STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075243	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierce Memorial Baptist Home, Inc.	44 Canterbury Road Brooklyn, CT 06234

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for one of five sampled residents (Resident #3) unnecessary medications, the facility failed to ensure the care plan included interventions to address the possible side effects and the monitoring that should accompany the use of an anticoagulant and for one sampled resident (Resident #26) reviewed for skin condition, the facility failed to develop a comprehensive care plan to address the specific type of support surfaces device being utilized, how often the device should be worn, and the general care or monitoring of the device as it relates to the resident. The findings include: 1. Resident #3's diagnoses included pulmonary embolism (blood clot that prevents or stops blood flow to the lungs), hyperlipidemia, and dementia. The annual MDS assessment dated [DATE] identified Resident #3 had severe cognitive impairment, required total assistance with personal hygiene, transfers, toileting, was non-ambulatory, and utilized anticoagulant medication (blood thinner) that the assessment noted to be a high-risk medication. A physician's order dated 1/31/24 through 2/6/24 directed Lovenox/Enoxaparin Sodium injection (a blood thinner used to prevent blood clots) 80 milligrams (mg) to inject one syringe subcutaneously every 12 hours for bilateral pulmonary embolism (PE). A physician's order dated 2/6/24 through 6/18/24 directed Apixaban/Eliquis (a blood thinner used to prevent blood clots) 5 mg one tablet by mouth twice daily for bilateral pulmonary embolism (PE). Review of Resident #3's care plan dated 3/25/24 failed to identify a plan of care that included the use of anticoagulant medications with interventions that would had included administering the medication as ordered, monitor for: bleeding, unusual bruising, bloody or black tarry stools, bleeding precautions, and sudden change in mental status. According to Eliquis.com, the use of the medication poses a bleeding risk, in that it increases the risk of bleeding and can cause serious, potentially fatal bleeding. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the ADNS, who is the MDS Coordinator on 6/17/24 at 1:43 PM identified Resident #3 care plan did not include a care plan that focused on anticoagulant therapy, but noted the resident should have had one. The ADNS added that she reviews the care plan when the MDS are due and should have identified at the time of the review that interventions addressing the side effects to monitor for a resident taking an anticoagulant medication could have been developed and implemented. The ADNS further identified that it was an oversight on her part as it was her responsibility as well as nursing to update and revise care plans as needed. Interview with the 7:00 to 3:00 PM Supervisor (RN #2) on 6/18/24 at 1:50 PM identified that a baseline care plan would be initiated when a resident was admitted or readmitted to the facility. RN # 2 added the admitting nursing supervisor would ensure care plans for pain, fall, skin conditions, elopement, and activities of daily living were initiated. RN #2 further added that a care plan should be initiated if the resident was currently taking an anticoagulant medication, and if the admitting nurse failed to add the care plan it is usually picked up by the MDS coordinator who reviews the final care plan. Subsequent to surveyor's inquiry a care plan for the use of anticoagulant dated 6/17/24 was developed and implemented with interventions that included administer anticoagulant as ordered, monitor for side effects and effectiveness, monitor for bleeding, and bleeding precautions. Review of the Baseline Care Plan policy identified that a baseline care plan should be developed within 48 hours of admission with the necessary information to properly care for the resident that includes but is not limited to falls, skin, psychotropic medication use, and anticoagulant use. Review of the Comprehensive Care Plan policy identified that the facility is to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychological needs within 7 days after the completion of the comprehensive MDS assessment. Additionally, the policy identified that the care planning/interdisciplinary team is responsible for periodic review and updating of the care plans. 2. Resident #26's diagnoses included dementia, muscle weakness, and dysphagia. The significant change MDS assessment dated [DATE] identified Resident #26 had severe cognitive impairment, and was dependent on staff for personal hygiene, dressing, transfers, mobility, and was non-ambulatory. Observation on 6/12/24 at 12:29 PM identified Resident #26 seated in wheelchair around a table in the dining room wearing a blue colored boots (heel floating boots/bunny boots) to bilateral lower extremities. Observation with the Charge Nurse (LPN #2) on 6/13/24 at 12:15 PM identified Resident #26 seated in wheelchair around a table in the dining room wearing a blue colored boots known as heel floating boots/bunny boots to bilateral lower extremities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical records with LPN #2 on 6/13/24 identified that Resident #26 had a wound to the right medial aspect of the foot inner aspect of the foot and wore the blue boots to bilateral feet. LPN #2 failed to identify a care plan or a physician's order directing the use of the light blue boots or any documentation on the nurse aides care card of Resident #26 for the use of the blue boots. LPN #2 added that an order or the care plan, and the nurse aide care card for Resident #26 should have been completed to indicate when the resident to wear the boots, to check skin integrity and when to remove for care. Interview with the Wound Nurse (RN #4) on 6/13/24 at 2:00 PM identified that Resident #26 wore the blue boots as a pressure relieving device due to a new wound identified on 6/1/24 on the right inner side of the foot. RN #4 further identified Resident #26 did not have a care plan nor an order but identified that the resident should have had one. RN #4 added that she recently took over the position as the wound nurse, and it was the responsibility of the charge nurse or the wound nurse to ensure that an order and a care plan was in place. Interview with the ADNS, who is the MDS coordinator, on 6/13/24 at 2:22 PM identified that the Resident #26 did not need a physician's order as the blue boots are being used preventable measure which was seen as a nursing measure. However, she added that the use of the blue boots should have had been documented in the resident's care plan and nurse aides care card of Resident #26 to indicate how often the boots to be worn, when to be removed, and the checking of the resident's skin integrity. In addition, the ADNS failed to identify a care plan that was developed and implemented regarding the use of the blue boots or the nurse aide care card for Resident #26 identifying the use of the blue boot. The ADNS added that it was both the responsibility of nursing and the MDS coordinator to review and update the resident's care plan, but it was the nurse's responsibility to update the nurse aide care cards. Interview with the Medical Record staff (Medical Record #1) on 6/17/24 at 10:00 AM identified that she would review the nurse aide binder with the resident's care card twice weekly for changes and retype the document. The Medical Record #1 identified that the blue boots were recently added to the nurse aide care card for Resident #26. Interview with the Physical Therapist (PT #1) on 6/17/24 at 10:05 AM identified that the blue boots or bunny boots are pressure redistribution devices which are utilized to prevent pressure injury, and to redistribute pressure by preventing the resident from being resting on a surface over a period. PT #1 identified that the blue boots can be worn at all times if the resident has a wound, however they should be removed for care, to check skin integrity, and to reposition the resident with knees supported to prevent improper body alignment. Interview with the former wound nurse (LPN #2) on 6/17/24 at 12:45 PM identified she had received the order from the wound physician for offloading heel per facility protocol, wherein the blue boots were applied, as she had documented in her notes dated 6/5/24. LPN #2 further identified that the blue boots were offloading. LPN #2 identified it was an oversight on her part and that the order and care plan should have had been updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan policy identified that the facility is to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's needs as identified in a comprehensive assessment with objectives that will be used to monitor the resident's progress, and alternative interventions will be documented as needed.

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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** 47489 Based on clinical record review, review of facility policy and interviews for for one of two sampled residents, (Resident #66) reviewed for accidents, the facility failed to ensure Resident #66 had a comprehensive care plan for wandering/elopement after found to be an elopement risk. The findings included: Resident #66 was admitted to the facility on [DATE] with diagnoses that included Heart Failure, AFIB, cognitive communication deficit and GERD. The Admission MDS dated [DATE] identified the resident had intact cognition and had functional range of motion impairment on both upper extremities and no impairment of the lower extremities, but used a walker for ambulation. Review of the nursing progress notes dated 5/1/24 at 2:56 PM identified the resident was found getting off of the elevator on the first floor and told staff he/she was just looking around. Subsequent nursing notes dated 5/1/24 at 3:29 PM identified a wander guard was placed on the resident's left ankle. Review of the Elopement Risk assessment dated [DATE] identified the resident scored an 11 and was at risk of elopement and should have had interventions to minimize risk of elopement. Review of the Physician's Orders dated 5/3/2024 identified order to monitor wander guard every shift for elopement risk. Additionally, that order was discontinued and a new order to monitor the wander guard was placed 5/9/2024. The Comprehensive Care Plan dated 5/9/2024 failed to identify Resident #66 was an elopement risk or had a wander guard bracelet in place. Review of the Treatment Administration Record (TAR) for May 2024 identified a treatment to monitor for attempts to elope every shift for attempted elopement. The first recorded date for monitoring for elopement was charted on 5/3/24 on the night shift. The TAR identified the resident was being monitored from 5/3/24 through the dates of the survey 6/18/2024. Review of the TAR for June 2024 identified two additional treatments to check battery function on elopement bracelet every night shift, which is checked off from 6/5/24 through 6/17/24, and to check for wander guard placement (L ankle) before and after each LOA, which had not been checked off during the month of June. Review of the nurse progress notes dated 6/4/2024 at 11:46 PM identified the resident had been outside alone and was escorted back to the resident floor by a staff member. It was noted that the wander guard was not in place on the left ankle as it should have been. A new wander guard was placed on the left ankle at that time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Elopement Risk assessment dated [DATE] identified Resident #66 scored a 12. A score of 10 or higher is at risk and interventions to minimize risk of elopement should be implemented. Review of clinical chart nurse progress notes dated 6/7/2024 at 3:52 PM identified Resident #66 was not found on the unit, but outside with a friend. The nurses' note identified that both the resident and the friend were educated on the need to notify a staff member of where the resident goes for safety. The note identified the wander guard was in place on the resident's ankle but did not alarm when the resident left the unit. Observation of Resident #66 on 06/12/24 at 1:06 PM identified the resident did not have a wander guard in place. Resident #66 communicated feelings and identified preferences to daily care without issue and was able to identified the desire to return home. Interview with LPN #3 on 6/13/24 at 1:35 PM identified another staff member brought the resident up to the floor on 5/1/2024 after the resident was found on the 1st floor and that was when the wander guard was placed on the resident. LPN #3 identified the facility completed an elopement assessment and notified the supervisor of the change in score. LPN #3 identified that finding the resident on another floor would be considered elopement I don't fill out any paperwork. I just notify the supervisor. I did check the wander guard prior to her leaving, it was not there when she came back. Interview with the DNS on 6/13/24 at 2:19 PM identified if the resident was found off of the unit, that would be an attempt at elopement and an elopement assessment would be completed and, if appropriate, a wander guard bracelet would be placed. The elopement assessment scores, the cognitive assessment, and status of the resident, and the reason for leaving the unit are taken into account for placement of the bracelet. The orders for the wander guard to check the batteries on 11-7 for function and to check for placement every shift. The DNS identified this would be placed in the care plan. Review of the facility Elopement Policy identified Residents at risk for elopement, through risk score and/or behaviors, will have an Elopement Risk Care Plan implemented and have an elopement band placed on wrist. The policy identified the placement of the elopement bracelet will be monitored every shift and documented in the EMAR. Exit door and elevator monitors will be tested throughout the week by the maintenance department to ensure proper functioning. Review of the Baseline Care Plan Policy identified that in the event that the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning not identified in the baseline care plan, those changes will be incorporated into the care plan within 48 hours of identification. Subsequent to surveyor inquiry, 6/13/2024, the elopement/wander guard was added to the resident care plan.

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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** 47489 Based on observations, clinical record review, review of facility policy, review of facility documentation and interviews for one of two sampled residents (Resident #66) reviewed for accidents, the facility failed to provide adequate supervision to prevent an elopement. The findings include: Resident #66 was admitted to the facility on [DATE] with diagnoses that included heart failure, atrial fibrillation, and cognitive communication deficit. The Admission Elopement Risk assessment dated [DATE] identified Resident #66 was not at risk for wandering. The admission MDS assessment dated [DATE] identified Resident #66 had intact cognition, no exhibited behaviors, range of motion impairments to both upper extremities and no impairment of the lower extremities and utilized a walker for ambulation. The nursing note dated 5/1/24 at 2:56 PM identified Resident #66 was found getting off of the elevator on the first floor and told staff he/she was just looking around. The Elopement Risk assessment dated [DATE] identified Resident #66 was at risk of elopement and should have interventions to minimize the risk of elopement. A nursing note dated 5/1/24 at 3:29 PM identified a wanderguard was placed on Resident #66's left ankle The physician's orders dated 5/3/2024 directed to monitor the wanderguard alarm every shift due to elopement risk. Review of the Treatment Administration Record (TAR) from May 3, 2024 through June 18, 2024 identified an intervention to monitor for attempts to elope every shift. Review of the TAR for June 2024 directed to check the battery function of the wanderguard bracelet every night shift. The TAR identified that it was checked off from 6/5/24 through 6/17/24. The TAR also noted to check for wanderguard placement (L ankle) before and after each LOA. The documentation did not reflect that the placement of the wanderguard had been checked. The nurse's note dated 6/4/2024 at 11:46 PM identified the resident had been outside alone and was escorted back to the unit by a staff member, and the wanderguard was not in place to the left ankle. A new wanderguard was placed on the left ankle at that time. The nurse's note dated 6/7/24 at 3:52 PM identified Resident #66 was found outside with a friend and noted that the resident and the friend were educated on the need to notify a staff member of where the resident goes for safety. Further, the note identified the wanderguard was in place but had not alarmed when the resident left the unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of clinical chart nurse progress notes dated 6/7/2024 at 3:52 PM identified Resident #66 was not found on the unit, but outside with a friend. The nurses' note identified that both the resident and the friend were educated on the need to notify a staff member of where the resident goes for safety. The note identified the wanderguard was in place on the resident's ankle but did not alarm when the resident left the unit. Observation on 6/12/24 at 1:06 PM identified Resident #66 did not have a wanderguard in place. Interview with LPN #3 on 6/13/24 at 1:35 PM identified another staff member brought the resident up to the floor on 5/1/2024 after the resident was found on the 1st floor and that was when the wanderguard was placed on the resident. LPN #3 identified the facility completed an elopement assessment and notified the supervisor of the change in score. Interview with the DNS on 6/13/24 at 2:19 PM identified that when a resident is found off of the unit it is considered an elopement attempt and an elopement assessment is completed and if appropriate, a wanderguard bracelet is placed. The elopement assessment score, the cognitive assessment, status of the resident, and the reason for leaving the unit are taken into account for placement of the wanderguard. She further identified that orders to check the batteries for function and placement on the 11-7 shift would also be put in place. In addition, the DNS identified a resident found outside of the building is considered an elopement. Further interview with the DNS identified she was unaware of Resident #66's elopement attempts and noted that, there were no reportable event reports completed and investigations conducted to ascertain how the resident got out of the building on two occurrences. A tour of the building with the DNS on 6/18/24 at 10:30 AM identified alarm sensors located at the exit doors on the units, at exits to the building, and in the elevators, and in order to for the elevators to move when a wanderguard alarm is present, a code that has to be entered into the keypad located in the elevator. At the doors on the units and to exit, when the wanderguard system alarms and the door is pushed open, there is an audible alarm, and the door remains secured for 15 seconds and then will open due to fire safety measures. There is an alarm code that can be entered that will silence the alarm and allow the door to open. The DNS noted that most family members have the codes. Additionally, there is not a way to print a record of activations. The DNS further identified the system is checked weekly for function. Review of the facility Elopement Policy identified Residents at risk for elopement, through risk score and/or behaviors, will have an Elopement Risk Care Plan implemented and have an elopement band placed on wrist. The policy identified the placement of the elopement bracelet will be monitored every shift and documented in the EMAR. Exit door and elevator monitors will be tested throughout the week by the maintenance department to ensure proper functioning. The facility failed to ascertain how the resident eloped from the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on observations, review of the clinical record, review of facility policy and interviews for one sampled resident (Resident #369) reviewed for Respiratory Care, the facility failed to provide sanitary care of the nebulizer equipment related infection control. The findings include: Resident #369's diagnoses included chronic obstructive pulmonary disease, obstructive sleep apnea and anxiety. A transfer and discharge report dated 6/9/24 identified an order for Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) milligram per milliliter; 3 milliliters-to be inhaled orally every 6 hours as needed for wheezing, dated 5/20/24. The admission nursing assessment dated [DATE] identified Resident #369 was alert and oriented, required a Continuous Positive Airway Pressure (CPAP) machine, had shortness of breath when lying flat and was an assist of 2 for bed mobility. The care plan dated 6/10/24 identified Resident #369 had limited physical mobility, confusion, and weakness. Interventions included Physical and Occupational therapy referrals. A physician's order dated 6/10/24 directed to administer DuoNeb (Ipratropium-Albuterol) solution 0.5-2.5 (3) milligrams per milliliter, 3 milliliters-to be inhaled orally every 6 hours as needed for wheezing. Observation on 6/12/24 at 11:09 AM in Resident #369's room, identified the nebulizer machine along with the equipment, including the mouthpiece and medicine cup lying on the windowsill without a covering and without a date. The mouthpiece and medicine cup were lying against the window screen. Interview on 6/12/24 at 11:10 AM with Resident #369 indicated she had not recently used the nebulizer machine and could not identify the last time it had been used. Interview on 6/12/24 at 11:22 AM RN #2, floor nurse, indicated the nebulizer equipment is normally dated and kept in a plastic bag, and not lying on the windowsill unbagged. The nurse then indicated she/he would change the equipment immediately, date it and place it in a bag per policy. Subsequent to surveyor inquiry, the nebulizer equipment was changed, dated, and placed in a plastic bag. Interview on 6/17/24 at 9:48 AM with the DNS identified the facility uses a company to help maintain the CPAP equipment, facility staff are required to maintain and provide the cleaning and storage of all respiratory equipment. nebulizer and oxygen equipment should be dated and stored in an oxygen bag in between uses. If a new resident came to the facility, the nebulizer or oxygen equipment is changed over to facility equipment and subsequently dated and bagged to maintain infection control. A Physician's order is then entered for monitoring and care of any oxygen, nebulizer, and CPAP equipment. The nebulizer sets/tubing are changed every Thursday by nursing on the 11-7 shift, dated and placed in an oxygen bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) dated 6/1/24-6/30/24 identified DuoNeb (Ipratropium-Albuterol) solution 0.5-2.5 (3) milligrams per milliliter, 3 milliliters-inhale orally every 6 hours as needed for wheezing, was administered on 6/12/24 at 2:42 PM. The Treatment Administration Record (TAR) dated 6/1/24-6/30/24 failed to identify the nebulizer treatment checks or care of nebulizer equipment. Review of the Nebulizer Procedure Policy directed, in part, to rinse tubing with water and let air dry after each use. Wrap tubing in a paper towel and place in a bag. Tubing should be dated and documented on the treatment sheet. Nursing will replace tubing, mask/mouthpiece every Thursday night shift and as needed. Review of the Care of Oxygen/Respiratory Equipment policy directed, in part, that small volume nebulizer's (SNV) and tubing are rinsed after each use and discarded weekly. New SNV's are dated and initialed when put into use. Documentation of any changes or checks are done on the resident's treatment Kardex.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observation, facility policy review, and interviews, the facility failed to ensure foods were dated and labeled appropriately, expired foods discarded and the cleanliness of the resident's nutritional refrigerator maintained. The findings include: Observation on [DATE] at 9:45 with [NAME] #1 identified the following in the walk-in freezer: * fajita meat in a large zip lock plastic container dated good through [DATE] * beef roast in a large zip lock plastic container dated good through [DATE] * ham and pork in a large zip lock plastic container dated good through [DATE] * ground ham in a large zip lock plastic container dated good through [DATE] * corned beef wrap with a saran wrap dated good through [DATE] * beef gravy in a large zip lock plastic container dated good through [DATE] * mac and cheese in a large zip lock plastic container dated good through [DATE] Interview with [NAME] # 1 on [DATE] at 10:00 AM identified that the Food Service Director (FSD) was responsible of ensuring there were no outdated food stored in the freezer. She identified that the good through date would be last day that the food item can be used and it should be thrown out after it expiration. She further identified that the expired food items should not be left in the freezer. Subsequent to surveyor inquiry, expired food items were thrown away. Observation on [DATE] at 10:05 AM with the Food Service Director (FSD) identified the following in the walk-in refrigerator: * macaroni pasta in a metal container cover with plastic with no label * open beef base in a manufacturer plastic container dated good through [DATE] Interview with FSD on [DATE] at 10:15 AM identified that all dietary staff should throw away expired food in the freezer and/or refrigerator. She typically checked the freezer and refrigerator for any outdated food items once a week and throw away any expired food. She also noted that any food stored in freezer and/or refrigerator should be appropriately label and no expired food should be kept in the walk-in freezer and/or refrigerator. Observation on [DATE] at 10:40 AM with LPN #1 identified the following in the resident's nutritional refrigerator: * 1 opened 46 ounces box thickened cranberry cocktail from concentrate without label (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 1 opened 46 ounces box thickened orange juice from concentrate without label * 1 opened 32 ounces box 100% HC Plus orange juice without label * 1 opened 32 ounces box 100% HC Plus prune juice without label Observation on [DATE] at 10:50 AM with LPN #1 identified the following in the resident's nutritional freezer: * 2 pints of opened Talenti ice cream and covered with freezer burn * 1 pint of price chopper chocolate ice cream and covered with freezer burn * 6 cups of 120 ml ice cream and covered with freezer burn. Further observation of the resident's nutritional refrigerator/freezer identified multiple areas of sticky brown stain material inside the refrigerator and in the freezer. Interview with LPN #1 on [DATE] at 11:00 AM identified that housekeeping and/or dietary was responsible for cleaning the resident's nutritional refrigerator. She also identified the opened juice and ice cream were for the residents use. She further identified that juice should be label once it was opened, but she could not identified how long it was good for once it was opened. Interview with the FSD on [DATE] at 11:20 AM identified that the housekeeping and/or dietary staff was responsible of cleaning the resident nutritional refrigerator. She could not identified when was the last time the refrigerator was last clean. She further identified any un-label food items would be thrown away. Review of the Food and Storage Supply Policy directed that all food, non-food items and supplies used in food preparation shall be stored in a manner that would prevent contamination to maintain safety and safe for human consumption. Food past the use by date should be discarded and open packages would be cover, label and dated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation and interviews for one sampled resident (Resident #2) reviewed for hospice care, the facility failed to have complete hospice records that were readily available for review and for one of four sampled residents (Resident #55) reviewed for advanced directives, the facility failed to ensure that a signed copy of the advanced directives consent form was accessible in the resident's medical record. The findings include: 1. Resident #2's diagnoses included congestive heart failure, asthma, and difficulty swallowing. A physician's order dated [DATE] directed: evaluate Resident #2 for hospice services. The care plan dated [DATE] identified Resident #2 was receiving hospice services. Interventions included, provide care that maintained maximum comfort through the next review. The significant change Minimum Data Set assessment dated [DATE], identified Resident #2 was severely cognitively impaired, was dependent for transferring, toileting, bathing and was receiving hospice services. Review of Resident #2's clinical record on [DATE] at 2:30 PM identified the medical record failed to provide documented evidence of the following: Up to date every 2-week Interdisciplinary team notes, beginning after the resident was admitted to hospice, through [DATE], the Plan of Care and Certificate of Terminal Illness (CTI) dated [DATE]-[DATE] and the Medicare/Medicaid Hospice Benefit Election dated [DATE] and hospice medication list. Interview on [DATE] at 2:33 PM with LPN #1 and LPN #2 identified the only hospice documents in the resident's chart were the hospice agency's cover sheet and 4 hospice visit notes. No hospice admission note, admission consents/documents, Certificate of Terminal Illness (CTI), Interdisciplinary Team (IDT) notes, or plan of care were found in the resident's chart or uploaded to the Electronic Medical Record (EMR). No other binders or folders were kept or utilized for hospice documentation, according to LPN #1 and LPN #2. Interview on [DATE] at 9:58 AM with the DNS identified that Social Worker #1 helps with hospice admissions in the facility and the hospice paperwork. Interview on [DATE] at 10:04 AM with social worker (SW) #1, indicated after the physician's orders a hospice evaluation, the SW contacts the hospice agency selected by the resident or family. The hospice agency then updates the SW when an evaluation will occur and when the resident is admitted to a hospice level of care. The hospice agency is responsible for the paperwork. Subsequent to surveyor inquiry, the Hospice Benefit Election form and the facility Care Plan Conference sheet were provided to this Nurse Consultant. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 11:48 AM with Hospice Manager RN #1 indicated, he/she would have to review the hospice admission process to ensure exactly which documents should have been included in the resident's medical record. He/she also indicated once a hospice referral is received from the facility, the hospice staff contacts the family. If the family or resident agreed to hospice services, then the hospice nurse would complete an evaluation and admit the resident to hospice care. The hospice Manager was not aware and was unable to explain why the hospice admission paperwork had not made it to Resident #2's chart. According to RN #1 hospice manager, there should have been a Hospice Medicare/Medicaid Benefit election form, a memo of understanding ([NAME]), between the hospice agency and facility, communication notes, and a cover sheet at least. The admitting hospice nurse brings a nursing home packet when admitting a resident. Which included all the hospice documents. All the hospice consent forms are configured electronically. RN #1 indicated a lack of awareness as to the requirement of the plan of care, Certificate of Terminal Illness (CTI) and the hospice Interdisciplinary (IDT) notes which should be part of the medical record. Subsequent to surveyor inquiry, RN #1 hospice manager, faxed over the Hospice Plan of Care dated [DATE]-[DATE]. RN #1 or the hospice medical record's personnel will fax over the hospice documents to the facility going forward, to ensure the resident's medical record is complete. Review of the Medical Records policy dated [DATE] directed, in part, that all active medical records are kept at the nurse's station, accessible only to authorized personnel. Although requested, a facility policy regarding Hospice documents was not provided. 2. Resident #55's diagnoses included dementia, type 2 diabetes mellitus, and anxiety disorders. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 cognition was severely impaired and required total assistance with personal hygiene, toileting, and was non-ambulatory. Review of the clinical record identified a physician's advance directive form consent dated [DATE] indicated Resident #55's code status of full interventions (full code), a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR (cardiopulmonary resuscitation). The care plan dated [DATE] identified Resident #55 advanced directive of Do not Resuscitate (DNR) which means that a person has decided not to have CPR attempted on them if his/her heart or breathing stops and Do not Intubate (DNI), which means that a person has decided not to be connected to a ventilator if his/her lungs not working, with a goal to maintain resident wishes through the next review, with interventions that included to follow the facility advance directive protocol (to discuss with the resident or responsible party about advanced directives planning, obtain physician's order and place the order in the electronic medical record and copy in the chart). A physician's order dated [DATE] directed a do not resuscitate (DNR)/do not intubate (DNI)/ nurse may pronounce (NMP) code status for Resident #55. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Charge Nurse (LPN #2) on [DATE] at 12:30 PM identified in the advance directive tab of the paper chart a physician's advance directive form consent dated [DATE] that indicates full interventions and a black dot on the outside of the chart which indicated DNR. In addition, the electronic medical records indicated DNR/DNI/NMP. LPN #2 further identified that Resident #55 code status was changed on [DATE] to DNR/DNI/NMP. LPN #2 added that when a resident's code status is changed the new physician's advance directive form should be kept in the chart. Also, LPN #2 added that it was the responsibility of the staff who received the new order to ensure that the signed copy of the consent form is in the paper chart in the advance directive section. LPN #2 indicated that if the resident required life-saving measures, the physical chart at the nurse's station was one of the places she would look to confirm the resident's advanced directives as well as the physician's order. The nursing note dated [DATE] at 10:24 AM written by ADNS, who is also the MDS coordinator, identified that an interdisciplinary team meeting was held with the Resident #55's representative and family when they decided to changed Resident #55's code status to DNR/DNI/NMP. Interview with the ADNS on [DATE] at 2:09 PM identified that it was the practice of the facility to review resident's code status at care conference meeting when Resident #55's family made the change from full intervention to DNR/DNI/NMP. She identified that all the required steps were taken which included documentation, physician's order, and the consent form was in place in Resident #55's paper chart. The ADNS added that the overflow chart was checked, and she was unable to locate a copy of the physician advance directive form consent. She added that the Resident #55 was sent to the hospital in March of 2024 wherein the form might had been sent to the hospital in error as there were a signed transfer of Do Not Resuscitate order form that identified a DNR order was written for Resident #55 on [DATE]. The ADNS identified that moving forward the advance directive form consent would be scanned into the resident's electronic medical record. Interview with the Resident #55's representative (Person #2) on [DATE] at 11:00 AM identified that he/she had a discussion with the ADNS at a care conference meeting where the code status was change to DNR/DNI. Review of the Care Plan Conference sheet dated [DATE] at 10:00 AM identified that Resident #55's family was in attendance. The care plan conference sheet further identified that the Resident #55's code status was CPR and was reviewed and changed to DNR/DNI/NMP. Subsequent to surveyor inquiry, a physician's advance directive form consent dated [DATE] was completed with a consent obtained from the Resident #55's representative by two nurses, signed by provider, and placed into the paper chart in the advance directive section. Review of the Advanced Directives policy identified that copies of the advance directives should be placed in the resident's chart. The policy further identified that when changes are made to the advance directives it should be documented in the resident's medial record. Review of the Medial Records policy identified that all active medical records are kept at the nurse's station and accessible to only authorized staff. 48335

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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** 47402 Based on review of facility policy, review of facility documentation, and interviews, the facility failed to implement Enhanced Barrier Precautions for residents who required enhanced barrier precautions and failed to include all residents that required tracking in their MDRO tracking and cohort accordingly. The findings include: 1. A tour of the facility on 6/13/24 at 9:24 AM identified that residents with a history of Multidrug Resistant Organisms (MDRO's), and residents with the presence of indwelling medical devices, the facility failed to place the residents on Enhanced Barrier Precautions (EBP). Review of the facility's MDRO log with the Infection Preventionist Nurse RN #4 on 6/13/24 at 12:49 PM identified 7 residents that she had identified as requiring EBP due to indwelling medical devices, or open wounds with infected organism. Interview with RN#4 on 6/13/24 at 2:35 PM identified that EBP was not implemented on the units currently, and the facility had just initiated the process. RN #4 identified that the facility was in the initial phase, which was formulating a policy, and identifying residents who would need EBP, however would need to start educating all staff, informing residents, families, and representatives. RN#4 identified that she knew this should have been implemented by 4/1/24 and has discussed this need with management however has received push back stating it would affect the dignity of the residents and the cost of the extra supplies were factors delaying the implementation. Interview with the Administrator on 6/13/24 at 2:50PM identified he was aware that the EBP process was in the works of being implemented however was unaware of it needing to be implemented by 4/1/24. The policy was in the works of being created however not currently implemented. The communication on implementation was never made clear to him of a date and felt as though the Infection Prevention Nurse RN#4 should have been responsible to know this information. On his behalf there was no pushback in the implementation as they are a non-profit organization and if they need funds to implement something they will find a way. Interview with the DON on 6/13/24 at 3:05 PM identified that they have started the process and are putting together education and the policy and starting to identify the resident affected and are really trying hard to protect the dignity of the residents and feels as though this is a huge dignity issue. She does not feel the need to have anyone on EBP but understands this is the new direction and did not understand there was a date this was to be implemented. The DON identified there was no pushback from department heads regarding this policy and there has been no discussion regarding financial constraints regarding implementation. The DON identified she is ultimately the person in charge of the Infection Preventionist and she should determine what information she would need and what would need to be implemented with what time frame. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Center for Clinical Standards and Quality Safety and Oversight Group (QSO) memo Ref: QSO-24-08-NH dated 3/20/24 identified that in 2019 the Centers for Disease Control and Prevention (CDC) introduced a new approach for the usage of personal protective equipment (PPE) called Enhanced Barrier Precautions which was updated in July 2022, and the Centers for Medicare and Medicaid (CMS) was updating its infection prevention and control guidance accordingly. The QSO-24-08-NH further identified that the effective date was April 1, 2024. Review of the facilities Enhanced Barrier policy received directed an order will be received for residents who do not have a chronic wound or indwelling medical devise and are infected or colonized with an MDRO that is not currently targeted by CDC but may ne considered epidemiogically important. An order for enhanced barrier precautions will be obtained for residents with any of the following, wounds, diabetic foot ulcers, unhealed surgical wounds, and chronic venous-stasis ulcer, and or indwelling medical devices, even if the resident is not known to be infected or colonized with a MDRO. 2. Review of the facility's MDRO list and with the Infection Preventionist Nurse (RN#4) on 6/18/24 at 10:26 AM failed to identify Resident #55 had a History of C-diff (clostridium difficile) on admission and was co-horted with an individual without a C-diff dx or history of. Resident #55 was admitted to the facility with enterocolitis due to clostridium difficile, gastro-esophageal reflux disease without esophagitis, irritable bowel syndrome with constipation. The care plan dated 10/21/22 did not identify Resident #55 had a history of C-diff. The admission MDS assessment dated [DATE] identified Resident #55 had moderately impaired cognition and required extensive assistance with toileting, hygiene, bathing, and dependent on personal hygiene, transfers. assistance with toileting hygiene, bathing and dependent on care personal hygiene, transfers, and non-ambulatory. A physicians order was not in effect for due to the fact the facility had not implemented EBP precautions. Interview with RN#4 on 6/18/24 at 10:30 AM identified that she was unaware of the history of C-diff on admission for Resident #55 admitted in October of 2022, however admission paperwork and current diagnoses included this diagnosis. RN#4 identified that she was responsible for identifying these diagnoses and reviews admission paperwork for each resident and took on this role in February of 2022 and it must have been an oversight. If she knew that Resident #55 had this diagnosis, she would have included it on her MDRO list and advocate for a single room for the resident or co-[NAME] with someone else with a history of C-diff. Interview with DON on 6/18/24 at 10:55 AM identified that someone with a history of C-diff should be reflected on the MDRO list. She would expect this to be reviewed by the infection control nurse upon admission. Typically, they would try to cohort with someone with the same diagnosis or give a single room to this person as they have a lot of single rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled Infection Control History Logs dated 8/2018 directed the infection control nurse to maintain a history log of residents who have been diagnosed with C-diff, MRSA, and VRE. The log is utilized when determining appropriate roommates and reviewing signs and symptoms of infections. When a new case of C-diff, MRSA, or VRE is diagnosed , the Infection Control Nurse enters the information in the appropriate history log. When the resident's infection has resolved and or colonized the information is documented in the log.