STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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 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** 43032 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #317) reviewed for ADL's the facility failed to feed the resident in a dignified manner and according to facility policy. The findings include: Resident #317 was admitted to the facility on [DATE] with diagnoses that included dementia, dysphagia, and abnormalities of gait and mobility. A Nutritional assessment dated [DATE] identified Resident #317 was total dependence with eating. The care plan dated 10/21/24 identified concerns with eating and nutrition related to dementia. Interventions included Resident #317 be provided an assist of one with eating, and to provide, and serve diet as ordered, as well as to monitor intake and record every meal. The admission MDS dated [DATE] identified Resident #317 had severely impaired cognition and was edentulous with no natural teeth or tooth fragments. Observation on 11/3/24 at 8:20 AM identified Resident #317 was seated on his/her bed which was in a low position, and being fed by NA #10, who was standing. The Residents head level with NA #10's mid chest. There was no observed dialogue between Resident #317 and NA #10. NA #10 identified at that time, it was up to him to sit or stand while feeding. Resident #317 was silent during the meal and continued to open his/her mouth as the spoon was presented. Interview with RN #10 on 11/3/24 at 8:25AM identified nurse aides have been trained to be seated while feeding. Interview with the DNS on 11/5/24 at 3:27 PM identified the nurse aides have received training on feeding residents, and NA #10, knows that he should be seated while feeding. The policy for Feeding (Dependent Feeding) identified that the employee is to give the resident their complete attention, and sit to be at eye level with the resident.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policies, and interviews for 1 of 2 residents (Resident #103) reviewed for advance directives, the facility failed to accurately document the resident's life support choices. The findings include: The Inter-Agency Referral Report dated 9/27/24 identified Resident #103 had a Full Code status during his/her hospital admission (full code directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency). Resident #103 was admitted to the facility on [DATE] with diagnoses that included hypertension, COPD, endocarditis, and heart valve disorders. The Advance Directive/Code Status Consent signed and dated 9/27/24 identified Resident #103 requested the following advance directive: DNR (Do Not Resuscitate). The MD Order/Progress Note dated 10/1/24 identified that advance directives had been reviewed with the resident and/or resident representative, in the event of a cardiac/respiratory arrest, the resident's DNR wishes would be honored. The admission MDS dated [DATE] identified Resident #103 had intact cognition. The Care Conference signature sheet dated 10/17/24 identified Resident #103 was a full code but failed to identify Resident #103's signature. The November 2024 Physician's Orders identified Resident #103 was a full code. Interview and review of the clinical record with the DNS on 11/4/24 at 11:00 AM identified that Resident #103 was admitted to the facility from the hospital with a status of full code. The advance directive form that was signed by the resident and dated 9/27/24 identified the residents wish was a DNR status. The DNS indicated that he would have expected that the change from full code to DNR would have been updated, by the nurse confirming Resident #103's advance directive/code status and reflected in the physician's orders. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directive-Decision-Making policy directs upon admission, the facility's designee will ask whether the resident has completed any other advance directive documents and review and place any documents received in the medical record, the resident and authorized decision maker will be provided with this advanced directive decision making policy and the code status policy and will be given the opportunity, but not required to submit any additional advance directive documents for inclusion in the medical record. The facility will review and make part of the medical record any advance directive documents presented to it at admission or any time after admission. The policy further directs a physician or other health care provider shall record in the resident's medical record any oral communication concerning any aspect of the resident's health care, including the withholding or withdrawal of life support systems, made by the resident directly to the physician or other health care provider or the resident's health care representative, legal guardian, conservator and next-of-kin. The Physician's Orders-Transcription policy directs physician orders will be transcribed by a licensed nurse and followed through in a manner consistent with quality standard of care practices; routine orders are reviewed on the Physician's order sheet and transcribed onto appropriate worksheets and signed off by the licensed nurse.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #76) reviewed for unnecessary medications, the facility failed to notify the physician or APRN of a change in condition and for 1 resident (Resident #111) reviewed for accidents, the facility failed to ensure that the resident representative was notified when the resident was found smoking in his/her room and was found with smoking materials in his/her room, and for 1 of 3 residents, (Resident #4) reviewed for ADL's, the facility failed to ensure the physician and resident representative were made aware when the resident continued to refuse showers. The findings include: 1. Resident #76 was admitted to the facility in July 2024 with diagnoses that included congestive heart failure, seizures, diabetes, and hypertension. The admission MDS dated [DATE] identified Resident #76 had intact cognition and required touching assistance by staff for ambulation in room and corridor. The care plan dated 8/8/24 identified Resident #76 was at risk for falls. Interventions included to record and report any concerns or changes in condition to the attending physician. A physician's order dated 10/22/24 directed to transfer the resident with assist of 2 staff person. A nurse's note written by LPN #1 on 11/4/2024 at 10:10 PM indicated that Resident #76 was observed with increased tremors and weakness to extremities which was reported to the supervisor. A notation was placed in the APRN communication book for evaluation. Interview with Resident #76 on 11/5/24 at 9:00 AM indicated last night he/she was ambulating to the bathroom with a staff member when he/she became so shaky, weak and was having tremors that he/she could not get off the toilet. Resident #76 indicated that it took 2 staff to assist him/her from the bathroom back to bed. Review of the clinical record 11/4/24 to 11/6/24 failed to reflect the APRN or physician was notified that Resident #76 was observed with increased tremors and weakness, could not get off the toilet and required assist of 2 to get back to bed from the bathroom on 11/4/24. Interview with the ADNS on 11/6/24 at 8:54 AM indicated that if there was a change in condition the LPN must notify the RN supervisor, the RN Supervisor must do an assessment of the resident and contact the physician or APRN at that time. The ADNS indicated that the LPN or the RN Supervisor cannot put change of condition information in the APRN communication book. The ADNS indicated that she had worked on 11/4, 11/5, and today from 7:00 AM to 3:00 PM and was not aware that Resident #76 became shaky, weak and was having tremors and could not get off the toilet on 11/4/24. Further, it was not discussed during supervisor daily report from shift to shift. After review of the clinical record, the ADNS indicated that the provider was not notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #6 with ADNS present on 11/6/24 at 9:04 AM indicated that she had worked on 11/4/24 from 3:00 PM to 11:00 PM as the RN supervisor. RN #6 indicated that she was called by LPN #1 to see Resident #76. RN #6 indicated that LPN #1 had reported to her that Resident #76 while ambulating to the bathroom became shaky, had fine tremors, and was weak. RN #6 indicted that she gave the directive for LPN #1 to place the change of condition in the APRN communication book and she would pass the information to the 11:00 PM to 7:00 AM supervisor. RN #6 indicated that on 11/5/24 about 10:00 PM she looked in the APRN communication book and had seen that APRN #1 indicated that Resident #76 was not her resident and was not going to see Resident #76 on 11/5/24. RN #6 indicated that she then wrote on a sticky note for APRN #2 so see Resident #76 but did not know or had confirmed that APRN #2 was coming into the facility on [DATE]. RN #6 indicated that she did not call a provider because she did not feel it was an emergency she just felt that Resident #76 may just need labs, so she left it in the APRN communication book. Interview with the ADNS on 11/6/24 at 9:14 AM indicated that her expectation was that RN #6 would have called via the phone the APRN on call at that time on 11/4/24, not just write it in the communication book or leave a sticky in the supervisor office. The ADNS indicated that the RN #6 should have called the APRN and then by the APRN directive could have left a note in the communication book. Interview with APRN #1 on 11/6/24 at 11:00 AM indicated that when there is a change of condition with a resident her expectation was there would be an RN assessment and documentation of the assessment, and then call the APRN on duty to give all the information to. Interview with the DNS on 11/6/24 at 10:27 AM indicated that when a resident has a change of condition the LPN must notify the RN supervisor. The DNS Indicated that the RN supervisor must perform an assessment and document the assessment in the progress notes and updated the provider via the phone and not just place it in the communication book. Although attempted, an interview with MD #1 was not obtained. Review of the Change of Condition Policy identified it is the policy to notify the physician when the resident's condition or status changes unexpectedly. This will ensure that the physician will be kept informed of changes in an appropriate and timely manner. A change of condition is a significant symptom(s) or development, which requires assessment and intervention. If a resident is evaluated by a charge nurse to have a change in condition, the charge nurse will notify the RN Supervisor on duty. The RN Supervisor will do a follow up assessment and to ensure that the assessment is documented and reported to the physician. All assessment findings and relevant information should be compiled prior to calling the physician to ensure accurate information. The physician will be contacted to report findings. The nurse will obtain new orders as warranted from the physician. The resident will be notified. The nurse will document in the nurse's notes regarding assessments, findings, changes, physician notification, and resident and/or representative notification. 46040 2. Resident #111 was admitted to the facility on [DATE] with diagnoses that included dementia, nicotine dependence, and aphonia. A physician's order dated 7/31/24 directed Resident #111 may have supervised smoking per facility policy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #111's census sheet identified he/she was placed on the secured dementia unit upon admission on 7/31/24 Review of the clinical record identified legal documentation that directed Person #1 as Resident #111's conservator of person. Review of the clinical record identified a CAN DO LIST dated 8/2024 for Resident #111. The list identified Resident #111 had moderately severe cognitive decline and did not anticipate safety hazards. The admission MDS dated [DATE] identified Resident #111 had severely impaired cognition, was always continent of bowel and bladder, required set up with showering, and was independent with toileting, dressing, and eating. The MDS also identified Resident #111 had current tobacco use. The care plan dated 8/9/24 identified Resident #111 enjoyed smoking. Interventions included to observe Resident #111 for any signs/symptoms of unsafe smoking and to complete smoking evaluations per facility policy. A smoking agreement dated 8/10/24 identified verbal consent was obtained from Person #1 (Resident #111's resident representative) on that date related to Resident #111 being able to have supervised smoking at the facility. Review of the agreement signatures identified an illegible staff member and Security Guard #3. A smoking evaluation completed on 8/10/24 by Security Guard #3 identified Resident #111 had an understanding of the facility smoking policy, safety issues, and the importance of the smoking rules and regulations. A nurse's note dated 8/21/24 at 3:38 PM identified Person #1 was notified that Resident #111 was caught smoking and vaping in his/her room. The note further identified that Resident #111 was informed of the smoking policy and that smoking in his/her room was a fire hazard. A nurse's note dated 9/4/24 at 11:36 AM identified that laundry staff alerted nursing of a strong odor of cigarette smoke when delivering clothing items to Resident #111's room. The note further identified that upon nursing staff entering the room and identifying the odor, Resident #111 initially denied but subsequently turned over a half a pack of cigarettes along with a lighter. Review of the clinical record failed, including the reportable event form dated 9/4/24 failed to identify any additional documentation related to the 9/4/24 smoking incident including that Person #1 was contacted or notified of this incident. A 9/5/24 psychiatric note identified Resident #111 was seen after smoking in his/her room and that Resident #111 normally smoked cigarettes on his/her assigned smoke break. The note identified Resident 111 was very forgetful, pleasantly confused, and forgot that he/she could not smoke in his/her room. A 9/17/24 nurse's note identified a lighter was found in Resident #111's room behind his/her television and removed from the room. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record including the reportable event form dated 9/17/24 failed to identify that Person #1 was contacted or notified of when the lighter was found and removed from the resident's room. Interview with Person #1 on 11/5/24 at 2:06 PM identified that he/she became Resident #111 conservator following issues with cognitive decline. Person #1 identified that Resident #111 had multiple incidents related to cognition, including forgetting about cooking items on a stove top that resulted in a house fire. Person #1 identified that the facility staff were making sure to check Resident #111 for smoking materials regularly following 8/21/24 smoking incident and that Resident #111 regularly left the faciity on leave of absence with family members and friends. Person #1 identified that because of these checks, Resident #111 had not had any other smoking related incidents the facility. Person #1 identified the facility staff had only notified him of one incident related to smoking on 8/21/24. Person #1 also identified he primarily communicated with SW #1 (Director of Social Work). The facility policy on change of condition directed that a change of condition was a significant clinical development that required assessment and intervention. The policy further directed that the resident representative would be notified. 3. Resident #4 was admitted to the facility in June 2024 with diagnoses that included diabetes, anxiety disorder, major depressive disorder, and history of traumatic brain injury. The physician's orders dated 8/2024 directed to perform a skin check on shower days however, the order failed to reflect the scheduled shower day. The unit shower schedule form identified Resident #4's shower days were Wednesday on the 3:00 PM - 11:00 PM shift. Review of the August 2024 TAR identified skin checks to be done on shower day, Wednesday during the 3:00 PM - 11:00 PM shift, and reflected Resident #4 refused his/her shower on 8/7/24 and on 8/14/24. Resident #4 was hospitalized on [DATE] and 8/28/24. Review of the nurse aide flowsheet dated 8/1/24 - 8/31/24 identified Resident #4 refused his/her shower on 8/7, and 8/14/24. Review of the nurse's note dated 8/1/24 through 8/19/24 failed to reflect Resident #4 refused the shower on his/her scheduled day Wednesday 8/7, and 8/14/24 during the 3:00 PM - 11:00 PM shift. The physician's orders dated 9/2024 directed to perform a skin check on shower days, the order failed to reflect the schedule shower day. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and required setup or clean-up assistance with shower. Review of the nurse aide flowsheets dated 9/1/24 - 9/30/24 identified Resident #4 refused his/her shower on 9/4/24, was provided a shower on 9/11/24, was independent with the shower on 9/18/24, and 9/25/24 was blank. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse's note dated 9/4/24 at 6:44 PM identified Resident #4 refused the shower and bed bath. The nurse's notes failed to reflect Resident #4 was provided or refused a shower on 9/11/24, 9/18/24 or 9/25/24 during the 3:00 PM - 11:00 PM shift. The care plan dated 9/23/24 identified Resident #4 had an Activity Daily Living (ADL's) self-care performance deficit related to disease process traumatic brain injury, and deafness. Interventions included to provide assistance with bathing/showering. Review of the nurse aide flowsheet dated 10/1/24 - 10/31/24 identified Resident #4 refused his/her shower on 10/2, 10/9, 10/16, 10/23, and 10/30/24. Review of the nurse's note dated 10/2/24 at 2:33 PM identified Resident #4 requested to take a shower. Resident #4 was informed his/her shower was tonight on the 3:00 PM - 11:00 PM shift and Resident #4 agreed. The nurse's note failed to reflect documentation that Resident #4 had been provided a shower on the 3:00 PM - 11:00 PM shift. Review of the nurse's note dated 10/3/24 through 10/23/24 failed to reflect documentation that Resident #4 had been provided a shower on his/her scheduled day Wednesday 10/9, 10/16, and 10/23/24 during the 3:00 PM - 11:00 PM shift. Review of the nurse's note dated 10/30/24 at 9:24 PM identified Resident #4 was alert and verbal. Resident #4 refused his/her shower. Staff made several attempts, and he/she continued to refuse. Resident #4 indicated he/she wanted the shower in the morning. Review of the nurse's note dated 10/31/24 at 2:07 PM identified Resident #4 was asked, verbally and written out on paper. When would he/she like to take a shower today? Resident #4 indicated he/she did not want to take a shower today and would like a shower tomorrow morning. Resident #4 was asked again by a different nurse aide, and he/she refused the shower today. Resident #4 was educated on importance of regular bathing and skin checks. The care plan dated 11/1/24 identified Resident #4 has a behavior problem related to refusal of showers. Interventions included to provide opportunity for positive interaction. The nurse aide care card dated 11/4/24 identified Resident #4 shower day is on Wednesdays on the 3:00 PM - 11:00 PM shift. Interview and review of the clinical record with the ADNS on 11/5/24 at 10:30 AM identified she was aware that Resident #4 had been refusing his/her showers. The ADNS indicated the staff has been making multiple attempts to encourage Resident #4 to take a shower, but the resident continues to refuse. The ADNS indicated the licensed nurses should have documented every Wednesday on the 3:00 PM - 11:00 PM shift when Resident #4 had refused his/her shower. Interview and review of the clinical record with the Interim DNS on 11/6/24 at 6:30 AM identified he was not aware that Resident #4 had not been receiving showers. The Interim DNS indicated that Resident #4 refuses care and shower per the clinical record. The Interim DNS indicated the licensed nurses should have documented every Wednesday on the 3:00 PM - 11:00 PM shift when Resident #4 had refused the shower. The Interim DNS indicated that all nursing staff will be in-service regarding showers and documentation. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the NA #10 on 11/7/24 at 12:31 PM identified she was aware that Resident #4 has not been receiving his/her schedule showers. NA #10 indicated Resident #4 refuses care and showers all the time. NA #10 indicated she reports to the charge nurse on duty when Resident #4 refuses his/her shower. NA #10 indicated she does document the resident refusal on the nurse aide flowsheet. Interview with the NA #13 on 11/7/24 at 12:45 PM identified she was aware that Resident #4 has not been receiving his/her schedule showers. NA #13 indicated Resident #4 shower day is on Wednesday on the 3:00 PM - 11:00 PM shift. NA #13 indicated Resident #4 refuses shower all the time. NA #13 indicated she reports to the charge nurse when Resident #4 refuses his/her shower. NA #13 indicated she does document the resident refusal on the nurse aide flowsheet. Interview with the NA #12 on 11/7/24 at 1:02 PM identified she was aware that Resident #4 has not been receiving his/her schedule showers. NA #12 indicated Resident #4 shower day is on Wednesday on the 3:00 PM - 11:00 PM shift. NA #12 indicated Resident #4 refuses showers or bed bath all the time. NA #12 indicated she reports to the charge nurse when Resident #4 refuses his/her shower. NA #12 indicated she does document the resident refusal on the nurse aide flowsheet. Interview with the LPN #10 on 11/7/24 at 1:44 PM identified she was aware that Resident #4 had been refusing his/her schedule showers. LPN #10 indicated she and the nurse aides has been making multiple attempts to encourage Resident #4 to take a shower, but the resident continues to refuse. LPN #10 indicated she always notified the RN supervisor when the Resident #4 refuses his/her shower. LPN #10 indicated she is aware that she does not document Resident #4 refusal of his/her schedule showers. LPN #10 indicated going forward she will attempt to document Resident #4 refusal of shower. Review of the clinical record failed to reflect that the physician or resident representative had been made aware of the residents continued refusal of showers.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observation, review of the clinical record, facility documentation, facility policy, job descriptions, and interviews, for 2 of 4 units, the facility failed to ensure the environment was maintained in good repair and in a homelike manner and for 1 resident, (Resident #95) the facility failed to ensure a homelike environment. The findings include: Observation on 11/5/24 at 8:35 AM through 11:00 AM, and on 11/5/24 at 11:49 AM with the Regional Maintenance Director and the Administrator identified the following: a. Damaged, chipped, stains and/or marred bedroom walls on A wing in rooms 102, 103, 105, 106, 109, 110, 114, 115, 116, and 117. B wing in rooms [ROOM NUMBER]. b. Damaged, chipped, stains and/or marred bedroom radiators on A wing in rooms [ROOM NUMBER]. B wing in room [ROOM NUMBER]. c. Damaged, chipped and/or marred bathroom radiators on A wing in rooms [ROOM NUMBER], 107, and 108. B wing in room [ROOM NUMBER]. d. Damaged, bent, and/or missing window blind in bedroom on A wing in room [ROOM NUMBER]. e. Damaged, broken, and/or missing nightstand, closet, and dresser drawer knobs on A wing in rooms 101, 102, 110, 111, and 119. B wing in room [ROOM NUMBER]. f. Damaged, broken, and/or missing nightstand, dresser drawer and/or door on A wing in room [ROOM NUMBER]. B wing in room [ROOM NUMBER], and 137. g. Damaged, bent, and/or missing window blind in bedroom on A wing in room [ROOM NUMBER]. h. Damaged, cracked, and/or stained ceiling in the bathroom on A wing in rooms 102, 105, 112, 117, and 118. B wing in rooms 122, 123, 124, 125, 126, 128, 129, 131, 132, 133,134, 135, 136, 137, and 138. i. Damaged, broken, and/or peeling nightstand, closet, and dresser drawer on A wing in rooms 102, 105, 110, and 119. B wing in room [ROOM NUMBER]. j. Damaged and/or missing bathroom wall tile on wing in room [ROOM NUMBER]. k. Damaged, broken, and/or cracked floor tile in bedroom and/or bathroom on A wing in rooms 102, 105, 109, 112, 114, and 116. B wing in rooms 121, 122, 124, 127, 136, and 137. l. Damaged, loose, and/or off-wall bedroom sink on A wing in rooms 105, 108, 115, and 117. B wing in room [ROOM NUMBER]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. Damaged, broken, missing, peeling and/or dirty cove base in the bedroom on A wing in rooms [ROOM NUMBER]. B wing in room [ROOM NUMBER]. n. Damaged, dirty, dusty, and/or black stains on window air conditioner on A wing in room [ROOM NUMBER]. Interview on 11/5/24 at 11:54 AM with the Regional Maintenance Director identified he was not aware of the issues. The Regional Maintenance Director indicated that maintenance of the facility is ongoing. The Regional Maintenance Director indicated that the facility is going through the process of changing the maintenance log onto a computer system log. The Regional Maintenance Director indicated that the staff are responsible for calling the maintenance department with any maintenance problems/issue that require repair and if there is an emergency or safety related concern, the staff members are responsible for calling maintenance department immediately. The Regional Maintenance Director indicated he will have a meeting with the Administrator, Interim DNS, Infection Preventionist, housekeeping department and the maintenance department. Interview on 11/5/24 at 11:56 AM with the Administrator identified she was not aware of the issues. The Administrator indicated it is the responsibility of the maintenance department to oversee the repairs of the facility. The Administrator indicated that she will in-service the maintenance department. Interview on 11/5/24 at 12:24 PM with the Interim DNS identified he was not aware of the issues. The Interim DNS indicated he will have an in-service with the maintenance department, and the Infection Preventionist. Review of the maintenance director job description identified the primary purpose of position is to direct and conduct physical plant maintenance and grounds upkeep at a designated facility and oversee these functions at other facilities/building. Such maintenance includes building improvements, grounds, utilities, and mechanical/electrical systems. Review of the maintenance assistance job description identified the purpose of this position is to maintain the facility grounds, and building in a safe and efficient manner. This position will also repair faulty and broken equipment.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #97 and 59) reviewed for resident to resident altercations, for Resident #97, the facility failed to protect Resident #97 from physical abuse by Resident #217 and 71 who had a history of resident to resident altercations, and for Resident #59 the facility failed to protect Resident #59 from physical abuse by Resident #73. The findings include: 1. Resident #97 was admitted to the facility in August 2023 with diagnoses that included adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, mood disorder and depressed mood. The physician's orders dated 11/2023 directed to administer Trazadone (antidepressant medication) 50mg tablet give half tablet (25mg) tablet twice a day for insomnia, agitation, and anxiety. The care plan dated 11/2/23 identified Resident #97 was involved in an altercation with Resident #7. Interventions included ensure Resident #97 adhere to the no contact boundary with Resident #7. The behavior/intervention monthly flow record dated 11/1/2023 - 11/30/23 directed to monitor behavior of agitation and anxiety every shift day, evening, and night. The behavior/intervention monthly flow record identified Resident #97 had one episode of behavior of agitation and anxiety on (11/5/23 during the 7:00 AM - 3:00 PM shift) for the month of November 2023. The quarterly MDS dated [DATE] identified Resident #97 had intact cognition and required total dependence with personal hygiene. Additionally, Resident #97 had exhibited physical and verbal behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, screaming and cursing at others). The reportable event form dated 11/27/23 at 10:45 AM identified Resident #97 alleges that Resident #217 came into his/her room after they had a verbal argument and hit him/her in the face. Both residents were immediately separated, and Resident #217 was placed on 1:1 monitoring. The left side of Resident #97's face was swollen and red. Resident #97 was alert, oriented and able to make his/her needs known. The APRN was notified and assessed Resident #97. The psychiatrist was notified and assessed both residents. Resident #217 was seen by the psychiatrist and was transferred to the hospital for further psychiatric evaluation. The Administrator and the police were notified, and an investigation was initiated. The neurological check sheet dated 11/27/23 at 10:45 AM identified Resident #97 was on neurological monitoring. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The APRN note dated 11/27/23 identified Resident #97 was evaluated for left jaw swelling and pain. Resident #97 was hit on the left jaw by Resident #217. Resident #97 complained of pain in the trauma area and ringing in the left ear. Resident #97 indicated Tylenol was not effective and was requesting stronger medication. The APRN ordered to monitor left mandible swelling, and report worsening symptoms to the physician. Cool compress with wash cloth. Apply to left mandible swelling for 10 minutes each time 4 times daily as needed for pain. Check vital signs every shift time 3 days. Tramadol (pain medication) 50mg tablet every 8 hours as needed for 3 days. The psychiatrist note dated 11/27/23 identified Resident #97 had a resident to resident altercation. Resident #97 was not currently a danger to self or others. Resident #97 was pleasant, engaging and in a fair mood. Resident #97 indicated Resident #217 came to his/her room after a verbal altercation and hit him/her on the left side of face causing swelling and pain. Resident #97 indicated he/she would not feel safe until Resident #217 was moved to another floor or transferred to another facility. Resident #97 endorsed feeling distress about the incident but denies suicidal/hallucination ideation. Recommend continuing current medications and monitor mood/sleep. No new orders. A written statement by the Security Specialist dated 11/27/23 at 1:15 PM identified Resident #217 thought Resident #97 was cutting the smoking line and addressed him/her. The Security Specialist indicated this resulted in a verbal altercation between Resident #97 and Resident #217. The Security Specialist indicated both residents were calling each other derogatory names. The Security Specialist indicated both residents were immediately separated and not allowed to smoke at the same time. The nurse's note dated 11/27/23 at 4:00 PM by the ADNS (RN supervisor for the 7:00 AM - 3:00 PM shift) identified she was notified to assess Resident #97 after an altercation with Resident #217. Resident #97 indicated he/she had an argument that started in the smoking line and Resident #97 alleged Resident #217 punched him/her on the left side of the face. An RN assessment was performed, and Resident #97 left side of face was swollen, red, and tender to touch. Neurological checks were initiated. Resident #97 also complained of left ear ringing. Resident #97 indicated he/she would like to press charges against Resident #217. The police department was called and came to the facility and interviewed Resident #97. The APRN, and psychiatrist APRN was notified. The care plan dated 11/27/23 identified Resident #97 had alleged that he/she was struck in the face by a peer. Interventions included to encourage Resident #97 to maintain a no contact boundary with Resident #217. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The summary report dated 12/1/23 at 5:39 PM identified this was an unwitnessed incident that occurred on 11/27/23 which started as a verbal altercation during smoke break. The verbal altercation was immediately broken up by the Security Specialist. However, after returning to their unit Resident #217 alleges that Resident #97 continued to call him/her derogatory name. Resident #217 indicated this angered him/her, so he/she went into Resident #97's room and punched him/her in the face. Resident #217 agreed to a room and unit change. Resident #217 was seen by the facility psychiatrist and Resident #217 indicated feeling anxious about the altercation and was having auditory hallucination and hearing impairment. Resident #217 was transferred to the hospital for further psychiatrist evaluation due to safety concerns. Resident #217 returned from the hospital with a letter of no harm. The facility continued Resident #217 on 1:1 supervision. The medication dose was adjusted, and labs ordered. Resident #217 was followed by facility psychiatrist and denied hallucinations, suicidal ideation, and hearing impairment. Resident #217 has agreed to maintain a no contact boundary with Resident #97. Resident #217 smokes in a group separate from Resident #97. The 1:1 was discontinued. The psychiatrist and social workers continue to follow and support residents. Interview and review of the clinical record with the ADNS on 11/5/24 at 2:00 PM identified she was the supervisor on 11/27/23 on the 7:00 AM - 3:00 PM shift. The ADNS indicated she was called to the unit to assessed Resident #97. The ADNS indicated an RN assessment was completed, and Resident #97 observed with the left side of face swollen, red, and painful to touch and neurological checks were initiated. The ADNS indicated Resident #97 indicated Resident #217 hit him/her in the face. The ADNS indicated both residents were seen by the APRN, and the psychiatrist APRN. The ADNS indicated Resident #217 was placed on 1:1 until transferred to the hospital. Both resident care plans were revised. Resident #217 was moved to another unit and room upon return from the hospital. 2. Resident #97 was admitted to the facility in August 2023 with diagnoses that included adjustment disorder with mixed disturbance of emotions and conduct, anxiety disorder, mood disorder and depressed mood. The care plan dated 2/20/24 identified Resident #97 was observed hitting another resident in the stomach. Intervention included Resident #97 had agreed to no contact boundary with other resident. The physician's orders dated 5/2024 directed to administer Trazadone (antidepressant medication) 50mg tablet give half tablet (25mg) tablet twice a day for insomnia, agitation, and anxiety. The quarterly MDS dated [DATE] identified Resident #97 had intact cognition and required total dependence with personal hygiene. Additionally, Resident #97 had no behaviors of physical or verbal directed toward others. The reportable event form dated 5/2/24 at 3:15 PM identified Resident #71 was observed by Resident #7 to have punched Resident #97. Resident #97 was in Resident #7's room when Resident #71 asked him/her to leave. Resident #97 refused to leave Resident #7 room. Resident #97 proceeded to knock over a cup of milk which splashed onto Resident #71. Resident #71 then punched Resident #97 on the left side of face. Resident #97 informed the nurse on the unit of the alleged incident. Resident #97's skin was intact, slight swelling and discoloration noted to left side of face. Both residents were placed on 1:1 monitoring. The police, Administrator, physician, and the resident representatives were notified. An investigation was initiated, an RN assessment was completed, and neurological checks initiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note dated 5/2/24 at 10:03 PM by the ADNS (RN supervisor) identified at 3:15 PM she was called to unit due to a resident to resident altercation. Resident #97 reported that he/she was in Resident #71's room and Resident #71 asked to Resident #97 to leave his/her room but Resident #97 refused. Resident #97 identified that Resident #71 punched him/her on the left side of the face twice and punched him/her once in the center of the chest. Resident #97 indicated he/she immediately went to the nurse's station and told the charge nurse of the altercation. Resident #97 reported pain to the left side of face. Subsequently there was swelling and a bruise forming to the left side of face by the cheek bone. No discoloration or swelling to mid chest. Resident #97 denies feeling shortness of breath. Lungs sound clear. Both residents were immediately placed on 1:1 monitoring. Resident #97 is responsible for self. Psychiatric APRN had a telehealth call with Resident #97 and discontinued 1:1 monitoring. Every 15 minute checks were initiated. No contact boundary with Resident #71. Social workers to follow up. The nurse's note dated 5/2/24 at 10:38 PM identified Resident #97 was currently on every 15 minute checks. Resident #97 was to have no contact with Resident #71. Resident #97 left side of face slightly bruised with redness. Resident #97 complained of pain with Tylenol given with some positive effect. Resident #97 remained in the room with no issues. A written statement by Resident #97 undated at 3:15 PM identified Resident #97 went into Resident #71's room for candy. Resident #97 indicated he/she was trying to turn the wheelchair to leave, and Resident #71 stood up and punched him/her on the left side of face and twice and in the center of the chest. Resident #97 indicated he/she left the room and notified the staff. Resident #97 identified it's not over, I want to retaliate and stab Resident #71 but promised he/she would not retaliate. A written statement by Resident #71 (with no date) at 3:15 PM identified Resident #71 indicated Resident #97 came into Resident #7 room without knocking. Resident #71 indicated he/she asked Resident #97 to leave. Resident #97 indicated Resident #7 said I can come to the room. Resident #7 indicated no I didn't. Resident #71 indicated Resident #97 then took a cup of milk off Resident #7 table and threw it toward them and tried to punch Resident #71 but missed. Resident #71 indicated he/she then punched Resident #97 on the left side of face and that is when Resident #97 left the room. Resident #71 indicated he/she will not retaliate. The care plan dated 5/2/24 identified Resident #97 had got into an altercation with another resident and was punched in the face by Resident #71. The care plan failed to reflect documentation of interventions. The psychiatrist note dated 5/3/24 identified met with Resident #97 due to a recent resident to resident altercation. Resident #97 was pleasant and appropriately processed the events by his/her recall. Reviewed with Resident #97 conflict de-escalation skills and conflict prevention skills. Resident #97 was not assessed to be a harm to self or other at this time. The note failed to address Resident #97's statement regarding the desire to retaliate and stab Resident #71. The summary report dated 5/7/24 at 1:31 PM identified both residents were placed on 1:1 monitoring. Both residents were seen by the psychiatrist and 1:1 were discontinued. Both residents were placed on monitoring every 15 minutes for 48 hours. Both residents are being followed by the psychiatrist. Resident #71's medication regimen was completed. Both residents were offered a room change and declined. Both residents were placed on a no contact boundaries. Both resident care plans updated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility abuse policy identified abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. 3. Resident #59 was admitted to the facility on [DATE] with diagnoses that included dementia, PTSD, and a traumatic brain injury. The quarterly MDS dated [DATE] identified Resident #59 had moderately impaired cognition, had no presence of the following behavioral symptoms: physical behavioral symptoms directed toward others, verbal behavioral symptoms, or other behavioral symptoms not directed toward others, and was independent with walking 150 feet or similar space. The care plan dated 8/24/23 identified Resident #59 would identify to the facility social work staff that he/she felt safe from risk of physical harm or mental anguish while receiving care in the facility. Interventions included offering 1:1 social worker visits to discuss conflict resolution techniques and having staff accompany Resident #59 when going to the second floor. The nurse's note dated 9/12/24 at 12:57 PM identified the nurse was called to the resident dining room by staff. On arrival Resident #59 was observed lying on his/her back with another resident (Resident #73) standing over him/her using profound language. The nurse separated both residents immediately and placed Resident #59 on a 1:1 for safety. Resident #59 identified that he/she was hit in the face by another resident during an argument that transpired between the two residents which contributed to Resident #59 falling. Resident #59 had a small abrasion to the back of his/her head; Resident #59 was alert and oriented, at baseline, no complaints of dizziness or headache, bilateral upper and lower extremities symmetrical, positive range of motion. Local police were called to facility, APRN notified, no new orders, continue facility protocol. The Reportable Event Form dated 9/12/23 identified that Resident #59, the alleged victim, asked Resident #73, the alleged perpetrator who had diagnoses that included intermittent explosive behavior and anxiety, to move out of the way, so he/she could pass by; Resident #73 accused Resident #59 of stepping on his/her foot and a verbal argument ensued. Resident #73 indicated that he/she pushed Resident #59, causing him/her to fall backwards. The report further identified that the facility staff entered the dining room and saw Resident #73 standing over Resident #59 and immediately separated the residents; Resident #59 was placed on 1:1 for safety until both residents could be seen by the Psychiatric Provider. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The APRN note dated 9/15/24 at 1:24 PM identified that Resident #59 was seen status post an altercation earlier in the week; Resident #59 stated that he/she walked past another resident, said excuse me, and the other resident pulled his/her shirt, punched him/her in the face, and he/she fell backwards hitting his/her head on the floor. Per staff there were witnesses who added the two parties were yelling at each other prior to the physical altercation and confirmed Resident #59 was punched and fell . On exam, Resident #59 denies headaches, light sensitivity, dizziness, nausea/vomiting, or changes in vision; he/she denied facial pain or tenderness. The nurse's noted dated 9/18/23 at 11:00 PM identified Resident #59 had complained of tinnitus. The nurse's note dated 9/20/23 at 1:54 PM identified that Resident #59 had new orders for an Ear, Nose, and Throat (ENT) referral & audiology with an outside provider. The ENT office visit notes dated 10/25/23 identified Resident #59's subjective history of the present illness included complaints of a right ear clogging sensation; he/she received a punch on his/her right ear about 2 months ago and started losing his/her hearing after that. Resident #59 reported hearing ringing sounds in the right ear that started after the trauma, reports feeling dizzy sometimes but denied ear pain or discharge. Resident #59's physical examination identified normal exterior ears, clear external auditory canal, normal tympanic membranes, intact and mobile on Pneumatoscopy (an examination that allows determination of the mobility of the tympanic membrane), and no middle ear mass. The report further identified that Resident #59 had diagnoses that included hearing loss to the right ear, with an unspecified hearing loss type, tinnitus of the right ear, dizziness, and giddiness; an ambulatory referral to Audiology was made. Interview with Resident #59 on 11/3/24 at 9:15 AM identified that approximately one year ago, Resident #73 had been threatening him/her, and while in the dining room after trying to walk by Resident #73, Resident #73 struck Resident #59 on the side of his/her face, threw him/her to the ground, and punched him/her in the ear, resulting in a blown-out ear drum. Resident #59 indicated that he/she was separated from Resident #73. Resident #59 identified that he has had no additional altercations with Resident #73, they reside on different units, and he/she stays away from Resident #73 but indicated that sometimes Resident #73 will follow him/her around. Interview with the DNS on 11/6/24 at 10:00 AM identified that he had been serving as the interim DNS for 2 days, and he could not speak to the specifics of the incident or investigation. The DNS indicated that a portion of the facility's population have psychosocial issues, and some residents have compromised coping skills with a limited ability for conflict resolutions; unfortunately, there may be times when individuals revert to their prior coping mechanisms. The DNS further indicated that sometimes incidents escalate in a matter of a seconds; the temper of an individual can escalate with no time for the staff to intervene despite interventions being implemented. The DNS identified that the facility handles their resident populations as best they can; they educate residents and staff frequently, update resident care plans and implement interventions, but they may not always be able to intervene timely. The facility's Abuse policy directs that residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. 47457

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15802 Based on review of the clinical record, facility documentation, facility policy, and interview for 4 of 4 residents (Resident #43, 84, 89, and 111) who reside on a locked dementia unit, the facility failed to provide the method of opening doors independently to the residents who voluntarily reside on the unit and do not meet the criteria for the unit, failed to educate the social worker on required assessments according to the Greater Hartford Memory Care Center Program guidelines, failed to complete initial and ongoing assessments of the residents according to the Greater Hartford Memory Care Center Program guidelines, and failed to ensure the clinical record included documentation according to 483.12(a)(1) to ensure the residents were free from involuntary seclusion. The findings include: 1. According to S483.12(a)(1) Each resident has the right to be free from involuntary seclusion. Involuntary seclusion includes, but is not limited to, the following: A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. A resident who chooses to live in the secured/locked unit and does not meet the criteria for placement, must have access to the method of opening doors independently. Staff should be aware of which residents have access to opening doors and monitor their use of the access to ensure other residents' safety. According to the Greater Hartford Memory Care Center Program guidelines, initial and periodic reviews of the residents continued stay in the program by the facilities interdisciplinary treatment planning team will be conducted for the resident, which will be updated and revised as needed on a quarterly basis, and concurrent with the resident's care plan. (Appendix C). Facility social worker will administer an Ability to Meet Minimal Basic Needs assessment (Appendix D) upon admission and on a quarterly basis. Resident #43 was admitted to the facility in December 2023 with diagnosis that included depression and bipolar disorder. The quarterly MDS dated [DATE] identified Resident #43 had intact cognition. Review of the clinical record identified Resident #43 was moved to the secured locked dementia unit on 7/23/24. A social worker progress note dated 7/23/24 identified Resident #43 had a room change today, will follow up with the resident for 72 hours. Resident #43 signed consent for locked unit and is free to come down as he/she pleases although it's a locked unit. Social worker will keep supporting the resident. Review of the dementia unit evaluation tool (Appendix C) dated 11/4/24, done for the first time subsequent to surveyor inquiry identified the following. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Quarterly evaluation. The resident does not present a risk to self or others, resident/resident representative choose to reside in the secured unit while not meeting program criteria. Resident's choice to go to unit, resident does not meet criteria but wishes to continue residing on the program unit. Two illegible signatures noted at bottom. Review of the clinical record failed to reflect documentation regarding a discussion with the resident/representative regarding the move to the secure locked dementia unit or a care plan with ongoing assessments regarding the resident residing on the locked dementia unit including how the resident will be provided independent egress from the unit. Further, the clinical record lacked the Ability to Meet Minimal Basic Needs assessment (Appendix D) upon the residents move to the locked unit or the next quarter. Interview with the Charge Nurse, LPN #11, on 11/4/24 at 11:15 AM identified that no residents are allowed to know the code to independently leave the locked dementia unit. Interview with the Director of Social Services, (SW #1) on 11/4/24 at 12:15 PM who was observed reviewing and toggling between the 2 Electronic Medical Records (EMR) (as the facility is in a transition from one electronic health system to another) identified there was no initial or quarterly dementia unit evaluation (Appendix C) done when Resident #43 was moved to the locked dementia unit on 7/23/24. Further, an initial care plan that addressed Resident #43's placement on the locked dementia unit or ongoing documentation of the review and revision of the care plan related to the resident's placement on the unit was not found. SW #1 also indicated that residents' who do not meet the criteria for the locked dementia unit but are on the unit by choice are not given the code to leave the unit independently. The residents need to be let out by staff. Additionally, there were no follow up social service notes after the resident was placed on the locked dementia unit on 7/23/24 and SW #1 identified she had never seen the Ability to Meet Minimal Basic Needs assessment (Appendix D) prior to today. The VP of Clinical Services and the Director of Specialty Programming were also in the room and in attendance during the interview reviewing both facility Electronic Medical Records (EMR) looking for the information requested Although according to S483.12(a)(1) a resident who chooses to live in a secured/locked unit and does not meet the criteria for placement, must have access to the method of opening doors independently, review of the Greater Hartford Memory Care Center Program Consent to Voluntarily Reside on a Secure Unit identified the exits to the unit are alarmed and secured, requiring staff intervention to permit egress. Your placement on this unit is by your choice. If your residency on any secured unit is by your choice AND you do not meet the criteria of the program, you are to be provided as needed egress from the unit. 2. According to S483.12(a)(1) Each resident has the right to be free from involuntary seclusion. Involuntary seclusion includes, but is not limited to, the following: A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further, it is expected that each resident's record would include the following. Documentation of the clinical criteria met for placement in the secured/locked area by the resident's physician along with information provided by members of the interdisciplinary team. Documentation that reflects the resident/representative's involvement in the decision for placement in the secured/locked area. Documentation that reflects whether placement in the secured/locked area is the least restrictive approach that is reasonable to protect the resident and assure his/her health and safety. Documentation by the interdisciplinary team of the impact and/or reaction of the resident, if any, regarding placement on the unit. Ongoing documentation of the review and revision of the resident's care plan as necessary, including whether he/she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continue to meet the needs of the resident. Review of the Greater Hartford Memory Care Center Program Guidelines directed initial and periodic reviews of the residents continued stay in the program by the facilities interdisciplinary treatment planning team will be conducted for the resident, which will be updated and revised as needed on a quarterly basis, and concurrent with the resident's care plan. (Appendix C). Facility social worker will administer an Ability to Meet Minimal Basic Needs assessment (Appendix D) upon admission and on a quarterly basis. Resident #84 was admitted in May 2023 to the secure locked dementia unit with diagnosis that included anxiety, schizoaffective disorder bipolar type, and vascular dementia. The quarterly MDS dated [DATE] identified Resident #84 had short and long term memory problems and severely impaired cognition. Review of the care plan dated 11/4/24, done subsequent to surveyor inquiry identified the following: I meet the criteria, and I and/or my responsible party have given consent to voluntarily live on a unit that is secure to protect myself or another resident from leaving the unit. The goal identified the resident will seek permission or assistance when I want to leave the unit. Assess me for the reason I may need to be on a unit that is secured. I acknowledge that I have voluntarily chosen to live on this unit. If I feel these circumstances do not apply to me, I will discuss with my social worker or nursing supervisor in order for a safe and effective means of providing me with access with access or egress at my discretion can be arranged. Review of the clinical record failed to reflect an initial or periodic review of the residents continued stay in the program (Appendix C), or the Ability to Meet Minimal Basic Needs assessment (Appendix D) had been done. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Social Services, (SW #1) on 11/4/24 at 12:15 PM who was observed reviewing and toggling between the 2 Electronic Medical Records (EMR) identified that an initial assessment, including whether the resident met the criteria for admission to the unit (Appendix C), or the Ability to Meet Minimal Basic Needs assessment (Appendix D) had not been done. SW #1 identified she had never seen Appendix D prior to today. The VP of Clinical Services and the Director of Specialty Programming were also in the room and in attendance during the interview and were reviewing both facility Electronic Medical Records (EMR) looking for the information requested and could not find the requested information. The facility failed to ensure the clinical record reflected documentation of the clinical criteria met for placement, documentation that reflected the resident/representative's involvement in the decision for placement, documentation that reflected the placement is the least restrictive approach, documentation of the impact and/or reaction of the resident and ongoing documentation of the review and revision of the resident's care plan, including whether he/she continues to meet the criteria, and if the interventions continue to meet the needs of the resident. 3. According to S483.12(a)(1) Each resident has the right to be free from involuntary seclusion. Involuntary seclusion includes, but is not limited to, the following: A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. Further, it is expected that each resident's record would include the following. Documentation of the clinical criteria met for placement in the secured/locked area by the resident's physician along with information provided by members of the interdisciplinary team. Documentation that reflects the resident/representative's involvement in the decision for placement in the secured/locked area. Documentation that reflects whether placement in the secured/locked area is the least restrictive approach that is reasonable to protect the resident and assure his/her health and safety. Documentation by the interdisciplinary team of the impact and/or reaction of the resident, if any, regarding placement on the unit. Ongoing documentation of the review and revision of the resident's care plan as necessary, including whether he/she continues to meet the criteria for remaining in the secured/locked area, and if the interventions continue to meet the needs of the resident. Review of the Greater Hartford Memory Care Center Program Guidelines Assessment directed initial and periodic reviews of the residents continued stay in the program by the facilities interdisciplinary treatment planning team will be conducted for the resident, which will be updated and revised as needed on a quarterly basis, and concurrent with the resident's care plan. (Appendix C). Facility social worker will administer an Ability to Meet Minimal Basic Needs assessment (Appendix D) upon admission and on a quarterly basis. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89 was admitted in July 2024 to the secure locked dementia unit with diagnosis that included dementia. The admission MDS dated [DATE] identified Resident #89 had moderately impaired cognition. Review of the clinical record failed to reflect a quarterly/periodic review of the residents continued stay in the program (Appendix C), or an initial or quarterly Ability to Meet Minimal Basic Needs assessment (Appendix D) had been done. Interview with the Director of Social Services, (SW #1) on 11/4/24 at 12:15 PM who was observed reviewing and toggling between the 2 Electronic Medical Records (EMR) identified that the quarterly assessment, including whether the resident met the criteria for admission to the unit (Appendix C), and the initial or quarterly Ability to Meet Minimal Basic Needs assessment (Appendix D) had not been done. SW #1 identified she had never seen Appendix D prior to today. The VP of Clinical Services and the Director of Specialty Programming were also in the room and in attendance during the interview and were reviewing both facility Electronic Medical Records (EMR) looking for the information requested and could not find the requested information. The facility failed to ensure the clinical record reflected quarterly documentation of the clinical criteria met for placement, documentation that reflects the resident/representative's involvement in the decision for placement, documentation that reflects the placement is the least restrictive approach, documentation of the impact and/or reaction of the resident and ongoing documentation of the review and revision of the resident's care plan, including whether he/she continues to meet the criteria, and if the interventions continue to meet the needs of the resident. 4. According to S483.12(a)(1) Each resident has the right to be free from involuntary seclusion. Involuntary seclusion includes, but is not limited to, the following: A resident placed in a secured area of the facility but does not meet the criteria for the unit and is not provided with access codes or other information for independent egress. A resident who chooses to live in the secured/locked unit and does not meet the criteria for placement, must have access to the method of opening doors independently. Staff should be aware of which residents have access to opening doors and monitor their use of the access to ensure other residents' safety. Resident #111 was admitted in July 2024 to the secure locked dementia unit with diagnosis that included alcohol abuse, opioid use disorder and acute toxic encephalopathy. A progress note dated 7/31/24 identified Resident #111 was admitted to the facility subsequent to a hospitalization for a fentanyl overdose. The baseline care plan dated 7/31/24 identified Resident #111 had a diagnosis of substance use disorder and had a conservator. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 8/2/24 identified I live on a unit which is locked to protect myself or another resident from leaving the area. I will not attempt to leave the unit without permission and/or assistance through my next review. Assess me for the reason I may need to be on a locked unit. If I choose to leave the unit, ensure I am not a wanderer and have permission to leave the unit. If I do not meet the criteria of the program I will be provided egress from the unit through my next review. If I feel these circumstances don't apply to me, I will discuss this with my social worker or nursing supervisor in order for a safe and effective means of providing me with access or egress at my discretion can be arranged. I acknowledge I have chosen to voluntarily reside on this unit. Review of the Greater Hartford Memory Care Center Program Consent to Voluntarily Reside on a Secure Unit identified the exits to the unit are alarmed and secured, requiring staff intervention to permit egress. Your placement on this unit is by your choice. If your residency on any secured unit is by your choice AND you do not meet the criteria of the program, you are to be provided as needed egress from the unit. I have read and understand the above information, and consent to reside in a secured dementia program under these circumstances. I attest that I have been made aware of the purpose and nature of this unit and understand that I have chosen to voluntarily reside on this unit. The name of the resident representative was printed on the form (as COP), the form was dated 8/10/24, the staff witness signature was illegible, and there was a notation of verbal consent obtained. The quarterly MDS dated [DATE] identified Resident #111 had moderately impaired cognition. A dementia unit evaluation tool (Appendix C) was done on 11/4/24, for the first time subsequent to surveyor inquiry. Review of the clinical record failed to reflect documentation regarding a discussion with the resident/representative regarding the move to the secure locked dementia unit or a care plan with ongoing assessments regarding the resident residing on the locked dementia unit. Interview with the Charge Nurse, LPN #11, on 11/4/24 at 11:15 AM identified that no residents are allowed to know the code to independently leave the locked dementia unit. Interview with the Director of Social Services, (SW #1) on 11/4/24 at 12:15 PM who was observed reviewing and toggling between the 2 Electronic Medical Records identified that residents who do not meet the criteria for the locked dementia unit but are on the unit by choice are not given the code to leave the unit independently. The residents need to be let out by staff. The VP of Clinical Services and the Director of Specialty Programming were also in the room and in attendance during the interview and were reviewing both facility Electronic Medical Records (EMR) looking for the information requested. Interview with Person #1 on 11/5/24 at 2:06 PM identified that staff reported Resident #111 resided on a dementia unit and that the dementia unit had extra staff due to the needs of the residents on the unit, however Person #1 identified he/she was not aware that the unit was locked, which was why Resident #111 was able to go on leave of absences from the facility. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Although according to S483.12(a)(1) a resident who chooses to live in a secured/locked unit and does not meet the criteria for placement, must have access to the method of opening doors independently, review of the Greater Hartford Memory Care Center Program Consent to Voluntarily Reside on a Secure Unit identified the exits to the unit are alarmed and secured, requiring staff intervention to permit egress. Your placement on this unit is by your choice. If your residency on any secured unit is by your choice AND you do not meet the criteria of the program, you are to be provided as needed egress from the unit. Although review of the Greater Hartford Memory Care Center Program Guidelines, Assessment, directed initial and periodic reviews of the residents continued stay in the program be conducted which will be updated and revised as needed on a quarterly basis, (Appendix C), and the social worker will administer an Ability to Meet Minimal Basic Needs assessment (Appendix D) upon admission and on a quarterly basis, Appendix C was not done initially, and according to an interview with SW #1, she had never seen, knew about, or completed the required Ability to Meet Minimal Basic Needs (Appendix D) assessment. Interview with the Director of Recreation on 11/4/24 at 12:24 PM identified she leads the recreation department and is not aware of the Greater Hartford Memory Care Center Program or any of its requirements. The Director of Recreation indicated she started at the facility 3 weeks ago. Interview with the Director of Specialty Programing on 11/4/24 at 1:00 PM identified she oversees the Greater Hartford Memory Care Center Program Coordinators in each care center and indicated the Director of Recreation is the designated Greater Hartford Memory Care Center Program Coordinator here in this building. The Director of Specialty Programing identified that the Greater Hartford Memory Care Center Program is a brand name of the facility memory care guidelines and is not a separate entity. The Director of Specialty Programing identified the previous Director of Recreation held the title of Greater Hartford Memory Care Center Program Coordinator.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Resident #102, 76) reviewed for Activities of Daily Living (ADL), the facility failed to ensure the residents were provided a weekly shower on scheduled shower days. The findings include: 1. Resident #102 was admitted to the facility in April 2024 with diagnoses that included severe morbid obesity, paraplegia, and spinal cord compression. The unit shower schedule form identified Resident #102's shower days were Friday on the 7:00 AM - 3:00 PM shift. Review of the nurse's notes and nurse aide flowsheet dated 7/1/24 - 7/31/24 failed to reflect documentation that Resident #102 had been provided a shower on his/her scheduled day Friday 7/5, 7/12, 7/19, and 7/26/24 during the 7:00 AM - 3:00 PM shift. Review of the nurse's notes and nurse aide flowsheet dated 8/1/24 - 8/31/24 failed to reflect documentation that Resident #102 had been provided a shower on his/her scheduled day Friday 8/2, 8/9, 8/16, 8/23 and 8/30/24 during the 7:00 AM - 3:00 PM shift. Review of the nurse's notes and nurse aide flowsheet dated 9/1/24 - 9/30/24 failed to reflect documentation that Resident #102 had been provided a shower on his/her scheduled day Friday 9/6, 9/13, 9/20, and 9/27/24 during the 7:00 AM - 3:00 PM shift. The quarterly MDS dated [DATE] identified Resident #102 had intact cognition and required total assistance with shower/bath. Review of the nurse's notes and nurse aide flowsheet dated 10/1/24 - 10/31/24 failed to reflect documentation that Resident #102 had been provided a shower on his/her scheduled day Friday 10/4, 10/11, 10/18, and 10/25/24 during the 7:00 AM - 3:00 PM shift. The care plan dated 10/30/24 identified Resident #102 has an activity of daily living self-care performance deficit related to paraplegia. Interventions include to provide bathing/showering: Check nail length, trim, and clean on bath day and as necessary. Report any changes to the nurse Interview with Resident #102 on 11/3/24 at 9:42 AM identified he/she has not had a shower since June 2024. Resident #102 indicated the nurse aides told him/her that the facility does not have a shower that fit him/her. Resident #102 indicated his/her shower day is on Friday on 7:00 AM - 3:00 PM shift. Resident #102 indicated he/she would like to take a shower. Resident #102 indicated the nurse aides has been providing him/her with a bed bath on Fridays on the 7:00 AM - 3:00 PM shift but that is not the same as taking a shower. The nurse aide care card dated 11/5/24 identified Resident #102's shower day is on Fridays on the 7:00 AM - 3:00 PM shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #6 on 11/5/24 at 9:38 AM identified she was aware that Resident #102 not has not been receiving his/her showers on Friday on the 7:00 AM - 3:00 PM shift. NA #6 indicated the old bariatric shower chair was not safe for Resident #102 to take a shower. NA #6 indicated the previous DNS was aware of the bariatric shower chair was not safe. NA #6 indicated a new bariatric shower chair was purchased sometime in June 2024. NA #6 indicated the new bariatric shower chair was too wide and did not fit through the shower room door. NA #6 indicated once Resident #102 was placed in the new bariatric shower chair, the bariatric shower chair did not fit through the shower room door even when attempted to push the bariatric shower chair through the door sideway. NA #6 indicated the nurse aides did notifiy the previous DNS and physical therapy that the bariatric shower chair did not fit through the shower room door. NA #6 indicated the previous DNS was aware of the issue. NA #6 indicated on Fridays she would provide Resident #102 with a complete bed bath and also washed his/her hair. Interview with NA #7 on 11/5/24 at 11:10 AM identified she was aware of Resident #102 not receiving his/her showers. NA #7 indicated the last time she had given Resident #102 a shower was sometime in May 2024 or the beginning of June 2024. NA #7 indicated the old bariatric shower chair was no longer safe to give Resident #102 a shower. NA #7 indicated she notified the previous DNS and physical therapy. NA #7 indicated the old bariatric shower chair was removed off the unit. NA #7 indicated the facility purchased a new bariatric shower chair in June 2024. NA #7 indicated the bariatric shower chair was too wide and did not fit through the shower room door. NA #7 indicated once Resident #102 was placed into the bariatric shower chair, the bariatric shower chair did not fit through the shower room door even when the staff tried to push the bariatric shower chair side way. NA #7 indicated when she is assigned to Resident #102 on a Friday, she would provide Resident #102 with complete bed bath and shampooed the resident's hair. NA #7 indicated the previous DNS was aware that the new bariatric shower chair did not fit through the door. Interview with NA #8 on 11/5/24 at 11:20 AM identified she was aware of Resident #102 has not been receiving his/her showers. NA #8 indicated she did not used the old bariatric shower chair to give Resident #102 a shower because the bariatric shower chair was not safe. NA #8 indicated she always provided Resident #102 with a complete bed bath and washed his/her hair on Fridays. NA #8 indicated the previous DNS was aware that the new bariatric shower chair did not fit through the door. Interview with the Administrator on 11/5/24 at 11:30 AM identified she was not aware that Resident #102 had not been receiving showers since June 2024, over 4 months. The Administrator indicated the facility will look into purchasing a different bariatric shower chair that is safe and can fit through the shower room door. Interview with the ADNS on 11/5/24 at 11:45 AM identified she was not aware that Resident #102 had not been receiving showers. The ADNS indicated the previous DNS during the summer was addressing the issue with the bariatric shower chair. Subsequent to surveyor inquiry, a new bariatric shower chair was acquired, and Resident #102 was provided a shower. Review of the facility personal care policy identified the facility nursing personnel will offer AM and PM care to all residents. Showers and/or baths and shampoos are scheduled at least weekly and more often as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report any changes to the nurse. Document according to facility guidelines. 42117 2. Resident #76 was admitted to the facility in July 2024 with diagnoses that included congestive heart failure (CHF), peripheral vascular disease, and hypertension. Review of the nurse's notes dated 7/10/24 to 11/6/24 failed to reflect Resident #76 had refused to take a shower or was offered a shower. The admission MDS dated [DATE] identified Resident #76 had intact cognition. Additionally, Resident #76 indicated that it was very important to him/her to choose between a tub bath, shower, bed bath, or sponge bath. Resident #76 needed touching assistance for showering/bathing with washing, rinsing, and drying self. The care plan dated 8/8/24 identified Resident #76 would be able to speak openly to the social worker any feelings or coping impairments. Interventions included to record and report any concerns or condition changes to the physician and the interdisciplinary team as needed. The care plan did not identify Resident #76's preferences for showers. The nurse's aides flow sheets for September 2024 identified shower documentation as follows. 9/7/24, was blank. 9/14/24, was blank. 9/21/24, NA #5 documented NA. 9/28/24, supervision was provided. The nurse's aides flow sheets for October 2024 identified shower documentation as follows. 10/5/24, moderate assistance from NA #3 (who in an interview indicated that she gave the resident a bed bath not a shower). 10/12/24, independent for a shower. 10/19/24, was blank. 10/26/24, partial assistance. The nurse's aides flow sheets for November 2024 identified shower documentation as follows. 11/2/24, independent, by NA #4, who in an interview indicated that she did not see Resident #76 in the shower room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #76 on 11/3/24 at 8:41 AM indicated that he/she has only had 1 shower since admission to the facility in July 2024 and wants at least one shower a week. Resident #76 indicated that the nurse's aides have given him/her a bed bath, but he/she has told the staff he/she really prefers and wants a shower. Resident #76 indicated that he/she asks the nurse's aides almost daily for a shower and the nurse's aides reply they don't have time or tomorrow and never give him/her a shower. Resident #76 indicated that he/she has told the charge nurses and SW #1, but nothing has changed. Resident #76 indicated that he/she has tried many times to talk with SW#1, but she tells Resident #76 she will go to his/her room later that day and never shows up. The unit shower schedule at first floor desk identified Resident #76's room and bed assigned was scheduled for a shower on Saturdays 7:00 AM to 3:00 PM shift. Interview with SW #1 on 11/4/24 at 9:53 AM indicated that Resident #76 had come to her office twice last week and she did inform Resident #76 she would see him later each day but did not see Resident #76 because she was busy with other residents. SW #1 indicated before 10/3/24 Resident #76 had gone to her office and had complained about not getting any showers, so SW #1 contacted the DNS at that time and Resident #76 received a shower on that day. SW #1 indicated that she did not document that Resident #76 was upset that he/she had not received a shower since admission and was only getting a bed bath. SW #1 indicated that Resident #76 indicated that he/she only wanted showers not a bed bath and that she had notified the prior DNS. SW #1 indicated that right after that she had gone out on leave and had just returned about a week ago and had not had time to speak to Resident #76 regarding showers. SW #1 indicated that resident #76 prefers to speak with her. Interview with NA #3 on 11/4/24 at 2:22 PM indicated that she works full time on the unit and sometimes has Resident #76 on Saturdays (shower day). NA #3 indicated that she does not recall giving Resident #76 a shower, only a bed bath. NA #3 indicated that Resident #76 would need assistance to go to the shower and receive a shower. NA #3 indicated that Resident #76's unit works short with only 2 nurse aides and that sometimes it is just too much to get everything done. NA #3 indicated that it is quicker to give a bed bath compared to a shower. NA #3 indicated that she does not recall if Resident #76 had informed her that he/she prefers a shower. After review of the nurse aide flow sheets, NA #3 indicated that she had signed off on 9/19 9/27, 9/30, 10/2, 10/5, 10/9, 10/11, and 10/14/24 that she had given Resident #76 a shower but she has never given Resident #76 a shower, and she documented incorrectly at times putting a number 1 indicating Resident #76 was totally dependent on staff for a bed bath or a shower and other times a 6 that Resident #76 was totally independent taking his/her own shower. NA #3 indicated that she was not sure how to answer that question on the computer but does know she has not given Resident #76 a shower and has only given bed baths because they were quicker. NA #3 indicated that her documentation was not accurate. NA #3 indicated that since Resident #76 was admitted in July 2024 she has not given Resident #76 a shower or brought him to the shower room. Interview with NA #5 on 11/5/24 at 9:09 AM indicated that she had documented on 9/10, 9/11, 9/21, 9/22 9/24, 10/27, and 10/29/24 NA every day and that meant not applicable. NA #5 indicated that she has not given Resident #76 a shower. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #4 on 11/5/24 at 9:52 AM indicated that Resident #76 can take his/her own shower independently. NA #4 indicated when she was assigned to Resident #76, she gives Resident #76 a washcloth and towel and it was up to Resident #76 if he/she took a shower or washed up at the sink. NA #4 indicated that she has not seen Resident #76 going into or coming out of the shower room. NA #4 indicated that she documented a number 6 on 10/21, 10/22, 10/24, 10/25, 10/31, 11/2, and 11/3/24, because she believed Resident #76 was independent with his/her own showers. NA #6 indicated that a number 6 means the resident was independent with taking showers. NA #4 indicated that she had never seen Resident #76 take him/herself into or out of the shower room down the hallway and could not verify that Resident #76 had received a shower. NA #4 indicated that she has never physically given Resident #76 a shower. NA #4 indicated that this unit is very busy with only 2 nurse aides, and she does not know if Resident #76 either washed him/herself or took a shower. Interview with the DNS on 11/5/24 at 2:02 PM indicated that all residents are scheduled at least weekly for showers and could ask for more often as the resident wanted another shower. The DNS indicated that Resident #76 required extensive assistance of one staff person for transfers was at risk for falls and has had falls at the facility. The DNS indicated that the nurse aides just started with this new electronic medical record in September 2024 and may need reeducation on how to document. The DNS indicated that the care plan would reflect residents' preference for showers or bed baths and would reflect if resident was refusing showers. The DNS indicated that Resident #76 could not give him/herself a shower and that Resident #76 was not to be left alone in the shower room. Interview with PTA #1 on 11/5/24 at 2:08 PM indicated Resident #76 required assist of 1 staff person for ambulation and transfers. PTA #1 indicated that Resident #76 could ambulate with a rolling walker and assistance of 1 staff person to the shower room, but not by him/herself. PTA #1 indicated that Resident #76 would have to have a staff person stay in the shower room with him/her for assistance and safety. PTA #1 indicated that Resident #76 definitely could not take a shower or be alone in the shower room by him/herself. Review of the Personal Care Policy identified showers and/or baths and shampoos are scheduled at least weekly and more often as needed. Document according to the facility guidelines. 3. Resident #116 was admitted to the facility in August 2024 with diagnoses that included syncopal fall related to alcohol abuse, subdural hematoma, and cervical spine fracture. The nursing admission assessment completed on 8/16/24 identified Resident #116 was alert and oriented, had a history of 2 or more falls in the last 3 months, was a high risk for falls, and required the assistance of 1 staff member with toileting and dressing, and 2 staff members for transfers. Review of the clinical record failed to identify a care plan related to Resident #116's recent history or risks of falls. A reportable event form dated 8/24/24 at 3:15 AM identified Resident #116 had an unwitnessed fall. The report identified Resident #116 reported attempting to retrieve a blanket, loosing balance and falling. The report also identified Resident #116 reported bumping his/her head during the fall. The report identified that the physician was notified and that neurological checks would be initiated per facility policy and would have monitoring every shift for 72 hours. (continued on next page)

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	075252	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any neurological checks or shift monitoring documentation completed after 5:00 AM on 8/26/24, approximately 50 hours after Resident #116's fall. Interview with MD #1 (Medical Director) on 11/5/24 at 3:12 PM identified that the nursing staff should have completed 72 hours of neurological monitoring and shift assessments on Resident #116 following the unwitnessed fall with a reported head strike on 8/24/24. MD #1 identified with Resident #116 history of falls and recent diagnosis of a subdural hematoma, he would have expected that the nursing staff would have adhered to the facility policy and completed the full 72 hours of monitoring to ensure Resident #116 did not have any new injury or worsening of his/her previous head injury. The facility policy on the fall management program directed that if a resident had an unwitnessed fall or if a head injury was suspected, neurological signs would be monitored, and that the resident would be monitored for 72 hours after the fall and any concerns identified would be documented. The facility policy on neurological checks directed that residents with a suspected head injury would have neurological signs monitored and recorded for 72 hours per policy unless otherwise ordered by a physician and would be performed as follows: Every 15 minutes for one hour (4x). Every 30 minutes for one hour (2x). Every hour for 4 hours (4x). Every 2 hours for 10 hours (5x). Every 4 hours for 16 hours (4x). Every 8 hours for 40 hours (5x). The policy further directed that the neurological check documentation should include blood pressure, pulse, respirations, hand grasp, level of consciousness, pupil reactivity to light, and any additional comments or findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 7 residents (Residents #76, 81, 116, 63, 103, 7 and 59) the facility failed to provide care in accordance with professional standards of practice, and physician's orders. For 1 of 5 residents (Resident #76) reviewed for unnecessary medications, the facility failed to document an RN assessment when the resident exhibited a change in condition and failed to obtain weights according to facility policy and physician order. For (Resident #81) reviewed for nutrition, the facility failed to monitor the resident's fluid intake and output and weights per the physician's orders. For 1 resident (Resident #116) reviewed as a closed record for discharge, the facility failed to ensure that neurological checks and post fall assessments were completed when the resident sustained an unwitnessed fall with a reported head strike. For 1 of 5 residents (Resident #63) reviewed for unnecessary medications and for 1 resident (Resident #103) reviewed for pain management, the facility failed to ensure orthostatic blood pressure monitoring was completed per the physician's order. For 1 resident (Resident #7) reviewed for falls, the facility failed to ensure neurological assessments were completed following 2 unwitnessed falls, per the facility policy. For 1 of 4 residents (Resident #59) reviewed for resident-to-resident abuse, the facility failed to ensure neurological assessments were completed and documented, per facility policy. The findings include: 1. Resident #76 was admitted to the facility in July 2024 with diagnoses that included congestive heart failure, seizures, diabetes, and hypertension. The admission MDS dated [DATE] identified Resident #76 had intact cognition, and needed touching assistance by staff for ambulation in room and corridor. The care plan dated 8/8/24 identified Resident #76 was at risk for falls. Interventions included to record and report any concerns or changes in condition to the attending physician. A physician's order dated 10/22/24 directed to transfer with assist of 2 staff person. A nurse's note written by LPN #1 on 11/4/24 at 10:10 PM indicated that Resident #76 was observed with increased tremors and weakness to the extremities which was reported to the supervisor and a notation was placed in the APRN communication book for evaluation. Review of the clinical record dated 11/4/24 to 11/6/24 failed to reflect that an RN assessment had been done when Resident #76 was observed with increased tremors and weakness to the extremities on 11/4/24 at 10:10 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #76 on 11/5/24 at 9:00 AM indicated last night he/she was walking to the bathroom with a staff member when he/she became so shaky and weak and was having tremors that he/she could not get off the toilet. Resident #76 indicated that it took 2 staff to assist walking him/her back to bed. Interview with the ADNS on 11/6/24 at 8:54 AM indicated that if there was a change in condition the LPN must notify the RN supervisor. The ADNS indicated that the RN must do an assessment of the resident and document the assessment under progress notes. The ADNS indicated that she had worked on 11/4, 11/5, and today for the 7:00 AM to 3:00 PM shift and was not aware that Resident #76 was observed with increased tremors and weakness to the extremities on 11/4/24 and it was not given during supervisor daily report from shift to shift. After review of the clinical record, the ADNS indicated that there was no RN assessment documented including a set of vital signs, a blood sugar or a neurological assessment. Interview with RN #6 with ADNS present on 11/6/24 at 9:04 AM indicated that she had worked on 11/4/24 from 3:00 PM to 11:00 PM as the RN supervisor. RN #6 indicated that she was called by LPN #1 to see Resident #76. RN #6 indicated that she had seen Resident #76 and had him/her squeeze her hands and she had asked what had happened. RN #6 indicated that LPN #1 had reported to her that while ambulating Resident #76 to the bathroom the resident became shaky, had fine tremors, and was weak. RN #6 indicted that she gave the directive for LPN #1 to place that information in the APRN communication book and she had passed the information to the 11:00 PM to 7:00 AM supervisor. RN #6 indicated that she did not write a progress note because she was busy with admissions. RN #6 indicated that on 11/5/24 about 10:00 PM she looked in the APRN communication book and had seen that APRN #1 indicated that Resident #76 was not her resident and was not going to see Resident #76 on 11/5/24. RN #6 indicated that she then wrote on a sticky note for APRN #2 so see Resident #76 but did not know or could verify if APRN #2 was coming into the facility on [DATE]. RN #6 indicated that when there is a change of condition, the expectation was for her to do the RN assessment and document the assessment. Interview with the ADNS on 11/6/24 at 9:14 AM indicated RN #6 should have done and documented an RN assessment of Resident #76's condition. Interview with APRN #1 on 11/6/24 at 11:00 AM indicated that when there is a change of condition with a resident her expectation was there would be an RN assessment and documentation of the assessment and then a report the to the APRN on duty. Interview with the DNS on 11/6/24 at 10:27 AM indicated that when a resident has a change of condition the LPN must notify the RN supervisor. The DNS Indicated that the RN supervisor must perform an assessment and document the assessment in the progress notes. Although attempted, an interview with MD #1 was not obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Change of Condition Policy identified it is the policy to notify the physician when the resident's condition or status changes unexpectedly. This will ensure that the physician will be kept informed of changes in an appropriate and timely manner. A change of condition is a significant symptom(s) or development, which requires assessment and intervention. If a resident is evaluated by a charge nurse to have a change in condition, the charge nurse will notify the RN Supervisor on duty. The RN Supervisor will do a follow up assessment and to ensure that the assessment is documented and reported to the physician. All assessment findings and relevant information should be compiled prior to calling the physician to ensure accurate information. The physician will be contacted to report findings. The nurse will obtain new orders as warranted from the physician. The resident will be notified. The nurse will document in the nurse's notes regarding assessments, findings, changes, physician notification, and resident and/or representative notification. 2. Resident #76 was admitted to the facility in July 2024 with diagnoses that included congestive heart failure (CHF), peripheral vascular disease, and hypertension. The hospital discharge summary dated 7/10/24 identified Resident #76 was hospitalized for fluid overload on examination and was started on Lasix 80 mg intravenously. Discharge medication changes identified Resident #76 was to start taking Torsemide 40 mg daily and continue Spironolactone 25 mg daily with breakfast. Discharge weight was 190 lbs. Additionally, the discharge summary identified and directed that daily weight monitoring was crucial for heart failure patients. Record daily weights and call physician if weight gain of 2 - 3 lbs. in a day or a gain of 5 lbs. in a week. The care plan dated 7/10/24 identified Resident #76 had a nutritional problem related to chronic heart failure and history of edema and fluid retention. Interventions included to weigh resident at the same time of day and record. Additionally, weigh resident as ordered by the physician. The physician's admission orders dated 7/10/24 directed to weigh Resident #76 daily per CHF guidelines. If weight is 2 lbs. over in 24 hours or over by 5 lbs. in a week notify the physician. Additionally, give Spironolactone 25mg (diuretic) daily for fluid retention (edema) and Torsemide 40 mg (diuretic) daily. Review of the Weight Summary dated 7/10/24 to 11/6/24 identified the following. 7/10/24, weight 191.2 lbs. 8/8/24, weight 177.5 lbs. 8/12/24, weight 177.5 lbs. 8/19/24, weight 185.0 lbs. 9/2/24, weight 193.4 lbs. 9/4/24, weight 187.4 lbs. 9/6/24, weight 193.4 lbs. 9/9/24, weight 187.4 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/18/24, weight 152.0 lbs. Although the July 2024 TAR identified to obtain a daily weight: if over 2 lbs. in 24 hours or over 5 lbs. in a week notify the physician, there were no signatures to indicate the weights had been obtained. The admission MDS dated [DATE] identified Resident #76 had intact cognition. The physician's readmission orders dated 8/8/24 directed to weigh Resident #76 daily per CHF guidelines. If weight is 2 lbs. over in 24 hours or over by 5 lbs. in a week notify the physician. Additionally, give Torsemide 40 mg (diuretic) daily. The physician's orders dated October and November 2024 directed to weigh Resident #76 daily per CHF guidelines. If weight is 2 lbs. over in 24 hours or over by 5 lbs. in a week notify the physician. Additionally, give Torsemide 40 mg daily and Spironolactone 12.5 mg daily. Review of the August, September, October, and November 2024 TAR's failed to reflect the readmission orders of 8/8/24 to weigh Resident #76 daily. A physician order dated 8/28/24 directed to decrease Spironolactone to 12.5 mg daily. Interview with NA #3 on 11/4/24 at 2:22 PM indicated that she works full time on the unit and sometimes has Resident #76. NA #3 indicated that she is not aware that Resident #76 required daily weights. Interview with Resident #76 on 11/5/24 at 9:27 AM indicated that the staff do not ask to weigh him/her daily. Resident #76 indicated that he/she has not refused to be weighted while at the facility and would have no problem to get weighted as needed. Interview with the DNS on 11/5/24 at 2:02 PM indicated that it was his expectation that the nursing staff would follow the physician's orders for daily and weekly weights and document the weights in the electronic medical record. The DNS indicated that the facility does not have a CHF program, protocol, or policy. Interview with the Dietitian on 11/5/24 at 3:12 PM indicated that Resident #76's weight on 10/18/24 appeared as a significant weight loss so she had requested a reweight to be done. The Dietitian indicated that she still has not received a reweight or the November weight for Resident #76. The Dietitian indicated that the reweight should be obtained within a couple of days and the November monthly weights by the 10th of each month. The Dietitian indicated that she has requested a reweight to the charge nurse and the ADNS on 10/18/24 and has not received the reweight yet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 11/6/24 at 8:15 AM indicated that she was responsible to oversee that all weekly weights and monthly weights were completed. The ADNS indicated that weekly weights were to be done on Mondays no later than Tuesdays because the dietitian comes in on Tuesdays and a reweight needs to be done by Wednesday. The ADNS indicated that the monthly weights were to be done by the 5th of the month. The ADNS indicated that a reweight was to be done by the next day. The ADNS indicated that the nurse aides were responsible to get the weights, and the charge nurse was responsible to document the weight in residents electronic clinical record or on the paper TAR. The ADNS indicated that Resident #76 had an admission weight of 191.2 lbs. on 7/10/24. After clinical record review, the ADNS indicated that there was a physician order since admission on 7/10/24 and readmission 8/8/24 for Resident #76 to have daily weights with parameters. The ADNS indicated that she did not see any documentation that the daily weights were being done. The ADNS indicated that she did not see any documentation that Resident #76 had refused to be weighted since admission. Interview with the DNS on 11/6/24 at 10:27 AM indicated that weights were to be obtained on day of admission and then follow the physician orders which include weekly times 4 weeks then monthly, unless the physician directs otherwise. The DNS indicated that if the physician orders daily weights he would expect that the nursing staff to weigh the resident daily at the same time every day and if the weight was outside of the parameters that the supervisor would notify the provider. Review of the Weight Policy identified weights will be obtained for all residents on admission. The frequency of weights will be determined by the interdisciplinary team post admission based on resident's individual needs. 3. Resident #81 was admitted to the facility in May 2024 with diagnoses that included congestive heart failure (CHF) and stroke. a. A physician order dated 5/29/24 directed to administer Torsemide 40 mg (diuretic) daily. Additionally, per CHF guidelines Resident #81 requires a fluid restriction of 1500 ml to 2000 ml per day. A physician's order dated 6/5/24 directed qn 1800 ml per day fluid restriction. The quarterly MDS dated [DATE] identified Resident #81 had intact cognition. The care plan dated 7/28/24 identified Resident #81 had a stroke. Interventions included to monitor for swelling and edema in the extremities, participate in cardiac rehab program, and encourage adequate fluid intake. Weigh resident as ordered by the physician. Review of the August, September, and October 2024 MAR's and TAR's failed to reflect documentation of fluid intake or fluid output. Review of the August, September, and October 2024 intake and output records identified many shifts and days were not completed and lacked any 24-hour total intake/output. A physician order dated 10/22/24 directed to discontinue the fluid restriction. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 11/4/24 at 7:20 AM indicated the intake and output records were to be completed every shift by the nurse aides and the charge nurses. The ADNS indicated that the 11:00 PM to 7:00 AM charge nurse or supervisor was responsible to add up the 3 shifts for a total to see if a resident went over the fluid restriction. The ADNS indicated that the supervisors should be checking to make sure the charge nurses are completing the 24-hour totals. The ADNS indicated that if the resident had gone over his/her fluid restriction the APRN or physician must be notified. After clinical record review, the ADNS indicated that during August, September, and October 2024 until 10/22/24 no 24-hour totals had been completed. Interview with the DNS on 11/6/24 at 10:16 AM indicated that Resident #81 was on an 1800 ml per day fluid restriction. The DNS indicated that his expectation was the nurse aides and nurses would document every shift what the resident drinks as the intake amount and the supervisor was responsible to do the 24 hour totals every day. The DNS indicated that if Resident #81 had gone over the 1800 ml fluid restriction the supervisor would notify the APRN or physician and document the notification. Interview with APRN #1 on 11/6/24 at 10:30 AM indicated the nurses were expected to follow the physician's orders for a fluid restriction. APRN #1 indicated that the nursing staff must document every shift what a resident drinks during their shift. APRN #1 indicated that if a resident goes over the fluid restriction nursing must notify the APRN or the physician and document it. b. A physician order dated 5/29/24 directed to administer Torsemide 40 mg (diuretic) daily. Additionally, Resident #81 was on daily weights per CHF guidelines: if weight gain over 2 lbs. in 24 hours or 5 lbs. in a week notify the physician. Review of the weight summary dated 5/29/24 to 6/14/24, 16 days, identified that weights were obtained on 5/29/24 (223.0 lbs.) and 6/3/24 (223.0 lbs.). A physician order dated 6/15/24 directed to discontinue daily weights and start weekly weights. Review of the weight summary dated 6/15/24 to 7/4/24 identified the following. 6/17/24 Resident #81 weighed 215.4 lbs. 6/24/24 Resident #81 weighed 213.8 lbs. 7/15/24 Resident #81 weighed 215.6 lbs. 8/1/24 Resident #81 weighed 214.0 lbs. 10/9/24 Resident #81 weighed 212.6 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 11/4/24 at 2:48 PM indicated that if there was an order for daily weights or weekly weights it would be transcribed by the nurse onto the MAR or the TAR. The ADNS indicated that the nurse aides are responsible to get the weights, and the charge nurses are responsible to record the weights and sign off as completed. The ADNS indicated that she did not realize that Resident #81 was on daily weights and had changed to weekly weights. The ADNS indicated she was responsible to make sure weekly weights were done but she did not realize Resident #81 was on weekly weights. The ADNS indicated that the nurse that that received the order for weekly weights did not transcribe it correctly by placing it on the MAR or TAR for the nurses to track weekly. After review of the clinical record, the ADNS indicated that the daily weights were not done from 5/29/24 until 6/15/24 and the weekly weights also were not consistently done. The ADNS indicated that if Resident #81 had refused to be weighed that it would have been documented. The ADNS indicated that there were no nurses notes that identified Resident #81 had refused weekly weights from 7/1/24 until 11/4/24. Interview with the DNS on 11/6/24 at 10:16 AM indicated that if there was a physician order for daily weights or weekly weights that the nursing staff would have obtained the weights and documented the weights in the clinical record. The DNS indicated that the nurse aides were responsible to get the weights, and the nurse or the nursing supervisor was responsible to make sure it was done. The DNS indicated that if Resident #81 had refused weights that he would expect to see that documented in a progress note in the clinical record. Interview with APRN #1 on 11/6/24 at 10:30 AM indicated the nurses were expected to follow the physician's orders for weights. APRN #1 indicated that if a resident refuses a weight that the nurse would educate the resident and document. APRN #1 indicated that refusal of weight needs to be reported to the APRN or physician. Review of the Hydration Policy identified a licensed nurse will review the daily monitoring sheets and intake and output record after 72 hours and determine if continued monitoring is indicated or per the physician's order. 46040 4. Resident #116 was admitted to the facility in August 2024 with diagnoses that included syncopal fall related to alcohol abuse, subdural hematoma, and cervical spine fracture. The nursing admission assessment completed on 8/16/24 identified Resident #116 was alert and oriented, had a history of 2 or more falls in the last 3 months, was a high risk for falls, and required the assistance of 1 staff member with toileting and dressing, and 2 staff members for transfers. Review of the clinical record failed to identify a care plan related to Resident #116's recent history or risks of falls. A reportable event form dated 8/24/24 at 3:15 AM identified Resident #116 had an unwitnessed fall. The report identified Resident #116 reported attempting to retrieve a blanket, loosing balance and falling. The report also identified Resident #116 reported bumping his/her head during the fall. The report identified that the physician was notified and that neurological checks would be initiated per facility policy and would have monitoring every shift for 72 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any neurological checks or shift monitoring documentation completed after 5:00 AM on 8/26/24, approximately 50 hours after Resident #116's fall. Interview with MD #1 (Medical Director) on 11/5/24 at 3:12 PM identified that the nursing staff should have completed 72 hours of neurological monitoring and shift assessments on Resident #116 following the unwitnessed fall with a reported head strike on 8/24/24. MD #1 identified with Resident #116 history of falls and recent diagnosis of a subdural hematoma, he would have expected that the nursing staff would have adhered to the facility policy and completed the full 72 hours of monitoring to ensure Resident #116 did not have any new injury or worsening of his/her previous head injury. The facility policy on the fall management program directed that if a resident had an unwitnessed fall or if a head injury was suspected, neurological signs would be monitored, and that the resident would be monitored for 72 hours after the fall and any concerns identified would be documented. The facility policy on neurological checks directed that residents with a suspected head injury would have neurological signs monitored and recorded for 72 hours per policy unless otherwise ordered by a physician and would be performed as follows: Every 15 minutes for one hour (4x). Every 30 minutes for one hour (2x). Every hour for 4 hours (4x). Every 2 hours for 10 hours (5x). Every 4 hours for 16 hours (4x). Every 8 hours for 40 hours (5x). The policy further directed that the neurological check documentation should include blood pressure, pulse, respirations, hand grasp, level of consciousness, pupil reactivity to light, and any additional comments or findings. 47457 5. Resident #63 was admitted to the facility on [DATE] with diagnoses that included dementia, bipolar disorder, and depression. The care plan dated 9/3/24 identified Resident #63 was at risk for falls related to deconditioning, gait/balance problems, medication side effects, and left AKA (above the knee amputation). Interventions included to anticipate the needs of the resident. The care plan identified that Resident #63 was using psychotropic medications related to bipolar disorder. Interventions included monitoring and reporting any adverse reactions of psychotropic medications: unsteady gait, rigid muscles, and frequent falls. The care plan further identified that Resident #63 was using antidepressant medications related to depression. Interventions included monitoring and reporting any adverse reactions to antidepressant therapy: decline in ADL ability, balance problems, falls, dizziness, and vertigo. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS dated [DATE] identified Resident #63 had intact cognition and was independent with sitting to standing, chair/bed-to-chair transfers, and toilet transfers. A physician's order dated 9/5/24 directed to complete orthostatic blood pressure monitoring weekly, times 4 weeks. The September 2024 MAR, Weights and Vital Signs Summary and nurse's notes failed to identify orthostatic blood pressure monitoring was completed during the weeks of 9/5/24, 9/12/24, 9/19/24, or 9/26/24. Interview with the DNS on 11/06/24 at 10:15 AM identified that he would expect orthostatic blood pressures to be completed, per the physician's order, by the floor nurse and documented in the resident's clinical record. The facility's Vital Signs-Blood Pressure-Orthostatic policy directs that orthostatic blood pressures are taken by licensed staff when ordered by a physician and/or when orthostatic changes are suspected. 6. Resident #103 was admitted to the facility on [DATE] with diagnoses that included endocarditis and heart valve disorders, hypertension, post-traumatic stress disorder (PTSD), and anxiety. A physician's order dated 9/27/24 directed to complete orthostatic blood pressure monitoring weekly times 4 weeks. The admission MDS dated [DATE] identified Resident #103 had intact cognition and required partial/moderate assistance with chair/bed-to-chair transfers, toilet transfers, and walking 10 feet. The care plan dated 10/17/24 identified Resident #103 had altered cardiovascular status related to endocarditis, was on intravenous (IV) antibiotics, and was followed by Cardiology and Infectious Disease. Interventions included monitoring vital signs, as ordered, and notifying the physician of significant abnormalities. The care plan further identified that Resident #103 had depression related to the admission. Interventions included administering medications as ordered and to monitor and document for side effects and effectiveness. The September and October 2024 MAR, Weights and Vital Signs Summary and nurse's notes failed to identify orthostatic blood pressure monitoring was completed during the weeks of 9/27/24, 10/4/24, 10/11/24, or 10/18/24. Interview with the DNS on 11/06/24 at 10:15 AM identified that he would expect orthostatic blood pressures to be completed, per the physician's order, by the floor nurse and documented in the resident's clinical record. The facility's Vital Signs-Blood Pressure-Orthostatic policy directs that orthostatic blood pressures are taken by licensed staff when ordered by a physician and/or when orthostatic changes are suspected. 7. Resident #7 was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy, type 2 diabetes mellitus, and abnormalities of gait and mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE] identified Resident #7 had intact cognition and was independent walking 150 feet. The care plan dated 7/6/24 identified Resident #7 did not want to have any falls with serious injuries. Interventions included observing for signs and symptoms of decreased balance, leaning, dizziness, or fatigue, encourage Resident #7 to take Lactulose, per the physician's order, and monitor labs (ammonia levels) per the physician's order. The nurse's note dated 8/10/24 at 6:49 AM identified that Resident #7 was noted to be sitting on the floor near the outside bathroom wall. Resident #7 indicated that he/she was trying to get the TV remote and slid out of the wheelchair, denied hitting his/her head, was alert and oriented to person, place, and time, denies injury, and denies pain or discomfort from the fall. Resident #7 was found sitting upright and was assisted back to the wheelchair, range of motion to all extremities, neurological checks within normal limits (wnl), vital signs stable, on-call APRN notified, will continue to monitor neurological status and vital signs per facility protocol. Review of Resident #7's clinical record dated 8/10/24 through 8/12/24 failed to identify documentation that neurological monitoring was completed. The reportable event form documentation following Resident #7's 8/10/24 fall failed to identify documentation that neurological monitoring was completed. Subsequent to surveyor inquiry, Resident #7's Neurological Check Sheet dated 8/10/24 was provided. The Neurological Check Sheet identified missing neurological assessments on 8/12/24 at 4:05 AM and 8/12/24 at 12:05 PM. The Neurological Check Sheet further identified a discrepancy in the timeline between the facility's policy and the documentation form. The Neurological Check Sheet outlined documentation for 62 hours only, not 72 hours, per the facility policy. The nurse's note dated 10/24/24 at 11:45 PM identified that Resident #7 appears to have slid out of his/her bed and was unable to state what happened, see status post fall evaluation, left message for conservator of person and APRN was notified, will continue neurologic checks and vital signs, per the facility protocol, denies pain or discomfort. Review of Resident #7's clinical record dated 10/24/24 through 10/27/24 failed to identify documentation that neurological monitoring was completed. The reportable event form documentation following Resident #7's 10/24/24 fall failed to identify neurological monitoring was completed. Subsequent to surveyor inquiry, Resident #7's Neurological Check Sheet dated 10/24/24 through 8/27 (August 27) was provided. The Neurological Check Sheet identified missing neurological assessments for an undated 1:30 AM assessment, undated 5:30 AM assessment, undated 9:30 PM assessment, and an 8/27 (August 27) untimed assessment. The Neurological Check Sheet further identified a discrepancy in the timeline between the facility's policy and the documentation form. The Neurological Check Sheet outlined required neurological assessment documentation for 62 hours only, not 72 hours, per the facility policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #12 on 11/6/24 at 6:59 AM identified that neurological assessments are expected to be completed on residents for 72 hours following an unwitnessed fall, by the charge nurse or the nursing supervisor. Interview with RN #12 on 11/6/24 at 7:02 AM identified that neurological assessments were to be completed in accordance with the facility policy and body assessments were to be completed every shift, for 3 consecutive days or longer if there is a clinical reason to continue monitoring. RN #12 further identified that following a fall the RN Supervisor always completes the first assessment, and the charge nurse will continue to monitor the resident with the oversight from the RN Supervisor. Interview with the DNS on 11/06/24 at 10:07 AM identified that he would expect the neurological monitoring to be completed by the nurse per the facility policy and the documentation sheet should reflect the facility's policy, which is 72 hours of neurological monitoring, following an unwitnessed fall. The Fall Management Program policy directs that in the event of an unwitnessed fall or when a head injury is suspected, to monitor neurological signs per physician orders (refer to Neurological Assessment policy). The facility's Neurological Checks policy directs that residents with a suspected head injury will have neurological signs monitored and recorded for 72, unless otherwise ordered by the physician. Neurological checks are performed as follows, unless otherwise ordered by a physician: Every 15 minutes for 1 hour (4 times). Every 30 minutes for 1 hour (2 times). Every 1 hour for 4 hours (4 times). Every 2 hours for 10 hours (5 times). Every 4 hours for 16 hours (4 times). Every 8 hours for 40 hours (5 times). 8. Resident #59 was admitted to the facility on [DATE] with diagnoses that included dementia, PTSD, and a traumatic brain injury. The quarterly MDS dated [DATE] identified Resident #59 had moderately impaired cognition, had no presence of the following behavioral symptoms: physical behavioral symptoms directed toward others, verbal behavioral symptoms, or other behavioral symptoms not directed toward others, and was independent with walking 150 feet or similar space. The care plan dated 8/24/23 identified Resident #59 would identify to the facility social work staff that he/she felt safe from risk of physical harm or mental anguish while receiving care in the facility. Interventions included offering 1:1 social worker visits to discuss conflict resolution techniques and having staff accompany Resident #59 when going to the second floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 9/12/23 at 12:57 PM identified the nurse was called to the resident dining room by staff. On arrival Resident #59 was observed lying on his/her back with another resident (Resident #73) standing over him/her using profound language. The nurse separated both residents immediately and placed Resident #59 on a 1:1 for safety. Resident #59 identified that he/she was hit in the face by another resident during an argument that transpired between the two residents which contributed to Resident #59 falling. Resident #59 had a small abrasion to the back of his/her head; Resident #59 was alert and oriented, at baseline, no complaints of dizziness or headache, bilateral upper and lower extremities symmetrical, positive range of motion. Local police were called to facility, APRN notified, no new orders, continue facility protocol. Resident #59 was seen by the Psychiatric provider, who ordered the discontinuation of the 1:1 supervision, based on his assessment. The APRN note dated 9/15/23 at 1:24 PM identified that Resident #59 was seen status post an altercation earlier i [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observations, review of the clinical record, facility documentation, facility policy, and interview for 3 of 7 residents (Residents #20, 13 and 111) reviewed for accidents, the facility failed to implement interventions and/or assistive devices to ensure the residents safety and a safe environment. For 1 of 2 residents (Resident #20) the facility failed to ensure the resident consistently utilized the smoking apron while smoking, for 1 resident (Resident #13) the facility failed to ensure a fan being used in the resident room had its cover in place, and for 1 of 7 residents (Resident #111) the facility failed to ensure the resident was reassessed and interventions implemented after multiple smoking policy violations to ensure the safety of the residents in the facility. The findings include: 1. Resident #20 was admitted to the facility in April 2022 with diagnoses that included generalized muscle weakness, traumatic brain injury and Schizophrenia. The annual MDS dated [DATE] identified Resident #20 had intact cognition but had verbal behavioral symptoms directed towards others such as threatening, screaming, and cursing at others. Additionally, Resident #20 had other behavioral symptoms not directed towards others such as physical hitting or scratching self, pacing, and throwing or smearing food or bodily waste. These behaviors significantly interfere with residents' participation in activities or social interactions and significant disrupt care or living environment. Resident #20 needs assistance with personal hygiene. Resident #20 uses tobacco. The care plan dated 5/22/24 and 7/23/24 identified Resident #20 was a smoker. Interventions included for the resident to wear a smoking apron while smoking and staff to observe clothing and skin for signs of cigarette burns. The Smoking Agreement dated 7/30/24, signed by Resident #20, identified the resident who smokes will be evaluated for smoking safely by a member of the interdisciplinary team at the time of admission or when a resident has a change in condition. If necessary, a smoking apron or other individualized intervention may be required as part of residents personalized plan of care for smoking. Smoking Evaluation dated 7/31/24, signed by Security Guard #3, identified Resident #20 was appropriate for supervised smoking without individualized interventions. Review of the physician's monthly orders dated October 2024 directed to have supervised smoking per facility policy. The care plan dated 11/1/24 identified Resident #20 was a smoker. Interventions included for the resident to wear a smoking apron while smoking and staff to observe clothing and skin for signs of cigarette burns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations outside during supervised smoking on 11/4/24 at 10:10 AM identified a second group of residents (7 residents) came outside with Security Guard #1 and NA #3. Resident #20 was given a cigarette by Security Guard #1 and the security guard lit the cigarette. Resident #20 was observed dropping ashes onto his/her black jacket. Security Guard #1 walked over to Resident #20 and brushed the ashes off Resident #20's jacket with his hand. At 10:12 AM Security Guard #1 went back over to Resident #20 and brushed off ashes from his/her jacket again and asked Resident #20 if he/she was done smoking. Security Guard #1 had Resident #20 place the cigarette but in a paint can. Resident #20 did not have the benefit of a smoking apron during this smoke break. Interview with Security Guard #1 on 11/4/24 at 10:20 AM indicated that Resident #20 wore a smoking apron a while ago but has not worn one in at least a month. Security Guard #1 indicated that when he started working at the facility, he was informed by the prior security guard that trained him that it was at his discretion if he felt a resident needed to wear a smoking apron or not. Security Guard #1 indicated there was not a list of residents that needed to wear a smoking apron for safety. Security Guard #1 indicated he did not need to inform anyone because it was at his discretion whether to put smoking aprons on residents. Security Guard #1 indicated he was not trained to do an evaluation of residents that smoke but to use his judgement. Observation outside during the supervised smoking on 11/5/24 at 10:12 AM identified Resident #20 seated in a wheelchair wearing a t-shirt and sweatpants was provided a cigarette from Security Guard #1, but the cigarette was not immediately lit. At 10:14 AM the Security Guard #1 lit the cigarette. After almost half the cigarette was smoked, NA #2 put the smoking apron on Resident #20. Resident #20 was dropping cigarette ashes onto the smoking apron. Interview with Security Guard #1 on 11/5/24 at 10:20 AM indicated that he put the smoking apron on Resident #20 today as a precaution and that no one had told him to put the apron on Resident #20 it was at his discretion to put the apron on residents. Security Guard #1 indicated that until Resident #20 can show him that he/she will not drop ashes on him/herself he will put the apron on Resident #20. Security Guard #1 indicated that in about 5 days he will consider taking off the apron on Resident #20 and see how Resident #20 does. Security Guard #1 indicated there was not a list on the smoking cart to identify which residents were to wear a smoking apron. Security Guard #1 indicated he did not tell anyone in management, the social worker, or the nursing supervisor that Resident #20 was dropping ashes on him/herself yesterday because he had made the decision to put the apron on Resident #20. Security Guard #1 indicated when he started about 2 months ago Resident #20 was wearing a smoking apron then but about a month ago, he decided to stop using the smoking apron on Resident #20 because he felt Resident #20 was safe to smoke without one. Security Guard #1 indicated he did not do a smoking assessment or ask nursing, as he made the decision, and it was at his discretion to stop using the smoking apron on Resident #20 a month ago. Security Guard #1 indicated after yesterday 10:00 AM smoke break when Resident #20 had multiple times dropped ashes on his/her jacket he decided for the afternoon smoke break to put the smoking apron on Resident #20 for the next 5 days and then will redetermine if it is necessary. Interview with Staff Development Nurse (LPN #2) on 11/5/24 at 12:10 PM indicated that she was responsible for staff education and competencies. LPN #2 indicated that all employees have general orientation at the corporate office and maintenance does fire safety at the facility. LPN #2 indicated that she has not done any education or competencies with the nurse aides or security guards regarding the resident smoking policy or their responsibilities during the resident smoking breaks in the last 2 and a half years she has been in this position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 11/5/24 at 12:11 PM indicated that she was responsible to oversee the security guards. The Administrator indicated that Security Guard #2 was the security guard at a sister facility and assists with the training for all new security guards. Interview with Security Guard #2 on 11/5/24 at 12:30 PM indicated he is responsible for doing smoke breaks and he had verbally told Security Guard #1 how to do the resident's smoking breaks 3 times a day. Security Guard #2 indicated that there should be a list of residents that need to wear a smoking apron on the cart. Security Guard #2 indicated that the security guards can determine or judge if the resident is a safe smoker or not a safe smoker. Security Guard #2 indicated that the security guards can judge if a resident was not safe and then should notify the nursing supervisor or a social worker. Security Guard #2 indicated that nursing or social worker would have to observe Resident #20 dropping ashes on him/herself and document it in the resident's clinical record. Security Guard #2 indicated that if a security guard felt a resident does not need a smoking apron anymore then the security guard must notify the management team and wait for further instructions. Security Guard #2 indicated that if Resident #20 was dropping ashes on him/herself then the security must notify the nursing supervisor or social worker, and they will take it from there. Security Guard #2 indicated that since the security guard is the one out there and if he felt someone was not safe, he could put a smoking apron on someone for that smoke break and then notify the management team, but he cannot remove the smoking aprons if they were required per nursing or social services. Security Guard #2 indicated that the security guards do not have access to the electronic medical record to view or update the care plans. Security Guard #2 indicated that the security guard cannot determine to put the smoking apron on and then in 5 days take it off if he feels resident is safe, that comes from nursing or social services. Security Guard #2 indicated that he verbally educated Security Guard #1 to do smoking at this facility but there wasn't any written education facility specific, nor did he do any competences of security guard #1. Interview with the Administrator on 11/5/24 at 1:00 PM indicated that she wrote Security Guard #1's 30-day evaluation but did not sign it based on a discussion with Security Guard #1 and not by observing him do the smoking break. The Administrator indicated that she did not observe a smoke break while Security Guard #1 was doing it, but when questioning Security Guard #1 he acknowledged he was not making sure all cigarette butts were picked up. The Administrator indicated that the security guards do the smoking evaluations to determine if residents need smoking aprons or not. The Administrator indicated the prior security guard, Security Guard #3, did the smoking evaluation dated 7/31/24 and nursing does the care plans. Interview with the MDS Coordinator (LPN #7) on 11/5/24 at 1:50 PM indicated the nurses must do the assessment/evaluation for a resident that smokes on admission and a change of condition and update the care plan. Interview with the DNS on 11/5/24 at 1:51 PM indicated the smoking assessment was to be done on admission, readmission, and a change in condition. The DNS indicated that a nurse must ask their resident the questions and observe the resident smoking safely to sign the smoking evaluation or assessment form. The DNS indicated that a security guard or nurse's aide can observe that a resident may need the smoking apron, but a nurse must do the assessment, that is why it is part of the nursing admission assessments. After review of the clinical record, the DNS indicated the care plan in both electronic medical records indicated that Resident #20 should have been wearing the smoking apron at every smoke break. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the MD #1 on 11/5/24 at 12 :00 PM indicated his expectation was since smoking was part of the physician orders that a nurse must do the smoking assessment and would have to do an observation to complete the assessment. Review of the Facility Smokers List, undated, identified a security guard and a nurse's aide must be present at all times during resident's smoke break. Review of the Resident Smoking Policy identified smoking evaluations should be done upon admission, readmission, and a significant change in a resident's status. During the supervised observation it will be determined if the resident requires adaptive equipment and or individualized intervention. Smoking care plans with appropriate interventions will be developed, reviewed, quarterly as part of the care plan review process and updated to reflect the resident's current status. 2. Resident #13 was admitted to the facility in August 2023 with diagnoses that included end stage renal disease with hemodialysis, congestive heart failure, and major depression. The annual MDS dated [DATE] identified Resident #13 had intact cognition and was independent with personal hygiene, transfers, and ambulation. Resident #13 was not on oxygen, a bi-pap, or a c-pap. Physician's orders dated October and November 2024 directed Resident #13 required a transfer with assist of 1 and could ambulate independently with a rolling walker. Additionally, Resident #13 was to use oxygen at 2 liters per minute continuously. Observation on 11/3/24 at 10:30 AM in a semiprivate room identified that Resident #13 had a pedestal fan at the foot of the bed that did not have a front cover on the front which exposed the blades. The fan was running on high at the time and Resident #13 was laying in the bed. Resident #13's roommate was in bed with a walker at the bedside. Observation and interview with NA #4 on 11/3/24 at 10:40 AM indicated that she had picked up the breakfast trays in this room, but did not notice the fan. NA #4 indicated that the nurse aides just bring in the food and drinks and then pick up the trays because the 2 residents in the room do not need assistance. NA #4 indicated that she has not noticed the fan without the cover exposing the blades. Interview with Resident #67 and NA #4 translating on 11/3/24 at 10:41 AM indicated that the fan has not had a cover in months, that Resident #13 removed it. Interview with the DNS and RN #5 on 11/3/24 at 10:45 AM indicated that the fan should not be running without the cover over the blades for safety. The DNS indicated that he would remove it immediately and noted that the fan was last inspected on 7-10 and 2 initials, but DNS was not able to state what year the 7-10 was from and whose initials were on the fan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Housekeeper #1 on 11/3/24 at 10:55 AM indicated that he was the full-time housekeeper for Resident #13's room. Housekeeper #1 indicated that he does recall seeing the cover off the fan before and he would put it back on but does not recall if he had seen it on or off yesterday and today. Housekeeper #1 indicated that he had already cleaned that room this morning and did not notice if the fan had a cover. Housekeeper #1 indicated that there have been many times that he has found the front cover of the fan on the floor or under the bed and he just puts it back on. Housekeeper #1 indicated that he did not inform anyone because he fixed it. Interview with NA #3 on 11/3/24 at 11:00 AM indicated that she works full time on the unit with Resident #13 and his/her roommate and they take care of themselves, and she and the other nurse aides just pick up their dirty linens and bring in their food and drinks for meals. NA #3 indicated that she had not noticed there was not a cover on the fan, but it had probably not been there since those 2 residents had moved to this unit a couple of months ago. Interview with RN #5 on 11/3/24 at 11:43 AM indicated staff would have put a notation of the fan without the cover in the maintenance book at the nursing station. RN #5 indicated that Resident #13 was provided a new fan, and a house wide audit was done, and no other residents have fans without covers. Interview with the DNS on 11/6/24 at 10:23 AM his expectation was that all fans have a cover so a resident would not get hurt if touched it. The DNS indicated that when staff see the fan without a cover, they should first unplug the fan and then notify maintenance. The DNS indicated that maintenance should put something on the cover so the resident cannot remove it. The DNS indicated the audit was done immediately after Resident #13's was found and there were no other fans in the facility missing covers. The DNS indicated that Resident #13 received a replacement fan that had a secure front cover that easily could not be pulled off. Interview with Regional Maintenance Director on 11/6/24 at 10:52 AM indicated that the first thing is to unplug the fan, call maintenance, and removed the fan from the area for the safety of resident so the resident cannot touch it. Regional Maintenance Director indicated that if Resident #13 was repeatedly removing the cover he would have zip tied it closed. Regional Maintenance Director indicated that the facility is in transition from the maintenance log at the nurse's station which had no current sheets in it and the new process of a web-based work order system from any phone or computer message. Regional Maintenance Director indicated that there was nothing regarding Resident #13's fan in either system for the last 3 months. Interview with Regional Maintenance Director and the DNS on 11/6/24 at 11:00 AM indicated that here was not a policy related to resident safety or use of fans in resident rooms. 3. Resident #111 was admitted to the facility in July 2024 with diagnoses that included dementia, nicotine dependence, and aphonia. A physician's order dated 7/31/24 directed Resident #111 may have supervised smoking per facility policy. Review of the clinical record identified legal documentation that directed Person #1 as Resident #111's conservator of person. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified a CAN DO LIST dated 8/2024 for Resident #111. The list identified Resident #111 had moderately severe cognitive decline and did not anticipate safety hazards. The admission MDS dated [DATE] identified Resident #111 had severely impaired cognition, was always continent of bowel and bladder, required set up with showering, and was independent with toileting, dressing, and eating. The MDS also identified Resident #111 had current tobacco use. The care plan dated 8/9/24 identified Resident #111 enjoyed smoking. Interventions included to observe Resident #111 for any signs/symptoms of unsafe smoking and to complete smoking evaluations per facility policy. A smoking agreement dated 8/10/24 identified verbal consent was obtained from Person #1 (Resident #111's resident representative) on that date giving permission for Resident #111 to smoke. Security Guard #3 and a staff member (illegible signature) signed the agreement. A smoking evaluation completed on 8/10/24 by Security Guard #3 identified Resident #111 had an understanding of the facility smoking policy, safety issues, and the importance of the smoking rules and regulations. A nurse's note dated 8/21/24 at 3:38 PM identified Person #1 was notified that Resident #111 was caught smoking and vaping in his/her room. The note further identified that Resident #111 was informed of the smoking policy and that smoking in his/her room was a fire hazard. Review of the clinical record failed to identify any additional documentation related to the 8/21/24 smoking incident for Resident #111 including any additional smoking evaluations or assessments completed by nursing staff or revisions to Resident #111's care plan related to smoking inside the facility. Review of the facility A&I reports failed to identify any documentation or investigation related to Resident #111 smoking and vaping in the facility on 8/21/24. A nurse's note dated 9/4/24 at 11:36 AM identified that laundry staff alerted nursing of a strong odor of cigarette smoke when delivering clothing items to Resident #111's room. The note further identified that upon nursing staff entering the room and identifying the odor, Resident #111 initially denied but subsequently turned over a half a pack of cigarettes along with a lighter. Review of the clinical record failed to identify any additional documentation related to the 9/4/24 smoking incident for Resident #111 including any additional smoking evaluations or assessments completed by nursing staff or revisions to Resident #111's care plan related to smoking inside the facility. Review of the facility A&I reports failed to identify any documentation or investigation related to Resident #111 smoking inside the facility on 9/4/24 and failed to identify that Person #1 was contacted or notified regarding this incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/5/24 psychiatric note identified Resident #111 was seen after smoking in his/her room and that Resident #111 normally smoked cigarettes on his/her assigned smoke break. The note identified Resident #111 was very forgetful, pleasantly confused, and forgot that he/she could not smoke in his/her room. A 9/17/24 nurse's note identified a lighter was located in Resident #111's room behind his/her television and removed from the room. Review of the clinical record failed to identify any additional documentation related to the 9/17/24 lighter located behind the television in Resident #111 including any additional smoking evaluations or assessments completed by nursing staff or revisions to Resident #111's care plan. Review of the facility A&I reports failed to identify any documentation or investigation related to the lighter being found in the resident's room or that Person #1 was contacted or notified regarding this incident. Interview with Person #1 on 11/5/24 at 2:06 PM identified that he/she became Resident #111 conservator following issues with cognitive decline. Person #1 identified that Resident #111 had multiple incidents related to cognition, including forgetting about cooking items on a stove top that resulted in a house fire. Person #1 identified that the facility staff were making sure to check Resident #111 for smoking materials regularly following the 8/21/24 smoking incident and that Resident #111 regularly left the faciity on leave of absence with family members and friends. Person #1 identified that because of these checks, Resident #111 had not had any other smoking related incidents the facility. Person #1 identified the facility staff had only notified him/her of one incident related to smoking on 8/21/24, and also identified that Resident #111 resided on a dementia unit and the facility had notified him/her on admission that the dementia unit had extra staff due to the needs of the residents on the unit, however the unit was not secured, which was why Resident #111 was able to go on leave of absences from the facility. Interview with MD #1 on 11/5/24 at 3:10 PM identified that it was the responsibility of the floor nurse caring for a resident or the RN supervisor to complete the smoking evaluations for residents of the facility. Interview with the DNS on 11/6/24 at 9:45 AM identified that there were no A&I documents related to the smoking incidents for Resident #111, and that the incidents were investigated, and education was provided to the resident in the moment but the facility did not document this information. The DNS identified he would have expected the nursing staff to notify Person #1 regarding the incidents on 9/4/24 and 9/17/24, and that the smoking evaluation should have been completed by the admission nurse as part of the admission assessment. The DNS also identified that while the facility may have provided Resident #111 additional education related to smoking materials in his/her room, he would not expect Resident #111 to comprehend the information well due to Resident #111's severely impaired cognition. The facility smoking agreement directed that residents who smoke would be evaluated for smoking safety by a member of the interdisciplinary team at the time of admission or when a resident experienced a significant change of condition. The agreement also directed that if a resident was suspected of having any hazardous material in their room (i.e. lighter, matches) that the staff would provide education on safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on care plans directed members of the interdisciplinary team included representatives from nursing (charge nurse and nurse aide with responsibility for the resident), MDS coordinator, social services, behavioral health, dietary, rehabilitation, activities, the resident, resident representative, and any other staff in disciplines as requested by the resident. The facility policy on resident smoking directed that smoking evaluations would be done on admission, readmission, and after a significant change in resident status. The policy also directed that smoking care plans with appropriate interventions would be developed, reviewed quarterly as part of the care plan review process, and would be updated to reflect the resident's current status. The policy further directed that environmental safety included no smoking in the facility, no unsafe behavior related to smoking, and in the event of policy infringement, each individual resident's needs/capabilities would be considered to determine the most appropriate revision to the resident's plan of care/course of action. The facility policy on Reportable Events-Reporting accidents and incidents; investigations directed that a reportable event was an event that was clinically unusual or inconsistent with the policies and practices of the facility. The policy further directed that a reportable event form would be completed at the time of identification of the incident, an investigation would be initiated within 24 hours of the identification of the event, would be concluded within 72 hours, and investigation findings and conclusions would be documented and submitted to the facility Medical Director for review. 46040

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interview for the 1 resident (Resident #7) reviewed for falls, the facility failed to ensure the resident's medication orders were correctly transcribed and administered resulting in a significant medication error. The findings include: Resident #7 was admitted to the facility in March 2023 with diagnoses that included hepatic encephalopathy, hepatic failure, and type 2 diabetes mellitus. The care plan dated 7/6/24 identified Resident #7 was at risk for falls due to comorbidities. Interventions included observing for signs and symptoms of decreased balance, leaning, dizziness, or fatigue. The care plan further identified Resident #7 may chose not to accept certain things that were recommended for his/her wellbeing including, treatments, medications, appointments/consultations, therapy, and personal care. Interventions included education and encouragement on the benefits and risks of not accepting services based on personal choices including, taking prescribed medications, attending appointments, and being seen by in-house providers and if care or services were not accepted by Resident #7, reapproach at a later time. The quarterly MDS dated [DATE] identified Resident #7 had intact cognition, was independent with a motorized wheelchair, and had sustained 2 or more falls since the prior assessment. A nurse's note dated 9/16/24 at 3:12 PM identified Resident #7 continued with blisters to the right hand, and reported this may be a result of wearing jewelry on his/her hand, resident was encouraged to remove jewelry from both hands. Resident #7 had orders for skin prep which was applied and he/she was refusing medications especially the Lactulose. Resident #7 was educated and took his/her medications, resident was lethargic, pupils were dilated, and abdomen was distended. APRN was notified and orders to check ammonia level and apply Hydrocortisone cream 1%, three times daily, as needed for itching, were obtained. A physician's order dated 9/17/24 directed to obtain the following labs, ammonia, complete blood count (CBC), comprehensive metabolic panel (CMP), erythrocyte sedimentation rate (ESR), prothrombin time/international normalized ratio test (PT/INR), and rheumatoid factor. The Laboratory and Pathology Services report dated 9/17/24 identified Resident #7's ammonia result was high at 179 umol/L (normal range 0 - 31umol/L). A physician's telephone order dated 9/18/24 (transcribed by RN #2) directed to administer Lactulose 60ml by mouth 6 times daily for 3 days, then decrease to 60ml once daily (qd) and repeat ammonia level on 9/20/24. The Laboratory and Pathology Services report dated 9/20/24 identified Resident #7's ammonia result was 33 umol/L(normal range 0 - 31umol/L). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September 2024 MAR identified on 9/19, 9/20, and 9/21/24, Resident #7 was administered Lactulose 60ml by mouth, 6 times daily and on 9/22/24 through 9/30/24, Resident #7 was administered Lactulose 60ml by mouth, once daily. The October 2024 MAR identified on 10/1/24 through 10/15/24 Resident #7 was administered Lactulose 60ml by mouth, once daily. The nurse's note dated 10/15/24 at 4:36 AM identified Resident #7 was laying on the floor at 1:45 AM, increased lethargy, weakness and altered mental status noted, color pale, skin warm and pale. Resident #7 was responsive by opening and closing his/her eyes and responsive only to yes/no questions. Resident #7 was unable to remain in an upright seated position, no apparent head injury noted.v EMS/911 was called for transfer to the ER for evaluation. Resident #7 was transferred to the ER via stretcher and attendants. The hospital discharge summary dated 10/16/24 identified Resident #7's reason for visit was acute encephalopathy and the resident was admitted with altered mental status and confusion. Resident #7 was initially admitted to the intensive care unit (ICU) due to abnormal blood pressures and high ammonia levels and was found to have a urinary tract infection (UTI). Resident #7 had a negative head and abdominal CT scan. Due to Resident #7's liver cirrhosis the Spironolactone was held and would be discontinued. Due to Resident #7's high ammonia levels, lactulose will be continued, and the UTI was treated with antibiotics. Due to improvement in symptoms, Resident #7 was downgraded to a medicine floor, and due to resolve of the altered mental status and no longer being confused, he/she was deemed safe and stable for discharge on 10/16/24. The discharge summary further identified Resident #7's ammonia level on 10/15/24 was 74 umol/L and home medications and new prescriptions included Lactulose 90ml by mouth, four times daily. The October/November 2024 MAR identified 10/17/24 through 11/4/24, 18 days, Resident #7 was administered Lactulose 60ml by mouth, once daily. Interview and clinical record review with APRN #1 on 11/04/24 at 9:52 AM identified that Resident #7 had chronic liver disease and cirrhosis, and he/she would often refuse Lactulose and had a history of high ammonia levels. APRN #1 identified that she was unaware that Resident #7 had been receiving Lactulose once daily, since 9/22/24, and that there must have been a transcription error from the hospital, as she did not recall initiating a once daily order for Lactulose. APRN #1 further identified that she would expect Resident #7 would be receiving Lactulose four times daily (QID) due to his/her chronic liver cirrhosis, and that she usually checks medication order changes, but she could not identify what happened in this situation. APRN #1 indicated that missed doses of Lactulose would decrease the amount of bowel movements the resident would pass and could lead to increased lethargy and confusion, however she did not think this was the case for Resident #7 because she had not observed any alterations in his/her mental status and had been more alert and active in recent days. APRN #1 indicated that refusing Lactulose had been an on-going issue for Resident #7, but recently he/she had been compliant, per her conversations with the nursing staff. Subsequent to surveyor inquiry, a physician's order dated 11/4/24 directed to administer Lactulose 60ml by mouth, four times daily. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1on 11/4/24 at 12:23 PM identified that elevated ammonia levels were not uncommon for Resident #7 due to his/her end stage liver disease. LPN #1 indicated that Resident #7's Lactulose order was frequently changing and that most times Resident #7's order would be three times daily or four times daily. LPN #1 identified that she confirmed that she was correctly reading the order, to administer Lactulose 60ml by mouth daily, with the evening RN Supervisor (RN #6), before transcribing it, because she had never seen Resident #7's Lactulose ordered for once daily, in the past. LPN #1 indicated that RN #6 was not the nurse that took the telephone order directing to administer Lactulose 60ml by mouth 6 times daily for 3 days, then decrease to 60ml daily (qd) and repeat ammonia level on 9/20/24, it was the day RN Supervisor (RN # 2) who took the telephone order (and RN #2 was no longer employed at the facility). Although attempted, an interview with RN #2 was not obtained. Although attempted, an interview with RN #6 was not obtained. Interview with the Medical Director (MD #1) on 11/05/24 at 3:03 PM identified Resident #7's baseline ammonia level runs high, and he/she has not always been compliant with the treatment. MD #1 identified that he did not know why Resident #7's Lactulose dose was decreased, but with Resident #7's end-stage cirrhosis Lactulose would need to be administered a minimum of three times daily to combat chronic encephalopathy; and a once daily dose could lead to an increased ammonia level, which could lead to the altered mental status. Interview with the DNS on 11/06/24 at 10:10 AM identified that he was not the DNS at the time of this incident, and he would have to have another conversation with APRN #1, to better identify what happened with Lactulose dosing; it was unclear at this point and the facility had not yet identified where the communication gap occurred. The DNS further identified that this situation was not something that he had seen happen, in any other instances at the facility. The DNS indicated that he would have to have another conversation with APRN #1 before he could identify if a subtherapeutic dose of Lactulose could have resulted in Resident #7's hospitalization . The facility's Telephone and Verbal Orders policy directs for paper systems: a. The nurse shall place the telephone or verbal order in the residence chart in such a manner to indicate the date and time of the order, and the nurse responsible for taking the order. b. All telephone and verbal orders shall be flagged in the Physician's order book. These orders shall be reviewed and signed by the attending physician, covering physician, licensed physician extender, or medical director. c. The nurse shall telephone the pharmacy indicating that a telephone order has been received. The facility's Physician Orders-Transcription policy directs orders will be transcribed by a licensed nurse and followed through in a manner consistent with quality standard of care practices. Telephone orders: 1. Only a licensed nurse may accept a telephone order from the Physician. 2. Record the order exactly as the physician dictates it onto the Physician Order Sheet. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Repeat the order back to the physician for verbal confirmation 4. Sign the order The facility's Medication Errors policy directs for the facility to establish a procedure for monitoring and keeping a record of any errors which may be observed in the medication system in this facility, whether they occur through the source of supply comma or in the ordering or administration of medications. The procedure: 1. The Director of Nursing and/or supervisory personnel will instruct licensed nursing personnel to enter any problems or errors they notice in the medication system at this facility. Licensed personnel will further be instructed to take appropriate action to have errors corrected and to enter that information in the medication incident/error report form. 2. Serious errors should be brought to the attention of the nursing supervisor and/or the attending Physician immediately. In the case of a medication error, the Physician and the Pharmacist must be notified immediately. 3. Any adverse effect to a resident resulting from a medication incident/error requires immediate notification of the attending physician and the pharmacist. 4. Medication errors will be reviewed at the quarterly pharmacy services committee meeting. The committee may direct that further follow up action be taken.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of facility documentation, facility policy, and interview the facility failed to ensure the nourishment refrigerator was clean and sanitary, and food items were labeled and dated, and discarded timely, and failed to ensure food transport carts were clean and sanitary prior to placing meals on carts. The findings include: 1. Observation of the first-floor nourishment refrigerator with RN #5 on [DATE] at 8:15 AM identified the following. Freezer items: a. 4 half gallon water pitchers full by weight but unable to open, not dated or labeled b. Freezer had a grocery bag with partial eaten sherbert cup and fudge pops not labeled or dated c. Freezer friendly ice cream half empty not labeled or dated. d. 3 ice cream sandwiches that appeared to have thawed and refrozen not dated or labeled e. Freezer snickers bar partially eaten not labeled or dated. Refrigerator: a. A package of [NAME] dean sausages expired on [DATE]. b. 15 kitchen prepared cups of pudding dated as prepared on [DATE] and expire on [DATE]. c. Rotted watermelon with odor dated [DATE] not labeled and expired. d. Half apple pie best by date [DATE] not labeled and expired. e. A tossed salad that appeared wilted store dated [DATE] without a label f. A store-bought baked potato cooked dated [DATE] without a label. g. A store-bought container of asparagus cooked dated [DATE] without a label. h. 2 pitchers of juice not labeled or dated. i. A half-gallon of whole milk half gone with expiration date [DATE]. Observation on [DATE] at 8:55 AM of the freezer identified large black frozen substance, and there was orange and brown spots in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #5 on [DATE] at 9:00 AM indicated that dietary was responsible to keep refrigerator and freezer clean and discard any food or drink items not labeled or dated and if not discarded within 3 days. RN #5 indicated that she would discard all food and drinks and have someone come and clean the refrigerator and freezer. Interview with the Director of Dietary on [DATE] at 10:30 AM indicated that dietary was responsible to clean the refrigerator and maintenance had to defrost and clean the freezers. The Director of Dietary indicated that the dietary aides were responsible to discard and food after 3 days and if any items were not labeled and dated. 2. Observation with the Director of Dietary in the first-floor dining room on [DATE] at 1:05 PM the cook was preparing plates of food from the steam table and handing to the dietary aide that placed the freshly made plates of food on a 3-shelf cart with wheels. The cart was soiled with stains and caked on filth in the wheels and sides of the cart. DA #1 placed 6 plates of food on the second shelf and another 6 plates of food on the top shelf. The DA #1 then took another cart that was soiled with white dried drippings and proceeded to place 6 plates of food from the cook onto the second shelf and 6 plates of food on the top shelf. The DA #1 proceeded to get the third cart which was soiled and proceeded to place 6 plates of food on the center shelf and 6 plates of food on the top shelf. DA #1 proceeded to get the fourth cart which was soiled and proceeded to place 6 plates of food on the center shelf and 6 plates of food on the top shelf. Interview with the Director of Dietary on [DATE] at 1:15 PM identified that the four 3 shelf carts were dirty, and the dietary staff were responsible to keep the carts clean. The Director of Dietary indicated that right after lunch she would make sure all the carts would be washed down and cleaned. Interview with DA #1 on [DATE] at 1:18 PM indicated that she had wiped down with a wet cloth this morning 2 of the carts but the other 2 carts were brought down from the second-floor dining room (where there is active covid-19) after lunch was served up there first. DA #1 indicated that she assumed the carts were clean and was just trying to get lunch served. Review of the Food Guide Policy posted on the front of the refrigerator identified that prepared foods brought in were good for 3 days, pudding was good for 7 days after opening, milk was good for 3 days after opening or manufacturers date, open ice cream for 4 weeks, frozen foods for 3 months from time placed in freezer, and a tossed salad for 1 day. Notice on front of refrigerator indicated for all nursing staff to make sure all items are labeled with resident's name and date to avoid items from being thrown away. This refrigerator is not for staff food or drinks. Please use the refrigerator in the staff break room. All food will be thrown away if no name and date is on the item when bought. Fridge/freezer will be checked daily by dietary. There is a guide dietary uses to follow with dates of how long we can keep food and drinks in the refrigerator and freezer. Review of the Dietary Cleaning Policy identified it was the responsibility of the dietary department to maintain all areas of the facility's kitchen and related areas in a clean and sanitary manner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Family and Visitor Provided Food Policy identified information provided is to provide for the safety and sanitary handling, storage, and consumption of food brought in by families and visitors. The nurse or designee with place the residents name and date on any food item prior to placing it in the refrigerator for storage. Nursing, dietary, and housekeeping staff are responsible to discard food outside the expiration dates, show signs of spoilage, or foods received more than 3 days prior to maintain sanitary conditions and resident safety. It is the facility's discretion to discard resident food if observed or evidence of being spoiled.

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Westside Care Center	349 Bidwell Street Manchester, CT 06040

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 3 residents (Resident #64, 79, and 368) reviewed for transmission based precautions (TBP), the facility failed to ensure that facility staff implemented infection control measures for 2 residents (Resident #64 and 79) who required transmission-based precautions due to active respiratory infections, and for 1 resident (Resident #368), the facility failed to ensure that transmission based precautions were implemented for a resident with an active infection related to a multi drug resistant organism (MDRO). The findings include: 1. Resident #64 was admitted to the facility in March 2023 with diagnoses that included COPD, viral infection, and hepatic encephalopathy. The care plan dated 6/26/24 identified Resident #64 had a history of viral infection. Interventions included monitoring for signs of active infection including elevated temperature, cough and shortness of breath. The quarterly MDS dated [DATE] identified Resident #64 had severely impaired cognition, was always incontinent of bowel and bladder and required maximum staff assistance with toileting, dressing, and bathing. A nurse's note dated 10/30/24 at 4:42 PM identified Resident #64 tested + for Covid 19. The physician's orders dated 10/30/24 directed Resident #64 be placed on droplet/contact precautions for Covid infection/isolation, Resident #64 was to remain in his/her room, and all services were to be brought in to Resident #64's room including rehab services and dining. A physician's order dated 11/1/24 directed Resident #64 was to isolate for 14 days for diagnosis of Covid 19 and stay in room. 2. Resident #79 was admitted to the facility on [DATE] with diagnoses that included dementia, COPD, and diabetes. The care plan dated 7/8/24 identified Resident #79 had a history of dementia. Interventions included to use a slow calm approach and explanation. The quarterly MDS dated [DATE] identified Resident #79 had severely impaired cognition, was frequently incontinent of bowel and bladder and was dependent on staff to assist with toileting, dressing, and bathing. A nurse's note dated 10/30/24 at 4:33 PM identified Resident #79 tested + for Covid 19. The physician's orders dated 10/30/24 directed Resident #79 be placed on droplet/contact precautions for Covid infection/isolation, Resident #79 was to remain in his/her room, and all services were to be brought in to Resident #69's room including rehab services and dining. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 11/1/24 directed Resident #79 was to isolate for 14 days for diagnosis of Covid and stay in room. Upon entrance to the facility on [DATE] as part of an annual recertification survey, the survey team was notified by the facility staff that 2 residents were currently on TBP, both due to positive Covid 19 results. Observations on 11/3/24 at 9:00 AM identified Resident #64 and Resident #79 in the unit dining room, seated in a communal dining space, unmasked, along with approximately 22 other residents, also unmasked. Observations of signage on Resident #64 and #79's door entryways on 11/3/24 at 9:10 AM identified PPE carts and 2 TBP signs for Droplet Precautions and Contact Precautions, which directed that in addition to standard precautions, only essential personnel should enter, everyone must (including visitors, doctors, and staff) clean hands when entering and leaving room, wear mask (fit tested n-95 or higher required when performing aerosol-generating procedures), wear eye protection (face shield or goggles), gown and gloves at the door and keep door closed. Interview with LPN #6 on 11/4/24 at 8:20 AM identified that the facility staff had given up on trying to ensure TBP were maintained for Resident #64 and Resident #79. LPN #6 reported that both residents had a history of combative and resistive behaviors, and due to this, the staff did not attempt to prevent the residents from leaving isolation, dining with other residents, or masking while out in common areas. Observation on 11/4/24 at 8:25 AM identified Resident #64 sleeping in his/her room with the door open. Resident #79 was observed walking in the unit hallway, unmasked, until 8:32 AM, when Resident #79 returned to his/her room. At 8:33 AM, Resident #64 began to walk in the unit hallway unmasked. At 8:37 AM, a female staff member, with a standard mask and no eye protection, was observed walking Resident #64 from the hallway to the unit dining room and assisting him/her to a seat at a table with 7 other residents, all unmasked. The residents directly to either side of Resident #79 were approximately 18 inches away, and the resident seated across the table from Resident #79 was approximately 2 feet away. During this observation, a total of 26 other residents were located in the dining area, all unmasked. Additionally, a large steam table was located approximately 10 feet from Resident #79, along with 4 facility dietary staff plating meals. An additional 4 facility staff were also observed assisting residents with meals and set up. No facility staff were observed wearing any additional PPE outside of a paper mask. Multiple residents were heard coughing during this observation. Observation on 11/4/24 at 9:48 AM identified Resident #79 seated at a table with LPN #6. During this observation, a large industrial wall mounted air conditioning (AC) unit was observed to be blowing a large force of air directly at the back of LPN #6 and directly to Resident #79's face, who was positioned approximately 6 feet from the unit. During this observation, LPN #6 was observed with a standard face mask and no eye protection. Additionally, a total of 18 other residents were seating in the dining area. Observation also identified that the force of the air from the AC unit could be felt by this surveyor approximately 12 feet from the unit. The observation was discontinued at 10:05 AM, at which time Resident #79 remained in the same seat in front of the AC unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/4/24 at 11:24 AM with LPN # 2 (Infection Control/Staff Development Nurse), RN #6 (Regional Coordinator of Education and Infection Control) and RN #8 (Regional Director of Infection Control) included review of the observations of Resident #64 and #79 on 11/3/24 and 11/4/24 as well as the lack of PPE use by facility staff including gloves, gown, N-95 mask, and face protection. LPN #2 and RN #6 identified that facility staff has been educated to offer continuous redirection to both residents, and identified they were not aware that Residents #64 and #79 were walking the unit ad lib or that the orders related contact and droplet precautions not being adhered to. Interview on 11/4/24 at 12:25 PM with the DNS identified he spoke with facility staff on 11/3/24 in the afternoon about source control for Resident #64 and 79. The DNS identified he was aware that there were issues related to maintaining contact/droplet precautions but identified the residents had cognitive and behavior issues and the staff were having difficulty instituting source control (masking/isolation) for the residents. Upon review of this surveyor's observations on 11/3/24, and the 11/4/24 observations of Resident #79 seated directly in front of a large AC unit blowing air directly towards Resident #79 and throughout the dining room with 18 other residents present without PPE in place, the DNS identified I guess we could try masking again. The DNS was unable to identify if there were any potential risks to other residents in the common areas with a large industrial AC unit running blowing forced air directly at a resident with newly diagnosed Covid 19 infection. Subsequent to surveyor inquiry, LPN #2 and RN #8 identified on 11/5/24 at 8:00 AM that they had been in contact with MD #1 regarding this surveyor's observations and begun testing all residents on the unit and that Resident #88 had a positive Covid 19 test on 11/4/24. RN #8 provided in-service education identifying he reviewed Covid 19 isolation precautions, redirections, and dining for Covid 19 positive residents with facility staff on 11/4/24. LPN #2 also provided PPE audit observations for 11/4/24 and 11/5/24. Interview with MD #1 (Medical Director) on 11/5/24 at 3:12 PM identified that Resident #64 and #79 should not have been dining in the communal dining area with other residents following their positive Covid 19 diagnoses on 10/30/24 or directly in front of a running industrial AC unit and indicated Covid 19 is not as bad as it was before but we still have to follow CDC guidelines. MD #1 identified that for any residents newly diagnosed with Covid, the resident should be placed on isolation, contact tracing should be done per CDC guidelines, the resident should be monitored with vital signs and symptoms, and all staff interacting with the resident should be donning and doffing appropriate PPE. The facility policy on strategies to reduce the risk of spread of Covid 19 or other influenza like respiratory illnesses directed strategies during identified outbreaks included wearing appropriate PPE when caring for Covid 19 infected residents and/or entering a Covid 19 isolation room (gown/gloves/eye protection/N-95 mask). The facility policy on droplet precautions directed these precautions should be used when a resident with a known or suspected infection with a microorganism transmitted by droplets generated by coughing, sneezing, talking, etc. PPE for droplet precautions should include a gown, mask, gloves and eye protection, and that an N-95 respirator was recommended when caring for a resident with active Covid 19. The policy also directed that a surgical mask must be applied to the resident if the resident was being transported outside of their room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on contact precautions directed that a resident's individual clinical situation (active signs and symptoms of infection or colonization) would determine if contact precautions were necessary. The policy also directed that a private room would be preferred and contact precautions should include donning gloves and a gown when entering the resident's room, removing gloves and gown prior to exiting the room, performing hand hygiene and using dedicated or disposable equipment for a resident on contact precautions when possible. 3. Resident #368 was admitted to the facility in October 2024 with diagnoses that included MRSA bacteremia, viral infection and sepsis. Review of hospital discharge documentation dated 10/14/24 identified Resident #368 had a positive blood culture for MRSA on 9/23/24. The documentation also identified Resident #368 had a PICC line placed on 10/2/24. The nursing admission assessment dated [DATE] identified Resident #368 had intact cognition, was continent of bladder, required a walker for ambulation, and had a PICC line in place at the upper right arm. Review of Resident #368's care plan failed to identify any interventions in place related to MRSA, the viral infection, PICC line use, or transmission-based precautions. Upon entrance to the facility on [DATE] as part of an annual recertification survey, the survey team was notified by the facility staff that 2 residents (Resident #64 and #79) were currently on TBP that included contact and droplet precautions due to positive Covid 19 results. Additionally, the survey team was notified Resident #67 had been transported to the hospital on 11/2/24. Review of a facility provided Enhanced Barrier Precautions (EBP) list, provided to the survey team on 11/4/24, identified Resident #368 required EBP due to a PICC line in place. Interview with LPN #2 (Infection Control/Staff Development Nurse), RN #6 (Regional Coordinator of Education and Infection Control) and RN # 8 (Regional Director of Infection Control) on 11/4/24 at 10:30 AM identified that 3 residents of the facility required TBP. LPN #2 identified that Resident #368 required Contact Precautions for newly diagnosed MRSA bacteremia. Observation with LPN #2 and RN # 8 on 11/4/24 at 12 PM identified that Resident #368 did not have any signage or PPE located outside of his/her room identifying the need for contact precautions or EBP. Additionally, the identification outside the room noted Resident #67 also resided in the room. LPN #2 identified that she had placed a contact precaution sign and PPE cart in front of Resident #368's room upon admission, and the sign as well as the PPE cart were in place as of 10/30/24. LPN #2 identified that without any signage posted, staff and visitors would not immediately know Resident #368 required contact precautions or EBP. LPN #2 also identified that while Resident #67's name was on the door, Resident #368 had been in the room alone since 10/14/24. Review of facility documentation identified Resident #67 had been in the same room since admission to the facility on [DATE] until transfer to the hospital on 11/2/24. Resident #67 had no history of MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #368's census sheet identified he/she was placed with Resident #67 in the same room on 10/14/24. Resident #368 and Resident #67 shared the same room from 10/14/24 -11/2/24. Interview with MD #1 (Medical Director) on 11/5/24 at 3:12 PM identified Resident #368 should have had a private room with no roommate if possible, or with a roommate who had a history of MRSA. MD #1 identified that Resident #368 had newly diagnosed MRSA, and it would not be appropriate to cohort Resident #67 and Resident #368 together due to the risk of MRSA transmission, and Resident #368 should have been maintained on contact precautions due to his/her MRSA diagnosis. The facility policy on transmission-based precautions directed that these precautions may be implemented by the physician, DNS, ADNS, Professional Development coordinator, or the nursing supervisor. The facility policy on contact precautions directed that a resident's individual clinical situation (active signs and symptoms of infection or colonization) would determine if contact precautions were necessary. The policy also directed that a private room would be preferred and contact precautions should include donning gloves and a gown when entering the resident's room, removing gloves and gown prior to exiting the room, performing hand hygiene and using dedicated or disposable equipment for a resident on contact precautions when possible.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 residents (Resident #49, 78, and 94) the facility failed to ensure that the resident or resident representative were provided education on the benefits and potential side effects of the influenza vaccine before receiving the vaccine. The findings include: During an infection control program review, conducted as part of an annual recertification survey, review of facility documentation was completed on 11/4/24 at 10:30 AM related to influenza education, consents, and vaccination administration for the 2024 flu vaccinations. Review of the facility vaccination documentation and clinical records identified Resident #78 and 94 received the influenza vaccination on 10/15/24. The documentation also identified Resident #49 received the influenza vaccination on 10/18/24. Review of the clinical record and facility documentation failed to identify that education related to the influenza vaccine including benefits, risks associated with, or potential side effects associated with the influenza vaccine were provided to or reviewed with Resident #78, Resident #49, Resident #94 or their resident representatives prior to administration of the influenza vaccination by LPN #2 (Infection Control Nurse) Interview with LPN #2 and RN #8 (Regional Director of Infection Control) on 11/5/24 at 9:20 AM identified that LPN #2 administered the influenza vaccinations for Residents #49, 79 and 94. LPN #2 identified she provided the residents of the facility with vaccine information statement (VIS) from the CDC related to the vaccine upon administration of the vaccinations but did not document any education provided to the residents, including providing the residents the VIS sheets, in the residents' clinical record. RN #8 identified that he thought providing the VIS to each resident was sufficient and was not aware that vaccination education that was provided to the residents should be documented in the clinical record. The facility policy on Resident Influenza Immunizations directed that the resident or the resident's legal representative would be educated about the risks and benefits of the influenza vaccine on an annual basis, would be provided with a copy of the current vaccine information statement (VIS), and that the education provided would be documented.