the ED. The Hospitalist Discharge Summary dated 12/15/24 identified Resident #37's active issue was a GJ tube dislodgement, and he/she underwent GJ tube replacement on 12/14/24, by IR. Interview and review of the clinical record with the DNS on 1/15/25 at 8:08 AM failed to identify Resident #37's care plan was updated with new interventions after 2 GJ tube dislodgements. The DNS identified that it was her expectation that when prior or current interventions have not worked that a new intervention be put in place. The DNS further identified that she would have expected Resident #37's care plan to be updated each time his/her GJ tube was dislodged and that she would also expect the responsible party and the family to updated of the new interventions, in a language that they understand. (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 LPN #6 on 1/15/25 at 8:55 AM identified that she was not sure why Resident #37's care plan had not been updated with new interventions after the GJ tube dislodgements, but the nursing staff had implemented different interventions to prevent the GJ tube from dislodging, including frequent checks and positioning techniques, but it had not been documented in the clinical record. LPN #6 indicated that it was the responsibility of all licensed nursing staff to update the care plan, as needed and quarterly. Interview with RN #4 on 1/15/25 at 9:40 AM identified that she would expect new interventions to be put in place and documented, by any of the nursing staff, every time Resident #37's GJ tube became dislodged, in an effort to prevent further dislodgement. The facility's Care Plan, Comprehensive Person-Centered policy directs that the Interdisciplinary Team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are the end point of an interdisciplinary process. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's conditions change. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment. 2. Resident #44 was admitted to the facility in September 2024 with diagnoses that included stroke, gastrostomy placement, and dysphagia. A physician's order directed to administer Osmolite (a liquid nutritional supplement used for gastrostomy tube feedings) to run continuously at 75 cc/hour and Clopidogrel (a medication used to help prevent blood clots) 75 mg daily via gastrostomy tube for history of stroke. The care plan dated 10/1/24 identified Resident #44 was dependent on tube feeding and was at risk for aspiration and other complications related to tube feeding. Interventions included to check placement and patency before each feeding or medication administration. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition and was dependent on staff assistance with bathing, dressing, and toileting. A nurse's note dated 10/11/24 at 5:39 AM by RN #1 identified that staff observed that Resident #44 had inadvertently pulled out his/her gastrotomy tube with scant blood noted at the insertion site. The note further identified following an attempt to insert a new gastrostomy tube, Resident #44 exhibited discomfort and pain, that the attempt was unsuccessful, and after contacting the APRN, Resident #44 was sent to the hospital for reinsertion of the gastrostomy tube. Review of the clinical record identified that Resident #44 was hospitalized [DATE] - 10/16/24 for gastrostomy displacement and reinsertion. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 10/24/24 at 12:34 AM by RN #1 identified that staff observed Resident #44 had inadvertently pulled out his/her gastrotomy tube with a small amount of blood noted at the insertion site. The note further identified that due to the blood observed, RN #1 contacted the APRN and Resident #44 was sent to the hospital to reinsert the gastrostomy tube. Review of the care plan failed to reflect the gastrostomy tube dislodgements and/or interventions to address such. Additionally, although RN #7 (MDS Coordinator) reviewed and revised the care plan on 10/29/24, the revision included to ensure the resident's head of bed was elevated to prevent shortness of breath and aspiration. Interview with RN #7 on 1/15/25 at 9:20 AM identified she does not review or revise care plans as that is the responsibility of the floor nurses. RN #7 identified she did review hospital discharge summaries to complete the MDS assessments, however RN #7 reiterated she did not have time to do any other tasks at the facility except MDS assessments, and that she also did not have time to review or revise care plans or attend resident care conferences. Interview with the DNS on 1/15/25 at 9:38 AM that it was the responsibility of the nursing staff to complete care plan revisions related to intermittent accidents and incidents and social services related to behaviors. The DNS identified that any care plan revisions related to hospitalization s or transfers were the responsibility of RN #7 (MDS Coordinator). The DNS identified Resident #44's care plan should have been revised to address the hospitalization s, and she was aware there were issues with those updates. The facility policy on comprehensive care plans directed that the care plan must be reviewed and updated when there was a significant change in the resident's condition, when the resident was readmitted to the facility from a hospital stay, and at least quarterly in conjunction with the required quarterly MDS assessment. The policy further directed that assessments of residents were ongoing and care plans were to be revised as information about the resident and the resident's condition changed. 47457

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review of the clinical record, facility documentation, facility policy and interview for 1 resident, (Resident #39) reviewed for activities of daily living, the facility failed to provide necessary set up and assistance with meals as per the comprehensive assessment and plan of care. The findings include: Resident #39 had diagnoses that included hemiplegia/hemiparesis (weakness and paralysis) affecting the left, non-dominant side following a cerebral infarction (stroke) and history of seizures. The baseline care plan dated 12/23/24 identified Resident #39 had a functional rehabilitation potential. Interventions included to provide the necessary, set up cueing support/assistance to carry out activities of daily living. The admission MDS dated [DATE] identified Resident #39 was cognitively intact, required substantial one person assist with bed mobility, two-person assist with transfers using a mechanical lift and set up assist with eating. Interview with Resident #39 on 1/12/25 at 9:07 AM identified he/she required assistance with meal set up due to left sided weakness and on occasion, a nurse aide, (NA #12) would drop off his/her food tray without opening or setting up food items. Resident #39 indicated he/she had felt intimidated by NA #12 and was reluctant to request the assistance that was needed. Interview with NA #12 on 1/13/25 at 10:59 AM identified he provides set up assistance to all residents assigned to him and he was not usually assigned to Resident #39. However, he would provide set up assistance with meals if he remembered and when requested. Interview with the DNS on 1/15/25 at 6:46 AM identified it was expected that staff ask all residents if assistance was needed with meals whether they were assigned to the resident or not. Education was provided to NA #12, and he was removed from any further interaction with Resident #39. A review of the facility policy for Activities of Daily Living (ADL) Support directs that residents will be provided with care and services appropriate to maintain or improve ability to carry out ADL's according to need including support and assistance needed with dining.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #12 and 48) reviewed for accidents, the facility failed to ensure neurological assessments were completed after 3 unwitnessed falls and an observed head strike. The findings include: 1. Resident #12 was admitted to the facility on [DATE] with diagnoses that included vascular dementia, chronic kidney disease, and muscle weakness. Review of the clinical record identified Resident #12 was hospitalized from 4/24/24 - 4/27/24 due to a left hip fracture following a fall. The care plan dated 4/29/24 identified Resident #12 had a history of falls with hip fracture. Interventions included to keep personal and frequently used items within reach. The significant change MDS dated [DATE] identified Resident #12 had severely impaired cognition, was frequently incontinent of bowel and bladder, and required maximal assistance from staff with transfers, bathing, and dressing. A reportable event form dated 5/28/24 identified Resident #12 had an unwitnessed fall at 12:30 PM. The investigation summary included in the report identified Resident #12 had reported conflicting information to facility staff on how the fall occurred, including falling while attempting to use a blanket, and also reporting attempting to reach a tissue box on the night stand and falling. A nurse's note on 5/28/24 by RN #3 identified that he was called to Resident #12's room following an unwitnessed fall. The note identified Resident #12 was found lying on his/her left side on the floor with his/her wheelchair behind him/her. The note identified Resident #12 reported sitting in his/her wheelchair eating lunch and standing up to wrap a blanket around him/her self at which point he/she lost his/her balance and fell to the floor. The note identified Resident #12 denied a head strike or pain, and had a bruise to the right shin that measured 0.5 cm x 0.5 cm. A post fall assessment dated [DATE] at 12:57 PM by RN #3 identified a neurological check done initially following the fall was within normal limits, with Resident #12 able to move his/her face, bilateral lower and upper extremities, 2mm pupil size with round and brisk response and shape, clear speech, and no mental status changes. Review of the clinical record failed to identify any additional neurological checks were documented for Resident #12 following the fall on 5/28/24. Interview and review of the clinical record with RN #3 on 1/14/25 at 12:17 PM identified that he would have completed a neurological assessment and initiated the neurological check flowsheet for Resident #12's unwitnessed fall on 5/28/24. RN #3 identified he would have likely completed the initial check and included the findings in the electronic record and then completed the remaining neurological checks on the flowsheet. Review of the clinical record with RN #3 failed to identify any neurological flowsheets for Resident #12 for the 5/28/24 fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/15/25 at 9:38 AM identified that she was not the DNS at the time of Resident #12's fall on 5/28/24 and only started as the DNS in 9/2024. The DNS identified she would expect neurological checks to be completed and documented on the neurological check flowsheet for any unwitnessed fall. The DNS further identified since taking the DNS position, she had found neurological flowsheets for multiple residents in a filing cabinet within the DNS office. A review with the DNS of these flowsheets failed to identify any documentation for Resident #12. Although requested, the facility failed to provide a policy related to falls or fall prevention for residents of the facility. Review of the neurological assessment flowsheet identified that neurological assessment checks would be initiated for all unwitnessed falls and witnessed falls with head strikes. The flowsheet identified that neurological checks would be completed following an unwitnessed fall every 15 minutes x 4, then 30 minutes x 4, then every hour x 2 hours, then every shift for a total of 72 hours. The facility policy on neurological assessments directed assessments would be completed with a physician's order, following an unwitnessed fall, subsequent to a fall with a suspected head injury, or when indicated by the resident's condition. The policy further directed that neurological assessments should include vital signs, pupil reaction, motor ability, sensation in the extremities, gag reflex, and facial muscle movements. The policy also directed that when documenting the assessment, all assessment data obtained should be included in the resident's medical record, and the physician should be notified for any change in neurological status. 2. Resident #48 was admitted to the facility in February of 2023 with diagnoses that included Parkinson's Disease, history of falls, and cognitive communication deficit. A physician order dated 4/25/24 directed to provide the assistance of 1 for transfers and activities of daily living. The nurse aide care card dated 6/24/24 identified that Resident #48 required the assistance of 1 with a rolling walker for transfers and utilized a seat belt on the standard wheelchair for proper positioning (original date 9/12/23). The quarterly MDS dated [DATE] identified Resident #48 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance with toileting and personal hygiene. Additionally, Resident #48 needed maximum assistance with transfers. The care plan dated 7/20/24 identified Resident #48 was at risk for falls due to age, dementia, and Parkinsons Disease. Interventions included to report any changes in gait or mental status and encourage the resident to wear proper footwear. A physician's order dated 11/5/24 (original date was 9/27/23) directed a seatbelt at all times for proper positioning while of bed to be in a standard wheelchair. a. A reportable event form dated 8/11/24 at 5:00 AM identified the nurse heard a thump and entered the room to see Resident #45 was sitting on the floor with his/her legs out in front of him/her and his/her back against the cushion from the wheelchair. Resident #45 noted with a bruised left index finger that was reddish blue color and swollen. There were no witnesses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SBAR dated 8/11/24 at 2:40 PM identified Resident #48 had an unwitnessed fall and needed a new wheelchair seat belt. Review of the neurological assessment form dated 8/11/24 at 5:00 AM identified 13 out of 24 assessments were not complete. The assessments included check level of consciousness, pupils responsive, motor function, hand grasps, range of motion for all 4 extremities, pain assessment, vital signs including blood pressure, temperature, pulse, and respirations. Interview with the DNS on 1/15/25 at 8:26 AM after review of the neurologic assessment form indicated staff should conduct neurological assessments with an unwitnessed fall and she did not know why the neurological assessments had not been completed. b. A reportable event form dated 11/29/24 at 5:30 PM identified Resident #48 had an unwitnessed fall attempting to self-transfer from the bed to the wheelchair. Interventions included to perform vital signs and neurological assessments and resident to always wear nonskid socks. Review of the neurological assessment form dated 11/29/24 at 5:30 PM identified neurological assessments were not completed. Interview with the DNS on 1/15/25 at 8:38 AM after review of the neurologic assessment form indicated her expectation that the neurologic assessments would be completed (every section) in full after an unwitnessed fall. c. A reportable event form dated 12/2/24 at 6:30 PM identified Resident #48 had an unwitnessed fall from the wheelchair. Review of the neurological assessment form dated 12/2/24 at 6:30 PM identified 18 out of 24 assessments were not complete. Interview with the DNS on 1/15/25 at 8:40 AM after review of the neurologic assessment form indicated her expectation that the neurologic assessments would be completed (every section) in full after an unwitnessed fall. d. A reportable event form dated 1/7/25 at 9:30 AM indicated while pushing Resident #48 in the wheelchair the nurse aide hit the residents head into the door frame and the resident sustained a 2.5 cm by 2.5 cm contusion to the right forehead. Review of the neurological assessment form dated 1/7/25 at 9:30 AM identified 10 out of 24 assessments were not complete. Interview with LPN #1 on 1/12/25 at 2:08 PM indicated she started the 72-hour neurological assessment form. LPN #1 indicated that she documented the resident had refused the neurologic assessments from 10:15 AM - 11:30 AM and again from 1:30 PM - 3:00 PM because the resident wanted to go downstairs and hang out in the recreation room. LPN #1 indicated that she informed the nursing supervisor, RN #4, that Resident #48 wanted to go to first floor to the recreation area and that she was too busy passing medications to go downstairs every 15 minutes to do the neurological assessments. LPN #1 indicated that RN #4 told her it was okay just put Resident #48 had refused. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 (day supervisor) on 1/14/25 at 11:33 AM indicated that on 1/7/25 at 9:30 AM the charge nurse, LPN #1, called her to the unit to assess a contusion on Resident #48's right forehead. RN #4 indicated that LPN #1 and NA #1 explained what had happened. RN #4 indicated that NA #1 informed her that she was transporting Resident #48 from the resident's room into the resident's bathroom and Resident #48 was bent over and NA #1 bumped Resident #48's forehead on the right side against the bathroom door frame. RN #4 indicated that NA #1 stated she was trying to adjust the wheelchair to get through the bathroom doorway, but Resident #48 was leaning to the side, so she hit Resident #48s head on the door frame. RN #4 indicated that she assessed the bump on the right forehead which was still rising as she was assessing it, and the initial measurements were 2.5cm by 2.5 cm and the area appeared red in color. RN #4 indicated that she called the APRN and received new orders for hold the aspirin and apply ice to area. RN #4 indicated that the neurological assessment form and vital signs were started for the head injury. RN #4 indicated that they follow the form starting with a complete assessment and vitals every 15 minutes then every 30 minutes and then continue to follow the form. RN #4 indicated that LPN #1 did not report to her that she would not be able to do the neurological assessments and vital signs because she was busy with her medication pass. RN #4 indicated that LPN #1 reported that the resident was going downstairs because. RN #1 identified that if LPN #1 had informed her that she could not do the required neurologic assessments, she would have done the neurological assessments and vital signs for Resident #48 downstairs. RN #4 indicated that if a resident refuses the neurological assessment and vital signs the APRN must be notified and documented in the clinical record. Interview with the DNS on 1/14/25 at 11:57 AM indicated that the charge nurse should assess the resident when an incident occurs and call supervisor so the RN can do the assessment. The DNS indicated staff are to follow the neurological assessment form for the timing of the checks and vital signs every 15minutes times 4, every 30 minutes times 4, then every hour for 2 hours, then every shift time 72 hours. The DNS indicated that her expectation was that staff would follow the neurological assessment protocol and policy. The DNS indicated that if the charge nurse was busy, she would notify the RN supervisor. After review of the neurological assessment form dated 1/7/25, the DNS indicated that if LPN #1 was busy to complete the neurological assessments, she could have called RN #4, the infection control nurse, or herself and they would have done the neurological assessments when required per policy. The DNS indicated that because the resident had left the floor was not an excuse for LPN #1 to not complete the neurological assessments and vital signs after a known head injury. Review of the Neurological Assessment Flow Sheet identified the assessments would be initiated for all witnessed head injuries and unwitnessed falls. Neurological Assessments will be completed every 15minutes times 4, then every 30 minutes times 4, then every hour for 2 hours, then every shift time 72 hours by nursing and documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Neurological assessment Policy identified a neurological assessment is done per a physician order, following an unwitnessed fall, after a fall with suspected head injury, or a when indicated by resident condition. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may indicative of increasing intracranial pressure. Any changes in vital signs or neurological status in a previously stable resident should be reported immediately to the physician. Included in neurological assessment includes: residents orientation to time, place, and person, residents pattern of speech and speech clarity, , take the residents temperature, pulse, respirations, and blood pressure, check residents pupils reactions, determine residents motor ability by moving all extremities, ask resident to squeeze your fingers for strength bilaterally, have resident plantar and dorsiflex and check sensation in lower extremities, check gag reflex, have resident smile to determine if any facial droop, record observations. Document the date and time of procedure was performed and name and title of who performed assessment. Document how the resident tolerated procedure. Notify the physician of any changes and notify the supervisor if the resident refuses. 46040

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for the only sampled resident (Resident #37) reviewed for pressure ulcers, the facility failed to ensure weekly skin assessments were completed, per the physician's order. The findings include: Resident #37 on was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia, neuromuscular dysfunction of the bladder, neurogenic bowel, and gastrostomy-jejunostomy (GJ) tube. A physician's order dated 10/31/22 directed to complete a weekly skin observation on shower days, once weekly, on Monday; 3:00 PM - 11:00 PM. The quarterly MDS dated [DATE] identified Resident #37 had severely impaired cognition, had an indwelling foley catheter, was always incontinent of bowel, was dependent for toileting hygiene, bathing, and sitting to lying, required maximal assistance for rolling left to right, and was at risk for developing pressure ulcers/injuries. The care plan dated 11/12/24 identified Resident #37 was at risk for the development of pressure ulcers/skin breakdown due to: impaired mobility, diabetes mellitus, dependent mobility status, and incontinence of bowel. Interventions included performing skin checks and treatments as ordered and reporting changes and/or concerns to the MD/APRN and responsible party, as needed. The Resident Census Report identified the following hospital transfers for Resident #37: Hospital leave and return to the facility on [DATE]. Hospital leave and return to the facility on [DATE]. Hospital leave began on 11/30/24 and returned to the facility on [DATE]. The weekly Skin Observation documentation dated 10/1/24 through 11/30/24 failed to identify weekly skin observations were completed during the weeks of 10/14, 10/28, 11/4, 11/11, and 11/25/24. The SBAR communication form dated 11/29/24 identified Resident #37 vomited two times, hard to touch protrusion noted in the right lower abdomen, tube feeding put on hold, APRN made aware and new order obtained to send to the ER for evaluation. Resident was sent to the hospital at 6:00 PM. The Inter-Agency Patient Referral Report dated 12/4/24 identified Resident #37 had a stage 3 pressure injury of the sacral region. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 12/4/24 at 12:29 PM identified Resident #37 returned to the facility via ambulance at 10:30 AM. Body audit performed by this writer and wound nurse shows scattered bruising to bilateral upper extremities and new onset deep tissue injury (DTI) to sacrum measuring 2.0 x 0.2 x 0.0. Admission orders verified with the APRN and family aware of the resident's return to the facility. Resident will be followed by wound team on wound rounds weekly. Interview and clinical record review with LPN #5 on 1/14/25 at 1:45 PM identified that Resident #37 was ordered to have weekly skin assessments completed every Monday, on the 3:00 PM - 11:00 PM shift and that would be completed by the charge nurse. LPN #5 indicated that sometimes she works on the evening shifts, but she could not recall if she had worked on any of the dates with missing skin assessments. LPN #5 further indicated that in addition to documenting that the skin assessment was completed in the MAR, the actual skin assessment is documented on the skin observation form in the electronic health record. Interview and clinical record review with the DNS on 1/14/25 on 12:28 PM failed to identify that weekly skin audits were completed during the weeks of 10/14, 10/28, 11/4, 11/11, and 11/25/24, prior to Resident #37's hospitalization . The DNS indicated that skin assessments were to be completed weekly, on the resident's shower day, by the charge nurse. The facility's Skin Assessment and Prevention policy directs for a full body audit to be completed on residents, at least weekly and documented in the resident's medical record utilizing facility forms.

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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** 37293 Based on review of the clinical record, facility documentation, facility policy and interview for 5 of 7 residents (Resident #23, 26 27, 39 and 48) reviewed for accidents and/or abuse, the facility failed to provide adequate supervision and/or assistive devices to prevent accidents. For Resident 23 and 26, the facility failed prevent an elopement. For Resident #27 the facility failed to ensure that staff transferred the resident safely via a hoyer (mechanical lift) to prevent an injury. For Resident #39, the facility failed to prevent a fall. For Resident #48 the facility failed to ensure that a seat belt was in good repair to prevent a fall and failed to ensure proper positioning while being wheeled into the bathroom to prevent the residents head being bumped on the door frame. The findings include: 1. A Preadmission Screening and Resident Review, PASARR (mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis) dated 2/8/18 did not reflect the resident had a history of wandering or exit seeking behavior. Resident #23 had diagnoses that included anoxic brain damage, Asperger's syndrome (neurodevelopment disorder) and psychotic disorder with delusions. The Elopement Risk Evaluation Tool dated 6/22/21 identified Resident #23 had never previously wandered or attempted to leave the facility, was at low risk for elopement and did not require interventions to prevent an elopement. The quarterly MDS dated [DATE] identified Resident #23 was had moderately impaired cognition, did not exhibit any wandering behaviors, was independent with bed mobility, transfers and ambulation. The care plan dated 2/20/23 identified Resident #23 had a preadmission screening for mental illness and impaired communication related to psychiatric diagnoses. Interventions included to allow resident to express their feeling, remove when agitated to ensure a safe environment and report any concerns to physician and resident representative. A Psychiatric Evaluation and Consultation dated 2/23/23 identified Resident #23 received ongoing services due to a developmental disorder, major depressive disorder with a history of homicidal ideations. Resident #23 mood was stable with no psychomotor agitation, delusions or paranoia, was not considered a threat to self or others with no changes recommended to the treatment plan. Medical progress notes dated 2/24/23 through 3/10/24 identified Resident #23 was being monitored routinely for chronic conditions with no documented maladaptive behaviors. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress notes dated 2/24/23 through 3/23/23 identified no verbal/non-verbal complaints of pain, all needs and safety measures were maintained. Behavior monitoring dated 3/27/23 identified Resident #23 did not exhibit any target behaviors. a. Nurse's note dated 3/28/23 at 1:47 AM identified on 3/27/23 at 11:45 AM, the front door alarms to the building sounded. No one was seen outside the building, but a resident check identified Resident #23 was not in his/her room or entire floor. A code for elopement was declared. Each nurse assigned to search for the resident on their units, while RN #1 And NA #11 searched the outside of the building, going in the opposite direction while another nurse aide from 3rd floor searched the first level of the building. At 12:00 AM, 911 was deployed while NA #11 used her car to look for the Resident #23 down the street. At 12:05 AM, NA #11 located Resident #23 down the street. Soon after, police arrived at the facility. Police questioned Resident #23 and RN #1 regarding the event to ensure the resident was not a threat to self or others. Resident #23 stated that the reason he/she left the building was to have a walk. Resident #1 was placed on 1:1 monitoring until further assessments could be done to ensure resident's safety. The Advanced Practice Registered Nurse, APRN and responsible party were notified. A Staff Statement, undated, completed by LPN #9 identified Resident #23 was last seen and provided care while in his/her bedroom at 11:30 PM. A reportable event form dated 3/30/23 identified on 3/27/23 at 11:45 PM identified Resident #23 left the facility and was found off the premises within 20 minutes, 0.4 miles away and was returned safely to facility. The resident was placed on 1:1 supervision pending the interdisciplinary team convening the following morning. A new plan of care was put in place that included a Wanderguard with Resident #23's approval and encouragement to stay away from exits. Interview with RN #1 on 1/13/25 at 6:22 AM identified he was the assigned nursing supervisor during the 11:00 PM to 7:00 AM shift on 3/27/23 overnight to 3/28/23. RN #1 identified Resident #23 had been at the facility a long time, was well known to him, had never previously exhibited wandering or exit seeking behaviors and had poor safety awareness. RN #1 identified he was not made aware of any reports of behaviors prior to the event. RN #1 identified it was close to the change of shift when he heard the front door alarm sound and there was no receptionist stationed in the lobby that time of night. RN #1 went outside and did not see anyone in the immediate area. RN #1 identified he notified the units to see if any resident was missing and was notified immediately that Resident #23 could not be located. RN #1 activated the elopement code used to notify all staff of a missing resident and initiate a search. The police were notified while NA #1 left the facility in her own car to locate Resident #23. NA #11 returned a few minutes later with Resident #23 who had no complaints or injuries and did not seem to have a specific goal in mind. An assessment was completed and 1:1 supervision initiated. A Wanderguard was placed subsequent to the event with no further attempts to leave the facility. (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 #11 on 1/13/25 at 7:04 AM identified she was working during the 11:00 PM to 7:00 AM shift on 3/27/23 overnight to 3/28/23 but was not assigned to Resident #23 and was not working on the floor where the resident resided. However, she was familiar with Resident #23 and never knew the resident to wander or attempt to leave, mostly going as far as the nurse's station when he/she wants something and then back to his/her room. NA #11 identified she was heading downstairs when she was notified by the nursing supervisor, RN #1 that Resident #23 had exited the building. NA #11 first went outside to look for Resident #23. When she was unable to locate the resident, she got into her personal vehicle and took a right out of the driveway, then another right. NA #11 drove approximately 2 blocks locating Resident #23 standing near a pole next to some type of enclosure on the side of the road with no traffic wearing a sweatshirt, jeans and sneakers. NA #11 got out of the vehicle, told Resident #23 who she was, and Resident #23 proceeded to get in the vehicle on his/her own. NA #11 returned Resident #23 to the facility without further incident. Interview with the DNS on 1/13/25 at 8:05 AM and 1/15/25 at 6:57 AM identified the front door was locked but would open if pushed on for 15 seconds allowing access to the outside. The alarm sounded once the door was opened. Resident #23 did not exhibit any wandering or exit seeking behaviors prior to the incident and was previously identified at low risk for elopement. A Wanderguard was placed following the incident and Resident #23 has not exhibited any wandering exit seeking behaviors or made any attempts to leave the facility. The DNS further identified she would expect staff to be providing supervision to the best of their ability to prevent an elopement. A review of the facility policy for Wandering and Elopements direct the facility to identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for all residents. Although attempted, interviews with LPN #9 and NA #13 were not obtained. b. The clinical record failed to reflect Elopement Risk Assessment tools were completed between 6/21/21 to 3/28/23 (21 months), 9/26/23 to 3/28/24 (6 months) and between 3/28/24 and 9/10/24 (6 months). Interview with the DNS on 1/13/25 at 8:05 AM identified the facility utilizes an Elopement Risk Evaluation tool to determine any resident at risk for elopement. The assessment was to be completed on admission, quarterly, annually and when there was a change in behavior. The charge nurses were responsible for the completion of the assessment and the MDS coordinator was responsible for ensuring it's completion. The DNS further identified the breakdown in process occurred when the nurses did not complete the assessments when due and the MDS coordinator did not ensure their completion. Interview with RN #7 on 1/14/25 at 2:01 PM identified she was the MDS coordinator for the facility for nine years and was not responsible for ensuring the completion of the Elopement Risk Evaluation tool. RN #7 further identified she believed nursing supervisors were responsible for the completion of the Elopement Risk Evaluation tool. Although requested, a policy for the use of the Elopement Risk Evaluation Tool was not provided. (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 facility policy for Wandering and Elopements direct the facility to identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for all residents. If a resident is identified at risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Although requested a policy for the implementation and use of the Wanderguard was not provided. 2. Resident #26 was admitted to the facility in April 2023 with diagnoses that included dementia with behavioral disturbance, cerebrovascular disease, and diabetes. Review of the elopement risk evaluation dated 4/19/23 at 6:10 PM identified Resident #26 was disoriented daily, ambulatory, and wanders the facility but does not try to leave. The elopement risk score identified Resident #26 was at risk for elopement. The care plan dated 4/20/23 - 7/31/23 failed to reflect documentation Resident #26 was at risk for elopement or interventions to address such. Review of clinical record identified Resident #26 was appointed a Conservator of Person on 8/3/23. The quarterly MDS dated [DATE] identified Resident #26 had intact cognition and was independent with walking 150 feet with the use of a walker. Review of the elopement risk evaluation dated 10/19/23 at 11:52 AM identified Resident #26 was not disoriented, was ambulatory, and had not wandered or attempted to leave the facility. The elopement risk score identified Resident #26 was at low risk for elopement. The physician's order dated 11/1/23 - 11/13/23 failed to reflect an order for leave of absence without supervision. A reportable event form dated 11/13/23 at 1:50 PM identified Resident #26 was observed off the facility property wearing a hat, coat, and ambulating with a walker. Resident #26 was found by the Admission Director who called the facility. Resident #26 indicated he/she was going to the bank to get some money for a cup of coffee. Resident #26 was placed on 1:1 monitoring, and a wanderguard was placed. The APRN and conservator were notified. Psychiatrist and social worker to follow up. Review of the elopement risk evaluation dated 11/13/23 at 2:53 PM identified Resident #26 was not disoriented, ambulatory, and had left the facility. The elopement risk score identified Resident #26 was at risk for elopement. The intervention implemented to prevent elopement was a wanderguard. A nurse's note dated 11/13/23 at 3:12 PM identified Resident #26 was escorted back to the facility without any issues and indicated he/she wanted to go to the bank and had no intention of leaving the facility for good. No injuries noted and no complaints of discomfort. Resident #26 declined the wander guard placement on body. Resident did allow the wanderguard to be placed on the walker which he/she uses consistently. Resident #26 was placed on 1:1 monitoring for safety until seen by the psychiatrist. The APRN was notified and 1:1 was discontinued. The staff were to perform frequent monitoring checks. The Conservator of Person and the police were notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The psychiatric evaluation dated 11/13/23 identified Resident #26 has been frustrated and preoccupied with his/her bank account since becoming conserved and declined telehealth session due to hard of hearing. No anxiety or agitation. Resident #26 was easily re-directed into the facility and allowed placement of wanderguard on the walker. May discontinued 1:1 and continue frequent monitoring checks. The care plan dated 8/18/23 - 11/26/23 failed to reflect documentation Resident #26 was at risk for elopement or that Resident #26 had an actual elopement on 11/13/23 or interventions to address such. A written interview with Resident #26 dated 11/13/23, untimed, by the previous DNS identified Resident #26 indicated he/she received a letter from the bank stating that his/her name was removed from his/her account. The previous DNS indicated the facility had taken Resident #26 to the bank before and he/she should have asked, and the facility would have taken him/her to the bank. Resident #26 indicated that he/she was wearing a jacket and would have called the police if anything had happened. The DNS indicated she explained to Resident #26 that he/she cannot leave the facility without a staff member or someone with him/her. Resident #26 indicated he/she understands and won't leave without letting someone know. A written statement by the Business Office Manager dated 11/13/23, untimed, identified Resident #26 was in her office around 1:20 PM (30 minutes prior to eloping) asking for his/her refund check. The Business Office Manager indicated she explained to Resident #26 that she would have to call his/her conservator and asked can she give him/her the check. The Business Office Manager indicated Resident #26 got upset and walked out. The summary report dated 11/14/23 identified Resident #26 had left the facility grounds without supervision or notification to the staff or conservator. On 11/13/23 at 1:45 PM the Admission Director informed the facility that she was with Resident #26 by the bus stop off the facility grounds. Resident #26 had informed her that he/she was going to the bank after receiving a letter from the bank indicating he/she was removed from the bank account. Resident #26 had intact cognition and was dressed appropriately for the weather with plans to return to the facility, and to call the police if any incident had occurred. Resident #26 had acknowledged that he/she had left the facility grounds without notifying the facility staff and agreed to notify the staff in the future if he/she needed to leave the facility for any reason. The facility concluded that this was an authorized leave versus an elopement. Although the summary report dated 11/14/23 identified the facility concluded that this was not an elopement but an authorized leave, Resident #26 had acknowledged that he/she had left the facility grounds without notifying the facility staff and based on interviews, the facility staff did not know that Resident #26 had left the facility. Interview with the DNS on 1/14/25 at 6:50 AM identified she was not the DNS at the time of the elopement. The DNS indicated Resident #26 was independent with ambulation with a rolling walker and should not have left the facility grounds. The DNS indicated that prior to the elopement, Resident #26 was able to go out onto the facility ground to the gazebo area without supervision and he/she would come back into the facility with no issues. The DNS indicated Resident #26 did not exhibit any elopement risk prior to the elopement on 11/13/23 and indicated the Admission Director found Resident #26 off the facility grounds approximately 0.4 miles down the street from the facility. (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 Admission Director on 1/14/25 at 7:50 AM identified on 11/13/23 at approximately 1:50 PM she had left the facility and observed Resident #26 ambulating with his/her walker down the street from the facility (which was approximately 0.4 miles away from the facility). The Admission Director indicated she called the facility and notified the DNS that Resident #26 was out of the facility, and she remained with the resident until the DNS, RN #3, and RN #2 came down the street to get the resident. The Admission Director indicated Resident #26 was agitated and indicated he/she was going to the bank. The Admission Director indicated she left after the DNS, RN #3, and RN #2 got there. Interview with RN #2 on 1/14/25 at 10:55 AM identified there was a couple of times the facility staff had to keep Resident #26 from leaving the facility grounds, but he cannot recall the incident on 11/13/23 as it was so long ago. Interview with Business Office Manager on 1/15/25 at 9:59 AM identified Resident #26 came to her office regarding a cashier's check. Resident #26 wanted the Business Office Manager to give him/her the cashier's check and she explained to Resident #26 that she had to call the conservator with him/her present in the office and that is when Resident #26 became very upset and did not want to hear anything else and walked out of the office. The Business Office Manager indicated she did not notify the nursing staff that Resident #26 was very upset about a cashier's check and the conservator. Interview with LPN #8 on 1/15/25 at 10:36 AM identified she had administered Resident #26 morning medications and does not recall the incident it was so long ago. LPN #8 indicated this was the first time she had ever heard of Resident #26 leaving the facility. Interview with the DNS on 1/15/25 at 9:00 AM identified she was unable to provide documentation of Resident #26's monitoring. Although attempted, an interview with the previous DNS, previous Social Worker, Receptionist #1, NA #8, and NA #12 were not obtained. Review of the facility wandering and elopements policy identified for residents who are at risk of unsafe wandering the facility strives to prevent harm while maintaining the least restrictive environment for residents. If identified at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain resident's safety. 3. Resident #27 was admitted to the facility in January 2018 with diagnoses that included severe morbid obesity, schizoaffective disorder, bipolar disorder, panic disorder, and major depressive disorder. The physician's order dated 5/31/23 directed to provide 2-person assistance with bed mobility, and hoyer (mechanical lift) transfers. The quarterly MDS dated [DATE] identified Resident #27 had severely impaired cognition and required total two-person assistance with transfers. The care plan 7/19/23 identified Resident #27 needs assistance with mobility, and Activities of Daily Living (ADL's), due to weakness, impaired mobility status, hoyer lift, and wheelchair bound. Interventions included to allow extra time to perform tasks as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The reportable event form dated 8/18/23 at 11:00 AM identified Resident #27 had an injury of unknown origin. During morning care, Resident #27 was noted to have discoloration, scattered abrasions and swelling to the right lower extremity from the knee to the foot. Resident #27 was unable to verbalize what had occurred. Resident #27 was alert and confused and can become combative with care at times. The APRN was updated with new orders for doppler ultrasound to rule out deep vein thrombosis, and x-rays of right lower extremity. Pain assessment every shift, bed rest, continue investigation to find route cause of injury. Investigation initiated and staff interviews are in progress. The conservator and the Administrator were notified. The nurse's note dated 8/18/23 at 1:54 PM identified Resident #27 was noted with scattered abrasions, discoloration and swelling to the right lower extremity (knee and foot). RN assessment identified some pain was noted with manipulation of the area. Review of the diagnostic test results dated 8/18/23 identified the right lower extremity doppler result was negative for venous clot. The x-ray results to the right hip, knee, femur, tibia, fibula, foot, and ankle were negative. A written statement by LPN #7 dated 8/18/23 identified she had performed a body audit on 8/17/23 during the 7:00 AM - 3:00 PM shift and did not observe any bruised areas on Resident #27. A written statement by NA #8 dated 8/18/23 identified she provided a bed bath to Resident #27 on 8/17/23 on the 7:00 AM - 3:00 PM shift and did not observe any discoloration, edema, or open areas to Resident #27 right leg. A written statement by NA #4 dated 8/18/23 identified on 8/17/23 on the 7:00 AM - 3:00 PM shift she assisted NA #8 to transfer Resident #27 via hoyer lift into the wheelchair. NA #4 indicated she guided the top half of Resident #27's body while NA #8 guided the resident's lower body. NA #4 indicated Resident #27 was fully dressed at the time of the transfer. A written statement by NA #9 dated 8/18/23 identified on 8/17/23 on the 3:00 PM - 11:00 PM shift he noticed bruises, and swelling to the resident's right leg while he was providing care. NA #9 indicated he did not report the bruises and swelling because he was under the impression that it had already been reported because Resident #27 was in bed already. A written statement by NA #10 dated 8/18/23 identified on 8/18/25 during the 7:00 AM - 3:00 PM shift when she started morning care she observed Resident #27's right leg to be discolored, with open areas, and edema. NA #10 indicated she called LPN #7 to come and looked at Resident #27's right leg. A written statement by LPN #7 dated 8/18/23 identified on 8/18/25 during the 7:00 AM - 3:00 PM shift she was called by NA #10 who pulled the sheet down and LPN #7 called the supervisor to come and assess Resident #27 The summary form dated 8/22/23 identified an investigation was conducted into the bruising, abrasions, discoloration and swelling to Resident #27's right leg and it was determined that they were caused during a hoyer lift transfer while Resident #27 was being pushed back in the wheelchair for positioning, the residents right leg struck the hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with the DNS on 1/14/25 at 7:11 AM identified she was a supervisor when the incident happened, and she was not aware that NA #9 saw the injuries to the resident's right leg and did not report them to LPN #9 or RN #6. The DNS indicated the expectation of the facility is when a staff member observes a resident with any injuries, they are to report it immediately to the charge nurse or the RN supervisor. Interview with RN #1 on 1/15/25 at 7:03 AM identified he does not remember the incident it was so long ago. Although attempted, interviews with the previous DNS, RN #6, LPN #9, NA #5, NA #9, LPN #8, LPN #7, NA #6, and NA #10 were not obtained. Review of the facility mechanical lift policy identified the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lift device. It is not a substitute for manufacturer's training or instructions. Up to two (2) nursing assistants are needed to safely move a resident with a mechanical lift. 4. Resident #39 had diagnoses that included hemiplegia/hemiparesis (weakness and paralysis) affecting the left, non-dominant side following a cerebral infarction (stroke) and history of seizures. The baseline care plan dated 12/23/24 identified Resident #39 had a functional rehabilitation potential and was at risk for falls. Interventions included to provide the necessary set up cueing support/assistance to carry out activities of daily living and complete fall assessment to identify level of risk for falls. A Physical Evaluation and Plan of Treatment dated 12/23/24 identified (when working with Rehabilitation staff only), Resident #39 required a maximum assist of one for transfers meaning Resident completes 25% of the task and therapy staff complete 75% of the task. The Evaluation further identified Resident #39 was at risk for falls. The admission MDS dated [DATE] identified Resident #39 was cognitively intact, required substantial one person assist with bed mobility, two-person assist with transfers using a mechanical lift with nursing staff, had a history of falls prior to admission and no falls since admission. The Nurse Aide Care Card identified the resident required assist of one with toileting, assist of two using a mechanical lift with transfers. A reportable event form dated 1/8/24 at 1:00 PM identified Resident #39 was lowered to the floor during therapy by Certified Occupational Therapist Assistant, (COTA #1) when it was noticed the resident was sliding out of his/her chair which did not result in an injury. The care plan was updated to include a Dycem (non-slip mat) applied under the wheelchair cushion to prevent sliding. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 1/9/25 at 10:31 AM identified they were called to therapy gym on 1/8/25 at 1:00 PM. Resident was lowered to the floor from the wheelchair by COTA #1. The resident had been sitting in his/her wheelchair participating with therapy session. COTA #1 noted Resident #39's cushion was sliding forward in the wheelchair and slowly lowered the resident to the floor to a sitting position on his/her buttocks. Per the resident and the facility employee, the resident did not strike his/her head and was at baseline mentation. Range of motion was at baseline and Resident #39 denied new onset of pain or discomfort. The APRN was updated with no new orders. A Dycem was applied between the wheelchair and seat cushion to prevent shifting of the wheelchair cushion by therapy. A review of the Daily Occupational Therapy note dated 1/9/25 for service provided on 1/8/25 failed to reflect that the resident had been lowered to the floor during the therapy session. An interview with Resident #39 on 1/12/25 at 9:10 AM identified he/she was placed in a wheelchair by two rehabilitation staff, COTA #1 and PTA #1 and was not boosted enough. PTA #1 walked away, COTA #1 turned away, and Resident #39 slid out of the chair and onto the floor hitting his/he left shoulder and arm. Resident #39 spoke with PTA #1 after the incident who said Resident #39 should not have been left alone. Resident #39 had been experiencing worsening pain and not wanting to participate in therapy. An interview with the Director of Rehabilitation on 1/13/25 at 9:42 AM identified Resident #39 required an assist of two with nursing staff with a mechanical lift for transfers and a maximum assist of one when working with therapy staff. The Director of Rehabilitation identified he was present and observed the incident involving Resident #39 on 1/8/25 at 1:00 PM. Resident #39 was completing a 'sit to stand' task at the parallel bars with COTA #1 and was attempting to sit back in the wheelchair located at the end of the parallel bars. Resident #39 ended up at the edge of the wheelchair seat, could not get him/herself fully back and began to fall. COTA #1 was there and assisted Resident #39 to the floor. The Director of Rehabilitation identified the staff that were with Resident #39 should have made sure the chair was safely under the resident before sitting and would expect that for any resident where the helper completes 75% of the task. An interview with PTA #1 on 1/13/25 at 10:48 AM identified he observed the fall. PTA #1 identified Resident #30 was standing at the parallel bars, appeared to have become weak and started to sit in the chair before being lowered to the floor by COTA #1. PTA #1 provided additional assistance once Resident #39 was on the floor. An interview with COTA #1 on 1/14/25 at 9:15 AM identified he was working with Resident #39 on the day of the incident. COTA #1 identified Resident #39 was working on a 'sit to stand' task on the parallel bars. Resident #39 was holding onto the bar with his/her right fully functional arm. When Resident #39 went to sit in the chair, he/she began to slide out of the chair. COTA #1 and PTA #1 both eased the resident to the floor. Resident #39 was wearing a gait [NAME] and COTA #1 was holding on with both hands while assisting into the resident into the wheelchair seat. It appeared that Resident #39 was fully on the seat, however, must have been closer to the edge resulting in the resident sliding out. COTA #1 identified there would have been no way for him alone to pull the chair closer to ensure Resident #39 was well seated while using both hands to manage the gait belt which likely resulted in the fall. COTA #1 further identified therapy staff normally have Resident #39 scoot back in the wheelchair but did not on this occasion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 1/15/25 at 6:49 AM identified she would have expected the wheelchair to be placed safely behind Resident #39 who required maximum assist. A review of the facility policy for Activities in daily Living (ADL) Support directs that residents will be provided with care and services appropriate to maintain or improve ability to carry out ADL's according to need including support and assistance needed with transfers. A review of the facility policy for Falls directed for any fall, details of the fall should be clarified and identify the likely cause of the incident. 37721 42117 5. Resident #48 was admitted to the facility in February of 2023 with diagnoses that included Parkinson's Disease, history of falls, and cognitive communication deficit. The care card, last updated, 6/24/24 identified that on 9/12/23 Resident #48 had a seat belt placed on the standard wheelchair and required transfer assist of 1 with a rolling walker, and The quarterly MDS dated [DATE] identified Resident #48 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance with toileting and personal hygiene. Additionally, Resident #48 needed maximum assistance with transfers. The care plan dated 7/20/24 identified Resident #48 was at risk for falls due to age, dementia, and Parkinsons Disease. Interventions included to report any changes in gait or mental status changes and encourage resident to wear proper footwear. The care plan did not reflect the resident utilized a seat belt on the wheelchair. Monthly physician's orders dated 8/1/24 (original date was 9/27/23) directed Resident #48 be in a standard wheelchair with a seat belt for proper positioning while out of bed. a. A reportable event form dated 8/11/24 at 5:00 AM identified Resident #48 had an unwitnessed fall. The nurse heard a thump and entered room to see Resident #48 was sitting on the floor with his/her legs out in front of him/her and his/her back against the cushion from the wheelchair. Resident #48 is alert, pleasant, and forgetful and was noted with a bruised left index finger that was reddish blue color and swollen. Interventions included the unwitnessed fall protocol for 72 hour and call APRN if any changes in status, Physical therapy evaluation, and needs a new seat belt for wheelchair. RN #5 wrote the wheelchair safety belt was not working, it was broken and the resident needs a new one. RN #5 indicated that Resident #48 informed her the seat belt had been broken. RN #5 documented the environmental factor that may have contributed to the fall was the seat belt was not working in the wheelchair. The SBAR dated 8/11/24 at 2:40 PM identified Resident #48 had an unwitnessed fall and needed a new wheelchair seat belt. A Physical Therapy Referral Form dated 8/11/24 identified the seat belt on the resident's wheelchair is broken and Resident #48 needs a new seat belt. (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 RN #5 on 1/14/25 at [TRUNCATED]

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record, facility policies, and interviews for 1 of 2 residents (Resident #37) reviewed for tube feeding, the facility failed to ensure an intervention to prevent the dislodgement of a feeding tube was in place and failed to ensure the family was educated on interventions to prevent the dislodgement of a feeding tube. The findings include: Resident #37 on was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia, neuromuscular dysfunction of the bladder, neurogenic bowel, and gastrostomy-jejunostomy (GJ) tube. The care plan dated 3/28/24 (last revised 11/12/24) identified Resident #37's GJ tube was at risk for coming out. The intervention was an abdominal binder. The quarterly MDS dated [DATE] identified Resident #37 had severely impaired cognition, had functional limitation in range of motion to both the upper and lower extremities, required maximal assistance for rolling left to right, and had a feeding tube. The nurse's note dated 11/4/24 at 10:34 AM identified that the writer was called into Resident #37's room by the charge nurse, resident's significant other at the bedside, Resident #37's GJ tube was noted to be dislodged. The medical provider was updated, and a new order was obtained to send Resident #37 to the ED for replacement of the GJ tube. The Interagency Patient Referral Report dated 11/4/24 identified Resident #37 underwent the following procedure: Interventional Radiology (IR) G-J tube change with guidance. The nurse's note dated 12/13/24 at 6:24 PM identified that at 5:00 PM during the medication pass, this writer noticed Resident #37's GJ tube dislodged completely. The RN supervisor was notified, and Resident #37 was sent to the ED. The Hospitalist Discharge Summary dated 12/15/24 identified Resident #37's active issue was a GJ tube dislodgement, and he/she underwent GJ tube replacement on 12/14/24, by IR. Observation of Resident #37's GJ tube on 1/13/25 at 11:50 AM with LPN #5 and NA #3 failed to identify an abdominal binder in place; a towel was placed over the GJ tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #3 on 01/13/25 at 2:58 PM identified that she doesn't know how Resident #37's GJ tube has become dislodged, but the resident can move the left arm, and she thinks Resident #37 may pull or scratch at the area causing the tube to come out. NA #3 indicated that when Resident #37's spouse visits, he/she provides care to the resident and repositions him/her and she felt that could also be a reason that the tube has come out. NA #3 indicated that they had tried to use the abdominal binder in the past, but Resident #37's spouse removed it, and they found the abdominal binder in the garbage after the spouse had visited. NA #3 further identified that they have attempted other interventions to prevent dislodgement such as covering the tube with a sheet or towel, and frequent checks. NA #3 believed that education was provided to the spouse on interventions to prevent dislodging the tube, but she did not personally educate him/her because of a language barrier. Interview with LPN #5 on 1/13/25 at 2:54 PM identified that Resident #37's feeding tube had dislodged 2 - 3 times; the first time Resident #37's spouse was visiting and he/she called her into the room and she saw that the tube was out so Resident #37 was sent to the hospital for a replacement and the other time she went to administer Resident #37's medication, the tube was dislodged before she got there. LPN #5 indicated that she flushes the tube every 4 hours to prevent it from becoming clogged and she was unsure the last time Resident #37 had the abdominal binder on, but she would obtain one from the supply house and put it on. Interview with LPN #5 on 1/14/25 at 10:41 AM failed to identify that she had provided education to Resident #37's responsible party or the spouse on the importance of the abdominal binder to prevent the GJ-tube from dislodging. Interview with LPN #6 on 01/14/25 at 10:42 AM identified that Resident #37's spouse has removed the abdominal binder, in the past, but he/she does not speak English, and due to the language barrier she has provided visual education on what not to do while visiting Resident #37, but she has not had a conversation with the responsible party or the spouse and provided verbal education on the importance of the abdominal binder. Interview with the RN Supervisor (RN #4) on 1/14/25 at 10:43 AM identified that she did not know how the GJ tube had gotten dislodged, but that Resident #37's spouse is well-intentioned and provides a lot of care to the resident. RN #4 identified that she was the nursing supervisor on 11/4/24 and she had sent Resident #37 to the ED; his/her spouse had been visiting, prior to the tube's dislodgement. RN #4 indicated that she would expect Resident #37 to have the abdominal binder on, but the spouse has removed it in the past. RN #4 indicated that she has not educated Resident #37's resident representative or the spouse on the importance of the abdominal binder as an intervention to prevent dislodgment of the GJ tube. Subsequent to surveyor inquiry, RN #4 called Resident #37's responsible party at 10:47 AM and provided education on the importance of keeping the abdominal binder in place to prevent dislodgement of the G-tube and requested that the education be communicated to Resident #37's spouse. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/14/25 at 12:34 PM identified that it was her expectation that Resident #37's resident representative would have been educated on the reason for utilizing the abdominal binder and the importance of keeping it in place, and that it would also be explained to Resident #37's spouse. The DNS indicated that it would have been the responsibility of the charge nurse to reach out the resident representative, at the time of the initiation of the abdominal binder, to explain the intervention and ensure the spouse was also educated on the intervention. The DNS further indicated that the facility has a language line that can be utilized at any time to provide education to family members in a language that they understand. The facility's Enteral Feeding Safety Precautions policy directs the facility will remain current in and follow accepted best practices on enteral nutrition. Instruction will be provided to non-clinical staff, residents, and visitors not to reconnect any tubing or lines, but instead to notify a nurse if tubing becomes disconnected, regularly inspect tubing for proper and secure connections, document all assessments, finding and interventions in the medical record, and report unusual findings and/or signs of complications to the physician. The facility's Care Plan, Comprehensive Person-Centered policy directs that the Interdisciplinary Team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the residents are the end point of an interdisciplinary process.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37721 Based on observation, review of facility policy and interview, the facility failed to ensure meals were served at appetizing temperatures. The findings include: Interviews with 4 residents on 1/12/25 identified food temperatures were frequently cold. Interview with the FSD on 1/13/25 at 12:28 PM identified she residents were generally happy with the food, however, there were occasional complaints of cold food and ongoing efforts were made to ensure the timely delivery of hot food items. Interview with the Administrator on 1/13/25 at 2:13 PM identified it appeared food was not getting to the resident timely after it was delivered to the floor. Observation and a food temperature check on 1/14/25 at 12:16 PM of the main lunch meal and alternative choices with the FSD identified the following: Chicken sandwich 136.7 F. Hamburger 106.7 F. Porkchop 134.4 F. Hot Dog 120.9 F. Baked ham 118.8 F. Noodles 119.4 F. Cabbage 119.3 F. Grilled cheese 108.1 F. Grilled ham and cheese 110.6 F. Green beans 112.2 F. Interview with the FSD on 1/14/25 at 12:16 PM identified hot foods should be served at 140 F. Interview with the DNS on 1/15/25 at 6:41 AM identified she was aware of periodic resident complaints of hot food items being served cold. The DNS further identified she would expect food to be served at adequate temperatures. The Food Preparation and Service policy directed proper hot and cold temperatures are be maintained during food service. The 'danger zone' for holding temperatures is between 41 F and 135 F. This temperature range promotes rapid growth of pathogenic organisms that cause foodborne illness.

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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. 15802 Based on observation, review of facility documentation, facility policies, and interviews, the facility failed to ensure dietary staff monitored food temperatures prior to meal service. The findings include: Review of the Service Line Checklists dated 12/1/24 through 1/12/25 failed to identify food temperatures had been obtained on the steam table, prior to plating dinner service on the following dates: 12/2/24, 12/23/24, 12/25/24, 12/31/24, 1/1/25, 1/2/25, and one undated checklist. Observation and interview with [NAME] #1 on 1/14/25 at 11:15 AM, during lunch service plating, identified that once all the food is on the steam table and ready to be plated, he obtains a temperature reading on each item to ensure the food is at the correct temperature. Interview with the Dietary Manager on 1/14/25 at 11:20 AM identified that she was aware that the Service Line Checklists dated 12/2/24, 12/23/24, 12/25/24, 12/31/24, 1/1/25, 1/2/25, and one undated form, were not completed. The Dietary Manager indicated that when she identified the missing documentation for temperatures on the checklist, she intended to speak with the cook that was responsible for documenting the missing temperatures, but it had been a busy month, and she had not had the opportunity to follow up with the cook responsible for the missing entries. The Dietary Manager identified that she was very involved in what happens on the food service line and that she believes that the cook most likely obtained the food temperatures but did not write them down. The Dietary Manager further indicated that even though the temperature fields, on the identified days, were left blank, the cooks were expected to obtain temperatures on all food items, including the alternative menu items, to ensure food safety and quality, and she expects the cooks to document all food temperatures on the Service Line Checklist for each meal. Interview and review of facility documentation with the Administrator on 1/14/25 at 1:38 PM identified he was unaware that Service Line Checklists dated 12/2/24, 12/23/24, 12/25/24, 12/31/24, 1/1/25, 1/2/25, and one undated form, were not completed, and that it was his expectation that the cook obtains and documents food temperatures for every single meal. The facility's Food Preparation and Service policy directs food and nutrition employees prepare and serve food in a manner that complies with safe food handling practices. Proper hot and cold temperatures are maintained during food service. The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services. The facility's Preventing Foodborne Illness-Food Handling policy directs food to be stored, prepared, handled, and served so that the risk of foodborne illness is minimized. Potentially hazardous foods will be cooked to the appropriate internal temperatures and held at those temperatures for the appropriate length of time to destroy pathogenic microorganisms.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 37721 Based on review of facility documentation and interview, the facility failed to ensure the 4th quarter Payroll Based Journal (PBJ) report was submitted timely. The findings include: Review of the 4th Quarter (7/1/24 - 9/30/24) PBJ submission report dated 10/15/24 at 10:52 AM identified the PBJ submission failed because the quarter was unavailable for submission. Interview with the Director of Human Resources on 1/13/25 at 2:47 PM identified the PBJ submission was due by 10/14/24 at 11:59 PM, however was instead transmitted the next day on 10/15/24 at 10:47 AM. The Director of Human Resources identified the report was held at the direction of a corporate staff who was waiting for all PBJ reports from all sites to review before submission. As a result, the PBJ submission was not submitted timely. Although a policy for PBG submission was requested, none was provided. 46040

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 of 2 residents (Resident #50) reviewed for pressure ulcers, the facility failed to ensure staff performed handwashing according to infection control policy, and for 1 of 4 residents (Resident #5) reviewed during medication administration, the facility failed to maintain infection control standards, and the facility failed to ensure the IP conducted environmental infection control rounds. The findings include: 1. Resident #50 had diagnoses that included failure to thrive. The admission MDS dated [DATE] identified Resident #50 had intact cognition and was at risk for the development of a pressure ulcer. The care plan dated 12/14/24 identified Resident #50 acquired a new pressure injury to the left heal with interventions to elevate heals, provide treatments as ordered and turn and position every two hours. A physician's order dated 12/14/24 directed to apply skin prep to the boggy area of the left heel every shift. Observation on 1/14/25 at 10:17 AM, with the Infection Preventionist (RN #3) present, identified LPN #10 washed her hands, donned gloves and applied skin prep to Resident #50's left heel. Subsequently, LPN #10 removed her gloves and moved 2 cups of liquid closer to Resident #50 without the benefit of washing her hands. Interview with LPN #10 on 1/14/25 at 10:17 AM identified that prior to touching the 2 cups of liquid on the resident's bedside table she should have washed her hands. Interview with RN #3 on 1/14/25 at 10:17 AM identified LPN #10 should have washed her hands first before touching the cups of liquids. Interview with the DNS on 1/15/25 at 6:43 AM identified she would expect handwashing to be performed after removing gloves and between tasks. The policy for hand hygiene identified hand hygiene was to be performed before putting on and immediately after removing gloves including after contact with a resident's skin. 2. Resident #5 had diagnoses that included depression and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #5 had intact cognition. The care plan dated 11/30/24 identified a concern related to psychosocial wellbeing with interventions that included to administer medications as ordered and monitor for effectiveness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/1/25 directed to administer Ativan 0.5mg (antianxiety medication) twice daily at 9:00 AM and 9:00 PM. Observation on 1/12/25 at 10:00 AM during medication administration identified LPN #2 touched the top and front surfaces of the medication cart, opened and closed the drawers, opened the medication cart and locked narcotic box with the medication cart keys and documented in the controlled drug binder using a pen with her right hand. LPN #10 removed one Ativan 0.5mg tablet from the blister pack by punching the medication from the foil backing using her right thumb directly into her right hand and then placed the medication in a medication cup using her thumb and first finger. LPN #10 took a second blister pack from the medication cart and began to punch the tablet from the back of the blister pack directly into the same medication cup before the task was interrupted by the surveyor. Interview with LPN #10 on 1/12/25 at 10:00 AM identified she usually pops the medication from the blister pack directly into the medication cup without touching the medication and did not on this occasion as an oversight. Interview with the DNS on 1/13/25 at 7:51 AM identified for safe infection control practices, she would expect nursing staff to be punching medication from a blister pack directly into the medication cup. A review of the facility policy for Medication Administration directs packaged medication tablets be dispensed directly into the medication cup. 42117 3. Review of environmental infection control rounds dated 11/2023 to 12/2024 identified the the rounds were not completed monthly in 12/2023, 1/2024, 3/2024, 5/2024, 6/2024, 7/2024, 8/2024. Interview with RN #3 on 1/13/25 at 11:55 AM indicated that he was responsible for doing the environmental infection control rounds monthly. RN #3 indicated that when he does the monthly infection control environmental rounds, he had the Administrator and Director of Maintenance with him. RN #3 indicated he took over in September 2024 and indicated that he could not provide the 12/2023, 1/2024, 3/2024, 5/2024, 6/2024, 7/2024, or 8/2024 environmental infection control rounds. An Environmental Survey Form identified the following areas are inspected; nursing units hallways, resident rooms, medication room, nourishment room, refrigerators, ice machines, resident lounge area, medication carts, treatments carts, resident bathrooms, shower areas, storage areas, storage and amounts of PPE equipment, recreation room for cleanliness, recreation of residents on isolation precautions, plant areas, pet areas, handwashing before and after programs, furniture is clean and in good repair, Rehabilitation gym look at walls, ceilings, floors, gym equipment, and observe disinfection of equipment between residents, handwashing in the rehab gym, dietary kitchen preparing of foods, kitchen refrigerators and freezers, cleaning and storage of dishes, Laundry services handling of dirty and clean linen. Each page of the form is dated the day of inspection, where was inspected, and by whom.

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	075222	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Cheshire	745 Highland Avenue Cheshire, CT 06410

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interview for 2 of 5 residents (Resident #44 and 61) reviewed for influenza and pneumococcal vaccination, the facility failed to offer the influenza and pneumococcal immunizations, provide education regarding the benefits and potential side effects of the immunizations or document in the clinical record that the resident either received the immunizations or declined. The findings include: 1. Resident #44 was admitted to the facility on [DATE] with diagnoses that included pneumonia, stroke, and a feeding tube. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition, did not receive the influenza vaccine in the facility for this year's influenza season and had not received the pneumococcal vaccine. Review of the physician's progress and nurses' notes dated 9/30/24 to 1/14/25 failed to reflect that staff offered the influenza immunization, provided education regarding the benefits and potential side effects of immunizations or that the resident either received the influenza immunization or did not. Review of the Preventative Health Report in the residents EMR, (vaccination record) on 1/14/25 failed to reflect the resident received the influenza vaccine in 2024 or that the resident had recieved a pneumoccal vaccine. Interview with the Infection Preventionist (RN #3) on 1/14/25 at 8:53 AM indicated that he was responsible to make sure all residents were up to date with their vaccinations and to ensure the charge nurses complete vaccination paperwork on admission. RN #3 indicated that all resident's and/or resident's representatives are offered the influenza vaccine and are educated on the day of admission or within 7 working days, and during each influenza season. RN #3 identified the clinical record did not reflect documentation to identify vaccine status had been discussed with the resident or representative on admission, the influenza vaccine form was blank and there was no signed consent for the resident to receive an influenza vaccine. RN #3 indicated he did not reach out to the resident's representative regarding the influenza vaccine. 2. Resident #61 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute respiratory failure, and insulin dependent diabetes. The admission MDS dated [DATE] identified Resident #61 had moderately impaired cognition and was not in the facility during influenza season. Review of the physician's progress and nurses' notes dated 9/30/24 to 1/14/25 failed to reflect that staff offered the influenza or pneumococcal immunizations, provided education regarding the benefits and potential side effects of the immunizations or that the resident either received the influenza and pneumococcal immunizations or did not. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Preventative Health Report in the residents EMR, (vaccination record) on 1/14/25 failed to reflect the resident received the influenza vaccine in 2024 or that the resident had recieved a pneumoccal vaccine. Interview and review of the clinical record with RN #3 on 1/14/25 at 9:42 AM identified that the influenza and pneumococcal vaccine forms were blank in the chart and were not addressed on admission. RN #3 identified that he is responsible to ensure that vaccinations are administered according to facility policy. Interview with the DNS on 1/14/25 at 2:00 PM indicated that RN #3 is responsible to make sure all residents are offered the influenza and pneumococcal vaccines on admission. Review of the Influenza Vaccine Policy identified all residents will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents, unless vaccine is medically contraindicated, or the resident has already been vaccinated that season. Residents admitted between October 1st and March 31st shall be offered the vaccine within 5 working days of resident's admission to the facility. Prior to the vaccination, the resident or resident's representative will be educated regarding the benefits and potential side effects of the influenza vaccine. Provision of education shall be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented on the informed consent form and placed in the resident's medical record. The infection preventionist will maintain surveillance data on influenzas vaccine coverage and reported rates of influenza among resident's and staff. Review of the Pneumococcal Vaccine Policy identified prior to or upon admission, residents are assessed for eligibility to receive pneumococcal vaccine series and are offered the vaccine series. Assessments of pneumococcal vaccination stats are conducted within 5 working days of the resident's admission. Before receiving a pneumococcal vaccine, the resident or resident representative receives information and education regarding benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. Resident representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date and time of the pneumococcal refusal of the pneumococcal vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #44 and 61) reviewed for Covid - 19 vaccination, the facility failed to ensure residents were offered Covid - 19 immunization, and those immunizations were tracked. The findings include: 1. Resident #44 was admitted to the facility on [DATE] with diagnoses that included pneumonia, stroke, and a feeding tube. The admission MDS dated [DATE] identified Resident #44 had severely impaired cognition. Additionally, Resident #44's Covid - 19 vaccine was not up to date. The Preventative Health Report identified Resident #44' Covid - 19 vaccine was last given on 1/15/23. Interview with RN #3 (Infection Preventionist) on 1/14/25 at 8:53 AM indicated that he was responsible to make sure all residents were up to date with their vaccinations. RN #3 indicated that all resident's or the resident's representatives are educated and offered the Covid - 19 vaccine or Covid - 19 booster on day of admission or within 7 working days. After clinical record review, RN #3 indicated that the Covid - 19 vaccine form indicated that Resident #44 could receive a booster dose but her did not reach out to the resident's representative to educate and offer the vaccine. 2. Resident #61 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, acute respiratory failure, and insulin dependent diabetes. The admission MDS dated [DATE] identified Resident #61 had moderately impaired cognition. Additionally, identified Resident #61's Covid - 19 vaccination status was not address. The Preventative Health Report did not identify Resident #61's Covid - 19 immunization status. Interview and clinical record review with RN #3 on 1/14/25 at 9:42 AM identified that the Covid - 19 vaccine form was blank in the chart and was not addressed on admission. RN #3 indicated that he was responsible to follow up but did no and it was not done. Interview with the DNS on 1/14/25 at 2:00 PM indicated that RN #3 as the infection control nurse was responsible to make sure all residents were offered the Covid - 19 vaccine or boosters on admission and when next doses were due. Interview with LPN #11 (Regional Clinical Nurse) on 1/14/25 at 10:03 AM indicated that RN #3 is the facilities infection preventionist and was responsible to offer Covid - 19 vaccination to new admissions and any resident that is do for their boosters and to keep track of the residents Covid - 19 vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Covid - 19 Vaccination Policy identified evidence supports that the best way to prevent the spread of Covid - 19 across all communities is vaccination with the primary series, regardless of previously being infected with Covid - 19. All residents and employees will be offered the Covid - 19 vaccination to encourage and promote the benefits associated with vaccination against Covid - 19. The facility will provide pertinent information about the significant risks and benefits of vaccines to staff and residents or resident's representatives and will be documented in the employees file and residents' medical record. Employee will be offered the Covid - 19 vaccination at no charge on site. Both staff and residents will be asked to sign a consent prior to administration. Provision of such education shall be documented in the residents/employee's medical record as well as the consent to be vaccinated. Residents and staff have the right to decline the vaccination, and it will be documented on the declination form and included in the employee/resident's medical record as well as the education provided. The infection preventionist will maintain surveillance data on all Covid - 19 vaccinations among all residents and staff. Surveillance data will be shared with staff as part of educational efforts to improve vaccination rates among staff. Residents and staff may obtain the Covid - 19 vaccines from their personal physicians, but documentation of vaccination should be provided to the facility.