STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075237	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall-South	1 Emerson Drive Windsor, CT 06095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident # 68) reviewed for activities of daily living (ADLs), the facility failed to ensure that the resident's choices related to care were honored. The findings include: Resident # 68 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, neuralgia, and neurogenic bowel. The quarterly MDS dated [DATE] identified Resident # 68 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing and transfers. A physician's order dated 4/26/24 directed to Resident #68 was to be assisted back to bed by 8 PM each day per resident request. Review of the record identified the order was originally entered into the electronic record by RN #3. The care plan dated 5/3/24 identified it was important to Resident #68 to have the opportunity to engage in daily routines relative to preferences. Interventions included Resident #68 choosing his/her own bedtime. (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #68 on 11/17/24 at 9:45 AM identified he/she had several issues with NA #1 who worked during the 3-11 PM shift, providing care. Resident #68 identified that NA #1 was very talkative and demanding when providing care, and many times did not answer his/her call light timely when NA #1 was assigned to him/her. Resident #68 also identified that NA #1 would often leave the unit multiple times a shift which the facility was aware of, and that Resident #68 had a physician's order to be assisted to bed by 8 PM, but due to the issues with NA #1 leaving the unit or not being available, he/she often had to wait, often until 10 PM. Resident #68 identified due to all of these issues; he/she had refused to allow NA #1 to care for him/her multiple times. Resident #68 identified that despite his/her refusals to allow NA #1 to provide care, several facility staff had spoken with him/her and asked him/her to allow NA #1 to assist with his/her car due to multiple reasons, including staffing assignments in the facility being based on seniority and Resident #68's care requirements that included 2 staff members to assist with transfers. Resident #68 identified he/she eventually allowed NA #1 to provide care with transfers, however Resident #68 identified he/she really did not want NA #1 involved in any of his/her care. Resident #68 identified he/she had told multiple people over the last year of his/her request to not have NA #1 provide care but could not remember all of the staff he/she discussed the matter with. Resident #68 denied any issues related to abuse but reiterated that he/she did not want NA #1 providing care for him/her due to their personalities not meshing. Review of NA #1's personal file failed to identify any documentation related to Resident #68's reporting of issues related to care or interactions with NA #1. Review of the resident grievance records for 2023 and 2024 failed to identify any grievances filed on behalf of Resident #68 related to NA #1. Interview with RN #3 on 11/19/24 at 9:45 AM identified that she was not aware of any issues related to Resident #68 requesting that NA #1 not be assigned to provide care. RN #3 identified that she was aware of issues related to staff complaining about NA #1 but that she had not received any complaints from Resident #68 related to NA #1. RN #3 failed to provide any specific issues related to NA #1 and care, but identified she was aware of some issues related to staff complaints regarding NA #1. RN #3 identified that she did enter the order related to Resident #68 being assisted to bed by 8 PM, but identified she did not remember why the order was placed. Interview with LPN #1 on 11/19/24 at 10:45 AM identified that Resident #68 had requested to be assisted to bed and had complained to her regarding the issue, and that she reported this to RN #3 who then placed the order for the physician to sign in April 2024. LPN #1 identified Resident #68 had notified her that he/she did not care for NA #1 and had personality conflicts with her, and had issues with being assisted to bed timely. LPN #1 identified that while she was aware that Resident #68 did not want NA #1 to provide care, she was not aware what the facility had done to address the situation other than putting the order in place. LPN #1 identified that everyone knows he/she doesn't like NA #1 and that LPN #3 and LPN #4 were the primary nurses on the 3-11 PM shift and would know more regarding the situation. LPN #1 also identified that LPN #3 had been trying to work on issues with NA #1 related to remaining on the unit and work assignments, but had not been successful. LPN #1 failed to elaborate any further on what the issues were. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 on 11/19/24 at 11:29 AM identified that Resident #68 had issues in the past with NA #1, but was okay with NA #1 working with him/her, as long as NA #1 was not in Resident #68's room by herself. LPN #4 identified that Resident #68 expected to be assisted to bed right away, but due to the need for a hoyer lift and 2 staff to transfer, at times Resident #68 had to wait until staff were available. LPN #4 identified that Resident #68 did not like NA #1 personally, and that was the issue with care. LPN #4 also identified that NA #1 was routinely assigned as Resident #68's primary nurse aide, but the staff on the unit worked as a team. When asked why, if Resident #68 had continually voiced that he/she did not want NA #1 to provide care or be assigned to him/her, was NA #1 still being assigned to the resident, LPN #4 reiterated that the staff on the unit worked as a team so even if NA #1 was assigned to Resident #68, it would not always be her addressing his care needs. LPN #4 identified that when Resident #68 initially requested for NA #1 not to be assigned or to provide care to him/her, multiple staff spoke with Resident #68 and identified that NA #1 would at least need to assist with transfers. LPN #4 identified that Resident #68 then allowed this. LPN #4 identified his understanding was as long as NA #1 did not go into Resident #68's room alone there was no issue with her providing care with another staff member. When asked who this information was reported to, LPN #4 identified it was common knowledge for all the staff, including RN #3, the Administrator who Resident #68 spoke with regularly, and the DNS. LPN #4 identified he had recently been out of work from 7/24-11/24, and the issue had been going on prior to his leave but was unable to identify how long Resident #68 had voiced issues with NA #1. Interview with the DNS on 11/19/24 at 11:40 AM identified she was aware with issues related to NA #1 remaining on task, leaving the unit multiple times during the shift, and not assisting other facility staff on the unit when needed. The DNS identified that she had spoken with NA #1 but did not place any documentation in NA #1's personnel file. The DNS identified she was not aware of any issues with Resident #68 reporting he/she did not want NA #1 assigned to him/her or to provide care and that she was only hearing of this at the time of this interview. The DNS identified that there were no issues with seniority at the facility that would prevent NA #1 from being reassigned to another unit, and that Resident #68 was cognitively intact and had the choice to decide who he/she wanted to provide care, unless there was an emergency that could potentially cause Resident #68 harm. The DNS identified that she was unsure why staff had not reported this information to her previously, and that she would address the matter right away. Interview with the Administrator on 11/19/24 at 12:00 PM identified he was not aware of any issues related to Resident #68 and NA #1, and Resident #68 had not requested or spoken with him regarding NA #1 not providing care. Subsequent to surveyor inquiry, the DNS notified Resident #68 and this surveyor on 11/19/24 at 12:20 PM that NA #1 would no longer be working on Resident #68's unit, would no longer be assigned to Resident #68, and that this change would be permanent. Although attempted, an interview with LPN #3 was not obtained. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on resident rights directed that residents of the facility had the right to be treated with respect and dignity, including the right to receive services of the facility with reasonable accommodation of the resident's needs and preferences. The policy further directed that residents of the facility had the right to, and the facility must promote and facilitate, the resident's right to self determination through support of the resident's choices, including the right to choose health care and providers of health care services, and that the resident had the right to make choices about the aspects of his/her life in the facility that were significant to the resident.

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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 policy, and interviews for 2 of 2 residents (Resident #66 and 70) reviewed for Advance Directives, the facility failed to review code status, with the resident and resident's representative according to facility policy. The findings include: 1. Resident #66 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, and stage 2 chronic kidney disease. The care plan dated [DATE], (revised [DATE], [DATE], [DATE], and [DATE]), identified Resident #66 had an established advance directive CPR (Cardiopulmonary resuscitation). Interventions included activating resident's advance directive, as indicated, providing resident/health care decision maker with sufficient information to make an informed decision, and reviewing contents and providing opportunity to update and/or make changes to Advance Directive with resident and/or healthcare decision maker quarterly and as needed. The admission MDS dated [DATE] identified Resident #66 was admitted from a short-term general hospital and had moderately impaired cognition. A physician's order dated [DATE] directed Full Code (a medical directive that instructs a patient's health care team to perform lifesaving procedures in the event of a medical emergency, such as cardiac or respiratory arrest). The Decree/Appointment of Conservator/Voluntary Representation document dated [DATE] identified Person #1 as Resident #66's conservator of the person and estate. The document directs that the conservator of the person shall have the authority over the Petitioner's personal needs in the following areas: personal care, comfort, safety and maintenance, medial or other professional care, subject to C.G.S section 45a-656(d), residence, subject to C.G.S section 45a-656b, and personal effects. The undated and unsigned Resident/Patient Health Care Instructions document identified an X for the following goals: No, do not attempt CPR; allow death to occur naturally (DNR). Transfer to hospital for any condition requiring hospital-level care. All medical tests acceptable (treatment planned for diagnosed condition). Two sticky notes attached to the Resident/Patient Health Care Instructions document dated [DATE] identified, refused to continue and will not sign-multiple excuses and dated [DATE] identified, reapproached and still refuses. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service (SS) note dated [DATE] at 12:13 PM identified social services called and also emailed patient's COP/E in order to sign off on patient's code status wishes. Awaiting a response so the code status to be returned. No issues noted at this time, SS will remain involved as needed. During an interview with the DNS and SW #2 on [DATE] at 2:00 PM, SW #2 identified that earlier in the day, she had left a voicemail and sent email to Person #1 to discuss Resident #66's advance directive choices. Subsequent to surveyor inquiry a Resident/Patient Health Care Instructions document, signed by Resident #66 but not dated, identified Resident #66's initials for the following goals: No, do not attempt CPR; allow death to occur naturally (DNR). Transfer to hospital for any condition requiring hospital-level care. Limited (noninvasive, low risk) medical tests only. Antibiotics acceptable. No artificial ventilation. No artificially administered fluids and nutrition. Other life sustaining treatments acceptable if recommended for an acute episode, but not indefinitely. The social service note dated [DATE] at 11:31 AM identified code status updated from the COP/E to reflect patient's new wishes for his/her code status. Orders and care plan updated. Interview and clinical record review with SW #2 on [DATE] at 7:51 AM identified that she had heard back from Person #1 and now Resident #66 was a DNR, per his/her wishes. SW #2 indicated that she was not sure why there was a gap in completing Resident #66's Resident/Patient Health Care Instructions document, but that she had challenges getting in contact with Person #1, and Person #1 had not attended the quarterly care conferences. SW #2 further indicated that it was not brought to her attention that Resident #66 had indicated that she wanted to be a DNR on admission, and that his/her Resident/Patient Health Care Instructions document had not been signed. SW #2 identified that upon Resident #66's admission, he/she was responsible for self, and ideally the advance directive documentation should be signed at the time of admission. SW #2 identified that she would have to obtain additional information to confirm who would be responsible for reapproaching a resident that initially refused to sign the Resident/Patient Health Care Instructions document. SW #2 identified that she would have assisted with getting the form signed if she was aware that Resident #66 had indicated that he/she would like to be a DNR. Upon clinical record review, it was identified that Resident #66's quarterly Care Conferences had not been completed from [DATE] through [DATE], but SW #2 indicated that she had discussed code status with Resident #66 during other meetings, prior to being conserved. SW #2 further indicated that code status was also discussed during Resident #66's [DATE], [DATE], and [DATE] quarterly care conferences; review of the [DATE], [DATE], and [DATE] attendance signature sheets identified Resident #66 did not attend the [DATE] or [DATE] conferences but attended the [DATE] conference. (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 Person #1 on [DATE] at 9:15 AM identified that while she believes she did discuss life support choices and advance directives with Resident #66 and the facility, she could not recall the outcome of the conversations, and she did not have documentation of those conversations. Person #1 indicated that she could not remember when it was brought to her attention that Resident #66's wishes were to be a DNR, but on [DATE] she signed Resident #66's advance directive documentation. Interview with the DNS and the Director of Clinical Operations on [DATE] at 10:51 AM identified that the expectation is that advance directive education would be reviewed with the resident and/or resident representative and documentation would be completed within the first 24 hours. The DNS further identified that advance directives would also be reviewed or updated, at the request of the resident and/or resident representative and during the resident's quarterly care conference. The Director of Clinical Operations identified that in this case where Resident #66 had refused to sign the documentation of his/her wishes, he would expect that a conversation would have occurred in order to understand the reasons for refusals; and that upon conservatorship he would have expected advance directive documents to have been reviewed and signed. The facility's Residents' Rights Regarding Treatment and Advance Directives policy directs the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The policy further directs the facility to provide the resident or resident representative information, in a manner that is easy to understand about the right to refuse medical or surgical treatment and formulate an advance directive, the facility will periodically assess the resident for decision making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities, the facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions, the facility will define and clarify medical issues and present them to the resident or legal representative as appropriate, during the care planning process the facility will identify, clarify and review with the resident or legal representative whether they desire to make any changes related to any advanced directives. 2. Resident #70 was admitted to the facility on [DATE] with diagnoses that included stroke, hemiplegia, and aphasia. Review the clinical record identified a signed advance directive form dated [DATE] for Resident #70 which directed do not resuscitate, do not intubate, and RN to pronounce in the event of death (DNR/DNI/RNP). The name and signature on the advance directive form did not belong to Resident #70, and further review of the clinical record failed to identify any resident representative or emergency contact with the name and signature identified on the form. A physician's order dated [DATE] directed Resident #70 had advance directives that included DNR/DNI/RNP. The annual MDS dated [DATE] identified Resident #70 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff assistance with dressing, toileting, and bathing. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated [DATE] identified Resident #70 has established advance directives that included DNR/DNI/RNP. Interventions included to review the contents and provide the opportunity to update and/or make changes to the advance directives with the resident or healthcare decision maker quarterly and as needed. Review of the clinical record failed to identify that the facility had reviewed advance directives with any of Resident #70's listed resident representatives since admission. Interview with RN #3 (unit manager) on [DATE] at 6:45 AM identified that the signature on Resident #70's advance directive form from [DATE] was a family member of the resident. RN #3 identified Resident #70 had other court appointed resident representatives and she was unable to locate any additional documentation to identify that Resident #70's advance directives with any additional resident representatives since admission to the facility. Interview with Social Worker #1 on [DATE] at 3:10 PM identified that after surveyor inquiry regarding with RN #3, she attempted to contact Resident #70's resident representatives to review the advance directives in place to determine if any changes needed to be made. Social Worker #1 identified she was not aware that the signed advance directives on file from Resident #70's admission had not been reviewed with any resident representative on record. The facility policy on advance directives directed that during the care planning process, the facility would clarify and review, with the resident or legal representative, whether they desire to make any changes to the advance directives. The policy further directed that decisions regarding advance directives and treatment would periodically be reviewed as periodically review as part of the comprehensive care planning process.

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #8 and 66) reviewed for non-pressure skin condition, the facility failed to notify the provider or resident representative of a change in condition and allegation of abuse. The findings include: 1. Resident #8 was admitted to the facility in January 2023 with diagnoses that included dementia and end stage renal disease requiring dialysis. The nursing admission assessment dated [DATE] identified a healed abrasion to the mid forehead. The physician's admission history and physician dated 1/24/23 did not reflect an area to the forehead. The quarterly MDS dated [DATE] identified Resident #8 had severely impaired cognition. a. Review of the provider notes and nurse's notes dated 1/1/24 to 5/12/24 did not reflect the area to the to the resident's forehead. Review of the skin weekly skin checks performed by a licensed nurse dated 4/3/24 to 5/8/24 did not reflect any new or current skin injury or wounds. A physician's order dated 4/18/24 directed to obtain a wound consult and treatment as indicated and weekly showers with skin checks on Wednesdays 3:00 PM to 11:00 PM shift. The nurse's note written by LPN #7 dated 5/13/24 at 5:32 AM identified that Resident #8 picked the scab on the mid forehead, and she cleansed it with normal saline and left open to air. Review of the nurse's notes dated 5/13/24 to 7/1/24 failed to reflect an RN assessment of the area on the resident's mid forehead had been done, or that the APRN/MD and resident representative were made aware of the area on the resident's mid forehead. Interview with the second floor Unit Manager (RN #3) on 11/19/24 at 7:30 AM indicated that when a resident has a change in condition there would be an RN assessment and the resident representative and APRN or physician would be notified. After review of the clinical record, RN #3 indicated that she did not see any documentation that on 5/13/24 there was an RN assessment of the scab that had been picked on the mid forehead nor that the APRN or physician and resident representative were notified. Interview with RN #3 on 11/19/24 at 8:47 AM indicated that on the admission assessment dated [DATE] there was a healed abrasion to the mid forehead and not until 5/13/24 there was an LPN who noted Resident #8 had picked the scab to the forehead causing it to bleed. RN #3 indicated that her expectation was that Resident #8 would have had an RN assessment, and the nurse would have notified the resident representative and the APRN or physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of the weekly skin checks performed by a licensed nurse dated 10/2/24 to 11/11/24 did not identify any new or current skin injury or wounds. Review of the nursing notes and the APRN/MD notes dated 10/2/24 to 11/17/24 did not identify an open or scabbed are noted to Resident #8's forehead. A physician's order dated 10/13/24 directed to give a weekly bed bath due to dialysis permacath with skin checks on Wednesdays 3:00 PM to 11:00 PM shift. Observation on 11/17/24 at 9:06 AM noted a scabbed area approximately nickel size with some fresh dry blood and some hard dried blood noted on the resident's mid forehead. Resident #8 was not able to indicate what had happened. Interview with LPN #6 on 11/17/24 at 11:07 AM observed Resident #8 had an area to the forehead and indicated that she had not seen that prior and did not receive anything regarding this area to the mid forehead during the change of shift-to-shift report. After clinical record review, LPN #6 indicated that the area on the mid forehead must be new because she could not find anything in the documentation under a change of condition assessment or in a progress note. LPN #6 indicated that her expectation was there would be a documented RN assessment and the APRN and resident representative would be notified. Review of the nurse's notes dated 11/17/24 to 11/19/24 did not identify there was an RN assessment or that the APRN/MD and resident representative were updated. Interview with DNS and Director of Clinical Operations (RN #5) on 11/19/24 at 10:05 AM indicated staff are aware that the area on Resident #8's forehead opens and closes but only had seen a nurses note dated 5/13/24 written by an LPN and there was not documentation that the resident representative and the APRN or physician were notified. Additionally, RN #5 indicated that on 11/17/24 when surveyor and LPN #6 observed the bleeding and partially scabbed area to Resident #8's forehead there was not an RN assessment and the resident representative and APRN or physician were not notified. RN #5 and the DNS indicated that the expectation was when there is any change of condition that the LPN notifies the RN, the RN does an assessment and documents the assessment and notifies the resident representative and provider. RN #5 indicated that he would have an RN do an assessment and notify the resident representative and APRN. Interview with second floor Unit Manager (RN #3) on 11/19/24 at 10:59 AM indicated she was responsible to do weekly wound measurements and documentation of pressure and non-pressure areas. RN #3 indicated that there was no documentation for the 5/13/24 and the 11/17/24 skin areas or that the APRN or physician and resident representative were notified. RN #3 indicated that she will do an RN assessment today and document it and notify the resident representative and the APRN today. Review of the Skin Assessment Policy identified it was the policy to perform a full body skin assessment as art of the systemic approach to pressure injury prevention and management. A full body head to toe skin assessment will be conducted by a licensed or registered nurse upon admission or readmission and weekly thereafter and if there is a change in condition. Documentation of skin assessment includes the date, time, nurses name and title. The documentation will include the observation, type of wound, measurements, color, wound bed, drainage, odor, and if there was pain noted. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Integrity for Skin Tears Policy identified it was the policy to provide proper treatment and care to maintain skin integrity. The facility will utilize a systemic approach for the prevention and management of skin tears, including assessment, care planning, monitoring, and modification of interventions as appropriate. The licensed nurse will conduct skin assessments according to facility policy. When a skin tear is discovered, the nurse will complete an accident and incident report. The following information shall be documented: the residents name, the employee who discovered the skin tear, the site and description of the skin tear, the date and time the skin tear was discovered, the name of the employee who provided care to the resident 24 hours previously, site care rendered and evaluation of the incident, the names of any witnesses, the date and time the physician and resident representative were notified , and any other information relevant to the incident. The attending physician will assume responsibility for the overall care and treatment of the resident's medical condition. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any skin tears, assessments of residents, and reporting any changes in condition to the physician. Interventions will be modified in the resident's plan of care as needed. Considerations for needed modifications include changes in medical condition or factors affecting the risk for skin tears, new onset or recurrent skin tears, lack of progression towards healing, resident is non-compliance, and changes in the resident's goals and preferences. 2. Resident #66 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, and stage 2 chronic kidney disease. The annual MDS dated [DATE] identified Resident #66 had intact cognition, was frequently incontinent of bowel and bladder, was dependent for rolling left to right and chair/bed-to-chair transfers and required a maximal assist with bathing and toileting hygiene. The care plan dated 11/8/24 identified Resident #66 exhibits verbal behaviors related to, accusatory statements, at times. Interventions included to evaluate the nature and circumstances of the verbal behavior with the resident and/or resident representative and to provide social service visits to provide support, as needed. During an interview with Resident #66 and SW #2 on 11/18/24 at 9:05 AM, Resident #66 identified that about 2 weeks ago, a nurse aide came into his/her room and woke him/her up by grabbing the top of his/her shirt. Resident #66 identified that when he/she asked the nurse aide what she was doing, the nurse aide indicated that she was there to wash him/her up. Resident #66 indicated that when the nurse aide was washing the upper part of his/her body he/she said something to the nurse aide but could not recall what was said, and the nurse aide told him/her to be quiet, shoved a washcloth in his/her mouth, and laughed. Resident #66 could not specifically recall the nurse aide's name but was able to provide a physical description; Resident #66 denied reporting this incident to any facility staff members prior to this interview. Review of the 11/18/24 through 11/19/24 nurse's notes failed to identify Resident #66's Conservator was notified of the abuse allegation. Review of the 11/18/24 through 11/19/24 social service notes failed to identify Resident #66's Conservator was notified of the abuse allegation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #66's Conservator (Person #1) on 11/19/24 at 9:15 AM identified that she had not been notified of Resident #66's allegation that a nurse aide put a washcloth in his/her mouth. Person #1 further identified that she had not received an email or a voicemail regarding the allegation and her voicemail box was not full. Interview with SW #2 on 11/19/24 at 9:53 AM identified that she did not notify Person #1 of Resident #66's allegation, but that she would inquire if the DNS or Nursing Supervisor made the notification to the responsible party. Interview and clinical record review with the DNS on 11/19/24 at 10:56 AM indicated that the Nursing Supervisor (RN #3) had notified Person #1 of Resident #66's allegation on 11/18/24, but review of the progress notes dated 11/18/24 through 11/19/24 failed to identify documentation that Person #1 was notified. The DNS indicated that following an allegation of abuse, she would expect the responsible party to be notified and documentation of the notification to be in the clinical record. Interview with RN #3 on 11/19/24 at 11:16 AM identified that she left a message in Person #1's confidential mailbox on 11/18/24 at around 3:00 PM. RN #3 indicated that she did not document the responsible party notification in Resident #66's clinical record, most likely because somebody called her away to go do something else. RN #3 indicated that she should have documented, in the progress notes, that she attempted to contact Person #1 and left a voicemail, and it is her usual practice to document such notifications in the progress notes. The facility's Notification of Changes policy directs the facility to promptly inform the resident, consult's the resident's physician, and notifies, consistent with his or her authority, the resident representative when there is change requiring notification. Circumstances requiring notification include: accidents, significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status, circumstances that require a need to alter treatment, a transfer or discharge from the facility, a change in room or roommate assignment, and a change in resident rights. 47457

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **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 6 of 6 residents (Resident #6, 66, 68, 73, 80, and 101), who had been transferred to the hospital, the facility failed to notify the Office of the State Long-Term Care Ombudsman of the hospital transfers. The findings include: 1. Resident #6 was admitted to the facility in [DATE] with diagnoses that included diabetes, end stage renal disease, and dependence on renal dialysis. Review of the census form identified Resident #6 was transferred to the hospital on [DATE]. An SBAR summary dated [DATE] at 8:18 PM identified Resident #6 was readmitted to the facility that evening with diagnoses of acute encephalopathy, returned to baseline mental status. Review of the action summary report for the month of [DATE] failed to reflect the Office of the State Long-Term Care Ombudsman had been notified of Resident #6's hospitalization on [DATE]. 2. Resident #66 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, and stage 2 chronic kidney disease. The census form identified Resident #66 began a hospital leave on [DATE] and returned to the facility on [DATE]. The Action Summary Report dated [DATE] failed to identify the Office of the State Long-Term Care Ombudsman had been notified of Resident #66's hospitalization on [DATE]. 3. Resident #68 was admitted to the facility on [DATE] with diagnoses that included neuralgia, and neurogenic bowel. Review of the clinical record identified Resident #68 was hospitalized from [DATE] - [DATE]. Review of the action summary reports for ,d+[DATE] and ,d+[DATE] failed to identify any notification to the state LTC Ombudsman related to Resident #68's transfer to the hospital on [DATE]. 4. Resident #73 was admitted to the facility in [DATE] with diagnoses that included congestive heart failure, end stage renal disease, and dependence on renal dialysis. Review of the census form identified Resident #73 was transferred to the hospital on [DATE], and [DATE]. A nurse's note dated [DATE] at 5:58 AM identified Resident #73 was readmitted to the facility. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	A nurse's note dated [DATE] at 9:29 PM identified Resident #73 was scheduled to be discharged home. Resident #73 insisted on going back to the hospital for further evaluation and treatment. Resident #73 called 911 and was transferred to the hospital. Review of the action summary report for the month of [DATE] failed to reflect the Office of the State Long-Term Care Ombudsman had been notified of Resident #73's hospitalization on [DATE] and [DATE]. 5a. Resident #80 was admitted to the facility in [DATE] with diagnoses that included pneumonia moderate protein-calorie malnutrition, and atrial fibrillation. Hospital Transfer Form dated [DATE] at 6:58 PM identified Resident #80 was being transferred to the hospital for being short of breath. The nursing readmission form dated [DATE] at 5:00 PM identified Resident #80 was readmitted to the facility from the hospital. Review of the action summary report for the month of [DATE] failed to reflect the Office of the State Long-Term Care Ombudsman had been notified of Resident #80s hospitalization on [DATE]. b. Hospital Transfer Form dated [DATE] at 2:16 PM identified Resident #80 was at a physician appointment and had an abnormal EKG and was transferred to the hospital. Review of the census form identified Resident #80 was transferred to the hospital on [DATE]. The social services note dated [DATE] identified Resident #80 was readmitted to the facility on [DATE] from the hospital. Review of the action summary report for the month of [DATE] failed to reflect the Office of the State Long-Term Care Ombudsman had been notified of Resident #80s hospitalization on [DATE]. 6. Resident #101 was admitted to the facility in [DATE] with diagnoses that included diabetes, chronic kidney disease stage 5, dependence on renal dialysis. Review of the census form identified Resident #101 was transferred to the hospital on [DATE]. Review of the skilled nursing to hospital transfer form dated [DATE] at 4:28 PM identified Resident #101 was transferred to the hospital. Review of the action summary report for the month of [DATE] failed to reflect the Office of the State Long-Term Care Ombudsman had been notified of Resident #101's hospitalization on [DATE]. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with SW #1 on [DATE] at 12:43 PM indicated that she was responsible to update the ombudsman every month within the first 2 weeks for the month prior for any residents that left the facility AMA (against medical advice), discharged home, left facility after a respite stay, or had expired at facility. SW #1 indicated that she does not update the ombudsman regarding residents that go to the hospital. SW #1 indicated that she generates a computerized list of residents to fax to the ombudsman. SW #1 indicated she does not recall who informed her that she does not have to report the hospitalization s to the ombudsman. SW #1 indicated that she would ask the Administrator for the policy. Interview with the DNS on [DATE] at 1:23 PM identified she was not aware that the resident transfers to the hospital were not being sent to the Office of the State Long-Term Care Ombudsman. The DNS indicated that the social service department will add the resident transfers to the hospital to the State Long-Term Care Ombudsman monthly list. Review of the facility transfer and discharge (including against medical advice (AMA) policy identified the policy of the facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances. Transfer - refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. The facility's transfer/discharge notice will be provided to the residents and the residents' representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. The facility will maintain evidence that the notice was sent to the Ombudsman. 42117 46040 47457

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #66) reviewed for Advance Directive, the facility failed to ensure resident care conferences (RCC) were completed quarterly. The findings include: Resident #66 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, and stage 2 chronic kidney disease. The admission MDS dated [DATE] identified Resident #66 was admitted from a short-term general hospital and had moderately impaired cognition. The care plan dated 11/17/23 identified Resident #66 was at risk for limited meaningful engagement related to self-isolation. Interventions included providing opportunities for choice during care/activities to provide a sense of control. The social service notes dated 11/4/23 through 11/19/24 failed to identity quarterly care conferences were completed from 11/4/23 through 7/17/24; quarterly care conferences were completed on 7/18/24, 8/1/24, and 11/7/24. Interview with Resident #66 on 11/17/24 at 10:20AM identified that he/she recalled attending one care plan meeting but could not remember if he/she had been invited to other care conferences and chose not to attend. Interview with Resident #66's Conservator (Person #1) on 11/19/24 at 9:15 AM identified that, since becoming Resident #66's Conservator on 3/11/24, she had been invited to Resident #66's RCC's and believed that she had participated in one care conference. Person #1 further identified that she and the facility social worker were also in contact, as needed, via email and telephone. Interview and clinical record review with SW #2 on 11/19/24 at 9:53 AM failed to identify documentation of quarterly resident care conferences from Resident #66's admission on 11/4/23 through 7/18/24. SW #2 identified that while official resident care conferences did not occur quarterly, she had frequent conversations and meetings with Resident #66. SW #2 indicated that the MDS coordinator is responsible for scheduling RCC's. Interview and clinical record review with the MDS Coordinator (RN #4) on 11/19/24 at 10:40 AM identified that Resident #66 was initially admitted for a short-term stay so social services would have been responsible for completing his/her initial RCC and that one of the social workers could better speak to why Resident #66's initial resident care conference was missed. RN #4 indicated that Resident #66 had MDS assessments completed at the end of January and April, so he/she should have been scheduled to have an RCC at the end of January or the beginning of February and then again at the end of April or the beginning of May. RN #4 indicated that it appeared that Resident #66's initial RCC and quarterly RCC's following the January and April MDS assessments were missed, and she was unsure how that could have happened. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 11/19/24 at 10:56 AM identified that she would expect the first resident care conference to be completed 72 hours after admission, and that would be completed by social services, if the resident was admitted as short-term. The DNS further identified that she would expect resident care conferences to be completed quarterly, after the initial RCC and the MDS Coordinator was responsible for scheduling those meetings. The facility's Resident, Family, Care Plan Conferences policy directs the facility to assure the resident and/or family/representatives are part of the interdisciplinary team and participate in the development and ongoing review of the person-centered interdisciplinary plan of care. The conferences will be scheduled based on identified needs and regulatory standards. If the resident and resident representatives do not participate in the development of the plan, an explanation will be included in the resident's medical record. The policy directs the procedure as follows: notify resident and family/legal representative of the next scheduled care conference, notify the appropriate interdisciplinary team members, review the interdisciplinary plan of care and the anticipated goals and interventions, ask the resident/resident representative to express their preferences about care, review the CAA's summary sheet, and summarize the outcome of the meeting and document attendance.

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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 1 resident (Resident #8) reviewed for non-pressure skin condition, the facility failed to document an RN assessment when the resident was identified with a scabbed area on the forehead, and for 1 resident (Resident #68) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure that a low air loss mattress was set per the physician's orders. The findings include: 1. Resident #8 was admitted to the facility in January 2023 with diagnoses that included dementia and end stage renal disease requiring dialysis. The nursing admission assessment dated [DATE] identified a healed abrasion to the mid forehead. The physician's admission history and physician dated 1/24/23 did not reflect an area to the forehead. The quarterly MDS dated [DATE] identified Resident #8 had severely impaired cognition. a. Review of the provider notes and nurse's notes dated 1/1/24 to 5/12/24 did not reflect the area to the to the resident's forehead. Review of the skin weekly skin checks performed by a licensed nurse dated 4/3/24 to 5/8/24 did not reflect any new or current skin injury or wounds. A physician's order dated 4/18/24 directed to obtain a wound consult and treatment as indicated and weekly showers with skin checks on Wednesdays 3:00 PM to 11:00 PM shift. The nurse's note written by LPN #7 dated 5/13/24 at 5:32 AM identified that Resident #8 picked the scab on the mid forehead, and she cleansed it with normal saline and left open to air. Review of the nurse's notes dated 5/13/24 to 7/1/24 failed to reflect an RN assessment of the area on the resident's mid forehead had been done. Interview with the second floor Unit Manager (RN #3) on 11/19/24 at 7:30 AM indicated that when a resident has a change in condition there would be an RN assessment. After review of the clinical record, RN #3 indicated that she did not see any documentation that on 5/13/24 there was an RN assessment of the scab that had been picked on the mid forehead. Interview with RN #3 on 11/19/24 at 8:47 AM indicated that on the admission assessment dated [DATE] there was a healed abrasion to the mid forehead and not until 5/13/24 there was an LPN who noted Resident #8 had picked the scab to the forehead causing it to bleed. RN #3 indicated that her expectation was that Resident #8 would have had an RN assessment b. Review of the weekly skin checks performed by a licensed nurse dated 10/2/24 to 11/11/24 did not identify any new or current skin injury or wounds. (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 nursing notes and the APRN/MD notes dated 10/2/24 to 11/17/24 did not identify an open or scabbed are noted to Resident #8's forehead. Observation on 11/17/24 at 9:06 AM noted a scabbed area approximately nickel size with some fresh dry blood and some hard dried blood noted on the resident's mid forehead. Resident #8 was not able to indicate what had happened. Interview with LPN #6 on 11/17/24 at 11:07 AM observed Resident #8 had an area to the forehead and indicated that she had not seen that prior and did not receive anything regarding this area to the mid forehead during the change of shift-to-shift report. After clinical record review, LPN #6 indicated that the area on the mid forehead must be new because she could not find anything in the documentation under a change of condition assessment or in a progress note. LPN #6 indicated that her expectation was there would be a documented RN assessment. Review of the nurse's notes dated 11/17/24 to 11/19/24 did not identify there was an RN assessment of the area on the resident's mid forehead. Interview with DNS and Director of Clinical Operations (RN #5) on 11/19/24 at 10:05 AM indicated staff are aware that the area on Resident #8's forehead opens and closes but only had seen a nurses note dated 5/13/24 written by an LPN. Additionally, RN #5 indicated that on 11/17/24 when surveyor and LPN #6 observed the bleeding and partially scabbed area to Resident #8's forehead there was not an RN assessment. RN #5 and the DNS indicated that the expectation was when there is any change of condition that the LPN notifies the RN, the RN does an assessment and documents the assessment. Interview with LPN #2 on 11/19/24 at 10:41 AM indicated she was the full-time charge nurse on the unit with Resident #8. LPN #2 indicated that the area on Resident #8's forehead opens and gets scabbed over and heals and then Resident #8 picks at it and opens it again and then it heals. LPN #2 indicated this has occurred many times since his/her admission. LPN #2 indicated that she does not know how many times the area to the forehead had opened and then healed. LPN #2 indicated that Resident #8 had not been seen by the facility wound physician and there were no weekly wound assessments completed by the RN unit manager RN #3 so she could not clearly identify when the area had opened and closed. Interview with second floor Unit Manager (RN #3) on 11/19/24 at 10:59 AM indicated she was responsible to do weekly wound measurements and documentation of pressure and non-pressure areas. RN #3 indicated that there was no documentation for the 5/13/24 and the 11/17/24 skin areas. Interview with second floor Unit Manager (RN #3) on 11/19/24 at 10:59 AM indicated she was responsible to do weekly wound measurements and documentation of pressure and non-pressure areas. RN #3 indicated that was responsible to do the weekly wound rounds with the wound physician that comes to the facility. RN #3 indicated that she is aware of the area on Resident #8's forehead that has opened and healed many times. RN #3 indicated that she has not followed Resident #8's forehead on a weekly basis from when it opens until when it heals. RN #3 indicated that she does not know why she has not followed it and done weekly documentation, because reflecting now she believes she should have followed it. RN #3 indicated that she recalls in the past once there was a treatment for bacitracin to the area. RN #3 indicated that LPN #6 did not notify her on 11/17/24 during the 7:00 AM to 3:00 PM shift that Resident #8 had a change of condition with an open area or scabbed area to the forehead and needed an RN assessment. (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 Skin Assessment Policy identified it was the policy to perform a full body skin assessment as art of the systemic approach to pressure injury prevention and management. A full body head to toe skin assessment will be conducted by a licensed or registered nurse upon admission or readmission and weekly thereafter and if there is a change in condition. Documentation of skin assessment includes the date, time, nurses name and title. The documentation will include the observation, type of wound, measurements, color, wound bed, drainage, odor, and if there was pain noted. Review of the Skin Integrity for Skin Tears Policy identified it was the policy to provide proper treatment and care to maintain skin integrity. The facility will utilize a systemic approach for the prevention and management of skin tears, including assessment, care planning, monitoring, and modification of interventions as appropriate. The licensed nurse will conduct skin assessments according to facility policy. When a skin tear is discovered, the nurse will complete an accident and incident report. The following information shall be documented: the residents name, the employee who discovered the skin tear, the site and description of the skin tear, the date and time the skin tear was discovered, the name of the employee who provided care to the resident 24 hours previously, site care rendered and evaluation of the incident, the names of any witnesses, the date and time the physician and resident representative were notified , and any other information relevant to the incident. The attending physician will assume responsibility for the overall care and treatment of the resident's medical condition. The attending physician will be notified of the presence, progression towards healing, or lack of healing of any skin tears, assessments of residents, and reporting any changes in condition to the physician. Interventions will be modified in the resident's plan of care as needed. Considerations for needed modifications include changes in medical condition or factors affecting the risk for skin tears, new onset or recurrent skin tears, lack of progression towards healing, resident is non-compliance, and changes in the resident's goals and preferences. 2. Resident #68 was admitted to the facility on [DATE] with diagnoses that included neuralgia, and neurogenic bowel. The annual MDS dated [DATE] identified Resident #68 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing and transfers. The MDS also identified Resident #68 was at risk for developing pressure ulcers. A physician's order dated 9/25/24 directed to set the specialty air mattress to Resident #68's weight (318 lbs.) and to check settings and function every shift. The care plan dated 9/26/24 identified Resident #68 had a low air loss (LAL) mattress. Interventions included to set per resident weight (318 lbs.) and check settings and functions every shift. Review of the clinical record identified Resident #68 had a weight of 323.6 lbs. on 11/4/24. Observation and interview with Resident #68 on 11/17/24 at 9:45 AM identified Resident #68's specialty air mattress was set to 220 lbs., 103.6 lbs. under Resident #68's last recorded weight. Resident #68 identified he/she could not remember how long the mattress had been in place, but that he/she did not weigh 220 lbs. and that the mattress was not set to his/her weight. Resident #68 also identified he/she would not be able to tell if there was an issue with the mattress due to his/her medical conditions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Resident #68's specialty mattress on 11/18/24 at 2:00 PM and 11/19/24 at 9:40 AM identified Resident #68's specialty air mattress was set to 220 lbs. Observation and interview with RN #3 on 11/19/24 at 9:45 AM identified Resident #68's air mattress was set to 220 lbs., which was more than 100 lbs. below Resident #68's most recent weight. RN #3 identified she was unsure why Resident #68's bed was set incorrectly and would look into the issue. During this observation, RN #3 changed the setting of Resident #68's specialty mattress to 290 lbs., the next weight setting, and identified she did not want to set it to the next setting, 350 lbs., as this would be over Resident #68's current weight. Interview with LPN #1 on 11/19/24 at 10:45 AM identified that she was typically assigned to care for Resident #68 on day shift and that she had been notified by RN #3 that Resident #68's specialty mattress setting was incorrect. LPN #1 identified that going forward she would make sure she was more careful in checking the setting was correct and would notify the nursing staff on the unit to make sure to check the physician's order against the mattress setting. Interview with the DNS on 11/19/24 at 11:40 AM identified the facility had recently changed over the specialty mattresses used for residents of the facility from a leased contract with a vendor to specialty mattresses purchased by the facility for residents. The DNS identified that the change happened in 9/2024, and she believed that the difference in the mattress settings-the prior mattresses were set to a specific number (i.e. 1, 2,3,4 etc.), while the new mattress settings were weight dependent-was the cause of the issue. The DNS identified that she would have expected the nursing staff to follow the physician's order, and going forward the staff would be educated to ensure that the specialty mattress was set currently. The facility policy on support surfaces directed that these surfaces included specialty mattresses. The policy further directed that support surfaces would be utilized in accordance with a physician's order, and that powered surfaces or those requiring air would be checked by the licensed nurse each shift and as needed for proper function and/or inflation. 46040

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075237	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Kimberly Hall-South	1 Emerson Drive Windsor, CT 06095

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #6) who required a specialty medical intervention and fluid restriction, the facility failed to ensure fluid intake and output were monitored according to professional standards and facility policy. The findings include: Resident #6 was admitted to the facility in August 2024 with diagnoses that included end stage renal disease, dependence on renal dialysis, and congestive heart failure. The admission MDS dated [DATE] identified Resident #6 had moderate cognitive impairment, required supervision with eating and dependent with toileting hygiene. The care plan dated 9/16/24 identified Resident #6 exhibited impaired renal function and was at risk for complications related to dependence of hemodialysis. Interventions included hemodialysis on Monday, Wednesday, and Friday at the dialysis center. Observe, document, and report to the MD/APRN for signs and symptoms of fluid overload (increase shortness of breath, significant weight gain, edema) as needed. The care plan dated 9/16/24 identified Resident #6 was at risk for dehydration related to fluid restriction. Interventions included to maintain fluid restriction per the physician's order. Monitor for signs of dehydration. Review of the nurse's note dated 10/1/24 - 10/31/24 failed to reflect documentation regarding the daily total of fluid intakes. The physician's order dated 11/1/24 directed to monitor daily fluid restriction of 1500 cc in 24 hours. Dietary 1080 cc, nursing 420 cc (180 cc on 7:00 AM - 3:00 PM, 150 cc on 3:00 PM - 11:00 PM, 90 cc on 11:00 PM - 7:00 AM). Review of the nurse's note dated 11/1/24 - 11/18/24 failed to reflect documentation regarding the daily total of fluid intakes. The dietitian's notes dated 11/6/24 at 4:58 PM identified Resident #6 as a renal diet, and 1500 cc fluid restriction. The dietitian's notes failed to reflect documentation regarding Resident #6 meeting the fluid restriction daily as per physician's order. Review of the medication administration record (MAR) dated 11/1/24 - 11/30/24 directed to monitor daily fluid restriction of 1500 cc in 24 hours. Dietary 1080 cc, nursing 420 cc (180 cc on 7:00 AM - 3:00 PM, 150 cc on 3:00 PM - 11:00 PM, 90 cc on 11:00 PM - 7:00 AM). The MAR identified documentation of fluid intake from nursing during medication administration. Review of the clinical record, and facility documentation failed to reflect documentation for the month of 10/1/24 - 10/31/24 and 11/1/24 - 11/18/24 of the dietary intake of 1080 cc from nursing during meals. The clinical record failed to reflect documentation of daily total fluid intakes. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record, and facility documentation for the month of 10/1/24 - 10/31/24 and 11/1/24 - 11/18/24 failed to reflect documentation of intake and output from nursing regarding dietary fluid intake of 1800 cc with meals. Review of the facility documentation failed to reflect documentation of the dietary intake of 1080 cc from nursing during meals. The clinical record failed to reflect documentation of daily total fluid intakes. Interview with RN #5 (Director of Clinical Operations) on 11/19/24 at 12:32 PM identified he was not aware of the issue until now. RN #5 indicated he was not aware that the computer did not total the resident fluid intake and output at the end of the day. RN #5 indicated he was not aware that the computer did not reflect documentation for the nurse aide input of fluid intake and output. RN #5 indicated he was not aware that the computer did not have a section for the nurse aide to document the resident fluid intake and output. RN #5 indicated he was not aware that the nurse aides did not have an intake and output form for documentation. RN #5 indicated he will provide the staff with a daily intake and output form and address the computer system. Interview with NA #5 on 11/19/24 at 12:35 PM identified there were no residents on fluid restriction or intake and output on the unit at this time. Interview with RN #7 (unit manager) on 11/1924 at 12:42 PM indicated she has been the unit manager for approximately 2 weeks. RN #7 indicated she was not aware that the nurse aides were not aware of the residents on fluid restrictions or intake and output. RN #7 indicated she was not aware that the nurse aides were not documenting the resident intake and output. RN #7 indicated she was not aware that the intake and output were not being tallied at the end of each day. RN #7 indicated she will educate the staff regarding documentation of intake and output. RN #7 indicated Resident #6 fluid intake and output should have been monitored, she was unable to find documentation to support that this was done. Interview with RN #2 (charge nurse) on 11/19/24 at 12:45 PM identified she was aware of the resident on fluid restrictions. RN #2 indicated the fluid restriction breakdown was on the MAR for nursing during medication administration. RN #2 indicated she had given report to the nurse aides on the unit that morning at the beginning of the shift regarding residents on fluid restrictions. RN #2 indicated she does not know where the nurse aides document the resident intake and output. RN #2 indicated that the old computer system with the previous company had a section where the nurse aides can document the resident fluid intake and output. RN #2 indicated with the old computer system with the previous company the total of the fluid intake and output for the day will automatically be documented at the end of the 3:00 PM - 11:00 PM shift. Interview with NA #5 on 11/19/24 at 12:47 PM identified she was not aware that Resident #6 was on fluid restrictions. NA #5 indicated she did not document Resident #6 fluid intake and output. NA #5 indicated that the old computer system with the previous company had a section where the nurse aides can document the resident fluid intake and output. NA #5 indicated that the previous company had an intake and output form that the nurse aide can document the fluid intake and output for each shift. NA #5 indicated the new company did not provide them with an intake and output form for documenting resident on fluid intake and output. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #8 (Regional Resource Nurse) on 11/19/24 at 12:50 PM identified she was not aware of the issue. RN #8 indicated she will educate the nursing staff regarding fluid restriction, intake and output documentation. Review of the facility hemodialysis policy identified the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of the residents receiving hemodialysis. The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. The licensed nurse will communicate to the dialysis facility via telephone communication or written format, such as a dialysis communication form or other form, that will include, but not limited itself to: Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered.