STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075244	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Health Center	652 West Avon Rd Avon, CT 06001

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, clinical record review, and review of facility policy for the only sampled resident reviewed for respiratory care (Resident #29), the facility failed to maintain a safe environment for a resident (Resident #29) on continuous oxygen by allowing long-term unsupervised use of petroleum-based jelly on the face and lips without a physician order, staff oversight, or self-administration assessment. Staff were aware of the resident's repeated use of petroleum jelly but did not intervene, despite flammability warning on the oxygen equipment and established contraindications. The facility also failed to monitor and control water temperatures at resident points of use, resulting in widespread temperatures exceeding 120 degrees ( ) Fahrenheit (F) and exposing residents to an immediate risk of scalding. These systemic failures demonstrated a lack of monitoring, a lack of staff awareness, a lack of adherence to policies, and a failure to protect residents from avoidable immediate harm. These failures resulted in the finding of immediate jeopardy. 1.Resident #29's diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and obstructive sleep apnea. Physician orders dated 1/20/26 and currently in effect directed to utilize Oxygen at 3 liters/minute continuously every shift via nasal cannula related to hypoxia for COPD. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 had intact cognition and was independent with toileting, transfers, and bed mobility. The MDS further indicated Resident #29 had a diagnosis of COPD and was receiving oxygen therapy. The Resident Care Plan (RCP) dated 2/23/26 identified Resident #29 had an altered respiratory status and difficulty breathing related to oxygen dependence and COPD. Interventions included to monitor Resident #29 for vital signs with oxygen saturations (sats) as ordered and providing oxygen at 3 liters (l) per minute via nasal canula. Observation during the initial tour of the facility on 3/9/26 at 11:00 AM identified Resident #29 was in his/her wheelchair at the bedside, not utilizing oxygen as ordered at 3 liters/minute via nasal cannula with 1 small (1.75 ounce) uncovered tub of petroleum-based jelly which was 3/4 empty located on the nightstand in front of other personal hygiene products such as shampoo. A second observation and an interview with Resident #29 on 3/11/26 at 10:22 AM identified his/her family member had brought in the small (1.75 ounce) tub of petroleum-based jelly (cocoa butter healing jelly) and the resident had been self-administering the jelly on his/her lips (with the oxygen running) several times a day especially at night for years. Resident #29 indicated he/she applied the jelly when his/her lips felt dry. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Observation, interview, and review of the clinical record with Nurse Aide (NA) #2 on 3/11/26 at 10:57 AM identified she was aware Resident #29 had 1 small (1.75 ounce) of petroleum-based jelly on the nightstand table that the family had provided. NA #2 indicated she was aware that the resident was self-administering the petroleum-based jelly to his/her face while on continuous oxygen and had been using petroleum-based jelly since admission [DATE]). Observation and interview with Resident #29 on 3/11/26 at 3:09 PM noted Resident #29 wearing oxygen via nasal cannula at 3 l/minute. Resident #29 identified his/her family member provided petroleum-based jelly and she/he liked to apply it to his/her lips frequently throughout the day due to having dry lips. Additionally, Resident #29 noted he/she had a second jar in his/her drawer because the current one was almost empty. Interview on 3/11/26 at 3:10 PM with Licensed Practice Nurse (LPN) #3 identified Resident #29 did not have a physician order to use petroleum-based jelly and the family brought in items at times but did not always check with staff. LPN #3 further identified she had not noticed the petroleum-based jelly on the nightstand table until the NA spoke to her earlier on 3/11/26 subsequent to surveyor's observation. Interview with the Oxygen Company Vendor on 3/11/26 at 3:14 PM identified a resident who was on oxygen should not be using any petroleum-based or oil-based products on their face (including the lip area) because it had the potential to burn or cause other injuries. Interview with the Director of Nurses (DNS) on 3/11/26 at 3:39 PM identified she was not aware Resident #29 applied petroleum-based jelly to his/her lips throughout the day wearing 02 continuously at 3 liters and did not think it was a concern. Subsequent to surveyor inquiry an observation on 3/11/26 at 4:03 PM identified the 1 small (1.75 ounce) of Petroleum-based jelly had been removed from the nightstand table and taken to the medication room by LPN #3 who also identified a second full container (1.75 ounce) petroleum-based jelly (original healing jelly) was found in Resident #29 drawer which was also removed from the resident's room. Interview on 3/11/26 at 4:20 PM with Person #1 noted he/she denied providing petroleum jelly to Resident #29. A second interview on 3/12/26 at 11:00 AM with Person #1 identified she/he did take Resident #29 shopping, and Resident #29 could have purchased the petroleum-based jelly at that time, but she/he did not notice and was unaware it was contraindicated with oxygen. Interview on 3/13/26 at 9:50 AM with LPN #3 identified she was the usual nurse on the unit for the 7:00 AM to 3:00 PM shift, and she noticed the petroleum-based jelly on the front part of the bedside nightstand when it was brought to her attention by the NA on 3/11/26. Interview on 3/13/26 at 1:52 PM with LPN #3 identified that when she enters a resident room to provide medication, treatments, etc. she scans the room but concentrates on the resident when entering a room and doesn't look for hazardous items. Interview with the DNS on 3/16/26 at 10:01 AM identified she would expect the nursing staff to observe general safety of a resident's room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Observation of the portable oxygen label on 3/16/26 at 10:38 AM noted a warning sticker adhered to the side identifying it was flammable and the oxygen concentrator had a label identifying contents vigorously accelerate combustions, keep oil and combustibles away. Review of the facility policy, Oxygen Therapy, identified to maintain proper oxygenation of body tissues and to provide for safety of the environment during oxygen administration. Oxygen therapy was to be administered and monitored by a licensed nurse. The above deficiency resulted in the finding of Immediate Jeopardy (IJ). After observations made on 3/11/26, the facility Administrator was provided with the IJ template on 3/11/26 at 3:43 PM and submitted a removal plan which was approved by the State Agency on 3/11/26. The Removal Plan noted in part, the petroleum-based jelly was immediately removed from Resident #29's room, and all residents utilizing oxygen were checked to ensure no petroleum-based products were present. Additionally, education was provided to all staff, residents and resident representatives regarding the contraindication of using petroleum-based products while using oxygen and if products were found, to immediately remove them. Additionally, the facility will implement weekly audits on each unit to ensure no petroleum-based products were in the room of residents receiving oxygen and laminated signs containing a list of prohibited items to use in the presence of oxygen will be posted in the medication room, supervisor's office and oxygen supply areas. Observations on 3/13/26 identified that the facility implemented the removal plan and the IJ was removed. 2.Observation during initial resident screening on 3/9/26 identified water temperatures in resident bathrooms were above 120.0 degrees F as follows: Unit North (N): Room N11/N12 (a shared bathroom) water temperature was 125.2 degrees F at 10:40 AM, Room N3/N4 water temperature was 127.4 degrees F at 10:46 AM, Room N5/N6 water temperature was 122.8 degrees F at 10:48 AM, Room N11/N12 water temperature was 125.2 degrees F at 10:50 AM, Room N12 (not a shared bathroom) water temperature was 130.1 degrees F at 11:25 AM, and Room N13/N14 water temperature was 129.0 degrees F. A Wing: Room A3 water temperature was 130.8 degrees F at 11:50 AM and Room A5/A7 water temperature was 125.4 degrees F at 11:53 AM. B Wing: Room B2 water temperature was 124 degrees F at 10:52 AM and Room B16/B18 water temperature was 122.5 at 12:30 PM. Unit South: Room S17/S18 water temperature was 135.8 degrees F, Room S21/S22 water temperature was 122.1 degrees F at 11:50 AM, and Room S25/S26 water temperature was 125.7 degrees F at 12:06 PM On 3/9/26 at 12:38 PM, interview and review of the elevated water temperatures taken by the survey team with the Director of Maintenance (DM) identified he was responsible for monitoring water temperatures, and that he monitored water temperatures in the boiler room for the main water supply pipe, mixing valves, holding tanks and water returns (but not in resident rooms/areas) and documented them on the clipboard located next to Mixing Valve #1. He indicated he randomly monitored those same water temperatures multiple times throughout the day but did not document those subsequent water temps on the clip board. Additionally, he identified that he did not monitor (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	water temperatures inside resident bathrooms or shower rooms and only monitored the water temperatures in the boiler room. He identified the water monitoring log binder did identify water temperatures in resident bathrooms and shower rooms, but that was from earlier in the year when he had an assistant who monitored the water temperatures in those areas, but when his assistant left, he (DM) did not continue to monitor water temperatures in the resident bathrooms and showers. Additionally, he identified the facility was in the process of purchasing an electronic mixing valve which would automatically maintain consistent water temperatures at the mixing valves throughout the day. Interview and conducting water temperatures with the DM on 3/9/26 at 12:51 PM identified B2 bathroom had a water temperature of 123.0 degrees F (taken by the surveyor's thermometer and the DM's thermometer). Additionally, N12A bathroom had a water temperature of 122.0 degrees F with the surveyor's thermometer and 123.0 degrees F with the DM's thermometer. While monitoring the water temperatures, in Room N12A, for approximately 30-45 seconds, the water pressure was observed to increase significantly while subsequently increasing in water temperature and then the water pressure would decrease back to the original flow rate with a subsequent drop in water temperature. Room N12A's water temperature taken by the DM ranged from 113.0 degrees F to 123.0 degrees F during the change in water pressure and by the surveyor was 111.0 degrees F to 122.0 degrees F. The DM could not identify the reason the water temperature elevated for a period of time and then dropped more than 10.0 degrees F. Interview with the DM on 3/9/26 at 2:40 PM identified the facility did not have a policy for monitoring water temperatures that he was aware of, and that he was not aware of a regulation which directed to monitor water temperatures in resident bathrooms. He identified if the water temperature for mixing valve #1 was above 120.0 degrees F he would monitor it for a few minutes, if it didn't decrease on its own, he would adjust the mixing valve and then monitor the water temperature at the mixing valve for a while (but not resident rooms). Subsequent to surveyor inquiry, monitoring of water temperatures in resident bathrooms and shower rooms was initiated for off shifts. On 3/10/26 review of the water temperature monitoring noted on 1/28/26 the shared bathroom in N11/N12 identified the water temperature was 130.0 degrees F. The water temperature monitoring log failed to identify what measures were taken in response to the temperature above 120.0 degrees F identified in Room N11/N12. Additionally, the water temperature monitoring log failed to identify the time of day the water temperatures were monitored. Subsequent to surveyor inquiry on 3/10/26, review of the undated Hot Water Temperature Safety policy located in the water monitoring log binder directed water temperatures on all sources accessible to residents would be checked and documented at least monthly. Additionally, the policy directed the water temperature must not exceed 120 degrees (a discrepancy to an interview with the DM on 3/9/26 that stated the facility did not have a policy for monitoring water temperatures on sources accessible to residents). On 3/10/26 at 11:08 AM, noted the shared bathroom of Room N5/N6 had a water temperature of 124.2 degrees F and Room N11/N12 had a water temperature of 122.4 degrees F. Interview with the Administrator on 3/10/26 at 11:15 AM identified the vendor for the company who maintains their Combined Heat and Power ([NAME]) system was in earlier that morning to make (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	adjustments to the system and prior to high water temperatures being identified by the surveyor). Interview and observation on 3/10/26 at 11:30 AM in the shared bathroom for N13/N14 with Licensed Practical Nurse (LPN) #2 identified the water temperature was 129.0 degrees F. LPN #2 tested the water with her finger and stated that it felt very hot and could burn someone. LPN #2 stated that she was to notify the maintenance department that the water was hot so they could determine what needed to be done (but did not instruct staff/resident to not use the faucet until Maintenance could bring water temperatures within acceptable range). Observation on 3/11/26 at 11:27 AM identified the private bathroom in Room B2 had a water temperature of 120.7 degrees F. Review of the water temperature monitoring logs dated 3/9/26 to 3/16/26 (during the re-certification survey) identified water temperatures were monitored in at least 2 resident rooms and/or shower rooms on each unit each day. The logs identified 5 out of the 80 entries indicated that water temperatures were above 120.0 degrees F. On 3/9/26 at 3:44 PM the water temperature in the shared bathroom for A9/A11 was 118.6 degrees F at 1 minute and 122.4 degrees F at 2 minutes; on 3/10/26 at 5:55 PM the water temperature in the only shower on the A wing was 113.7 degrees F at 1 minute and 125.2 degrees F at 2 minutes; on 3/10/26 at 6:00 PM the water temperature in the shared bathroom for B8/B10 was 121.8 degrees F at 1 minute and 130.8 degrees F at 2 minutes; on 3/10/26 at 6:08 PM the water temperature in the shared bathroom for B20/B22 was 129.6 degrees F at 1 minute and 125.1 degrees F at 2 minutes; and on 3/11/26 at 6:47 PM the water temperature in the shared bathroom for B24/B26 was 119.1 degrees F at 1 minute and 122.3 degrees F at 2 minutes. Interview with the Administrator on 3/11/25 at 3:43 PM identified that the Director of Maintenance should be monitoring water temperatures inside resident bathrooms and shower rooms and it was his understanding that this was being done. Interview with the Administrator on 3/13/26 at 1:45 PM identified he had been unaware water temperatures were not being monitored in resident care areas and thought that the DM had been monitoring the water temperatures in resident bathrooms at least regularly if not daily. He identified he had initiated purchasing an electronic mixing valve for the facility at the beginning of the year to help streamline the management of the water temperatures throughout the building but had not completed the process. Interview with Maintenance #1 on 3/13/26 at 2:15 PM identified on 3/10/26 the facility was experiencing water temperature issues. He identified he was checking the water temperatures frequently after 3/10/26 and even though he tried balancing them at the mixing valve, the water temperatures would not remain steady even with putting in 2 refurbished mixing valve cartridges and calling the vendor to order 2 new mixing valves. He identified on 3/11/26 that both mixing valves (Mixing Valve #1 and Mixing Valve #2) were replaced with new mixing valves. He identified that previously Mixing Valve #1 provided water to most of the building and all resident care areas and Mixing Valve #2 provided water to the kitchen. He indicated some changes were made and the facility was operating with just Mixing Valve #1 which was working well and water temps remained steady. Interview with the DM on 3/16/26 at 11:30 AM identified that he followed the contents in the Plant Manager Guide regarding water temperatures and the guide directed to check water temperatures but did not specify the when or where. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Plant Manager guide identified under Part 1 Section D Heating, Venting and Air Conditioning (HVAC) Systems, bullet #3 directed to check water temperature. The guide failed to identify directives to monitor water temperatures in resident care areas or provide a frequency for monitoring of water temperatures. Interview with the Administrator on 3/16/26 at 11:45 AM identified he had located the water temperature monitoring policy and that he made sure it was located in the Maintenance office for use by Director of Maintenance. Review of the Water Temperature Monitoring Policy directed, in part, the facility would monitor and document water temperatures in resident care areas to ensure water delivered to sinks, showers, and tubs (resident-use fixtures) was maintained within a safe range. The policy directed water temperatures would be monitored on a routine schedule of weekly testing of resident sinks, weekly testing of bathing areas and showers, and additional testing after plumbing repairs and/or maintenance and testing sites would rotate weekly to ensure all fixtures are periodically monitored. Additionally, the policy directed when water temperatures fall outside the safe range maintenance staff would immediately adjust the mixing valve, retest the fixture with the out-of-range water temperature, and document the corrective action. The policy directed in the event the immediate correction was not possible the fixture would be removed from resident use until the repairs were completed. The failure to monitor water temperatures in resident bathrooms and shower rooms to identify the potential for water temperatures to exceed 120.0 degrees F to prevent the risk from scalding resulted in a finding of Immediate Jeopardy. On 3/11/26 at 3:43 PM the IJ Template was provided to the Administrator. On 3/11/26 at 6:40 PM the facility submitted the removal plan which was accepted by the State Agency. The Removal Plan noted in part, staff implemented safety measures which included monitoring water temperatures in the affected areas and halting resident showers until water temperatures were to be within proper limits. Additionally, a heating contractor replaced both mixing valves at the source on 3/11/26, water temperatures were re-tested in resident rooms and were within the range of 105.0 degrees F to 120.0 degrees F. The Removal Plan also included education to Maintenance staff on utilizing the temperature log to complete routine water temperature monitoring in resident rooms daily in a rotating sample of 2 resident rooms per unit for 2 weeks and then weekly on a rotating unit basis. Any water temperature reading outside the acceptable range will result in immediate corrective action and re-testing (signage posted over the sink instructing to not use the faucet and notifying staff/resident not to use the faucet). Also, if the staff determine water feels too hot, they will notify maintenance immediately. Observations on 3/17/26 identified that the facility implemented the removal plan and IJ was removed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, facility documentation and facility policy for 1 of 2 residents (Resident #76) reviewed for mistreatment, the facility failed to complete a thorough investigation related to an allegation of untimely incontinent care. The findings include: Resident #76 was admitted to the facility in March 2021 with diagnoses that included cerebral infarction (CVA), hypertension, and behavior disturbances.Physician orders dated 7/16/25 directed to provide 2 caregivers for care. The Resident Care Plan (RCP) dated 7/16/25 identified Resident #76 had urinary incontinence with interventions that included providing incontinent care every 2 hours and as needed, utilize an incontinent pad and brief, and preventive skin care with each incontinent episode.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #76 had a short and long term memory problem, was moderately cognitively impaired in making decisions related to daily care, was always incontinent of urine and totally dependent on staff for incontinent care. A facility Grievance Form completed on 8/2/25 by Registered Nurse (RN) #3 for Person #2 indicated that at 11:30 AM on 8/2/25, Person #2 stated that Resident #76's incontinent brief and draw sheet were saturated with urine when/he/she came to visit. RN #3 spoke to NA #6 (an agency Nurse Aide) that was assigned to Resident #76 and NA #6 indicated that she had not yet provided incontinent care to Resident #76. RN #3 reminded NA #6 that incontinent care should be given at the start of shift. The Grievance Form also indicated that Person #2 activated Resident #76's call bell which was turned off at the nursing station without being answered. The facility follow-up response on the Grievance Form indicated that NA #6 was spoken to and a message was given to the Staff Development Nurse to educate staff not to turn off the call light at the nursing station without answering first. Education was initiated on 8/4/25 regarding call bells however no education was located for agency staff aides regarding timely care and communicating concerns regarding timely care to Nursing Supervisors.Interview with the DNS on 3/11/26 at 10:18 AM indicated that she was made aware of the grievance from Person #2 when she returned from being off but could not recall the exact date. In addition, the ADNS was off on extended leave at that time. The DNS indicated that the supervisors were responsible for investigating grievances or allegations of abuse/neglect when the DNS/ADNS were unavailable as they were aware of the facility's policies. Although the DNS followed up with Person #2 when she returned to work, she was not aware of any statements for the investigation by RN #3 regarding timeliness of incontinent care and the call bell being turned off. The DNS was unaware if the Administrator was made aware of Person #2's concerns regarding the lack of incontinent care and shutting off the call bell at the nurse's station.Interview, review of the Grievance Form dated 8/2/25 and review of documentation in the clinical record with RN #4 on 3/11/26 at 10:52 AM indicated that she was made aware of the grievance that occurred over the weekend on 8/2/25 when she returned to work on Monday on 8/4/25. She indicated that she had spoken to RN #3 and that RN #3 had contacted the nursing staffing agency to inform them that NA #6 was no longer able to come to the facility due to not performing incontinent care timely for a resident. RN #4 indicated that she was not aware of any written statements that were obtained for the investigation and that she would have to contact RN #3 to inquire about the investigation and statements. RN #4 was unable to determine when the last time Resident #76 received incontinent care due to lack of statements obtained by NAs for the investigation. In addition, documentation in Resident #76's nursing notes and behavior monitoring for 8/1/25 and 8/2/25 identified that Resident #76 had not refused any care offered. RN #4 indicated that the facility policy was that incontinent care be provided every 2 to 3 hours and that statements should have been obtained to investigate the concern related to lack of timely incontinent care. Lastly, she was aware that education would be provided to staff regarding the call bell concern, however; she was unaware if any statements were obtained regarding this concern.Interview with RN #3 on 3/11/26 at 2:31 PM indicated that she had not investigated or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtained any written statements from NA #5 and NA #6 or any other staff members that worked on the 11:00 PM to 7:00 AM on 8/1/25 or on the 7:00 AM to 3:00 PM shift on 8/2/25 regarding the timeliness of incontinent care. RN #3 indicated that she did not review the NA flowsheets for documentation regarding the times incontinent care was provided for 8/1/25 on the 11:00 PM to 7:00 AM shift or on 8/2/25 for the 7:00 AM to 3:00 PM shift. RN #3 indicated that she did speak to NA #6 who indicated that she just had not gotten to provide care to Resident #76 yet as it was very busy. RN #3 indicated that NA #6 did not notify her that she was behind in providing timely care until Person #2 had vocalized concerns related to Resident #76 being saturated in urine. RN #3 stated that the facility policy was that residents receive incontinent care every 2 to 3 hours. Lastly, RN #3 indicated that she should have investigated the concern further and obtained statements from the staff.Interview with Person # 2 on 3/13/26 at 10:00 AM indicated that Resident #76 was saturated in urine around 11:00/11:30AM on 8/2/25. Person #2 stated that Resident #76 was upset about being saturated in urine. Person #2 indicated that he/she immediately reported the concern to RN #3, did not wait for NA #6 and provided incontinent care to Resident #76 him/herself. Person #2 indicated that the DNS did contact him/her regarding the concern but he/she has never received a call from the Social Worker (SW)Interview with SW #1 on 3/13/26 at 11:00AM indicated that she was aware of the grievance and signed the Grievance Form on 8/4/26. She indicated that nursing was responsible for investigating the concerns and following up as it was a nursing issue related to care. A second interview with the DNS on 3/13/26 at 11:23 AM indicated based on facility policy the investigation was not complete and RN #3 should have interviewed and obtained statements from staff and reviewed NA documentation.The Abuse Policy dated 7/2021 directed, in part, all allegations will be investigated thoroughly by the facility. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish and emotional distress. A thorough investigation will be conducted by the administrator and/or nursing representative. The investigation will include but is not limited to interviewing the alleged perpetrator, all staff, residents, and visitors who are believed to have knowledge of the event.

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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** Based on interviews, observation, review of the clinical record, and facility policy for 1 resident of 1 resident (Resident #29) reviewed for respiratory therapy, the facility failed to administer oxygen as per physician orders. The findings include: Resident #29's diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and obstructive sleep apnea. Physician orders dated 1/20/26 and currently in effect directed Oxygen at 3 liters/minute via nasal cannula related to hypoxia for COPD and continuous every shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 had intact cognition and was independent with toileting, transfers, and bed mobility. The MDS further indicated Resident #29 had a diagnosis of COPD and was on oxygen therapy.The Resident Care Plan (RCP) dated 2/23/26 identified Resident #29 had an altered respiratory status and difficulty breathing related to oxygen dependence and COPD. Interventions included to monitor Resident #29 for vital signs with oxygen sats as ordered and providing Oxygen at 3 liters per minute via nasal canula. Observation during the initial tour on 3/9/26 at 11:00 AM identified Resident #29 was in his/her wheelchair at the bedside, not utilizing oxygen despite a physician order for Oxygen at 3 liters/minute continuously every shift.A second observation on 3/10/26 at 10:51 AM noted Resident #29 at the hairdresser without oxygen in place and a portable oxygen tank hanging from the back of the wheelchair.A third observation on 3/11/26 at 10:22 AM noted Resident#29 seated in his/her wheelchair with a portable oxygen tank hanging from the back of the wheelchair, but Resident #29 was not wearing any oxygen.Interview and observation on 3/11/26 at 10:22 AM with Resident #29 identified he/she utilizes oxygen at night only while sleeping.Interview on 3/11/26 at 10:33 AM with the Assistant Director of Nursing Services (ADNS) identified Resident #29 had a current order for Oxygen 3 liter via nasal canula continuously and Resident #29 does not have a care plan for refusals. Additionally, the ADNS identified Resident #29 was not wearing oxygen as per the physician order, the resident should be wearing oxygen and physician orders should be followed.Interview on 3/11/26 at 3:35 PM with Nurse Aide #1(NA) identified Resident #29 used oxygen at night.Subsequent to surveyor inquiry on 3/11/26 at 3:09 PM, Resident #29 was observed in his/her room wearing Oxygen at 3 liters via nasal canula.Review of the facility policy, Oxygen Therapy, oxygen therapy to be provided upon physician's order in following forms, oxygen cylinder, concentrator, liquid oxygen, and portable oxygen tank. Oxygen therapy was to be administered and monitored by a licensed nurse.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and review of facility policy for 2 of 3 medication storage rooms, the facility failed to ensure expired heparin syringe flushes for Intravenous (IV) lines and IV 0.45% hydration bags were not expired. The findings include:Observation and interview with Registered Nurse (RN) #5 on 3/13/26 at 6:49 AM identified that there were 52 expired (7/2022) Heparin lock flushes 50 United States Pharmacopeia (USP) (medication meets official standards)/units 5 milliliters (mL) in10 units/mL syringes (for flushing IV line to prevent blood clots) in a drawer in the medication storage room on the North unit. In addition, there were 2 expired (one bag expired April 2025 and one expired November 2025) 1000mL 0.45% Normal Saline (NS) IV hydration bags in the over the counter (OTC) storage room where IV stock supplies were stored. RN #5 indicated there should be no expired IV supplies stored in the medication storage rooms per facility policy. RN #5 indicated that she was not sure of who was responsible for removing the expired IV supplies, but it was not assigned to RN supervisors on the 11:00 PM to 7:00 AM shift. She indicated that she does not check for IV medications and supplies. Interview with the DNS on 3/13/26 at 10:30 AM indicated that there should be no expired IV medications or solutions stored in the medication storage rooms. Although she indicated that there probably had not been an IV on the North unit in a long time since it was not a short-term rehabilitation unit, the policy was that expired medications were to be removed. She indicated that she was not aware of what shift the task of removing expired IV medications and solutions was assigned to but it was nursing who was responsible to ensure that expired medications are removed from the storage rooms. Subsequent to surveyor observations, RN #5 removed the 52 expired heparin flushes and the (2) 0.45% NS hydration bags from the medication storage rooms.The Medication Storage Policy directed, in part, all expired medications will be removed from the active supply and destroyed in facility regardless of amount remaining. The medication will be destroyed in the usual manner

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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** Based on interviews, observation, review of the clinical record, and facility policy for 1 of 1 resident (Resident #6) reviewed for enteral (tube) feedings, the facility failed to adhere to Enhanced Barrier Precautions (EBP) during the initiation of a tube feeding. The findings include:Resident #6 was admitted to the facility on [DATE] with diagnoses that included severe dysphagia with gastric tube (G-tube) dependence, traumatic brain injury, and schizophrenia. The quarterly Minimal Data Set (MDS) assessment dated [DATE] identified Resident #6 was severely cognitively impaired, dependent on activities of daily living, and had a swallowing disorder that required a tube feed. The Resident Care Plan (RCP) dated 1/13/26 identified that Resident #6 was on enhanced barrier precautions related to receiving enteral feeding through a gastric tube, with interventions that included maintaining enhanced barrier precautions as ordered and ensuring that personal protective equipment (PPE) was available to staff on the nursing unit. A physician order dated 1/28/26 directed staff to maintain enhanced barrier precautions secondary to the resident's Gˆtube. A physician order dated 2/10/26 directed Gˆtube feeding via pump using Jevity 1.5 (nutrient) at a rate of 70 milliliters per hour for 21 hours and water flushes 25 milliliters per hour for 21 hours, totaling 1,470 milliliters of nutrient per day and 525 milliliters of water per day. Observation of Resident #6's room on 3/13/26 at 12:30 PM showed signage was posted outside the door for enhanced barrier precautions that directed everyone upon entering and exiting the room must clean their hands. The signage also directed staff to wear gloves and a gown for highˆcontact resident care activities such as dressing, bathing, providing hygiene, wound care, and device care or use involving central lines, urinary catheters, and feeding tubes. Observation on 3/13/26 at 12:40 PM identified that Licensed Practical Nurse (LPN) #3 initiated a tube feeding for Resident #6. LPN #3 performed hand hygiene, donned gloves, prepared the tube feeding with appropriate labels, verified the physician's order, checked tube placement by assessing residuals (which were zero), and confirmed that the resident's head of bed was elevated greater than 30 degrees. However, LPN #3 did not don a gown as indicated by the enhanced barrier precaution signage outside the resident's room. Interview with LPN #3 on 3/13/26 at 12:47 PM identified that Resident #6 was on enhanced barrier precautions related to being on tube feedings, and that these precautions must be maintained during highˆcontact resident care activities such as administering tubeˆfeeding nutrition, which includes donning a gown. LPN #3 noted that she should have worn a gown when initiating Resident #6's tube feeding but did not, stating that she forgot. Interview with the DNS on 3/13/26 at 1:15 PM indicated that tube feeding was considered a highˆcontact resident care activity that required enhanced barrier precautions, and that when enhanced barrier precautions were in place, the use of a gown and gloves were required. Review of the undated policy, Enhanced Barrier Precautions, directed that enhanced barrier precautions are required for residents with chronic wounds, multidrugˆresistant organism colonization or infection, or indwelling medical devices. The policy further defined indwelling medical devices as central lines, urinary catheters, and feeding tubes. The policy identified the required PPE for enhanced barrier precautions as a gown and gloves when providing highˆrisk activities such as care related to activities of daily living, wound care, and device care such as tube feeding.

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F 0561 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on observation and interviews for 2 of 3 residents (Resident #83 and Resident #102) reviewed for choices and 7 out 7 residents (Resident #12, Resident #37, Resident #52, Resident #67, Resident #70, Resident #75, and Resident #85) that attended the Resident Council meeting, the facility failed to ensure dining rooms were opened for meals. The findings include: 1.Resident #83 was admitted to the facility in March 2025 with diagnoses that included Type 2 diabetes, chronic kidney disease and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #83 had intact cognition and was independent with eating. The Resident Care Plan (RCP) dated 12/11/25 Resident #83 had a history of noncompliance with his/her diet with interventions that included providing diet as ordered, monitoring food consumption, providing food preferences, when possible, providing diet education and reinforcement, review labs, and endocrinology as ordered.Physician orders dated 1/20/26 directed to provide a calorie carbohydrate restriction (CCD) and 2-gram sodium diet. Interview and observation on 3/9/26 at 1:30 PM identified Resident #83 was sitting on the side of the bed eating lunch. Resident #83 stated that he/she would eat in a dining room daily unless he/she was not feeling well. Resident #83 stated that he/she did not think a dining room was available for daily for meals. Observation on 3/11/26 at 11:30 AM noted Resident #83 eating lunch in the dining room on the first floor for the weekly pub lunch that was sponsored by recreation only on Wednesdays. 2.Resident #102 was admitted to the facility in March 2024 with diagnoses that included congestive heart failure (CHF), hypertension, and muscle weakness.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #102 was mildly cognitively impaired and was independent with eating. The Resident Care Plan (RCP) dated 12/23/25 identified that Resident #102 leaves greater than 25% of food uneaten for most meals with interventions that included providing diet as ordered, monitoring food consumption and weight, and review labs as ordered. Physician orders dated 2/12/26 directed a dysphagia advanced diet (soft, regular foods) and no added salt (NAS).Observations and interviews with Resident #102 on 3/9/26 and 3/10/26 at 1:30 PM identified that Resident #102 was sitting in his/her chair at his/her bedside eating lunch in his/her room. Resident #102 stated that he/she ate in the room because there was no dining room for meals and if a dining room was opened he/she would eat most meals in the dining room unless he/she did not feel up to it on a certain day. Resident #102 stated that he/she did not believe anyone had ever offered him/her to eat meals in a dining room.3.A Resident Council meeting was held on 3/11/26 at 1:00 PM which identified that all 7 residents that attended the meeting (Resident #12, Resident #37, Resident #52, Resident #67, Resident #70, Resident #75, and Resident #85) stated they would eat in a dining room for meals if a dining room was available. They stated that a dining room was not available for all meals except for the special breakfast and lunches that were held by Recreation. The residents indicated that they do not believe they were ever offered a choice to eat in the dining room daily and that they did not recall discussing the issue at a Resident Council meeting.On 3/11/26 the Recreation Director provided a list of all residents that attended the weekly luncheon in the dining room on 3/11/26. A total of 17 residents attended the luncheon. There were 6 of the 7 residents that attended the resident council meeting on 3/11/26 at the luncheon (Resident #12, Resident #37, Resident #52, Resident #67, Resident #75, and Resident #85). Interview with the Administrator and DNS on 3/16/26 at 10:40 AM identified that dining rooms have not been opened since the COVID-19 pandemic. The Administrator indicated it had been about 3 years, but the facility did have a special dining program once a week for lunch and a special breakfast for some of the residents. He indicated that in December 2025 he had discussed that the facility needed to re-start meals in the dining room and that they would have a Quality Assurance and Performance Improvement (QAPI) plan in the works related to dining room. Also, there was a new Food Service Director in place (continued on next page)

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F 0561 Level of Harm - Potential for minimal harm Residents Affected - Some	for about 3 months to work on the QAPI program. He stated that having a high number of agency staff for nursing assistants had posed challenges for the use of the dining room which was on the first floor and that there would be an improvement in nurse aide staffing as the facility has hired many nurse aides. The facility goal was to start with lunch at some point in the spring. Furthermore, he indicated that many equipment items for dining and kitchen have been purchased to improve the dining experience. In addition, the DNS indicated that when she started 3 years ago, she noted that the dining rooms were not in use.Review of the facility daily staffing schedule indicated Dining Room: all units responsible for transporting their residents to the elevator for dining.On 3/16/26 at 11:47 AM the Administrator indicated that the statement on top of the daily nursing schedule, DINING ROOM: All units responsible for transporting their residents to elevator for dining had been in use for a very long time and it had not been updated to reflect the current status of the nonuse of the dining room.A review of the Dining and Food Preferences policy dated 10/2022 directed, in part, the Dining Service Director or designee will interview the resident or resident representative to complete a food preference interview within 72 hours of admission. The purpose of this interview will be to determine individual preferences for dining, location, mealtimes including times outside of the routine schedule.The Resident [NAME] of Rights states that Residents have the right to receive quality care and service with reasonable accommodations of your individual needs and preferences except when your health and safety or others would be endangered by such accommodations.

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	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** Based on review of the clinical record, facility policy and interviews for 1 of 1 resident (Resident #37) reviewed for a change in code status, the facility failed to ensure the advance directives CPR/DNR Discussion Form was signed by the resident when the code status was changed by the physician. The findings include: Resident #37's diagnoses included hypertension, anxiety, and encephalopathy.A Cardiopulmonary Resuscitation (CPR) /DNR Discussion Form signed by Resident #37 and a staff member, dated [DATE] and located in the paper chart identified Resident #37 as a full code.Physician orders dated [DATE] directed Resident #37 was a Do Not Resuscitate (DNR).The Resident Care Plan dated [DATE] identified advance directives codes status Do Not Resuscitate (DNR), Do not Intubate (DNI), Registered Nurse May Pronounce (RNP). Interventions included for resident/family wishes to be honored, the DNR/CPR sheet reviewed with resident/family and consent signed.The quarterly Minimum Date Set (MDS) assessment dated [DATE] identified Resident #37 was moderately cognitively impaired and independent with eating, transfers, bathing, toileting and dressing.The electronic medical record (EMR) identified Resident #37 was a Do Not Resuscitate (DNR): DNI, RNP dated [DATE] (a discrepancy with the CPR Discussion Form signed by Resident #37 identifying he/she requested to be a full code). On [DATE] at 10:15 AM interview with Resident #37 identified he/she would want to have CPR and be a full code should he/she become unresponsive (and not have a code status as DNR).Interview on [DATE] at 10:27 AM with Licensed Practice Nurse (LPN) #1 identified Resident #37 was a full code per the signed form in the paper chart dated [DATE]. LPN #1 also identified the EMR identified Resident #37 as a DNR. Further, identifying if Resident #37 was to code during her shift CPR would be provided as per the signed form in the resident's paper chart.Interview on [DATE] at 10:31 AM with the Assistant Director of Nursing Services (ADNS) identified there was a discrepancy with the paper chart and the EMR. The DNS also identified that both the paper chart and the EMR should match.A second interview on [DATE] at11:14 AM with the ADNS identified a physician's progress note dated [DATE] identified a conversation had taken place with Resident #37 by the physician and the order was changed based on the physician identifying Resident #37 wanted to be a DNR but the ADNS was unable to locate a signed CPR/DNR Discussion Form regarding changing of the code status on [DATE]. The ADNS further identified Resident #37 was able to sign the form him/herself, was responsible for him/herself and the nursing staff was responsible for filling out the CPR/DNR Discussion Form with the resident.A second interview with Resident#37 on [DATE] at 11:30 AM with the ADNS present noted Resident #37 stated he/she would like to be a full code.Interview on [DATE] at 12:11 PM with the DNS identified a CPR/DNR Discussion Form was to be filled out and signed by the resident whenever the code status was changed. Also the DNS indicated if there was a conflict with the orders, the facility would follow the physician orders and see if there was a note with a discussion and would not necessarily go by the CPR/DNR discussion form signed by the residents.Review of the facility Advanced Directives Policy directed, in part to establish the residents' wishes regarding medical care. If a decision was made by a resident to change their Advanced Directives status, a new form must be completed.Subsequent to this surveyor's inquiry Resident #37 Advanced Directives were changed to a Full code, the care plan updated, and the CPR/DNR Discussion was completed on [DATE].