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	075250	A. Building B. Wing	04/11/2025

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Parkville Care Center	5 Greenwood Street Hartford, CT 06106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, review of facility documents, facility policy and interviews, the facility failed to act promptly on residents' grievance and ensure grievance forms were within reach of residents who utilized a wheelchair. The findings include: Review of Residents Council 3/26/25 minutes indicated Grievance forms run out on resident units. The residents stated we would like staff to introduce themselves and explain the grievance process to residents. On 4/9/25 at 1:30 PM a meeting was held during Resident Council. during the meeting residents expressed their concerns that grievances and recommendations were not responded to timely. Resident# 6 and Resident #76 identified prior to attending Resident Council meeting the forms were still not replenished. Observation on 4/9/25 at 2:11 PM on units 5 and 6 identified the forms were not replenished. Resident #6 pointed out information related to how to fill out grievance was out of reach for residents who are wheelchair bound. Observation on 4/9/25 at 3:43 PM identified the grievance form being replenished. Interview with Regional Director of Behavioral Health on 4/11/25 at 11:53 AM identified the replacement of grievance forms is an collective process for all social work staff. She also reported staff should be replacing the forms when empty. Facilities Resident Grievances policy (reviewed on 1/26/24) indicated in part Facility residents have the right to have prompt effort made by the facility to attempt to resolve grievances. The facility will make prompt efforts to attempt to resolve grievances within 7 business days.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy and interviews for two 2 of 2 sample residents (Resident #6 and Resident #51), reviewed for personal funds, the facility failed to provide quarterly statements for personal funds account. The findings include: 1. Resident #51's diagnoses that included chronic kidney disease stage 3, hypertensive heart disease with heart failure, depression, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 as severely cognitively impaired, dependent (required assistance of 2 or more helpers) with toileting hygiene, lower body dressing, personal hygiene and chair and shower transfers. The assessment further identified Resident #51 was non-ambulatory and utilized a wheelchair for mobility. Interview with Person #3 on 4/8/25 at 9:11 AM identified quarterly statements for personal funds account were not provided to them by the facility. Further, Person #3 indicated that he/she has never received a quarterly statement for personal funds account and did not realize that they should have received one. 2. Resident #6's diagnoses included chronic kidney disease stage 3, hypertensive heart disease with heart failure, peripheral vascular disease, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #6 as cognitively intact, dependent on care with toileting hygiene, putting on and taking off footwear, and required maximal assistance with shower, lower body dressing, and chair and shower transfers. The assessment further identified Resident #6 was non-ambulatory and utilized a wheelchair for mobility. Interview with Resident #6 on 4/7/25 at 12:08 PM identified he/she does have the personal funds the facility manages and has not received any quarterly statements since he/she has been at the facility. Interview with the Business Office Manager on 4/8/25 at 1:47 PM identified she is responsible for mailing quarterly statements for personal funds to the parties responsible and the Recreation Department delivers to residents in the facility. The Business Office Manager was unable to provide evidence or verification that quarterly statements for personal funds were mailed out or printed and/ or given to the Recreation Department for delivery to residents. She indicated that she would develop a process to ensure residents receive quarterly statements. On 4/8/25 at 3:30 PM, after surveyor inquiry, the Business Office Manager initiated the mailing of personal funds quarterly statements, printing and the delivery to residents in the facility. Review of the facility's Resident Trust Policy dated 01/11/2019 indicated the facility will provide residents and responsible parties with a quarterly accounting of their individual accounts and quarterly statements are printed and sent to the family/responsible party at the end of every quarter. (March, June, September, December of the year).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, facility policy and interviews for 1`of 6 residents reviewed for environment (Resident #76), the facility failed to ensure a homelike environment in resident rooms and for 1 resident (Resident #237) who utilized the resident lounge on 200-300 unit failed to ensure the home-like environment to ensure the area was free of wheelchair storage to promote easy resident access. The findings included: 1. Resident #76's diagnoses included morbid obesity and heart failure. The annual MDS assessment dated [DATE] identified Resident #76 was cognitively intact and noted it was very important for the resident to choose what clothes to wear and to take care of the resident's personal belongings. Additionally, the MDS assessment identified Resident #76 utilized a wheelchair for mobility and noted independent for upper body dressing. The resident required supervision or touching assistance for lower body dressing.The care plan revised on 1/29/2025 indicated Resident #76 was at risk for self-care performance deficit related to shortness of breath and limited mobility. Interventions included encouraging the resident to participate to the fullest extent possible in each interaction.On 4/7/2025 at 11:12 AM, an observation and interview in Resident #76's room identified a bariatric bed in a double room. The distance between the foot of the bed and the wall appeared to be less than 3 feet. Resident #76 indicated she/he was unable to wheel him/herself through the space between the wall and the foot of the bed to get to the closet. With permission from Resident #76, the closet was observed to contain hangers with four shirts, three pairs of pants, five sweaters, one comforter, and one large pink bag. The drawer under the closet contained undergarments. Resident #76 indicated she/he had spoken to the facility Administrator regarding turning his/her bed sideways several months ago but could not recall the date. The resident indicated at the time, she/he was informed the facility would require a special permit. In the meantime, Resident #76 indicated she/he keep the majority of his/her personal items outside the closet to the side of the bed for convenience, and when she/he need an item of clothing from the closet. Resident # 76 needed to ask staff for help despite being independent.On 4/10/2025 at 11:48 AM, an interview with NA#6 identified Resident #76 kept his/her clothes in boxes and the resident was independent with dressing. NA#6 indicated she was not aware the resident had difficulty getting around the room. NA#6 also indicated Resident #76 would call if she/he required assistance, such as obtaining items from the closet.On 4/10/2025 at 1:52 PM, an observation with the Director of Maintenance identified the space between the foot of the bed and the wall was 28 inches and the distance between the bed frame of Resident #76's bed to the bed frame of their roommate was 16 inches. On 4/10/2025 at 2:57 PM, an interview with the Administrator indicated she had not spoken to the resident about turning his/her bed in a different position for more room and the conversations she had with the resident was regarding placing some of her/his belongings in storage to make more space in the resident's room.2 Resident #237's diagnoses included muscle weakness, unspecified abnormalities of gait and mobility, and depression.The Resident Care plan dated 3/21/25 identified the resident has limited physical mobility. Interventions included ambulation and transfers with assist of one.The admission Minimum Data Set assessment dated [DATE] identified Resident #237 as cognitively intact and requiring partial assistance with bathing, personal hygiene and supervision with toileting.Observation on 4/8/2025 at 11:00 AM of the 200-300-unit lounge identified there were 10 wheelchairs and a crash cart in the resident lounge. Resident #237 was sitting at the table reading and stated he/she likes to go in the lounge in the early AM to read because he/she doesn't want to turn on his/her room light and wake up his/her roommate. Resident # 237 further indicated she/he cannot get into the lounge room that early because it is full of wheelchairs causing difficulty to move his/her wheelchair and get to the table.Observation on 4/9/2025 5:45 AM of the 200-300 unit resident lounge identified 18 wheelchairs, obstructing both exits and a chair obstructing the crash cart. No residents in the lounge at that time. Interview and observation made with MDS Coordinator #1 at 5:50 AM on 4/9/2025 identified wheelchairs were kept in a different room, however, with the construction taking place in that room wheelchairs are now stored in the 200-300 resident lounge. She also indicated the crash cart was blocked by a chair.In an interview and observation with the DNS verified that the chairs were stored in the room that is now under construction and that an in-service would be provided for the staff to ensure the emergency exits and the crash cart are accessible. Further she stated that if a resident wants to watch television in the early hours they can watch in their room or go to an alternate lounge off the unit. When questioned further she confirmed that the residents should be able to access the lounge on their floor. Based

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record reviews, facility policy and interviews for 3 of 3 residents (Residents #12) reviewed for care planning and (Resident # 36 and Resident # 79) reviewed for restraints, the facility failed to hold quarterly care planning meetings. The findings included: 1. Resident #12 's diagnoses included hypertensive heart disease, chronic kidney disease, and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 as cognitively intact and dependent for personal hygiene, bathing, and Activities of Daily Living (ADL). The Resident Care Plan (RCP) with a revision date of 2/13/25 identified the resident had an ADL self-care performance deficit. Interventions included to assist with personal care and ADL. Interview with Resident #12 on 4/7/2025 during the screening process identified he/she has not been involved in a care planning meeting in a long time. Resident #12 was unable to quantify specifically what the time frame was. A physician's order dated 4/10/25 directed to provide care as outlined in the care plan. Resident Care conference documentation for 5/1/24 and 8/15/24 were present in the record. No further care conferences were documented in Resident # 12's record for 2024 and 2025. 2. Resident #36's diagnoses included Gastrointestinal Hemorrhage, dysphagia, and hemiplegia. The Resident Care Plan with a revision date of 1/27/25 identified the resident required tube feedings. Interventions included monthly evaluations by the Registered Dietician. The annual Minimum Data Set assessment dated [DATE] identified Resident #36 as cognitively impaired and dependent for all personal care and ADL. Resident Care Conference documentation for 5/22/25 and 8/7/24 were present in the record. However, no further care conferences were documented in Resident # 36's record for 2024 and 2025. 3. Resident #79's diagnoses included Hereditary Spastic Paraplegia, depression, and dysphagia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #79 as cognitively impaired and dependent for personal hygiene and ADL. The Resident Care Plan with a revision date of 2/3/25 identified the resident required tube feedings. Interventions included monthly evaluations by the Registered Dietician. Resident Care Conference documentation for 5/15/24, 7/17/24, and 2/24/25 were present in the resident record. However, no further care conferences were documented Resident # 79's record for 2024 and 2025. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	In an interview with Regional Nurse #1 on 4/9/2025 at 10:00 AM identified care conferences should be held quarterly, after the quarterly MDS is completed. Regional Nurse # 1 also stated that the MDS staff schedules the meetings. She was unsure why the meetings hadn't occurred for the residents and indicated the facility had a change in social workers which could be the reason. Review of the Care Plan Policy dated 4/17/24, currently in effect, directed in part, Resident Care Conference is held within 7 days of completion of the admission MDS, at least quarterly, annually, and when a significant change in status assessment when needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility policy review and staff interviews for the only resident reviewed for ADL (Resident # 77), the facility failed to ensure the resident who utilized an anticoagulant was assessed for change in condition when the resident was cut by a razor. The findings include:Resident #77's diagnoses included vascular dementia, cerebral infarction, long term (current) use of anticoagulants.The Resident Care plan dated 2/11/25 identified the resident was on an anticoagulant and at risk for bleeding. Interventions included staff reporting any bruising or bleeding from gums, nose, mouth or with bowel movements.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #77 as severely cognitively impaired, and required total assistance for bathing, personal hygiene and ADL.Observation on 4/7/25 at 11:30 AM identified Resident # 77 had a cut on the right side of his/her face with a small amount of blood. It appeared to be a razor cut. Interview with Nurse Aide (NA#1) on 4/7/25 at 11:30 AM identified she was shaving the resident with a disposable razor and cut him/her as she/he was resisting. NA #1 further stated she/he Resident # 77 was resistive to care, and she told the nurse about the resident.A telephone interview on 4/10/2025 with Licensed Practical Nurse (LPN #2) at 12:15 PM identified she was the agency nurse on unit 2 on Monday 4/7/25. She identified NA#1 told her that Resident # 77 was bleeding from a razor cut. When asked her what she did about it, LPN # 2 stated she gave NA#1 an alcohol pad because she asked for it. When asked if she assessed Resident # 77 after the cut she stated no, she was too busy, and she was running late. When asked what she would normally do if a resident had a change in condition, she identified she would write a note. However, she did not write a note on Resident #77 because she was too busy. Further questioning of the incident identified LPN 3 2 did not know Resident # 77 was on an anticoagulant and indicated she would not normally review the record to determine if a resident was on an anticoagulant even if the resident was bleeding. When asked what she would do if a resident was bleeding from his/her gums, or a cut or anywhere, LPN # 2 stated she would write a note, but she would not review the record.On 4/10/25 at 12:25 PM an telephone interview with LPN#2 in the presence of Regional Nurse #1 and the Director of Nursing Services (DNS) identified the facility expectation would be for the nurse to assess any change in condition with a resident. They also identified agency nurses complete an on-line orientation prior to reporting to work.On 4/11/25 an interview with NA #1 to clarify what actions were related to the razor cut. NA #1 stated she cleaned the area around the cut with the alcohol pad the nurse gave her and then applied A&D ointment around the cut. NA 31 further LPN #2 nurse on duty did not give her any direction, however from previous experiences she knew to hold pressure on the area until the bleeding stopped.Review of the Anticoagulation Therapy policy dated 3/20/24, directed in part the resident should be observed for any possible signs of bleeding, including hematuria, hemoptysis, bleeding gums, epistaxis, bruising, dark/tarry stools. Additionally, the policy directed to notify the practitioner of the findings as soon as possible.Review of the Physician Notification-Change of Condition policy dated 6/10/24, in effect at time of survey, directed in part, a change in condition is a significant clinical symptom(s) or development, which requires assessment and intervention.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. Deficiency Text Not Available

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Deficiency Text Not Available

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 clinical record review, observations, facility policy and staff interview for one sampled resident (Resident # 97), the facility failed to follow physician's orders regarding the application of hand splints as directed. The findings include: Resident #97's diagnosis included contracture of muscles, multiple sites. The physician's orders dated 7/28/2024 directed to check skin before and after application of the left-hand Orthotic and to apply the left-hand orthotic with HS (bedtime care) care and with AM(morning) care. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #97 had severe cognitive impairment. The care plan dated 3/10/2025 indicated Resident #97 utilized splints. Intervention included : to check skin before and after application of the left-hand orthotic, to apply with bedtime (HS) care and remove with morning(AM) care. An observation on 4/07/25 at 12:00 PM identifed Resident #97 sleeping in bed covered up with the exception of her/his feet. On the bed side table were multiple splints in a wall mounted basket with laminated instructions to use splints to feet, left elbow and left hand. A physician's order dated 4/08/2025 directed patient will tolerate left elbow extension splint to be donned with AM care and doff with PM care with skin checks performed before and after. On 4/08/2025 at 12:20 PM an observation and interview with the Regional Therapy Director identified Resident #97 up in an adaptive wheelchair wearing an elbow splint and the left hand was flexed downward from the wrist. The Regional Therapy Director identified the hand splint is worn overnight as the elbow and hand splint cannot be worn at the same time. An interview and record review with the Director of Nursing Services(DNS) on 4/9/2025 at 11:21 AM identified it is the nurse aide's responsibility to apply splints, and the charge nurse signs off in the Kardex after verifying splints have been applied. On 4/9/2025 at 5:45 AM an interview and record review with NA#9 (regular nurse aide on the unit) identified she/he was training a new employee and indicated Resident #97 have had issue with the left hand and did not wear any splints. NA#9 hand wrote the assignment on a roster sheet since there were no assignments left in the book and gave the sheet to the new employee to reference the next time working on the assignment. The Roster made no indication of any splints to be utilized for Resident #97 or any other resident. NA#9 identified charting is done electronically which tells nurse aides what care to provide for a resident and to sign off the task. However, the documentation page made no mention of splints. NA#9 further indicated there was no mention of splints for any other resident in her electronic charting assignment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/09/2025 at 11:20 AM an interview and observation with the DNS, Regional RN#2 and the Regional Therapy Director were updated regarding Resident #97 not having his/her left-hand splint in place this morning at 5:30 AM and the nurse aide assigned to the resident on the 11:00 PM-7:00 AM shift indicating Resident #97 did not wear splints. The DNS, reviewing the clinical record, indicated a physician's order was present to apply a left-hand splint with HS (bedtime) care and to remove with AM (morning) care(7-3 PM shift). The Regional RN #2 indicated she and the DNS had been working diligently with the Regional Therapy Director regarding splints, placing pictures of the splints inside the closet doors as well as laminated directions for all residents. RN #2 further indicated they were working to get the physician's orders into the facility software and indicated they would educate the Nurse Aide on the 11:00 PM-7:00AM (11-7 AM) shift. Further review of the clinical record for the 11-7 AM shift for the charge nurse electronic documentation identified no mention Resident #97 wearing a splint overnight, which would have alerted the charge nurse to check to the physician's orders to ensure the application of the splits at HS on Resident # 97 to prevent further contracture. After the surveyor inquiry, the Regional Therapy Director indicated Resident #97's left hand remained unchanged from previous evaluations and there was no need to evaluate the hand at this time. On 4/9/2025 at 11:45 AM an interview with the 3:00PM -11:00 PM nurse(LPN #8) who worked 4/8/2025, indicated the nurse aide applied the splint at around 8:30 PM when providing care to Resident #97. She/he also indicated the splint was on Resident #97's left hand. The facility policy labeled Splints, dated 9/18/2024, indicated splints are applied per the physician orders and the order would include the extremity to be applied and a schedule for use (time on-off).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, review of facility policy and interviews for 1 sampled resident (Resident # 57), who received specialized treatment services, the facility failed to ensure staff was knew the location of the emergency kit and the facility failed to obtain physician's orders for vital signs, weight monitoring and evaluation of specialized treatment site and failed to maintained the specialized treatment communication book. The findings included: Resident #57's diagnosis includes end stage renal disease. A physician's order dated 7/28/2024 directed: dialysis site and central venous catheter. A physician's order dated 7 /28/2024 directed not use the access arm to take blood samples, administer intravenous fluids, give injections or to take blood pressure every shift. A physician's order dated 7/28/2024 directed if bleeding occurs from the Access site (post dialysis) apply pressure to the insertion site, call the physician, and call 911 as needed. A physician's order dated 7/28/2024 directed to keep the emergency kit nearby every shift. A physician's order dated 7/28/2024 directed to check site for bleeding and signs or symptoms of infection every shift. The admission nursing assessment note dated 1/8/2025 indicated Resident #57 was admitted with specialized treatment port in the left chest. A physician's order dated 2/14/2025 directed to monitor the left upper arm wound site for signs of infection and swelling, to keep the dressing in place and do not remove until seen by the surgeon. If bleeding occurs reinforce the dressing and notify the supervisor. A physician's order dated 3/05/2025 directed to cleanse the left arm surgical site with normal saline and apply a dry protective dressing daily. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #57's cognitive status was not assessed and the resident had received specialized treatment. The care plan dated 3/31/2025 indicated Resident #57 needed Hemodialysis related to renal failure and noted specialized treatment device access located in the left chest. Interventions included in part; to change the dressing daily at the access site and document, do not draw blood or take blood pressure in arm with graft, monitor for signs of infection to the access site. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkville Care Center	5 Greenwood Street Hartford, CT 06106

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.An observation and interview on 4/10/2025 at 11:55 AM with LPN #6 identified part of the care provided for Resident #57 was to check for bruit and thrill of the left arm fistula, nothing was done for the catheter in the chest and an emergency kit was located in the resident's room. Although LPN #6 was unable to locate an emergency kit in Resident #57's room including the bedside stand, the surveyor asked what the clear plastic bag on the bulletin board was and LPN #6 indicated the bag contained a rolled gauze and a dressing. LPN #6 indicated s/he would use a dressing to the left arm access site if bleeding occurred but was unsure how to stop the Permcath (central line) from bleeding. On 4/10/25 at 01:25 PM an interview and record review was conducted with the Director of Nursing Services (DNS), the Assistant Director of Nursing Services (ADNS), the Administrator and Regional RN #2. The DNS and RN #2 indicated Resident #57 had an arm fistula and a central line catheter (Permcath). The DNS indicated dialysis was using the Permcath for specialized treatment access as the AV- fistula was surgically placed in February 2025. The DNS indicated s/he would expect the nurses to check the Permcath for signs of bleeding and infection and have the emergency pack available with a clamp and gauze. The DNS further indicated the clamp would be used to clamp off the Permcath if it started to bleed. Although the emergency kit in Resident #57's room did not include a clamp, the ADNS verbalized conducting rounds weekly and noting a black bag labeled with the resident's name was on the wall but not label of the bag did not indicate contents. On 4/10/25 at 1:45 PM the ADNS indicated the black emergency bag was found in the bedside stand but usually kept on the wall and had no label with contents. The DNS also indicated the bag could be mistaken for personal items of Resident #57. The ADNS further indicated a need to clearly label emergency items and have a consistent location for the kit and provided verbal education for LPN #6. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b.On 4/11/2025 at 10:15 AM an interview and record review and facility policy review with the DNS, the ADNS, Regional RN#2, and LPN #3 (the Infection Preventionist) identified vital signs including weight were required to be taken and documented prior to leaving for a specialized treatment appointment. Upon review of the clinical record identified vital signs including weights were not documented in the clinical record on specialized treatment days and the facility was unable to provide a copy of the facility communication sheets containing facility information sent with the resident to the specialized appointments from 4/01/2025 through 04/10/2025. Documentation of the evaluation of the access site upon return from specialized treatment center did not include the access site used (the Permcath, central venous catheter). The DNS indicated the physician orders flow into the electronic Medication Administration Record (MAR) and the Treatment Administration Record (TAR) where the nurse would be made aware of the care needed to be provided and sign off if it was or was not completed. The DNS further indicated documentation should also be completed in the specialized treatment communication book, the progress notes, and the vital signs and weight tabs. However, there was no physician's order to obtain vital signs and weight prior to specialized treatment or the evaluation of the access site after specialized treatment were found, leaving licensed nursing staff without the benefit of a prompt to complete the needed tasks as required by the facility policy for a resident who received specialized treatment. While reviewing the physician's orders there was no indication of the name of the access sites, and location of the AV Fistula were found and the physician's orders only indicated the access site not distinguishing between the two separate access sites Resident #57 had or physician's orders for care and evaluation of the two separate sites. Further review of the facility policies, Hemodialysis and Hemodialysis-Care of the Access Site only mentioned 3 types of Access sites: AV Fistula, a graft or shunt. Neither policy contained the use of a Permcath for specialized treatment along with the care needed to be provided by the facility staff. Review of the care plan noted Resident #57 had a Permcath. Intervention indicated to change the dressing daily without clearance from the specialized treatment physician or an physician's order to do so. Regional(RN #2) indicated the facility would review and update the policies and orders as necessary. The facility labeled Hemodialysis reviewed 6/19/2024 indicated in part notes the dialysis communication form would be utilized each time a resident is to receive a dialysis treatment documenting the resident's blood pressure, pulse, respirations, temperature and weight before leaving for the treatment. The policy further indicated upon return of the resident from the dialysis center the communication form would be reviewed for any new recommendations and licensed staff were directed to evaluate the resident upon return from their treatment to include an evaluation of their access site. The facility policy labeled Hemodialysis- Care of the Access Site reviewed 6/19/2024, indicated in part to determine the type of access site the resident has: A-V Fistula, A-V graft, or AV-shunt, to report any signs of infection, bruit and thrill of the fistula, signs of swelling in the distal part of the extremity with the fistula, changes in circulation sensation and functional mobility of the extremity and if the shunt fistula or graft ruptures or bleeds to apply pressure call 911 and if the access site is an external shunt, to use serrated clamps to the ruptured shunt. Neither policy contains how to care for a Permcath(central line) used for dialysis treatment or what to do in an emergency.

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F 0725 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Deficiency Text Not Available

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation of a test tray, review of facility policy and interviews, the facility failed to ensure food items were attractive, palatable, and at an appetizing temperature. The findings include: Observation of the dietary tray line (preparation of individualized meals for each resident) on 4/9/2025 at 7:30 AM through 8:20 AM with the Dietary Manager identified the main entrée of waffles coming out of the oven slightly overlapping each other in the pan, then placed into a steamer to bring up to temperature before placed on the steam table. The appearance of the waffles was pale, appeared uncooked and were noted to be floppy. The Dietary Manager indicated s/he cannot use the type of toaster the kitchen is equipped with as it cannot accommodate frozen items, so they do not get browned. During a meeting with Resident Council members on 4/9/2025 at 1:30 PM, Resident #6, one of many residents voiced concerns they had said to the Dietary Director during Resident Council meetings, regarding food being either over or under cooked and nothing had changed. An observation and interview on 4/9/2025 at 8:45 AM of a test tray last tray on the last served breakfast unit with the Dietary Manager identified the waffle was noted at 100 degrees Fahrenheit (F). After a couple attempts to provide a higher temperature of the waffle the Dietary Manager was unsuccessful. The Dietary Manager agreed the appearance of the waffles were very pale, floppy and did not hold a temperature. She/he further indicated the waffles should come off the menu. On 4/10/2025 a test tray for surveyors to taste was provided at 12:00 PM. Two surveyors tasted the food items and observed the visual appearance, finding the main entrée of ham pale without browning on the sides or edges. However, the ham tasted like ham and was soft. Although the ham was noted at an appropriate temperature had the appearance of being undercooked and not visually appealing. The sweet potatoes were somewhat visually appealing and noted with lumps of potato with a spicy taste (allspice) that was left in the mouth and throat for several minutes after eating them. The green peas had a basic visual appearance, were soft to the bite and tasted like peas. The fruit which was not visually appealing initially was difficult to determine the type of fruit it was, having a translucent appearance with accentuated dots throughout all the fruit pieces. Some of the fruit was very hard and difficult to chew. The fruit tasted like pears, but the texture was inconsistent, varying from very soft to hard. An interview and observation with the Dietary Manager on 4/10/2025 at 2:45 PM of the pears with the Director of Dietary in the kitchen indicated the pears were canned pears and agreed the textures may be difficult for some residents secondary some hard pieces. He indicated the fruit was packed in water which might cause the fruit to become translucent and the dot areas to be accentuated. The facility policy labeled Meal Presentation/Refusal Policy indicated in part; food will be served attractively, and at a palatable temperature within the resident's prescribed dietary orders. The policy further indicated palatable food temperatures included cold foods equal to or less than 41 degreesF and hot foods equal to or greater than 135 degrees F at the point of receiving the meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations of the kitchen, facility policy and interviews, the facility failed to ensure staff items stored in the dry storage area contained name of its contents, stored open dry goods in air-tight containers, ensured syrup was stored to prevent leakage, and failed to ensure items in the freezer were labeled with content and dated. The findings included: An observation and interview on 4/07/2025 from 9:45 AM through 10:30 AM with the Dietary Director identified dry goods including a bag of powdered thickener for drinks left open to air, a box of cornstarch with a loose-fitting piece of plastic wrap surrounding the top of the box with access to its side opening, a large bag of enriched rice was loosely rolled in an attempt to close the bag, and an open box of new sugar free syrup was on its side on a shelf with one bottle leaking its contents onto the cardboard box with drops of the syrup noted on the floor. Two bags of what was identified by the Dietary Manager as unopened frozen taco meat, were in the freezer without labels or dates. The Dietary Manager indicated the items that were not sealed or closed should have been closed without access to air, the leaking sugar free syrup bottle was removed and discarded, and the frozen taco meat was placed in a box located in the freezer area that had the name of its contents and dated. The Dietary Manager was unsure why the bags were out of the original box. The facility policy labeled Food Storage indicated in part; all dry storage items are required to have a date in which the product is delivered or the manufacturer's best by date and opened food items need to be labeled to maintain an expiration date or use by dating system.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Deficiency Text Not Available

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations of the environment and interviews, the facility failed to ensure emergency exits and an emergency response cart were readily accessible in a resident lounge. The findings include. An observation on 4/9/2025 at 5:45 AM of the [NAME] Webster lounge located behind the nurse's station was seen with 18 wheelchairs lined up in rows obstructing the access to emergency exit doors and a standard chair and a charging electric wheelchair obstructing ease of access to the facility emergency response cart. On 4/9/2025 at 5:50 AM an observation and interview of the [NAME] Webster lounge behind the nurse's station with RN #3 indicated the room the wheelchairs used to be kept in was now under construction and staff are keeping the wheelchairs in this lounge overnight. RN # 3 further verbalized the wheelchairs should not be in front of the emergency exit or the emergency cart. After surveyor inquiry, RN # 3 indicated she/he would rearrange wheelchairs and chairs at this time and will educate the staff. On 4/9/25 at 6:50 AM an observation and interview with the Administrator who was provided with pictures of the lounge with wheelchairs and chairs obstructing the emergency exit and the emergency cart and made aware of the interview with RN #3 earlier that she/he would rearrange the wheelchairs and chairs and educate staff. The Administrator indicated the wheelchairs used to be in a room that is under construction but there is another room next to the conference room where the wheelchairs should have been stored overnight. The Administrator indicated after being asked about resident access and use of the lounge overnight in the case residents wanted to use the lounge, the Administrator indicated residents should have access to the lounge on their unit. On 4/9/25 at 08:07 AM an interview with the Administrator indicated the facility plan to in-service staff to bring the wheelchairs to the storage room next to the conference room, however some chairs may need to remain in the lounge overnight without obstructing the emergency exits, the emergency cart or resident access to the television or use of the lounge overnight.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observations, review of facility policy and staff interviews, the facility failed to consistently implement their smoking policy regarding appropriate disposal of smoking materials. The findings include: On 4/9/2025 at 10:19 AM observation of supervised smoking of residents with NA#5. Four residents participated in supervised smoking. There were four black cigarette disposal containers. On 4/9/2025 at 10:30 AM, after the smoking session had ended, an observation was made with NA#5 of the smoking area. The observation identified three cigarette butts on the concrete smoking patio by the door and next to a disposal container. Four additional cigarette butts were noted scattered along the remainder of the concrete smoking patio near the building. Additionally, over 50 cigarette butts were observed on the pathways of the courtyard and on gravel flower beds next to the building. On the gravel beds, there were green leafy plants and brown dried leaves. An interview with NA#5 indicated she did not know why there were cigarette butts scattered in the patio and courtyard. NA#5 indicated that smoking supervision is rotated among nurse aides from each nursing unit. NA#5 also indicated she believed residents can smoke in the courtyard with family but would need to obtain smoking materials from the receptionist. On 4/9/2025 at 10:40 AM, an interview with the Receptionist indicated residents may not smoke with family unless they are going on leave of absence. Residents on leave of absence are required to leave the building and not use the courtyard for smoking. The Receptionist further indicated visitors would not smoke in the courtyard because she can see them through video surveillance. An observation with the Receptionist of the video screens identified the smoking patio visible but the rest of the courtyard was not. On 4/9/2025 at 11:00 AM, an observation was made of housekeeping cleaning the concrete smoking patio. An interview with the Director of Housekeeping indicated the housekeeping staff cleans the patio daily and there are not usually a lot of cigarette butts. On 4/9/2025 at 11:15 AM, an observation and interview with the Administrator identified the cigarette butts on the concrete smoking patio had been cleaned. However, the cigarette butts in the gravel beds and the courtyard pathway were still there. The Administrator indicated the smoking patio should be cleaned every day and she/he could not explain why the cigarette buts had been on the patio and the gravel beds of the courtyard. Additionally, the Administrator indicated staff were not allowed to use the courtyard for smoking. The facility policy for smoking given during the survey identified safety standards for resident smoking including smoking materials must be extinguished safely.