STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075257	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation Center	745 Main St East Hartford, CT 06108

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, observation and staff interview, the facility failed to ensure resident smoking area was free from hazards. The findings include:On 1/22/2026 at 10:02 AM observation of the outdoor smoking area in the back of the building made with Environmental Worker#3. The observation identified the area was located to the right outside the exit door in a parking space located under a full overhang of the building. The ground had a wooden pallet and on the pallet was the bottom of an ash/butt receptacle with its long neck piece off and on its side on the pallet. Another receptacle was located to the right side of the area. Upon closer observation numerous cigarette butts were seen on the ground between the slats in various locations of the wooden pallet. Environmental Worker #3 indicated not being sure why the pallet was on the ground and indicated the receptacle was apart as it may have been emptied but did not know why the cigarette buts were on the ground within the wooden pallet. During an interview and review of pictures of smoking area with the Administrator on 1/22/2026 at 10:18 AM s/he did not know why a pallet was located on the ground of the smoking area and indicated people without homes are around the area and may have emptied the receptacle looking for cigarette butts they may be able to use. The administrator indicated that the environmental services are responsible for keeping the smoking area clean and safe and ensure they clean the area. An interview with the Director of Environmental Services/Maintenance on 1/22/2026 at 10:25 AM indicated Environmental Workers #1 and #3 were responsible for checking and keeping the smoking area clean, Environmental Worker #1 and another worker are responsible for supervising the two smokers. They were also responsible for checking the area during the smoking times for butts, cleaning the area and emptied trash. An interview and observation with the Administrator on 1/22/2026 at 10:45AM identified the smoking area was clean and staff informed her/him, the pallet had been placed in the parking spot used for the smoking area to prevent someone from parking there. The Administrator indicated the pallet should not have been placed there and it was removed. The facility policy labeled Safe Smoking (Resident) indicated that all residents who smoke and require supervision will be observed by staff who will be in the direct area of the designated smoking area during facility smoking. i

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, reviews of facility policies and interviews for 3 of 4 residents reviewed for ventilators and tracheostomies (Residents #76, 198, and 261), the facility failed to ensure that ventilator equipment and suction equipment were consistently changed as per facility policy. The findings included: 1. Resident #76 was admitted with diagnoses including chronic respiratory failure and ventilator dependence. A 5-day MDS assessment dated [DATE] identified Resident #76 had short-term and long-term memory problems and required tracheostomy and invasive mechanical ventilator care. A physician's order dated 1/13/2026 directed to change the ventilator circuit on the first Saturday of every month starting on 2/7/2026.A further review of the medical record failed to identify an order prior to 1/13/2026 for the changing of ventilator circuit tubing.An observation on 1/15/2026 at 10:00 AM with Respiratory Therapist (RT#1) identified Resident #76 was connected to the ventilator, and the ventilator circuit tubing was dated 12/7/2025. 2. Resident # 198 was admitted with diagnoses including acute and chronic respiratory failure with retention of carbon dioxide, and ventilator dependence. A quarterly MDS assessment dated [DATE] identified Resident #198 had long-term and short-term memory problems and was dependent for self-care. The MDS further indicated that Resident #198 required tracheostomy care. The physician's orders dated 12/26/2025 directed to suction via tracheostomy every shift and to change the suction canister and tubing weekly and as needed.A review of the Treatment Administration Record (TAR) for 1/1/2026 to 1/14/2026 identified the suction tubing and canister were documented as changed on 1/6/2026 and 1/13/2026. A review of respiratory therapy notes from 1/1 to 1/14/2026 did not identify any respiratory incidents on 1/6 or 1/13.2026.An observation with RT#1 on 1/15/2026 at 10:15 AM identified Resident #198's suction canister contained about 300 mL of green fluid; the canister was dated 12/30/2025. 3. Resident #261 was admitted with diagnoses including chronic respiratory failure with hypoxia and ventilator dependence. A quarterly MDS assessment dated [DATE] identified Resident #261 had short-term and long-term memory problems and required tracheostomy and invasive mechanical ventilator care.A physician's order dated 1/13/2026 directed to change the ventilator circuit on the first Thursday of every month to start on 2/5/2026. A further review of orders failed to identify an order prior to 1/13/2026 that directed the change of the ventilator circuit.An observation with RT#1 on 1/15/2026 at 10:10 AM identified Resident #261 was in bed and connected to the ventilator. Additionally, the ventilator circuit tubing was dated 12/7/2025 on an inhalation filter that was attached to the inhalation tubing and ventilator. On 1/15/2026 at 10:18 AM, an interview with RT#1 indicated suction canisters and suction tubing needed to be changed weekly. Additionally, RT#1 indicated that ventilator circuit tubing should be changed monthly and was not sure why the ventilator tubing for Residents #76 and #261 had not been changed yet.On 1/20/2026 at 1:10 PM, an interview with the Director of Respiratory identified ventilator circuit tubing, including inhalation and exhalation filters, was a single-use component and should be changed in the first week of the month. The Director of Respiratory indicated different residents are scheduled for ventilator circuit changes on different days of the week to balance the workload among the respiratory therapists. Additionally, the Director of Respiratory indicated that the suction canister and tubing should be changed weekly. The Director of Respiratory indicated he was working on a method to monitor compliance with ventilator circuit tubing changes. A review of the ventilator manufacturer's cleaning and maintenance recommendations indicated that single-use components should be replaced regularly following institutional standards. A facility policy for Clinical Services Ventilation Management identified that ventilator circuits and filters should be replaced per manufacturer guidelines. A facility policy for Clinical Services Equipment and Supply Cleanliness identified ventilator circuits were to be changed every 30 days and documented in the electronic medical record. The policy did not indicate when suction canisters and tubing should be replaced; however, it identified that the [NAME] suction device (a component of the suction set-up for a ventilator patient) should be changed weekly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, review of facility policy and staff interviews for 3 of 4 (3AB and 2CD units) medication rooms observed, the facility failed to ensure medication was labeled appropriately, controlled medications were safely stored and failed to ensure that food items were not stored in the medication rooms. The findings included: On 1/20/2026 at 3:00 PM, an observation with the nurse manager (RN#2) of the 3AB medication room identified two bottles of chlorhexidine gluconate 0.12% oral rinse on a shelf with other resident-specific medications. The bottles were noted to have torn resident labels that did not allow for the identification of the residents to whom the bottles belonged. Additionally, the medication refrigerator was noted to have a locked narcotics box that was affixed to a shelf in the refrigerator; however, the shelf was not permanently affixed to the refrigerator and was readily removable. The narcotics box contained five bottles of lorazepam (anti-anxiety) 3 milligrams (mg)/1 milliliter (mL). Three of the bottles were unopened and contained 30mL each, and two bottles were open and contained over 22mL each. An interview with RN#2 indicated she was not sure why the chlorhexidine gluconate had torn labels and medications that were no longer being used would be put on the side to be returned to the pharmacy or destroyed. RN#2 further indicated that she was not aware that the narcotics box would need to be permanently affixed to the refrigerator. On 1/21/2026 at 10:20 AM, an observation of the 3CD medication room with LPN#2 identified a food refrigerator with an egg sandwich and a peanut butter sandwich with resident room numbers. On one counter of the medication room, there were multiple individually packed shelf-stable fruit smoothies and crackers. The packet of smoothies and crackers had resident names and room numbers on them. There was also an open 1-pound packet of cream-filled chocolate sandwich cookies. The cookies were not individually wrapped and were in a self-sealing package; the adhesive of the self-sealing flap was worn and did not seal the cookies effectively. An interview with LPN#2 indicated that the refrigerator was used only for food and not for medications, and that the unit also had a food refrigerator in the unit's nourishment room. LPN#2 indicated that the sandwiches were for resident evening snacks but was not sure why the sandwiches were kept in the medication room versus the nourishment refrigerator. LPN#2 also indicated the fruit smoothies, crackers, and cookies were food items brought in by family for specific residents and were kept there for safekeeping. LPN#2 did not know how long the food items had been stored in the medication room. On 1/21/2026 at 11:35 AM, an observation of the 2CD medication room with LPN#6 identified a black colored mini refrigerator that contained an unopened 30mL bottle of morphine oral concentrate 20mg/5mL (a schedule 2 medication) and an unopened 30mL bottle of lorazepam 2mg/1ml oral solution. The mini refrigerator was sitting on a medication room counter, not permanently affixed, and was readily movable by the surveyor. An interview with LPN#6 indicated that the refrigerator does not have a lock box or separate compartment inside because the whole mini refrigerator was used for holding narcotics. On 1/22/2026 at 12:04 PM, an interview with the DNS identified the lock box and narcotics refrigerator had been addressed on 1/21/2026 after surveyor observations. Additionally, the DNS indicated that food items, including those belonging to residents, should have been stored in the nourishment room and not in the medication room. A review of the facility policy for Medication Storage identified that schedule 2 to schedule 5 medications must be maintained in a separately locked, permanently affixed compartment or cabinet. The facility policy for Medication Storage did not identify whether food would be stored in the medication rooms. The facility policy for Use and Storage of Food Brought to Residents by Family or Visitors identified that non-perishable foods stored in a resident's room must have been in an air-tight container or plastic food storage bag and that perishable food must have been stored in the nursing unit kitchen nourishment refrigerator.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, observations, clinical record reviews, review of facility documentation, review of resident menu selections, review of facility policies, and staff interviews for 10 of 10 sampled residents (Residents #238, #82, #121, #55, #71, #183, #163, #174, #220, and #290), the facility failed to support residents in exercising their right to make choices regarding meals. The findings included: 1.Resident #220 had diagnoses that included heart failure, respiratory failure, and lymphedema. The quarterly MDS dated [DATE] identified Resident #220 had intact cognition and was independent with oral hygiene and feeding him/herself. The RCP dated 10/27/25 identified Resident #220 was obese with interventions that included providing diet per physician's order, obtain, provide, honor, and monitor food and beverage preferences. A physician's order dated 1/9/26 directed to provide a 2-gram sodium regular texture diet. Interview with Resident #220 on 1/15/2026 at 6:30 AM identified he/she completes weekly select menus and fills his/her daily meal selections. Resident #220 indicated he/she does not receive the foods circled or foods handwritten on the menus. Resident #220 indicated he/she requests sausage daily for breakfast, but he/she had not received sausage for approximately six months, despite continued requests. Resident #220 stated he/she has reported to the nurse aides and no staff member from dietary or nursing explained why the requested items were not provided. Resident #220 identified that the handwritten menu slips were not returned for comparison and did not match the typed meal tickets on trays. Observation on 1/15/26 at 8:00 AM identified Resident #220's breakfast tray did not include sausage, and the meal ticket did not list sausage in a typed or handwritten form. Interview with Resident #220 on 1/20/26 at 8:15 AM identified he/she still did not receive the sausage as requested. Resident #220 identified he/ she had not seen the dietician in many months. Resident #220 indicated that last week he/she requested a ham sandwich for dinner in addition to the main meal but never received it. Resident #220 identified every day on the prefilled out the select menus for dinner he/she crosses off the chef salad and handwrites in a small salad but continues to receive chef salad. Resident #220 indicated no dietary staff had spoken with him/her in several months. Observation on 1/20/26 at 8:20 AM identified Resident #220's breakfast tray on the overbed table, did not include sausage and the and the meal ticket did not have sausage typed on it or handwritten on it. Review of Resident #220's meal ticket dated 1/20/26 identified handwritten on the ticket: sausage for breakfast underlined 3 times, lunch add a small salad, and for dinner Resident #220 had crossed off chef salad, wrote the word delete next to it, and wrote in small salad. Interview with the Directory of Dietary (DOD) on 1/20/26 at 2:21 PM identified residents have select menus for each day of the week on separate pieces of paper, but they can fill out all 7 days for the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	next week. The DOD indicated the daily selection on the paper select menu slips go in a bucket at the nurse's station, then the dietary aide brings them to the kitchen and puts them in a pile. The DOD identified he or someone in the kitchen bring the menu slips to the front desk receptionist who is responsible the day before to input the requests for the next day in the meal tracker system. The DOD indicated a few residents requested their actual slips be returned because they had complained or had forgotten what they had requested for a meal. Interview with Resident #220 on 1/21/26 at 1:00 PM identified although he/she continues to do the select menu he/she does not receive the sausage with breakfast that he/she requests or the fresh fruit. Resident #220 indicated he/she writes it on the form he/she wants sausage on the select menu. Resident # 220 indicated he/she has asked the nurse aides for missing items and informed the nurse aides he/she did not get what he/she requested. Resident #220 indicated the nurse aides tell him/her they call the kitchen, but he/she still does not receive what he/she orders. Resident #220 indicated months ago he/she had spoken with the dietitian regarding these concerns, but nothing changed. Resident #220 indicated that he/she has not seen the dietitian or someone from the kitchen in months to discuss why he/she does not get the items requested on the select menu he/she fills out for every meal. Interview with Director of Dietary (DOD) on 1/21/26 at 1:50 PM identified sausage links and sausage patties are not an everyday item. The DOD indicated he was not aware Resident #220 was not receiving sausage, fresh fruit, or other handwritten requests. Interview with Dietitian #1 on 1/21/26 at 2:23 PM identified select menus are provided to the residents on Tuesdays so they can complete the menus for the following week. Dietitian #1 identified every Saturday which is two days before the service week begins, kitchen staff bring the upcoming week's menus to the front desk so the overnight receptionist can enter residents' selections into the select menu system, which guides food preparation. Dietitian #1 identified sausage is not offered every day, so the receptionist would need to add it in the comment section labeled as server notes for that meal ticket. Dietitian #1 stated if the receptionist does not put an item into the meal tracker program, she is responsible for notifying him of the resident request. Dietitian #1 stated the receptionist had not notified him about any of Resident #220's meal requests that were not put into the meal tracker system daily. Dietitian #1 indicated he had been notified he would have spoken with Resident #220 regarding his/her meal choices. Interview and review of Resident #220's handwritten meal tickets/menu with Dietitian #1 on 1/21/26 at 2:30 PM identified Resident #220's handwritten selected menu for 1/22/26 did not match the kitchen's typed out menu that the cook follows for 1/22/26. Dietitian #1 stated that Resident #220 would not receive any of the items he/she had written in because they did not appear on the kitchen menus for 1/22/26. Review of the Front Desk Training dated 8/17/23 identified menu rules were to notify the dietitians via phone or email if a resident is requesting to not receive a tray, a resident is asking for items that we do not offer, a resident is ordering an excessive amount of food, a resident frequently not ordering full meals, or any other questions you might have. Review of the Culinary and Nutrition Policy identified planned menus are developed and used to (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Reasonable efforts mean assessing individual residents' needs and preferences and demonstrating actions to meet those needs and preferences, including reviewing availability of procurement sources of each food item, identifying preparation methods and approaches, and determining whether purchasing and serving such items can occur. The facility will make a reasonable and good faith effort to develop a menu to meet residents' preferences. Residents provide input into menu development through resident council or separate food committee, interviews with residents, their families, by the food service director, registered dietitian or their designee. Resident food and beverage preferences are obtained directly from residents. Reasonable alternative food items that are reasonable and accommodate individual resident needs, intolerances, and preferences are available and offered to residents at each meal if the primary menu or immediate selections for a particular meal are not to the residents' liking. 2 a. Resident #238 's diagnoses included type 2 diabetes mellitus with circulatory complications, chronic kidney disease stage 3 with anemia, type 2 diabetes mellitus hypothyroidism and adjustment disorder with anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #238 was cognitively intact and required assistance with eating and oral hygiene. The MDS documented significant weight changes and the use of a therapeutic diet. The resident participated in assessment and goal setting at that time. A physician's order, dated 4/9/25, directed Resident #238 have a renal, non-dialysis, diet with regular/whole texture and thin consistency. A dietitian's note dated 5/1/25 documented a weight warning, noting a 15-pound weight loss in one month following a 15-pound gain the prior month. Despite intake concerns, there was no evidence that resident dissatisfaction with meals or food preferences was incorporated into the care plan or addressed through documented resident choice discussions. A dietitian's note dated 5/9/25 documented Resident #238 requested milk at breakfast and dinner, which was not included in the renal diet. The dietitian documented a compromise to provide four ounces of milk at breakfast and dinner and noted menus were updated; however, there was no evidence that this preference or related communication needs were incorporated into the resident plan of care. A dietitian's note dated 6/6/25 documented Resident #238 reported poor meal intake due to a dislike of meals being served, stating his/her appetite was intact, but the meals were unacceptable. There was no evidence addressing food preferences or meal choice communication occurred in the plan of care following this report. An email exchange dated 7/18/25 between front desk staff and Dietitian #1 reflected concerns that grilled cheese sandwiches and salads no longer appeared on Resident #238's menu due to renal diet restrictions. Although Dietitian #1 responded to the staff, there was no evidence that the residents were informed of these changes or involved in alternate meal selection. Care plan meetings held on 10/21/25 and 1/20/26 documented Resident #238 was invited but did not attend. Despite ongoing documented meal dissatisfaction, there was no evidence the interdisciplinary (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team incorporated the resident's food preferences, menu concerns, or communication needs into the care plan through alternate means. A quarterly MDS assessment dated [DATE] identified Resident #238 was cognitively intact and independent for eating, oral hygiene, and personal hygiene, and continued to receive a therapeutic diet. The resident participated in assessment and goal setting at that time. A care plan dated 1/15/26 included goals addressing nutritional status and renal disease. One focus, initiated 2/24/25, identified risk for malnutrition related to worsening renal disease, with goals to maintain adequate intake and weight stability. Interventions included honoring food and beverage preferences and monitoring intake; however, these interventions were last updated 2/26/24 and did not reflect subsequent documented concerns related to resident dissatisfaction with meals. A second focus addressed chronic renal failure related to kidney disease and diabetes, initiated 2/25/25 and revised 1/15/26, with dietary-related interventions last updated 2/25/25. The care plan did not include interventions to address meal dissatisfaction, menu substitutions, or communication with the resident about food choices. During an interview on 1/15/26, Resident #238 stated that meals ordered were not consistently received, portions were incorrect, disliked foods were repeatedly served, and requested alternatives were not provided. Resident #238 expressed frustration that food choices were not honored. A comparison of Resident #238's selected menus with meals served from 1/20/26 through 1/22/26 identified multiple instances in which requested food items were altered or substituted without evidence that the changes were discussed with the resident. Requested items such as grilled cheese sandwiches, ham, tomato, mashed potatoes, and bagels were replaced with tuna sandwiches, hamburgers, or reduced portions without explanation or documented resident communication. During an interview and menu review, on 1/20/26 at 2:28 PM, the Director of Dining Services identified substitutions provided to Resident #238 were inappropriate and should have been discussed with the resident and dietitian prior to implementation. The Director stated he was not made aware of the substitutions. During an interview and menu review on 1/21/26 at 2:55 PM, Dietitian #1 identified the facility lacked a consistent process to notify residents when meal selections were changed. The dietitian confirmed that discussions regarding repeated menu changes were not routinely documented and acknowledged Resident #238 had not been re-educated regarding menu restrictions recently, despite the identified issues. The dietitian further stated that front desk staff training did not clearly require notifying the dietitian or the Director of Dining Services when resident selections could not be filled, further confirming this when he provided the last documented discussion with Resident #238 from May of 2025 and the training to the front desk. A dietitian's note dated 1/21/26, completed after a surveyor inquiry, documented resident education regarding renal diet restrictions and implementation of diet liberalization to allow preferred foods. This intervention occurred after repeated undocumented substitutions had already occurred. Although Dietitian #1 was able to provide documentation of front desk staff training, dated 8/17/23, which directed staff to notify the dietitian when resident selections required changes. Subsequent Meal Suite system training dated 12/23/24 failed to reinforce these directives. Dietitian #1 confirmed that inconsistencies with communication and education may have contributed to failure to honor (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' choices for menu changes. a. Additional residents sampled, including #82, # 121, 55, 71, 183, 163, 174, and #290, all of whom expressed concerns about menu substitutions during the facility tour. Review of their clinical records identified inconsistent or absent evidence of discussions regarding food substitutions or preferences when selected foods were unavailable. A review of facility policies, including Menu Development and Nutrition Adequacy (July 2025), Residents' [NAME] of Rights (February 2024), and Culinary and Nutrition Policy (July 2023), directed that resident preferences be accommodated, substitutions discussed and documented, and care plans reflect resident goals and choices. The facility failed to ensure residents were supported in exercising their right to make choices regarding meals by failing to honor resident selections, inform residents of meal substitutions, incorporate resident preferences into the plan of care, and ensure staff were adequately educated to implement individualized menus.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 three residents (Resident #195), reviewed for change in condition the facility failed to ensure the physician was notified timely when the resident experienced a change in cardiac status and for 1 of 2 residents (Resident #227), reviewed for pain, the facility failed to ensure the physician was notified when a medication was not administered timely. The findings included: 1.Resident #195 had diagnoses that included heart failure, atherosclerotic heart disease with angina, and hypercholesterolemia. A physician's order dated 11/6/2021 directed to administer metoprolol succinate extended release 25 mg tablet give 1/2 tablet by mouth twice a day hold if systolic blood pressure is under 110 or heart rate is under 55. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #195 had a Brief Interview of Mental Status (BIMS) score of seven (7) indicative of severely impaired cognition, required setup assistance with personal hygiene, and was independent with bed mobility and transfers. The RCP dated 10/24/2025 identified Resident #195 had congestive heart failure. Interventions directed to give cardiac medications as ordered, monitor vital signs and notify medical doctor of significant abnormalities, and oxygen as ordered. Review of the vital signs report dated 1/5/2026 at 8:20 AM identified Resident #195 had a heart rate of 40 beats per minute with a regular rhythm, and on 1/5/2026 at 7:06 PM Resident #195 had a heart rate of 36 beats per minute with an irregular rhythm. Review of Resident #195's clinical record dated 1/5/2026 failed to reflect documentation that the APRN or physician was notified when Resident #195 experienced a change in his/her cardiac status on 1/5/2026 at 8:20 AM when noted with a heart rate of 40 beats per minute. Review of the facility's on-call telephone log dated 1/5/2026 identified the facility placed a call at 9:24 PM (13 hours and 4 minutes after the 1st episode of bradycardia) to APRN #4 and reported Resident #195's apical heart rate was between 35-40 beats per minute, and the resident was sent to the emergency room. Review of the hospital documentation dated 1/7/2026 identified Resident #195 arrived on 1/5/2026 at 11:19 PM with a heart rate in the 30's and found to be in complete heart block (a serious condition where electrical signals from the heart's upper chambers do not reach the lower chambers, leading to independent beating of the atria and ventricles and possible sudden cardiac arrest). Resident #195's lab results identified an elevated N-terminal pro B-type natriuretic peptide level (a laboratory measurement of stress on the heart to help diagnose or rule out heart failure) of 2693 picograms (pg)/milliliter (ml) (normal levels are below 125 pg/ml). Resident #195 was admitted to the hospital, received treatment, and placement of a dual-chamber pacemaker. Interview with LPN #5 on 1/20/2026 at 1:51 PM identified on 1/5/2026 at 8:20 AM Resident #195 was (continued on next page)

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Riverside Health & Rehabilitation Center	745 Main St East Hartford, CT 06108

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bradycardic (low heart rate) with a heart rate was 35-37 beats per minute, and his/her heart didn't sound right. LPN #5 stated she called LPN #2 into the room for assistance at which time Resident #195's heart rate increased to 40 beats per minute. LPN #5 identified she notified RN #2 (7 AM- 3 PM unit manager) that Resident #195 had a heart rate of 35-40 beats per minute. LPN#5 stated she did not notify the APRN because RN #2 (unit manager) stated she would notify the APRN. Interview with LPN #2 on 1/20/2026 at 2:07 PM identified she was called into Resident #195's room by LPN #5 for help because Resident #195's heart rate was very low. LPN #2 stated she advised LPN #5 to notify RN #2. Interview with RN #2 on 1/20/2026 at 2:31 PM identified she was notified by LPN #5 on 1/5/2026 that Resident #195's heart rate was 35-40 beats per minute. RN #2 indicated she assessed Resident #195, who seemed okay, and noted Resident #195's heart rate was maybe 60 beats per minute. RN #2 stated on 1/5/2026 she notified APRN #1 that Resident #195 was experiencing bradycardia but could not recall the time of notification. Interview with APRN #1 on 1/21/2026 at 12:08 PM identified on 1/5/2026 she was notified by RN #2 that Resident #195 had bradycardia . APRN #1 stated she was not Resident #195's provider and identified APRN #2 as the provider who should have been notified. Interview with the DNS on 1/21/2026 at 3:00 PM identified when a resident experiences a change in cardiac status, staff must notify the provider. The DNS stated both nurses and nurse supervisors are responsible for notification. The DNS stated she would have expected RN #2 to document the name of the provider she notified and the provider's response. Interview with APRN #2 on 1/22/2026 at 9:29 AM identified that she was not notified on 1/5/2026 that Resident #195 experienced a change in cardiac status. APRN #2 stated she would have expected notification. Interview with RN #5 (3 PM-11 PM supervisor) on 1/28/2026 at 3:59 PM identified on 1/5/2026 he was not notified during shift change report that Resident #195 had experienced a change in cardiac status. RN #5 stated he should have been notified, had he been notified, he would have instructed the nurses to closely monitor Resident #195. RN #5 identified in the evening on 1/5/2026, LPN #4 (3 PM-11 PM charge nurse) notified him that Resident #195's heart rate was in the 30's. RN #5 stated he assessed Resident #195, notified APRN #4, documented in the SBAR, and sent the resident to the hospital. Interview with LPN #4 (3 PM-11 PM charge nurse) on 1/28/2026 at 4:28 PM identified she was not notified during the change of shift report on 1/5/2026 that Resident #195 had experienced any change in cardiac condition on the first shift. LPN #4 stated had she been informed she would have monitored Resident #195 closely. Interview with APRN #4 on 1/30/2026 at 1:01 PM identified she had was not notified on 1/5/2026 by RN #2 that Resident #195 was noted with bradycardia. APRN #4 stated she first notified on 1/5/2026 at 9:24 PM by the facility that Resident #195 had a change in cardiac status and the resident was sent out to the hospital. Review of the facility Change in Condition Notification policy identified in part that the facility will inform the resident, resident's healthcare provider, and the resident's family/legal representative (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when there is a change in condition. The licensed nurse will notify the resident, resident's healthcare provider, and the resident's family/legal representative of the change in condition. The nurse will document all attempts, noting date and time. In the event of an emergency, the licensed nurse can transfer the resident to the hospital via 911. Physician/family notification must be documented in the electronic health record. 2.Resident #227's diagnoses included chronic pain and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #227 was cognitively intact and received pain medication on a scheduled and as needed (PRN) basis. The care plan dated 11/18/2025 indicated Resident #227 received pain medication therapy due to neuropathic pain and chronic pain. Interventions included: to administer medications as ordered by the physician, to monitor and documents side effects and effectiveness. A physician's order for January 1, 2026, through January 21, 2026, directed to administer Robaxin a 750 Milligrams (MG) tablet by mouth 3 times daily for muscle spasms. An interview and record review with the Director of Nursing Services (DNS) on 1/20/2026 from 1:00PM - 1:20 PM indicated the pain medication, Robaxin, was scheduled to be given 3 times/day at 8:00 AM, 12:00 Noon and 4:00 PM an hour before or after the scheduled time to be considered administered timely. However, during review of the Medication Administration Record (MAR) Audit Report noted on 1/01/2026 the 8:00 AM dose was given at 09:32 AM (32 minutes late). On 1/02/2026 the 8:00AM dose was given at 11:10 AM, (2 hours 10 minutes late) with the next dose due at 12 noon (in 50 minutes). The 12:00 noon dose was given to resident #227 at 1:02 PM (1 hour 51 minutes after the prior dose) with no documentation noted in the clinical record regarding the reason the Robaxin was given late. The DNS indicated it was possible the medication pass was taking longer than usual due to the influenza outbreak and the addition of 18 residents receiving additional preventative medication due to the outbreak. The DNS further indicated s/he would have expected the nurse, Licensed Practical Nurse (LPN) 8, to have notified the supervisor and physician/ Advanced Practice Registered Nurse (APRN) to notify administration regarding late administration. An interview with LPN #8 on 1/21/2026 at 10:41AM indicated Resident #227 did not agree with the 1 hour before or 1 hour after the scheduled medication time but instead expected the medication to be provided at the scheduled time not considering the time it takes to provide all residents with their medication. LPN #8 indicated Resident #227 was often angry when the nurse was not fast enough when providing medication. LPN #8 indicated during the outbreak s/he was able to complete the medication pass timely but during review of the Robaxin administration audit review (the time the medication was signed by the nurse as given) the untimeliness of the 8:00 AM dose on 1/01/2026 and 1/02/2026 were noted without explanation as to why the medications were administered late without the supervisor and/or the physician being notified. On 1/21/2026 at 10:50 AM an interview with the Assistant Director of Nursing Services (ADNS) and DNS and review of the medication administration audit report verified the medication administration audit was the actual time the nurse signed the medication out and administered the Robaxin (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication to Resident #227 and indicated the physician/APRN should have been notified. An interview and record review with APRN #3 on 1/21/2026 at 12:10 PM indicated s/he expected to be called if a medication was given outside the hour before or hour after the scheduled dose time. APRN #3 further indicated in this case since Resident #227 had an order for a PRN dose of the same medication, when LPN #8 provided the 12:00 noon dose 1 hour 51 minutes after the late 8:00 AM dose given at 11:10 AM s/he would not have expected any side effects like drowsiness as Resident #227 had built up a tolerance to pain medication, but s/he would have been expected notification and would have adjusted the times of the remaining doses. The facility policy labeled Medication Administration and Documentation- General, indicated medication must be given during a 2-hour window of 1 hour before and after the scheduled administration time, use prudent judgment by informing the physician in a timely manner when medications are held refused or otherwise not administered and document an explanatory note in the progress notes.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews for 1 of 2 (Residents #10) reviewed for Activities of Daily Living, the facility failed to ensure staff complete a significant change in status assessment timely when the resident experienced a change in condition. The findings include:Resident #10's diagnoses included a neuromuscular disorder, pressure ulcers and diabetes mellitus.The quarterly MDS assessment dated [DATE] indicated Resident #10 was cognitively intact required set up and clean up for eating, superficial touching assistance for personal hygiene, partial moderate assistance for toileting and upper body dressing, dependent on staff for lower body dressing, supervision touching assistance for rolling left to right in bed and transfers, had one stage 3 pressure ulcer that was present on admission, and weight loss greater than 5 % in the last 30 days or 10% in the last 6 months.The quarterly MDS assessment dated [DATE] indicated Resident #10 was cognitively intact required to set-up and clean-up assistance from staff for eating, was dependent on staff for toileting, upper and lower body dressing), bed mobility (rolling left to right in bed), transfers and bathing/showering (all areas decline since the last assessment on 7/25/2025). The assessment also indicated Resident #10 had 2 stage 3 pressure ulcers (the development of one additional pressure ulcer since the last assessment on 7/25/2025. The care plan dated 11/06/2025 indicated Resident #10 had a deficit in the ability to complete self-care with interventions including to provide substantial/maximum assist of one person for bathing/showering, dressing, and toileting and to monitor document and report any changes including declines in function. An interview and record review with Registered Nurse (RN # 4) on 1/22/2026 at 12:10 PM indicted Resident #10 should have had a significant change MDS assessment completed in October 2025 due to the Activity of Daily Living (ADL) declines from the previous assessment and refusals for getting out of bed were contributing to the decline. Although RN#4 indicated s/he was new to the facility at the time of the last assessment in October 2025 the decline in ADL status was overlooked. She further indicated a significant change assessment would be completed at this time. The Resident Assessment Instrument (RAI) Manual for competing Resident assessments in the long-term care setting indicated in part a significant change is a major decline or improvement in a nursing home resident's health and or functional status that affects multiple areas and the change will not resolve on its own and requires an interdisciplinary team review and care plan revision to ensure care aligns with the resident's new needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #2) reviewed for Preadmission Screen Resident Review (PASRR), the facility failed to review and for 1 of 1 sampled resident (Resident # 138), reviewed for positioning and mobility, the facility failed to revise the resident care plan in a timely manner. The findings included: 1.Resident #2 had diagnoses that included anxiety and major depression. Review of the PASRR Level 1 screen outcome dated 8/29/25 identified Resident #2 was approved for a 30-day hospital exemption for a suspected or confirmed PASRR condition of a mental health disability. The rescreening must occur by or before the 30th day if Resident #2 is expected to remain in the facility beyond the authorized timeframe. The RCP dated 9/6/25 identified Resident #2's PASRR was in progress. Interventions included PASRR services will be provided to the resident that include talking with the resident, treatment providers, and other supports about how to recognize the resident's mental health symptoms, monitor behaviors and symptoms carefully and contact the treating psychiatrist. The social worker progress note dated 9/8/25 at 3:11 PM written by SW #1's identified Resident #2's PASRR level 2 was completed, see the care plan for the recommended services. SW #1 identified Resident #2's referral was made to psychiatry with a request for an initial evaluation for treatment and management of mental health symptoms and medication management as needed. The admission MDS dated [DATE] identified Resident #2 had severely impaired cognition, without behaviors, hallucinations, or delusions, and not on any antidepressants. Review of the PASRR Level 1 screen outcome dated 9/15/25 identified Resident #2 did not require a Level 2 screen. Resident #2 had a current diagnosis of major depression and was not on any medications. The Level 1 screen indicated that a PASRR disability is not present because of the following reason: there is no evidence of a PASRR condition of intellectual or developmental disability or a serious behavioral health condition. If changes occur or there is new information a new screen must be submitted. Resident #2 had a current diagnosis of major depression but there are no indicators identified that would signify the need for further evaluation at this time. The RCP dated 12/30/25 identified Resident #2's PASRR was in progress. Interventions included PASRR services will be provided to the resident that include talking with the resident, treatment providers, and other supports about how to recognize the resident's mental health symptoms, monitor behaviors and symptoms carefully and contact the treating psychiatrist. Interview and clinical record review with SW #1 (Director of Social Services) on 1/21/26 at 8:58 AM was unable to provide documentation to reflect Resident #220's care plan was updated and revised on 9/15/25 and 12/15/25. SW #1 identified she was responsible for tracking all Level 1 and Level 2 PASRR's and for updating and revising care plans regarding PASRR updates. SW #1 identified Resident #2 was admitted with a diagnosis of major depression and on 9/8/25 given a 30-day hospital exempt stay. SW #1 indicated on 9/15/25 she resubmitted Resident #2's PASRR but never reviewed the results until today 1/21/26. SW #1 stated on 9/15/25 and 12/15/25 she should have updated Resident #220's care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan Policy (CPCCP) identified the interdisciplinary team will utilize the comprehensive person-centered care planning process to address resident strengths, needs and/or problems as identified on the admission discharge summary, as well as other professional assessments and orders from the healthcare provider, dietary team, therapy, social services and PASRR, and MDS. The CPCCP is developed to include information necessary to properly care for the residents and will address the residents' preference, goals, desired outcomes, and the plan for discharge. Although requested, a PASRR policy was not provided. 2.Resident #138's diagnoses include contracture of the right wrist and elbow, legally blind, bilateral hearing loss and dementia. An Advanced Registered Practice Nurse (APRN) progress note dated 8/15/2025 indicated upon exam, Resident #138 had contracted upper and lower extremities and directed to monitor changes in mobility and function. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #138 had severe cognitive impairment, had limitation of range of motion on the right and left sides of the body including the upper and lower extremities and was dependent on staff for all activities of daily living. The care plan dated as reviewed on 9/1/2025 indicated Resident #138 had a deficit in self-care due to deconditioning due to a displaced right intertrochanteric proximal femur fracture requiring surgical repair. Interventions included helping with all aspects of activities of daily living therapy to evaluate, to monitor/document/report any signs or symptoms of developing immobility or worsening of any functional limit or contractures blood clot formation skin breakdown or fall related injuries. The care plan further indicted Resident #138 had the behavior of calling out, yelling and screaming related to dementia and agitation. Interventions include: to administer medications ordered, speak in a calm manner and to explain all procedures. The care plan indicated an actual/potential risk for pain due to a right hip fracture An APRN note dated 9/09/2025 indicated Resident #138 was being seen for severe muscle stiffness of the legs and the facility staff's inability to take blood pressure due to extremity stiffness and to give Baclofen 5 MG via the G-tube 3 times per day for muscle relaxing. An APRN progress note dated 9/12/2025 indicated Resident #138 on a follow-up visit had severe muscle stiffness not only of the arms but of the legs and indicated the muscle relaxant, Baclofen, should be continued. An observation on 1/15/2026 at 11:15 AM identified Resident #138 asleep in bed with his/her right hand bent at the wrist and fingers curled inward with no splints visible in the room or on resident. An interview and clinical record review on 01/21/2026 9:38 AM with the therapy Director Occupation Therapy (OT) 1, indicated Resident #138 was last treated by the therapy department from 8/18/2025-09/10/2025 upon admission to the facility. Splints were attempted but due to extreme resistance within the contractures attempting to apply/trial splints took 2 persons with maximum assistance, and it was determined the risk of skin issues/injury outweighed the benefit and the recommendation for the use of muscle relaxant medication was discussed with nursing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and clinical record review with the unit manager/supervisor RN #5, on 1/21/2026 at 10:08 AM indicated Resident #138 had contractures of the upper and lower extremities but could not find any direction as to what staff were to do about the contractures but had indicated Resident #138 had splints in the past, and although the Nurse Aide (NA) care card mentions to turn and reposition Resident #138 every 2 hours but failed to mention the resident having any contractures. On 1/21/2026 at 10:23 AM an interview and record review with RN #4 the MDS Director and LPN #7 an MDS nurse both indicated nothing was in the care plan regarding Resident #138 having contractures. However, the hip fracture care plan mentioned to monitor the formation and worsening of contractures further indicating the care plan needed to be updated to include all contractures and how the contractures affect all other aspects of Resident #138's care and well-being including the risk for skin breakdown and pain. On 1/21/2025, after surveyor inquiry, the MDS Director, RN # 4, revised Resident #138's care plan to include having the potential for altered musculoskeletal status due to a history of joint surgery and contractures of the right wrist and elbow with interventions including providing medication as ordered and therapy to evaluate and treat as indicated

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 three residents (Resident #195) who had a change in condition, reviewed for hospitalization, the facility failed to ensure care and services were provided in accordance with professional standards. The findings include:Resident #195 had diagnoses that included heart failure, atherosclerotic heart disease with angina, and hypercholesterolemia.The physician's order dated 11/6/2021 directed to administer Metoprolol succinate (medication used to treat high blood pressure) extended release (ER) 25 mg tablet give 1/2 tablet by mouth twice a day hold if systolic blood pressure is under 110 or heart rate is under 55. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #195 had a Brief Interview of Mental Status (BIMS) score of seven (7) indicative of severely impaired cognition, required setup assistance with personal hygiene, and was independent with bed mobility and transfers. The RCP dated 10/24/2025 identified Resident #195 had congestive heart failure. Interventions directed to give cardiac medications as ordered, monitor vital signs and notify medical doctor of significant abnormalities, and oxygen as ordered.Review of the vital signs report dated 1/5/2026 at 8:20 AM identified Resident #195 had a heart rate of 40 beats per minute with a regular rhythm. Review of Treatment Administration Record (TAR) dated 1/5/2026 at 9:00 AM identified LPN #5 did not administer Metoprolol Succinate ER 25 mg.Review of the hospital documentation dated 1/7/2026 identified Resident #195 arrived on 1/5/2026 at 11:19 PM with a heart rate in the 30's and found to be in complete heart block (a serious condition where electrical signals from the heart's upper chambers do not reach the lower chambers, leading to independent beating of the atria and ventricles and possible sudden cardiac arrest). Resident #195's lab results identified an elevated N-terminal pro B-type natriuretic peptide level (a laboratory measurement of stress on the heart to help diagnose or rule out heart failure) of 2693 picograms (pg)/milliliter (ml) (normal levels are below 125 pg/ml). Resident #195 was admitted to the hospital, received treatment, and placement of a dual-chamber pacemaker.Interview with LPN #5 on 1/20/2026 at 1:51 PM identified on 1/5/2026 at 8:20 AM Resident #195 was bradycardic (low heart rate) with a heart rate was 35-37 beats per minute, and his/her heart didn't sound right. LPN #5 stated she called LPN #2 into the room for assistance at which time Resident #195's heart rate increased to 40 beats per minute. LPN #5 identified she notified RN #2 (7 AM- 3 PM unit manager) that Resident #195 had a heart rate of 35-40 beats per minute. LPN#5 stated she did not notify the APRN because RN #2 (unit manager) stated she would notify the APRN. Interview with RN #2 on 1/20/2026 at 2:31 PM identified she was notified by LPN #5 on 1/5/2026 that Resident #195's heart rate was 35-40 beats per minute. RN #2 indicated she assessed Resident #195, who seemed okay, and noted Resident #195's heart rate was maybe 60 beats per minute. RN #2 stated on 1/5/2026 she notified APRN #1 that Resident #195 was experiencing bradycardia but could not recall the time of notification. Interview with APRN #1 on 1/21/2026 at 12:08 PM identified on 1/5/2026 she was notified by RN #2 that Resident #195 had bradycardia . APRN #1 stated she was not Resident #195's provider and identified APRN #2 as the provider who should have been notified.Interview with the DNS on 1/21/2026 at 3:00 PM identified when a resident experiences a change in cardiac status, a change in condition should be initiated include an RN assessment and the physician should be called. The DNS stated on 1/5/26 when Resident #195 was initially noted with bradycardia RN #2 should have completed an SBAR form and documented in the clinical record. Interview with APRN #2 on 1/22/2026 at 9:29 AM identified that she was not notified on 1/5/2026 that Resident #195 experienced a change in cardiac status. APRN #2 stated she should have been notified. Interview with RN #5 (3 PM-11 PM supervisor) on 1/28/2026 at 3:59 PM identified on 1/5/2026 he was not notified during shift change report that Resident #195 had experienced a change in cardiac status. RN #5 stated he should have been notified, had he been notified, he would have instructed the nurses to closely monitor Resident #195. Interview with LPN #4 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3 PM-11 PM charge nurse) on 1/28/2026 at 4:28 PM identified she was not notified during the change of shift report on 1/5/2026 that Resident #195 experienced a change in cardiac status during the first shift. LPN #4 stated had she been informed she would have monitored Resident #195 closely. Interview with APRN #4 on 1/30/2026 at 1:01 PM identified she had not been notified on 1/5/2026 by RN #2 that Resident #195 was noted with bradycardia. APRN #4 stated she first notified on 1/5/2026 at 9:24 PM by the facility that Resident #195 had a change in cardiac status and the resident was sent out to the hospital.Review of the facility Change in Condition Notification policy identified in part that the facility will inform the resident, resident's healthcare provider, and the resident's family/legal representative when there is a change in condition. The licensed nurse will notify the resident, resident's healthcare provider, and the resident's family/legal representative of the change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075257	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation Center	745 Main St East Hartford, CT 06108

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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 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** Based on clinical record reviews, facility policy, facility documentation, observations and interviews for 2 of 2 residents (Resident #49, Resident #269), reviewed for accidents the facility failed to ensure safety alert devices were removed in accordance with the physician's orders and for 1 of 2 residents (Resident #227) reviewed for pain, the facility failed to ensure staff administered medication timely and failed to update the physician (provider) for further instructions. The findings included: 1. Resident #49's diagnoses included dementia, non-traumatic subarachnoid hemorrhage, and difficulty in walking. The RCP dated 1/9/2025 identified Resident #49 was at risk for elopement. Interventions directed an elopement evaluation per facility protocol and placement on a secure unit. The admission MDS assessment dated [DATE] identified Resident #49 had a Brief Interview of Mental Status (BIMS) score of nine (9) indicative of moderately impaired cognition, exhibited wandering behavior one to three days a week, required supervision with chair/bed-to-chair transfers, and was independent with using a manual wheelchair for locomotion. A physician's order dated 1/15/2025 directed to check expiration date on the Wander Guard on the day shift for 7 days. A physician's order dated 1/25/2025 directed to discontinue checking expiration date on the Wander Guard. Observation on 1/15/2026 at 7:32 AM identified Resident #49's had a Wander Guard on his/her left ankle. Observation on 1/16/2026 at 9:57 AM identified Resident #49 had a Wander Guard on his/her left ankle. Interview and observation with LPN #2 on 1/16/2026 at 9:59 AM identified Resident #49 had a Wander Guard in place on his/her left ankle. LPN #2 stated Resident #49 no longer needed the Wander Guard on his/her left ankle because he/she resided on the secure unit. LPN #2 identified when the physician's order directed to discontinue Resident #49's Wander Guard the night shift was responsible for the removal. LPN #2 could not explain why Resident #49 still had a Wander Guard on his/her left ankle. Interview and observation with RN #2 on 1/20/2026 at 9:22 AM identified Resident #49 had a Wander Guard on his/her left ankle. RN #2 identified when the physician's order directs to discontinue a Wander Guard, she is responsible for removing the resident's Wander Guard. RN #2 stated she did not remove Resident #49's Wander Guard because she was not aware Resident #49's Wander Guard had been discontinued since 1/25/2025. 2. Resident #269 diagnoses included dementia, traumatic subarachnoid hemorrhage, and difficulty in walking The quarterly MDS assessment dated [DATE] identified Resident #269 had a BIMS score of six (6) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicative of severely impaired cognition, did not exhibit wandering behavior, and independent with transfers and ambulation. The RCP dated 12/23/2025 identified Resident #269 was at risk for elopement. Interventions included an elopement evaluation per facility protocol, placement on a secure unit, and that the Resident would not go outside without constant supervision. The care plan failed to include placement of a Wander Guard (a bracelet used as part of a safety alert system). A physician's order dated 3/28/2025 directed to check functioning of Wander Guard every night shift for monitoring. A physician's order dated 8/14/2025 directed to discontinue checking function of Wander Guard every night shift for monitoring. Observation on 1/16/2026 at 10:48 AM identified Resident #269 had a Wander Guard on his/her right ankle. Interview and observation with LPN #3 on 1/16/2026 at 10:49 AM identified Resident #269 had a Wander Guard on his/her right ankle. LPN #3 identified she was aware Resident #269 had a Wander Guard because she checks it daily. LPN #3 stated she was not aware Resident #269's Wander Guard order had been discontinued since 8/14/2025. Interview with the DNS on 1/20/2026 at 12:04 PM identified if a physician's order directs to discontinue a Wander Guard the device should be removed. The DNS could not explain why Resident #49 and Resident #269's Wander Guards had not been removed. The DNS stated Resident #49 and Resident #269's Wander Guards should have been removed on the dates the physician's orders directed to discontinue. Review of the facility Wander Guard/Secure Care Alarm policy identified in part for Residents with a Wander Guard, the device will be checked for placement every shift and documented on the Treatment Administration Record (TAR). The device will be checked daily by the licensed nurse and documented on the TAR. Expiration dates of the Wander Guard transponders will be checked weekly and documented on the TAR. 2.Resident #227's diagnosis included chronic pain and major depressive disorder. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #227 was cognitively intact and received pain medication on a scheduled and as needed (PRN) basis. The care plan dated 11/18/2025 indicated Resident #227 received pain medication therapy due to neuropathic pain and chronic pain. Interventions included: to administer medications as ordered by the physician and to monitor and documents side effects and effectiveness. A physician's order dated January 2025 directed to administer Robaxin a 750 Milligrams tablet by mouth 3 times daily for muscle spasms. An interview and record review with the Director of Nursing Services (DNS) on 1/20/2026 from (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:00PM - 1:20 PM indicated the pain medication, Robaxin, was scheduled to be given 3 times/day at 8:00 AM, 12:00 Noon and 4:00 PM an hour before or after the scheduled time and to be considered administered timely. During review Medication Administration Record Report on 1/01/2026 the 8:00 AM dose was given at 9:32 AM (32 minutes late). On 1/02/2026 the 8:00AM dose was given at 11:10 AM, (2 hours 10 minutes late) with the next dose due at 12:00 PM (in 50 minutes). The 12:00 noon dose was given to Resident #227 at 1:02 PM (1 hour 51 minutes after the prior dose) with no evidence noted in the clinical record regarding the reason the Robaxin was given late. The DNS indicated it was possible the medication pass was taking longer than usual due to the influenza outbreak and the addition of 18 residents receiving additional preventative medication due to the outbreak. The DNS further indicated s/he would have expected the nurse, Licensed Practical Nurse to notify the supervisor, physician/ APRN regarding the late administration. An interview with LPN #8 on 1/21/2026 at 10:41AM indicated Resident #227 did not agree with the 1 hour before or 1 hour after the scheduled medication time. The residents expected the medication to be provided at the scheduled time not taking into account the time it takes to provide all residents with their medication. LPN #8 indicated Resident #227 was often angry when the nurse was not fast enough when providing medication. LPN #8 further indicated during the outbreak s/he was able to complete the medication pass timely but during review of the Robaxin administration audit review (the time the medication was signed by the nurse as given) the untimeliness of the 8:00 AM dose on 1/01/2026 and 1/02/2026 were noted without explanation as to why the medications were administered late without the supervisor and physician being notified. On 1/21/2026 at 10:50 AM an interview with the ADNS and DNS and review of the medication administration audit verified the medication administration audit was the actual time the nurse signed the medication out and administered it to Resident #227. They both indicated that the physician/APRN should have been notified. An interview and record review with APRN #3 on 1/21/2026 at 12:10 PM indicated s/he expected to be called if a medication was given outside the hour before or hour after the scheduled dose time. APRN #3 further indicated in this case since Resident #227 had an order for a PRN dose of the same medication, when LPN #8 provided the 12:00 noon dose 1 hour 51 minutes after the late 8:00 AM dose given at 11:10 AM s/he would not have expected any side effects like drowsiness as Resident #227 had built up a tolerance to pain medication, but s/he would have expected to be notified and would have adjusted the times of the remaining doses. The facility policy labeled Medication Administration and Documentation- General, indicated medication must be given during a 2-hour window of 1 hour before and after the scheduled administration time, use prudent judgment by informing the physician in a timely manner when medications are held refused or otherwise not administered and document an explanatory note in the progress notes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and staff interviews for 1 of 4 residents (Resident #111) reviewed for nutrition, the facility failed to implement interventions for a resident with significant weight loss. The findings include:Resident #111 had diagnoses that include dysphagia, dementia, multiple sclerosis, and feeding difficulties.The physician's orders dated 6/4/2024 directed to provide a regular, whole texture, thin liquid consistency house diet.The Resident Care Plan (RCP) dated 10/9/2025 identified Resident #111 at risk for weight loss related to inadequate calorie intake and dementia. Interventions directed to notify the Registered Dietician, family, and Medical Doctor of significant weight changes, and obtain/record weights per facility protocol.Review of Resident #111's weight record dated 10/1/2025 identified weight was recorded as 153.4 pounds (lbs.).The quarterly MDS assessment dated [DATE] identified Resident # 111 had a Brief Interview of Mental Status (BIMS) score of five (5) indicative of severely impaired cognition, required supervision with eating and oral hygiene, and had no signs or symptoms of a swallowing disorder.Review of Resident #111's weight records identified on 10/31/2025 weight was recorded as 140.4 lbs., (13 lb. weight loss/8.5% loss over 1 month), on 11/3/2025 weight was recorded as 140.4 lbs., on 12/2/2025 weight was recorded as 142.2 lbs., on 1/3/2026 weight was recorded as 134 lbs. (8.2 lb. weight/5.7% loss over 1 month, and a 19.8 lb./12.8% loss over 6 months).Review of the clinical record dated 10/1/2025 through 1/3/2026 failed to reflect any additional physician orders for nutritional supplements, or interventions to address Resident #111's weight loss.Interview with RN #2 on 1/20/2026 at 9:47 AM identified Nutrition is responsible for monitoring residents with weight loss. RN #2 identified if a resident experiences a significant weight loss, Nutrition would notify nursing of the weight loss and place an order for a re-weight to confirm the weight loss. RN #2 stated that Nutrition did not address Resident #111's 8.5% weight loss in October 2025 or the 8.2% weight loss in January 2026.Interview with Dietitian #1 on 1/20/2026 at 10:36 AM identified he was aware Resident #111 had an 8.5% weight loss in October 2025. Dietitian #1 identified in October 2025 he did not implement interventions to address Resident #111's weight loss because he/she was thinking about Hospice services. Dietitian #1 stated Resident #111 was not placed on Hospice, and he forgot to follow up. Dietitian #1 stated had he implemented an intervention in October 2025 it could have slowed down Resident #111's weight loss.Review of the facility Weight Policy identified in part that significant weight changes will have verification of weight measurement for accuracy and documentation purposes. If verification of weight indicates significant weight change (1 month - 5%; 3 months - 7.5%; 6 months - 10%), the resident and/or family representative and the interdisciplinary care team (IDT) will be notified, and the plan of care will be revised as appropriate. Residents with significant weight changes will be added to weekly weights x four weeks or until the weight stabilizes as determined by the IDT.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for 1 of 5 residents (Resident #195) reviewed for change in condition, the facility failed to ensure the clinical record was complete and accurate to include an RN assessment. The findings include:Resident #195 had diagnoses that included heart failure, atherosclerotic heart disease with angina, and hypercholesterolemia.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #195 had a Brief Interview of Mental Status (BIMS) score of seven (7) indicative of severely impaired cognition, required setup assistance with personal hygiene, and was independent with bed mobility and transfers.The RCP dated 10/24/2025 Resident #195 had congestive heart failure. Interventions directed to give cardiac medications as ordered, monitor vital signs and notify medical doctor of significant abnormalities, and oxygen as ordered.Review of the vital signs report dated 1/5/2026 at 8:20 AM identified Resident #195 had a heart rate of 40 beats per minute with a regular rhythm, and on 1/5/2026 at 7:06 PM Resident #195 had a heart rate of 36 beats per minute with an irregular rhythm.Interview with LPN #5 on 1/20/2026 at 1:51 PM identified she noted on 1/5/2026 Resident #195 was bradycardic (low heart rate) with a heart rate between 35-40 beats per minute and notified RN #2. Interview with RN #2 on 1/20/2026 at 2:31 PM identified she was notified by LPN #5 on 1/5/2026 that Resident #195's heart rate was 35-40 beats per minute. RN #2 indicated she assessed Resident #195, who seemed okay, and noted Resident #195's heart rate was maybe 60 beats per minute. RN #2 stated she forgot to document an RN assessment in Resident #195's clinical record.Interview with the DNS on 1/21/2026 at 3:00 PM identified her expectation when a resident experiences a change in condition an RN assessment is completed and documented in the resident's clinical record. The DNS stated on 1/5/2026 that RN #2 should have documented in Resident #195's clinical record that she conducted an RN assessment.Review of the facility Change in Condition Notification policy identified in part the licensed nurse will conduct a complete physical/mental evaluation and document findings in the medical record. The resident's reactions to symptoms must be documented.