STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075246	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Rehabilitation Care Center	2798 Whitney Avenue Hamden, CT 06518

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 - 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** Based on interviews, review of clinical records, and facility policy for 1 of 5 sampled residents, (Resident #5) reviewed for accidents, the facility failed to provide adequate supervision with toileting resulting in a fall with major injury. The findings include:Resident #5's diagnoses included fracture of unspecified part of neck of right femur, difficulty in walking, weakness, reduced mobility, and need for assistance with personal care. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 had a Brief Interview of Mental Status score of 7 indicating severe cognitive impairment, required partial/moderate assistance with toileting hygiene and supervising/touching assistance with toilet transfers. A Morse Fall scale assessment dated [DATE] at 7:24 PM identified Resident #5 was at a high risk for falling. A Physical Therapy evaluation and plan of treatment evaluation dated 2/25/26 identified Resident #5 was an assist of two for transfers as his/her baseline. A Physician order dated 2/25/26 and in effect through 3/14/26 for Resident #5 directed an assist of two with toileting. The Resident Care Plan (RCP) dated 3/5/26 identified Resident #5 required assistance with activities of daily living related to decreased mobility and weakness. Interventions included an assist of one with washing, bathing, dressing, and toileting. Review of the facilities Certified Nurse Assistant resident assignment documented in effect on 3/14/26 for Resident #5 identified he/she was a fall risk and an assist of two for toileting. A Registered Nurse (RN) assessment note dated 3/14/26 at 10:41 AM for Resident #5 identified that while seated on toilet, resident suddenly got up, started to fall, and was lowered to the floor by the aide. Resident #5 stated I got up, my right leg gave out, and I lost balance. The note indicated that Resident #5 did not communicate or ask for help prior to the incident, had shoes on, denied hitting his/her head, and hit his/her right hip on grab bar during the loss of balance. The note indicated Resident #5 complained of right hip pain and had limited range of motion to the right lower extremity (right leg). The Advanced Practice Registered Nurse (APRN) was notified and an order for x-ray of right hip was obtained. A Situation, Background, Assessment, and Recommendation (SBAR) communication form and progress note dated 3/15/26 at 12:27 AM for Resident #5 identified that unilateral hip/pelvis x-ray results identified an acute right subcapital (beneath the head of long bone) hip fracture. The APRN was notified and a new order to transfer to the emergency room for evaluation and treatment was obtained.A RN assessment note dated 3/15/26 at 1:15 AM for Resident #5 identified that he/she was transferred to the emergency room. Review of the State Agency Reportable Event summary report dated 3/17/26 at 12:00 AM identified Resident #5 sustained a right femoral neck fracture after being lowered to the floor by his/her Nurse Aide (NA). Resident #5 was sitting on the toilet with the NA near him/her in the bathroom. Resident #5 suddenly stood up, losing his/her balance and bumped his/her right hip on the bar. The NA immediately lowered him/her to the floor. The RN supervisor was notified and assessed the resident. Resident #5 was noted to have right hip pain, and the right leg was externally (limb turning outward away from midline of body) rotated. Per NA, Resident #5 did not hit his/her head. APRN was notified and placed an order to have a right hip x-ray done at the facility. X-ray results showed a right femoral neck fracture. APRN was notified and placed orders to send to the ER for evaluation. Responsible party was notified and in agreement (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 - Actual harm Residents Affected - Few	with plan to transfer to hospital. Review of the Hospital transfer handoff document dated 3/19/26 for Resident #5 identified a right hip imaging result of impacted transcervical right femoral neck fracture (fractured neck of femur is driven into the head). Interview with the DON on 5/5/26 at 9:29 AM identified that if a resident has a physician order for two persons assist for toileting then there should be two staff members present to help with getting the resident to the bathroom, onto and off the toilet, and back to their chair or bed. The DON indicated that after she was notified of the fall with major injury for Resident #5, she notified the state agency and started an investigation. The DNS indicated that NA #4 identified that she was the only staff member present when transferring Resident #5 to the bathroom and that while Resident #5 was on the toilet, he/she stood up and lost balance. NA #4 indicated to the DON that she was behind the resident after he/she lost balance and assisted the resident slowly to the floor, preventing him/her from falling to the floor. The DON indicated that their investigation found that NA #4 failed to review Resident #5's care card resulting in NA #4 not following the physicians order and improperly assisting him/her while toileting. The DON indicated that following the investigation, the facility initiated a QAPI and plan of corrective action which included in-servicing all staff on transfers and conducting random audits to ensure physician orders and resident care cards were followed. Interview and clinical record review with the facility Medical Director (MD) on 5/5/26 at 11:07 AM identified that Resident #5 had orders on 3/14/26 for an assist of two while toileting and that there should have been two staff present at the time Resident #5 was on the toilet and received the major injury. The MD indicated that Resident #5's diagnosis of a impacted transcervical right femoral neck fracture would most likely be due to a traumatic fall or direct blow to the area if the individual did not have osteoporosis (decreased density and strength in bones), which Resident #5 did not have. Additionally, the MD indicated that a individual would not typically receive that type of fracture while being assisted to the floor. Interview with the Director of Rehabilitation on 5/6/26 at 9:03 AM that Resident #5 was evaluated by Physical Therapy on 2/25/26 and was assessed as an assist of two for all transfers including toileting. He indicated that the expectation for residents who are an assist of two with toileting is that two facility staff assist the resident to the bathroom, onto the toilet, off the toilet, and are both present during the entire duration. Interview with NA #3 on 5/6/26 at 10:43 AM identified that she was working on 3/14/26 on the unit when Resident #5 had the fall with major injury. She indicated that she was not assigned to Resident #5 and was not present in the bathroom when the fall with major injury occurred. NA #3 indicated that when a resident is an assist of two for toileting, the assigned NA should not perform the transfer without the assistance of another staff member. Additionally, NA #3 indicated she was not asked to help transfer Resident #5 by NA #4 and should have been. Interview and clinical record review on 5/6/26 at 12:45 PM with the Hospital Radiologist identified that for the impacted right femoral neck fracture Resident #5 received 3/14/26 there would need to be some kind of impact to the area. Additionally, he indicated Resident #5's fracture is a very common type of fracture in falls for the elderly. Multiple attempts to contact NA #4 were unsuccessful. NA #4 is no longer employed by the facility. Review of the facilities Two Person Transfer policy, not dated, directed in part that when able transfer to the strongest side of the resident, both persons use gait/transfer belts as applicable, explain procedure and allow resident to assist with transfer as much as able, first person stands in front of resident assisting pivot or steps for transfer, and second person stands behind resident as needed for extra assistance. Review of the facilities Plan of Correction (POC) for not transferring and toileting per Medical Director (MD) orders identified that a resident who was transferred and toileted incorrectly sustained a right hip fracture. Any resident who has transfer and toileting orders of assist of two have the potential to be affected by the alleged deficient practice. Licensed and certified staff will be educated on transferring and toileting the residents what are assist of two per the MD orders, care plan, and NA care card. Random audits will be done weekly for four weeks, then monthly to observe that residents who are assist of two for transferring and toileting are transferred and toileted correctly. Findings and trends will be reported to QA committee with additional recommendations as (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	necessary or until substantial compliance is met. Licensed and certified staff were in serviced between 3/16/26 and 4/3/26 with 155 staff signatures. The POC was reviewed at the facility QAPI meeting on 4/22/26 and identified that audits were completed weekly for four weeks and were in progress for monthly audits with no negative findings observed.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 3 sampled residents (Resident #42, Resident #133, and Resident #159) reviewed for discharge, the facility failed to develop a discharge plan of care. The findings include: 1. Resident #42 's diagnoses included a non-displaced fracture of lateral malleolus of the right fibula, chronic myeloid leukemia, and anxiety disorder. The Resident Care Plan dated 2/16/26 identified Resident # 42 required assistance with Activities of Daily Living (ADLs) due to decreased mobility related to weakness. Interventions included providing the assistance from one staff with personal hygiene, bed mobility, toileting, transfers using a walker, ambulation, bathing, and dressing. The Resident Care plan failed to identify a discharge plan to return to the community. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #42 had a Brief Interview for Mental Status score of 15 indicating intact cognition and required total assistance with dressing and toileting, substantial assistance with bed mobility, transfers and ambulation, and independent with eating. The MDS further identified Resident #42 had an active discharge plan with a plan to return to the community and a referral was made to the local contact agency. Review of the physician, Advanced Practice Nurse Practitioner (APRN) notes dated 1/16/26 to 4/24/26 failed to identify a discharge plan. A nurse's note dated 5/4/26 at 7:04 AM identified Resident #42 was to be discharged home today. Review of the physician's orders on 5/6/26 failed to direct an order to discharge to the community. 2. Resident #133's diagnosis included Alzheimer's disease, morbid obesity and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #133 had a Brief Interview for Mental Status score of 13 indicating intact cognition, and was independent with hygiene, dressing, toileting, bed mobility, transfers and ambulation. The MDS further identified Resident #133 had an active discharge plan with a plan to return to the community and a referral was made to the local contact agency. The RCP dated 4/29/26 identified Resident #133 wanted to go home and had tried to leave the facility on several occasions, refused to wear a wander guard device, and went down the stairwell. Interventions included check the wander guard device for placement every 2 hours, staff to accompany the resident to another floor and return him/her to the unit, placing on 1:1 observation, changing the stair codes, social service to follow up, psych services as needed, add to the wanderer/elopement list, and reeducate the resident to notify staff when leaving the floor. The RCP failed to identify a discharge plan. Interview with Social Worker (SW) #1 on 5/6/26 at 12:40 PM identified that a discharge care plan is not always developed for every resident unless concerns or barriers to discharge are identified. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing (DON) on 5/6/26 at 1:25 PM identified she could not locate discharge care plans for Resident #42 and Resident #133. The DON stated she would expect a discharge care plan to be developed at the first care plan meeting, so the interdisciplinary team is aware of the resident's specific needs. The DON identified the Social Services Department was responsible for developing the discharge care plan and could not explain why it had not been completed. Review of facility Care Planning policy not dated, directed in part, for the care plan to be a good working tool, it should reflect the resident's current status. Interim problems, goals, and interventions should be added at any time after the conference if minor changes occur, which alter the care to be provided. Review of facility Discharge/Community Services policy not dated, directed in part, to initiate discharge planning upon admission to the facility. Social Services to coordinate discharge plans with the resident/responsible party. 3. Resident # 159's diagnoses included congestive heart failure, hypertension, and lower back pain. A social work progress note dated 11/13/2025 identified that Resident #159 was participating in therapy with the goal of discharging to the community at his/her prior level of function and social services would assist with discharge planning. The admission MDS assessment dated [DATE] identified Resident # 159 had a Brief interview for Mental Status score of 15 indicating intact cognition and required total assistance with toileting hygiene, lower body dressing, putting on and taking off footwear, and personal hygiene, substantial assistance with showering, and set-up assistance for oral hygiene and eating. The MDS further identified Resident #159 had an active discharge plan with a plan to return to the community. The RCP dated 11/18/2025 identified Resident #159 required assistance of one staff for ADLs to decreased mobility related to pain, weakness, and spinal stenosis. The RCP failed to identify a discharge plan. Review of the nursing notes from 11/11/25 through 2/10/26 failed to provide documentation to reflect a discharge plan or discharge teaching. The APRN facility Discharge summary dated [DATE] identified Resident #159 was stabilized and cleared for discharge home with services, medications, and a follow-up appointment with the primary care provider within two weeks of discharge. A social work progress note dated 2/11/26 identified that Resident #159 was discharged home with home health services and a follow-up appointment with the primary care provider. Interview with Social Worker (SW) #1 on 5/6/26 at 12:40 PM identified that a discharge care plan is not always developed for every resident unless concerns or barriers to discharge are identified. Interview with the Director of Nursing (DON) on 5/6/26 at 1:25 PM identified she could not locate a discharge care plan for Resident #159. The DON stated she would expect a discharge care plan to be developed at the first care plan meeting, so the interdisciplinary team is aware of the resident's specific needs. The DON identified the Social Services Department was responsible for developing the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharge care plan and could not explain why it had not been completed. Review of facility Care Planning policy not dated, directed in part, for the care plan to be a good working tool, it should reflect the resident's current status. Interim problems, goals, and interventions should be added at any time after the conference if minor changes occur, which alter the care to be provided. Review of facility Discharge/Community Services policy not dated, directed in part, to initiate discharge planning upon admission to the facility. Social Services to coordinate discharge plans with the resident/responsible party.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, and facility policy for 1 of 2 sampled residents (Resident #14) reviewed for urinary catheters, the facility failed to provide a privacy cover for a urinary collection bag. The findings include:Resident #14's diagnoses included retention of urine, presence of urogenital implants and hydronephrosis with renal and ureteral calculous obstruction.The significant change in status Minimum Data Set assessment dated [DATE] identified Resident #14 had a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment and was dependent on staff for toileting hygiene and transfers. Additionally, it identified Resident #14 had an indwelling catheter.The Resident Care Plan (RCP) dated 3/27/26 identified Resident #14 had an indwelling catheter related to retention and obstructive uropathy. Interventions directed to assess intake and output per facility policy, and position catheter bag and tubing below the level of the bladder and away from entrance room door.A physician's order dated 4/14/26 directed to change foley catheter every 4 weeks using a 24 French with 30 cubic centimeters (cc) balloon.Observation on 4/29/26 at 10:00 AM identified Resident #14 was in bed by the door with the urinary collection bag attached to the left side of the bed, fully visible from the hallway, containing 350 milliliters (mL) of yellow urine without the benefit of a privacy cover.Observation on 5/4/26 at 10:28 AM identified Resident #14 was in bed by the door with the urinary collection bag attached to the left side of the bed, fully visible from the hallway, containing 300 milliliters of yellow urine without the benefit of a privacy cover.Interview and observation with Licensed Practical Nurse (LPN) #2 on 5/5/26 at 6:38 AM identified per facility policy urinary collection bags must have a privacy cover. Observation with LPN #2 noted Resident #14 was in bed by the door, with the urinary collection bag attached to the left side of the bed, fully visible from the hallway, containing 300 milliliters of yellow urine without the benefit of a privacy cover. LPN #2 stated Resident #14's urinary collection bag should have had a privacy cover, and it was undignified for Resident #14 not to have one. LPN #2 indicated the facility urinary collection bags typically come with attached privacy covers, but the new supply did not. LPN #2 identified she was unable to locate a privacy cover. Subsequent to surveyor inquiry, LPN #2 moved Resident #14's urinary collection bag to the opposite side of the bed, out of view from the hallway and indicated she would notify her supervisor.Interview and observation with Registered Nurse (RN)# 1 on 5/5/26 at 6:54 AM identified urinary collection bags should always have privacy covers. RN #1 stated it is undignified if urinary collection bags are not covered. RN #1 identified the nurses on the unit are responsible for ensuring urinary collection bags have a privacy cover. RN #1 indicated privacy covers are stored in the supply room located in the basement. Observation of the supply room with RN #1 identified one box containing 3 privacy covers. RN #1 indicated although the facility normally provides urinary collection bags with attached privacy covers it was unacceptable a privacy cover was not present on Resident #14's urinary collection bag.Interview with the Assistant Director of Nurses (ADON) on 5/5/26 7:19 AM identified the facility policy requires that urinary collection bags hang attached to the bed below the level of the resident's bladder with privacy cover. The ADON identified all staff are responsible for ensuring urinary collection bags are covered. The ADON indicated that the supply clerk was recently hired and ordered the wrong type of urinary collection bags. The ADON indicated he would have the supply clerk order the urinary collection bags that come with a privacy cover.Review of facility Catheter Drainage System policy, not dated, directed in part that drainage bags are emptied by nursing personnel every shift and PRN and for staff to explain procedure to residents and provide privacy. Although requested, a catheter privacy bag policy was not provided.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, facility documentation, and interviews for 2 of 3 residents (Resident #42 and Resident #159) reviewed for discharge, the facility failed to notify the Office of the State Long-Term Care Ombudsman of discharges from the facility. The findings include:1. Resident #42 's diagnoses included a non-displaced fracture of lateral malleolus of the right fibula, chronic myeloid leukemia, and anxiety disorder. The Resident Care Plan dated 2/16/26 identified Resident # 42 required assistance with Activities of Daily Living (ADLs) due to decreased mobility related to weakness. Interventions included providing the assistance from one staff with personal hygiene, bed mobility, toileting, transfers using a walker, ambulation, bathing, and dressing. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #42 had a Brief Interview for Mental Status score of 15 indicating intact cognition and required total assistance with dressing and toileting, substantial assistance with bed mobility, transfers and ambulation, and independent with eating. The MDS further identified Resident #42 had an active discharge plan with a plan to return to the community and a referral was made to the local contact agency. A nurse's note dated 5/4/26 at 7:04 AM identified Resident #42 discharged home today. Interview with Social Worker #1 on 5/6/26 at 12:40 PM identified she only notifies the Ombudsman for discharges involving Against Medical Advice (AMA) or hospitalization bed-hold issues. SW #1 identified does not notify the Ombudsman when a resident discharges home. Social Worker #1 indicated the Director of Admissions was responsible for notifying the Ombudsman of residents discharged home. Interview with the Director of Admissions on 5/6/26 at 12:45 PM identified she did not notify the Ombudsman on 5/4/26 that Resident #42 was discharged home. The Director of Admissions identified she does not notify the Ombudsman of residents discharged home. The Director of Admissions indicated that if a resident leaves AMA or is transferred to the hospital the Ombudsman is notified. 2.Resident # 159's diagnoses included congestive heart failure, hypertension, and lower back pain. A social work progress noted dated 11/13/25 identified Resident #159 was participating in therapy with the goal for discharge to the community to their prior level of function and social services would assist with discharge plans. The admission MDS assessment dated [DATE] identified Resident # 159 had a Brief interview for Mental Status score of 15 indicating intact cognition and required total assistance with toileting hygiene, lower body dressing, putting on and taking off footwear, and personal hygiene, substantial assistance with showering, and set-up assistance for oral hygiene and eating. The MDS further identified Resident #159 had an active discharge plan with a plan to return to the community. The RCP dated 11/18/2025 identified Resident #159 had decreased mobility related to pain, weakness, and mobility with interventions that directed to provide the assistance of one staff for ADLs. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The APRN facility Discharge summary dated [DATE] identified Resident #159 was stabilized and cleared for discharge home with services, medications, and a follow-up appointment with the primary care provider within two weeks of discharge. A social work progress note dated 2/11/26 identified that Resident #159 was discharged home with home health services and a follow-up appointment with the primary care provider. Interview with Social Worker #1 on 5/6/26 at 12:40 PM identified the Director of Admissions is responsible for notifying the Ombudsman. Interview with the Director of Admissions on 5/6/26 at 12:45 PM identified she did not notify the Ombudsman on 2/10/26 that Resident #159 was discharged home. The Director of Admissions identified she does not notify the Ombudsman of residents discharged home. The Director of Admissions indicated that if a resident leaves AMA or is transferred to the hospital the Ombudsman is notified. The facility Discharge/Community Services Policy not dated, directed in part, initiate discharge planning upon admission to the facility and Social Services to coordinate discharge plans with the resident/responsible party. The policy failed to direct Ombudsman notifications.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #161) reviewed for respiratory care, the facility failed to develop a baseline care plan for respiratory care including oxygen use and anxiety. The findings include: Resident #161 was readmitted to the facility on [DATE] diagnoses included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), anxiety disorder and polysubstance abuse. An admission physician's note dated 4/21/26 indicated Resident #161's chief complaint upon admission was shortness of breath and flu-like symptoms with acute on chronic respiratory failure, a history of end stage COPD on chronic prednisone and 2 liters of oxygen. Resident #161 presented with shortness of breath and flu-like symptoms and a history of aspiration pneumonia. During a recent hospitalization in January 2026, the resident developed suspected pulmonary edema with right ventricular strain and was admitted to the Intensive Care Unit (ICU) for acute hypoxemic hypercapnic respiratory failure requiring bilevel positive airway pressure (BiPAP) support. The clinical course was complicated by COPD exacerbation, aspiration pneumonia and a small acute right upper lobe pulmonary embolism, requiring escalation to 5 liters of oxygen and aggressive diuresis with intravenous Lasix followed by intravenous Bumex for pulmonary edema management. The COPD exacerbation was treated with Solumedrol and prednisone taper and the aspiration pneumonia with antibiotics.Physician's orders, in effect on 4/21/26, directed continuous oxygen at 2 liters/minute via nasal cannula to keep oxygen saturation greater than 90% every shift.The baseline care plan dated 4/21/26 failed to identify the resident's recent respiratory failure with hypoxia, COPD or oxygen use. It also failed to identify respiratory monitoring including monitoring oxygen saturations and monitoring for anxiety. The admission MDS dated [DATE] identified Resident #161 had intact cognition and required continuous oxygen.Observation on 4/29/26 at 2:21 PM identified Resident #161 with eyes closed, head tilted back with deep breaths followed by 5-10 second periods of apnea. Nursing staff notified and woke Resident #161. Resident #161 was alert and oriented and verbalized concerns with anxiety and medications for anxiety. Resident #161 had oxygen on via nasal canula at 2 liters/minuteInterview with RN #2 (MDS Coordinator) on 5/5/26 at 1:59 PM indicated the baseline care plan was started on 4/21/26 without a plan for respiratory care, oxygen use or anxiety. RN #2 identified respiratory care, oxygen use and anxiety should be in the baseline care plan. RN #2 further indicated the baseline care plan is begun by the supervisor or admitting nurse and the comprehensive care plan is done by the MDS Coordinator. Interview and clinical record review with DNS and ADNS on 5/5/26 at 2:13 PM indicated that the supervisor is responsible for the baseline care plan and it was usually done within 24 hours. The DNS further indicated that there should be a care plan for respiratory care, oxygen use and anxiety. The DNS and ADNS indicated that the clinical record failed to reflect documentation of a baseline care plan for respiratory care, oxygen use or anxiety. The DNS and ADNS were unable to explain why the baseline care plan for respiratory care, oxygen use or anxiety was not completed.Review of the care planning policy directed upon admission, a brief interim plan shall be established to guide care givers until the full care plan was developed. This interim plan should include any problem and key approaches from each department involved in the resident's care. The plan is documented on the admission worksheet from the interdisciplinary team members. In order for the care plan to be a good working tool, it should reflect the residents' current status, interim problems, goals and interventions should be added at any time after the conference if minor changes occur which alter the care provided.

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	075246	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #3 and 126) reviewed for range of motion and positioning, for Resident #3, the facility failed to obtain a physician's order for a splinting device and failed to follow up on splinting device recommendations and for Resident #126 who had a contracture, the facility failed to apply palm guards to both hands per OT recommendations and physician's orders. The findings include:1. Resident #3 had diagnoses that included primary osteoarthritis, disorders of bone density and structure, and muscle weakness.The quarterly MDS dated [DATE] identified Resident #3 had severe cognitive impairment, was totally dependent on staff for all activities of daily living (ADL's) including eating, dressing and personal hygiene and received occupational and physical therapy at least 15 minutes a day on one or more days in the past 7 days. The Occupational Therapy (OT) Discharge Summary signed by OT #2 on 4/22/26 at 1:27 PM recommended that Resident #3 continue wearing a left palm guard and staff to pursue fitting of left resting hand splint.Observation on 4/29/26 at 10:35 AM and 5/4/25 at 10:49 AM identified Resident #3 with a palm guard on left hand. The care plan dated 5/1/26 identified Resident #3 required assistance with ADL's and had decreased mobility. Interview and record review with the Director of Rehabilitation (OT #1) on 5/5/26 at 11:38 AM identified it was facility policy for residents to be evaluated by therapy upon admission, and, if needed, skilled therapy services were initiated. OT #1 further identified that upon discharge from therapy services, the therapist writes orders reflecting the discharge summary recommendations, which are then transcribed by nursing. Review of Resident #3's clinical record with OT #1 identified that the resident received therapy services from 3/3/26 to 4/22/26. The discharge summary recommendations included continuation of the left palm guard and pursuit of a fitting for a resting leftˆhand splint. However, further review with OT #1 failed to reflect that a physician's order for the leftˆhand palm guard had been obtained, and there was no documentation that a fitting for a resting leftˆhand splint had been set up. OT #1 indicated that the physician's order should have been entered at the time of discharge from therapy services on 4/22/26 and added that he would need to check with OT #2 regarding the status of the resting left hand splint fitting, since it requires an outside vendor.Review of physician's order failed to identify the recommendation for a resting left hand splint fitting or the palm guard. Interview and documentation review with OT #2 on 5/5/26 at 12:12 PM identified that the splint vendor was initially contacted on 4/15/26 via text message to perform a splint fitting for Resident #3 and was scheduled for 4/23/26, however, the vendor cancelled that appointment on 4/23/26. OT #2 stated the vendor was not contacted to reschedule until surveyor's inquiry on 5/5/26 (12 days later), and the fitting was rescheduled for 5/7/26. OT #1 was unable to explain why there had been no prior followˆup. OT #2 identified that there should have been a physician's order for Resident #3's palm guard and that she would be entering that order. Subsequent to surveyor inquiry a physician's order dated 5/5/26 directed palm guard to the left hand, on after morning care, off after evening care and assess skin integrity every shift. Additionally, the nurse aide Resident Assignment sheet for Resident #3 dated 5/5/26 directed to apply left hand palm guard with morning care and take off with evening care. Review of the Splinting Policy directed that nursing staff was to follow therapeutic interventions including splinting and wearing schedule as indicated by therapy, nursing staff to document splinting application and notify rehabilitation of changes in resident condition regarding splinting (poor tolerance, increased or decreased range of motion in the joint, redness, change in edema).Review of the Therapy Orders Policy directed the purpose was to obtain accurate orders for therapy evaluation and treatment procedures to ensure services and treatments established in the plan of care or developed during the course of treatment will be accurately reflected in the medical record. Additionally, therapy orders will be entered by a therapist in the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility Electronic Medical Record upon completion of evaluation.2. Resident #126 diagnoses included weakness and unspecified dementia.The quarterly MDS dated [DATE] identified Resident #126 had severely impaired cognition and was totally dependent on staff for all activities of daily living including eating, dressing and personal hygiene. Additionally, the MDS identified Resident #126 had impairment of range of motion to both sides of the upper extremities (shoulder, elbow, wrist, hand) and failed to identify Resident #126 rejected care.The care plan dated 3/11/26 identified Resident #126 had actual alteration to skin integrity with potential for further alteration. Interventions included right hand palm pillow splint and geri-sleeves on at all times and treatments as ordered. Review of the Occupational Therapy Treatment Encounter Note dated 3/25/26 identified Resident #126 had a discharge assessment completed with instruction for daily wear of the right palm guard and left hand orthotic carrot. Resident #126 was compliant with treatment despite moderate cognitive impairment.The CNA Resident Assignment Card dated 3/31/26 directed for the right palm guard to be on at all times, removed for hand hygiene and left palm carrot to be applied after morning care and removed after hour of sleep care with photographs instructing proper placement of splints.Review of the April 2026 monthly physician's orders (original date 9/2/25) directed a right palm pillow to be on at all times, remove for hand hygiene and skin checks.A physician's order dated 4/9/26 directed left palm carrot to be on with morning care and removed at hour of sleep, check for skin. Observation on 4/29/26 at 12:05 PM identified Resident #126 sitting in the common area without the benefit of the ordered right palm pillow or left palm carrot. Resident #126's fingers were curled inward into fists.Observation on 5/4/26 at 9:40 AM identified Resident #126 sitting in common area without the benefit of the ordered right palm pillow or left palm carrot. Resident #126's fingers were curled inward into fists. Observation and interview with NA #1 on 5/4/26 at 12:05 PM identified Resident #126 was without the benefit of the ordered splinting devices to the right and left hands, fingers were curled inward into fists. NA #1 identified she was the regular nurse aide for Resident #126, and any special device instructions pertaining to care would be found in the care card book at the nurses station. Review of Resident #126's care card with NA #1 identified the resident should have a splinting carrot in left hand and a splinting palm pillow in the right hand. NA #1 indicated the therapist or the aide was responsible for application. Subsequent to Resident #126's care card review, NA #1 identified she had applied the splinting carrot, but the resident must have taken it out. A search for the left-hand splinting carrot by NA #1 identified it was in the closed nightstand drawer. NA #1 identified Resident #126 sometimes had another round splint in his/her right hand, but could not identify why she did not apply it.Subsequent to surveyor inquiry NA #1 applied the splinting carrot to Resident #126's left hand, by gently slowly uncurling the residents fingers, which were in a tight fist, fingers pressed into the palm. NA #1 indicated the resident will remove it by the time you come back.Interview with the Director of Rehabilitation, OT #1 on 5/4/26 at 12:25 PM identified splinting orders were provided by therapy after treatment, with the nursing department responsible for application and removal per orders. Review of Resident #126 physician's order with OT #1 identified the resident had 2 splinting devices; a right palm pillow to be on at all times and a left hand carrot to be worn in the morning, and off in the evening. Additionally, OT #1 identified failure to apply the splints could lead to skin break down, maceration and ultimately increase in contractures.Observation on 5/4/26 at 1:52 PM identified Resident #126 sitting in common area without the benefit of the right hand splint.Observation and interview with NA #2 on 5/6/26 at 9:06 AM identified Resident #126 fully dressed, in the process of being assisted with his/her meal in the dining area by NA #2, without the benefit of the left or right hand splints in place. NA #2 stated that the unit manager already brought to her attention that Resident #126 should have hand splints in place, she reported that she would apply the splints after the meal, adding there was a delay in her applying them because it is difficult due to the resident's contractures.Review of the Splinting Policy directed that nursing staff was to follow therapeutic interventions including splinting and wearing schedule as indicated by therapy, nursing staff to document splinting application and notify rehabilitation of changes in resident condition regarding (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splinting (poor tolerance, increased or decreased range of motion in the joint, redness, change in edema).

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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 observations, interviews review of clinical records and policy for 1 of 3 sampled residents (Resident #59) reviewed for respiratory care, the facility failed to ensure oxygen administration was set according to the physician order. The findings include: Resident #59 diagnoses included Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, and emphysema. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 had a Brief Interview of Mental Status score of 14, indicating the resident was cognitively intact. The MDS also identified that the resident required set-up, or clean-up assistance with oral hygiene, was dependent with personal hygiene, and required substantial/maximal assistance with transfers. The MDS also identified that Resident #59 experienced shortness of breath or trouble breathing when lying flat and required supplemental oxygen while he/she was a resident within the last 14 days of the assessment date. The Resident Care Plan (RCP) dated 5/6/26 identified Resident #59 had altered respiratory status/difficulty breathing related to COPD/Emphysema (a progressive, chronic lung disease making it difficult to breathe) with chronic oxygen use. Interventions included for staff to observe for signs and symptoms of respiratory distress and report them to the MD as needed. The RCP also identified that nursing staff administer oxygen as ordered, and document in the resident's medication administration record (MAR), or treatment administration record (TAR).A physician's order dated 5/6/26 directed to administer continuous oxygen at 3 liters per minute via nasal canula to keep oxygen saturation level greater than 90 percent.Observation on 4/29/26 at 11:15 AM, at 11:18 AM, and 11:54 AM identified Resident #59 sitting in his/her bed, with the head of bed (HOB) elevated and oxygen being administered via nasal cannula from an oxygen concentrator at 4 liters per minute (despite physician orders directing oxygen at 3 liters per minute). Interview and observation with Licensed Practical Nurse (LPN) #5 at 11:56 AM identified that the physician order for supplemental oxygen was for 3 liters per minute, and that the policy for checking oxygen administration settings was that the resident's on continuous oxygen, and the staff check his/her oxygen saturation, and it was 96-97 percent earlier that morning. Observation of the clinical record identified that the resident's oxygen saturation was documented on 4/29/26 as 96% and was documented as 97% by LPN #5 on 5/6/26. LPN #5 also identified that all staff should check the settings for the oxygen concentrator to make sure they reflect the orders placed by the physician, but it's the nurse's responsibility to change the oxygen administration settings on the oxygen concentrator. LPN #5 also indicated that she checked Resident #59's oxygen administration setting earlier this morning prior to surveyor interview. LPN #5 identified that Resident #59 was lying in bed wearing a nasal canula while having his/her oxygen administration was set at 4 liters per minute and stated the concentrator should be set at 3 liters per minute. The oxygen concentrator was observed behind Resident #59's bed, out of his/her reach, with the front of the concentrator that housed the control settings facing away from the patient towards the back wall of the room. LPN #5 indicated she wasn't sure who increased the resident's oxygen administration setting to 4 liters per minute, and why it wasn't set at 3 liters per minute. Interview with the Unit Manager (RN #5) on 5/6/26 at 12:05 PM identified the policy for supplemental oxygen administration was dependent on the physician's order, which would direct how much oxygen to administer, and how frequently it should be administered. RN #5 also identified that it's everyone's responsibility for checking residents' oxygen administration settings, although it's the nurses who can change the oxygen administration settings on the oxygen concentrator. RN# 5 identified that since the physician's orders directed staff to administer Resident #59's at 3 liters per minute, then the resident's oxygen administration setting should be set at 4 liters per minute. Interview with the ADNS on 5/6/26 at 12:25 PM identified that the policy for oxygen administration was dependent on the physician's order to direct how much oxygen was administered to the residents and how frequently the residents received supplemental oxygen. The ADNS further identified that all facility staff should (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check the settings on resident's supplemental oxygen concentrators, but nursing staff was responsible to change the oxygen settings if they're not correct. The ADNS also identified that he observed Resident #59's physician's orders directed staff to administer supplemental oxygen to the resident at 3 liters per minute, and indicated that based on those orders, the nursing staff should have administered Resident #59's supplemental oxygen at 3 liters per minute instead of 4 liters per minute as the oxygen was set. Review of the facility policy for Oxygen Administration directs, in part for staff to place the patient on a nasal cannula at 2 liters per minute unless otherwise instructed by the physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 resident (Resident #36) reviewed for Hospice and End of Life, the facility failed manage the resident's pain according to professional standards. The findings include:Resident #36 was admitted to the facility in November 2020. Diagnoses included Alzheimer's Disease, anxiety disorder, and dementia with agitation.The quarterly MDS dated [DATE] identified Resident #36 had severely impaired cognition, required total assistance with all care, had impairment of range of motion of the upper extremity on one side, was at risk to develop a pressure ulcer/injury, had no current pressure ulcers, and had no reports of pain. The care plan dated 2/4/26 identified the resident was at risk for pain and was on hospice care due to progressive decline. Interventions included assessing, treating, and documenting pain every shift and as needed, identifying the cause of pain and treat accordingly, administering pain medications as ordered, meet/anticipate needs, notify the hospice company with a change in condition, and observe for signs and symptoms of pain/discomfort/anxiety and report/treat as ordered. The care plan also identified Resident #36 had a left-hand contracture with splinting. Interventions included to apply a resting left hand splint during morning care and off at evening care. The care plan also identified that the resident had the potential for alteration in skin integrity related to decreased mobility and incontinence which was updated on 2/25/26 to include that MASD on the gluteal cleft had deteriorated to an unstageable pressure ulcer to the coccyx. Interventions included an air mattress, provide incontinent care 4 times per shift, pressure reducing cushion to chair and weekly skin checks. Hospice care interventions included to notify the Hospice Care Company with changes in condition and observe for signs and symptoms of pain/discomfort/anxiety and report/treat as ordered.A wound care note dated 4/29/26, written by RN #3, identified the resident denied pain. Review of the May 2026 monthly physician's orders directed to administer Acetaminophen 650 mg every 6 hours as needed (prn) for temperature greater than 101 F or pain, directed to administer Morphine Sulfate (pain medication) 5 mg every 3 hours prn for shortness of breath and directed apply a left palm guard following morning care and remove after evening care; check the skin for any issues daily.Review of the May 2026 MAR dated 5/1/26 - 5/6/26 identified no documented reports of pain. Further, the MAR identified Morphine Sulfate 5mg was administered on 5/4/26 at 1:39 PM.Observation on 5/4/26 at 2:05 PM of RN #3 performing sacral wound care identified Resident #36 was on his/her side in bed, appeared tense, hands in fists, and had occasional labored breathing (deep inspirations and expirations). RN #3 was not observed to explain the procedure to the resident and was not observed to converse with the resident during the wound care. Interview with the Wound Nurse, RN #3, on 5/6/26 at 10:50 AM, identified Resident #36 exhibits pain during wound care. Interview with NA #5 on 5/5/26 at 1:30 PM identified Resident #36 has occasional grimacing when he/she is put in bed. NA #5 indicated reports Resident #36's pain to everybody.Interview with LPN #5 on 5/5/26 at 1:35 PM identified the resident is placed in bed in the afternoon to offload pressure to his/her sacral wound. LPN #5 reported Resident #36 shows signs of discomfort during transfers and when the palm guard is placed. Although RN #3, LPN #5 and NA #5 identified in interviews that Resident #36 exhibits pain when being put in bed (grimacing), during transfers, when the palm guard is placed, and when wound care is performed, the clinical record lacked documentation of such, including the administration of pain medications with the exception of the Morphine Sulfate administration on 5/4/26. Subsequent to surveyor inquiry, the updated care plan dated 5/6/26 included interventions to medicate for pain as needed prior to wound dressing changes. Review of the Pain Assessment Policy Item 3 noted to observe for non-verbal indicators of pain and Item 4 noted to provide for a pain intervention. Review of the Care Planning Policy Item 4 notes: In order for the care plan to be a good working tool, it should reflect the patient's current status. Interim problems, goals and interventions should be added at any time after the conference if minor changes (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occur which alter the care provided. These interim notes can be completed by any team member and should not be considered the sole responsibility of the RCC.Review of the wound care policy identified wound care is provided by a licensed nurse to any resident with a physician's order. The procedure included to explain the procedure to the resident.

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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 observation, review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #52) the facility failed to ensure hand hygiene was performed after providing personal care and failed to appropriately handle soiled linens. The findings include: Resident #52 had a diagnosis of dementia without behavioral disturbance. The nurse aide care card dated 2/2/26 identified Resident #52 required the assistance of 1 person for bathroom use. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #52 had severe cognitive impairment and required total assistance for toileting hygiene and personal hygiene. The Resident Care Plan dated 5/5/2026 identified the potential for alteration in skin integrity with an intervention for incontinent care/toileting 4 times per shift and as needed. Observation on 5/4/2026 at 10:40 am identified NA #8 exit Resident #52's bathroom with gloves on after providing personal care to the resident. NA #8 was noted to place soiled linens (towels, clothing) on the floor at Resident #52's bedside. NA #8 continued to touch the closet door, retrieved items from the nightstand, and touched the room door handle, all without the benefit or removing gloves, and washing hands. NA #8 also placed Resident #52's wig on the resident's head with the same soiled gloves in place. NA #8 then picked up the linens and discarded them in containers located outside of the room and then removed her gloves and washed her hands. Interview with NA #8 at 10:45 am on 5/4/2026 identified that she had assisted the resident with toileting hygiene in the bathroom and had not removed her gloves after assisting the resident in the bathroom. She noted that soiled linens should not be placed on the floor but should be placed directly in the receptacles in the corridor. NA #8 further noted that she should have removed the soiled gloves and washed her hands prior to touching on the closet, the door and placing Resident #52' wig. Interview with the Infection Preventionist (RN #4) on 5/6/2026 9:45 am identified that gloves should be removed after performing personal care and handling soiled linens. She also noted that clean surfaces should not be touched with soiled gloves and linens should not be placed on the floor but in the bins provided. She further noted that hand hygiene should be performed after providing personal care. Interview with DON 5/6/2026 10:15 am identified the same response as RN #4 regarding hand hygiene and disposal of soiled linens. The facility policy for Hand Hygiene directed, in part, that all personnel working in the long-term care facility are required to perform proper hand hygiene in the following situations: before and after resident contact, before and after performing any procedure, and after removing gloves.The facility policy for Standard Precautions directed, in party, that standard precautions include but are not limited to hand hygiene, the proper use of PPE personal protective equipment, and care of the environment, textiles, and laundry. Also, equipment or items in the resident environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents.