STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075268	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Hill Care Center	151 Hillside Ave Hartford, CT 06106

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 46117 Based on review of resident council minutes, review of facility policy, and interviews, the facility failed to provide documentation of the facility's response to resident council's grievances. The findings include: Review of the monthly resident council group meeting minutes from May 2024 to September 2024 identified the following concerns: In the May 2024 resident council meeting minutes residents voiced concerns regarding staff not folding or hanging cleaned clothing up after it was laundered, staff using cellphones while providing care, and residents not being able to choose when to be put back to bed. The June 2024 resident council minutes identified the facility's documented resolution to the expressed concerns were to provide staff education concerning the hanging and folding of resident clothing, storage of the clothing neatly, no cellphone usage in resident care areas, and giving residents the choice to decide the time they want to go to bed. In the August 2024 resident council meeting minutes, the concern about the staff's usage of cellphones was again voiced. The September 2024 resident council minutes identified the facility's resolution was that staff would again receive education regarding cellphone usage. The completed staff education was requested, and the facility provided documentation that the cellphone usage was addressed in June of 2024. There was no other education provided regarding the in-servicing of the staff regarding cell phone usage in resident areas. Interview with Recreation Director (RD #1) on 10/24/24 at 10:20 AM identified he is responsible for scheduling and organizing the monthly resident council meetings. He further identified that during the meetings he reviews the previous month's minutes and concerns with the resolution to the concern. He further identified that the department head of each department is responsible for resolving the expressed residents' concerns brought up during the meetings. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Staff Development Nurse (LPN #2) on 10/24/24 at 10:45 AM identified she is responsible for staff education. She noted that she was not aware that the staff required education on ensuring resident clothing is folded and hung up, or respecting the resident's choice of when to go to bed or staff cellphone usage in resident areas. She further identified the former DNS may have addressed the documented concerns. Interview with the former DNS (RN #1) on 10/24/24 at 11:00 AM identified that when she was the DNS, she was responsible for providing the resolution for nursing concerns voiced in the monthly resident council meetings. She also identified that depending on LPN #2 the issue/concern she would initiate staff education and pass it on to LPN #2 to continue the staff education. She further identified that she could not remember whether or not she communicated to LPN #2 that the staff needed to be educated on ensuring resident clothing was folded and stored properly, the residents' choice of when to go back to bed, and staff cellphone usage in resident care areas. Additionally, she identified that she had not conducted the staff education regarding the concerns. The Resident and Family Council policy identified that any issues raised at the resident council meeting would be addressed by the respective department head and responses to a concern would be forwarded for review at the subsequent council meeting.

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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** 47900 Based on review of the clinical record, review of facility policy and interviews for one of twenty-four sampled residents (Resident #377) reviewed for advance directives, the facility failed to ensure the physician's order accurately reflected the resident's chosen code status. The findings include: Resident #377's diagnoses included osteomyelitis, viral hepatitis C and major depressive disorder. The Nursing Admission assessment dated [DATE] identified Resident #377 was cognitively intact. Resident #377's Advance Directives/Code Status Consent form indicated the resident elected a code status of Do Not Resuscitate (DNR), which means to withhold cardiopulmonary resuscitation (CPR)in the event that the resident stops breathing. The form was signed by APRN #1 on [DATE]. Review of the MD Order/Progress Note form dated [DATE] and also located in the same location of the clinical record as the advance directives/code status consent form identified APRN #1 reviewed advance directives with Resident #377 and determined that the resident's medical condition and prognosis were appropriate for the code status of do not resuscitate (DNR). The form was signed by APRN #1. The physician's order dated [DATE] identified a code status of full code (rather than DNR). A full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. Interview with the Charge Nurse (LPN #5) on [DATE] at 11:55 AM identified that if Resident #377 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the clinical record under the advance directive section and review the advance directive/code status form, and the physician's order in the clinical record and she would also check the resident's status in the electronic health record. After reviewing the advance directive/code status consent form, the physician's orders and the electronic health record with LPN #5, she noted that the physician's order and the electronic health record indicated full code while the advance directive/code status consent form indicated DNR. Additionally, LPN #5 identified that the physician's order should match the advance directive/code status consent form. LPN #5 identified that after the provider reviews and signs the advance directive/code status consent form, the form is flagged in the chart for the charge nurse/nursing supervisor on the unit to transcribe the order. Interview with APRN #1 on [DATE] at 12:10 PM identified that she reviewed and discussed the advance directive/code status consent form with Resident #377 on [DATE] due to his/her selection of the DNR status. After reviewing the advance directive/code status form and the physician's order for full code with APRN #1, she noted that it was her signature on the consent form dated [DATE] and the physician's order directing a code status of full code which she signed on [DATE] after discussing with Resident #377. APRN #1 identified that she signed the advanced directive/code status consent form, then flagged the form in the resident's chart for the nurses to transcribe and note the order. APRN #1 further added that although she reviewed and signed the order for full code, she acknowledged that it was done in error and should have reflected that the resident had a code status of DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Code Status policy identified that the upon admission and thereafter the Code Status is established identifying decisions regarding cardiopulmonary resuscitation. The policy further identified that once the resident's preferred status has been established, the attending physician will document the order of either CPR or DNR in the resident's clinical record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 41682 Based on observations, review of clinical records, review of facility documentation, review of facility policy, and interviews for two of five sampled residents (Residents #30, #31, #35 and #51) reviewed for abuse, the facility failed to ensure the residents were free from abuse. The findings include: 1. Resident #30's diagnoses included dementia, anxiety and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #30 had moderate cognitive impairment, no behaviors, and was independent with ambulation. The care plan dated 5/3/24 identified Resident #30 had an altercation with another resident with interventions that directed to assist in keeping the residents separated, encourage resident to voice his/her frustrations to staff and to have close observation levels applied as indicated. The care plan further identified Resident #30 was admitted to the behavioral health program located on the secured unit due to the diagnoses of schizophrenia and behaviors and symptoms such as delusions, verbal aggression, physical aggression, social disruptiveness, inappropriate acts towards others, sexually inappropriate comments towards staff with interventions that included resident would not be involved in altercations with others, provide increased attention/observation when needed and provide mental health professional services as indicated or ordered. Review of the behavioral intervention monthly flow record for the month of May through June 2024 identified Resident #30 was monitored for inappropriate sexual behaviors and agitation. Resident #32's diagnoses included alcohol induced dementia, anxiety disorder and adjustment disorder. The quarterly MDS assessment dated [DATE] identified Resident #32 had moderate cognitive impairment, no behaviors, required moderate assistance with personal hygiene, independent with bed mobility, and ambulation. The care plan dated 4/24/24 identified Resident #32 had a history of resident-to-resident altercations due to being unable to recognize appropriate boundaries with interventions that included if resident is bothered by the presence of another resident, assist in keeping them separated, encourage resident to voice his/her frustrations to staff and to have resident seen by psychiatry for medication and symptom management. The care plan further identified Resident #32 was at risk for psychosocial well-being due to chronic medical and/or psychological conditions with interventions that included refer to facility's social worker for any newly identified psychosocial concerns as needed and refer to psychiatric consultants as needed for significant impaired coping or psychosocial complications. Review of the behavioral intervention monthly flow record for the month of May through June 2024 identified Resident #32 was monitored for depression and physical aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Reportable Event Report dated 6/3/24 identified at 9:30 AM LPN #7 witnessed Resident #32 throw a chair at Resident #30 hitting the resident on the right lower extremity resulting in a skin tear to the right ankle that measured 1.0 centimeter (cm) by 0.5 cm. The report further noted Resident #30 complained of pain to the left ankle. Resident #32 identified that he/she was annoyed that Resident #30 was walking up and down the hall singing. Resident #32 was placed on one-to-one observation until seen by psychiatry. The Reportable Event Report further identified Resident #32 was moved to a different unit with less stimulation and both residents were seen by the psychiatric service provider. The facility's investigation dated 6/3/24 identified Resident #32 was agitated with the housekeeper for emptying the garbage and was last seen in his/her room at 8:50 AM. Resident #30's physician's order dated 6/3/24 directed to wash the excoriated area to the right lower extremity with normal saline, pat dry, apply Bactroban and cover with a bordered gauze on a daily basis and as needed for 10 days and to monitor the area for any signs or symptoms of infection. The Psychiatric evaluation and consultation dated 6/3/24 identified Resident #30 was pleasant, loud, engaged in conversation and offered no memory or report of the event that took place in the AM. The note further noted to continue to offer supportive nursing care and behavioral monitoring. Social Worker #2's progress note dated 6/3/24 at 9:59 AM identified she was notified that Resident #30 was involved in a resident-to resident altercation. The note further identified Resident #30 was doing well and sitting in a chair by the nurse's station in good spirits. Observation on 10/23/24 at 2:30 PM identified Resident #30 seated in a wheelchair near other residents close to the nursing station and appeared pleasant and engaging with staff. Interview with LPN #7 on 10/25/24 at 10:31 AM identified at the time of the incident, he observed Resident #30 walking ahead of Resident #32 in the hallway and heard both residents talking but was unable to understand what the conversation was about. LPN #7 further noted he then saw Resident #32 pick up a chair that was in front of the nurse's station and walk towards Resident #30. LPN #7 further identified that he ran down the hallway calling out to Resident #32 and when he got to Resident #32, the resident threw the chair and hit Resident #30 on the ankle. LPN #7 indicated that he made it to Resident #32 just in time and stated that Resident #30's injury would have been worse had he not attempted to stop Resident #32 while the resident was in the process of trying to hit Resident #30 with the chair. In addition, LPN #7 identified Resident #32 had a history of displaying aggressive behaviors toward others, and he/she was unpredictable with his/her actions. Review of the Abuse policy identified that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property was prohibited. The policy further identified that residents would not be subjected to abuse by anyone including not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. 2. Resident #31's diagnoses included vascular dementia, major depressive disorder and heart failure. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The quarterly MDS assessment dated [DATE] identified resident #31 had severe cognitive impairment, no behaviors, required maximal assistance with personal hygiene, was non-ambulatory and utilized wheelchair for mobility. The care plan dated 4/24/24 identified Resident #31 was admitted to the behavioral health program located on the secured unit due to the diagnoses of dementia with behavioral disturbances, due to the following behaviors and symptoms of delusions, intrusions, social disruptiveness, and attempts to leave the unit. Interventions included monitor resident in common areas, provide increased attention/observation when needed, redirect when needed/direct and provide mental health professional services as indicated or ordered. Review of the behavioral intervention monthly flow record for the month of May through June 2024 identified Resident #31 was monitored for restlessness and tearfulness. Resident #32's diagnoses included alcohol induced dementia, anxiety disorder and adjustment disorder. The quarterly MDS assessment dated [DATE] identified Resident #32 had moderate cognitive impairment, no behaviors, required moderate assistance with personal hygiene, independent with bed mobility, and ambulation. The Reportable Event Report dated 6/8/24 identified that at 10:15 AM NA #2 witnessed Resident #32 hit Resident #31 in the face. Resident #31. Resident #31 was not noted to have any visible injuries and vital signs, and neurological assessments were ordered for the next 72 hours. Resident #32 was placed on one-to-one observation prior to being transfer to the emergency room for evaluation. NA #2's written statement dated 6/8/24 at 10:15 AM identified Resident #32 was ambulating in the hallway then screamed and punched Resident #31 in the face and appeared very agitated and upset. The Reportable Event report summary dated 6/14/24 identified Resident #32 was moved to another unit when he/she returned from the hospital. The nurse's note dated 6/8/24 at 10:15 AM identified Resident #31 was hit in the face by another resident with no obvious painful distress, no redness, swelling or open areas noted. The note further identified that neurological checks were initiated, and resident remained at baseline. Social Worker #2's progress note dated 6/10/24 at 1:17 PM identified she met with Resident #31, and he/she was doing well after the incident with Resident #32. The note further identified the resident was provided with emotional support. The psychiatric evaluation and consultation dated 6/12/24 identified Resident #31 was seen after being involved in a peer-to-peer altercation wherein the resident was not the aggressor, nor did he/she retaliate according to the nursing staff. The note further identified Resident #31 offered no meaningful information during the visit, made eye contact when name called with no vocalization. The note further noted to continue supportive nursing care and psycho pharmacotherapies as prescribed. Observation on 10/25/24 at 10:25 AM identified Resident #31 in his/her room lying in bed and attempts to interact with the resident identified he/she was not communicative. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	An interview was attempted with NA #2 on 10/25/24 which was unsuccessful. The DNS on 10/25/24 identified that she was unable to reach NA #2 after several attempts. Interview with LPN #7 on 10/25/24 at 10:31 AM identified Resident #31 does not speak much and only responds when his/her name is called and was unaware of any prior incidents between Resident #31 and Resident #32. Review of the Abuse policy identified that abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property was prohibited. The policy further identified that residents would not be subjected to abuse by anyone including not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. 3. Resident #31's diagnoses included vascular dementia, traumatic brain injury, and adjustment disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had a Brief Interview for Mental Status (BIMS) score of one out of fifteen (1/15), indicative of severe impaired cognition and required supervision for mobility with a wheelchair. The Resident Care Plan (RCP) dated 9/11/2024 identified Resident #31 was at risk for altered mood and behaviors related to dementia with behavioral disturbances and wandering. Interventions directed to redirect with minimal cues if exhibiting socially inappropriate behavior, allow to vent feelings in a non-confrontational manner, and offer unit programs/times as directed by resident's safety level/status. Resident #112's diagnoses included vascular dementia with agitation, anxiety disorder, and depression. The admission MDS assessment dated [DATE] identified Resident #112 had a BIMS score of six out of fifteen (6/15), indicative of severe impaired cognition and required partial assistance for mobility with a wheelchair. The RCP dated 9/10/2024 identified Resident #112 was at risk for altered mood and behaviors related to vascular dementia and a history of threatening to inflict physical injury on residents/staff. Interventions directed to encourage appropriate and therapeutic expression of emotions, use calming/gentle approach due to a low frustration level. A facility reportable event form and investigation dated 10/2/2024 at 7:15 PM identified LPN #9 and LPN #10 witnessed a physical altercation between Resident #112 and Resident #31; Resident #112 slapped Resident #1 in the face, punched him/her in the neck and kicked him/her on the left side of the chest and staff immediately separated the residents. Resident #112 reported that he/she was upset because Resident #31 went into his/her drawer. Resident #112 was immediately placed on a one-to-one (1:1) observation until transferred to the hospital. Resident #31 complained of head/back and neck pain, with two (2) scratches noted to the left chest and left side of the face. Resident #31 was transferred to the hospital and returned without any further interventions/treatment plans. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A nursing note dated 10/2/2024 at 10:44 PM written by RN #6 identified she was called to the unit at approximately 7:15 PM. Resident #112 was upset that Resident #31 entered his/her room and went into his/her bureau, and staff witnessed Resident #112 hit Resident #31. Resident #31 was in the hallway, when Resident #112 came into the hallway yelling and poured urine on Resident #31 and started punching him/her in the back of neck/head, slapping him/her in the face and kicking him/her on the side of the body and the residents were immediately separated. Resident #112 appeared agitated, and RN #6 spoke with Resident #112 to try to calm him/her down. Resident #112 reported that he/she was going to hit Resident #31 anytime he/she sees Resident #31 and reported that he/she doesn't care if the nursing staff calls the police. Resident #112 placed on a 1:1 until transferred to the hospital. Interview with LPN #10 on 10/29/2024 at 11:25 AM identified on 10/2/2024, LPN #10 witnessed Resident #112 poured urine on Resident #31 and began hitting and kicking him/her and staff immediately separated the residents. Resident #112 identified that he/she was upset because Resident #31 went into his/her bureau, and alleged Resident #31 took unidentified belongings. LPN #10 identified that Resident #112 had a stop sign on his/her door, but Resident #31 had removed it prior to entering the room. LPN #10 indicated Resident #31 had a reddened area to the right side of his/her neck/face and was transferred to the hospital for evaluation and Resident #112 was placed on a 1:1 monitoring until transferred to the hospital. Although attempted, interview with LPN #9 was unable to be obtained during survey. Interview with the DON and Administrator on 10/29/2024 at 2:30 PM identified the incident involved a physical interaction between the residents. Interview further identified the facility did not substantiate the incident as abuse because the residents were confused. 4. Resident #51's diagnoses included vascular dementia, schizoaffective disorder, post-traumatic stress disorder, and depression. The annual MDS assessment dated [DATE] identified Resident #51 had a BIMS score of fourteen out of fifteen (14/15), indicative of being alert and oriented and was supervision for mobility with a wheelchair. The RCP dated 9/20/2024 identified Resident #51 was at risk for psychotic symptoms such as delusions, hallucinations, and disorganization of thoughts and behaviors related to schizoaffective disorder, depression, and post-traumatic stress disorder. Interventions directed to encourage to voice frustrations to staff, and to offer support and kindness. Resident #35's diagnoses included vascular dementia with behavior disturbances, schizoaffective disorder, and anxiety disorder. The RCP dated 9/25/2024 identified Resident #35 was at risk for altered mood and behaviors related to schizoaffective disorder and dementia with behavioral disturbances, as evidence by exhibiting symptoms such as verbal and physical aggression, intrusion, socially disruptive, and combative with care. Interventions directed use calm and gentle approaches to redirect resident to a quiet environment, encourage diversional activities and psychiatric/social services as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The annual MDS assessment dated [DATE] identified Resident #35 had a BIMS score of three out of fifteen (3/15), indicative of severe impaired cognition and was dependent for mobility with a wheelchair. A facility reportable event form and investigation dated 10/3/2024 at 7:00 PM identified LPN #11 and NA #3 witnessed Resident #51 in his/her wheelchair wheeling past Resident #35, when Resident #35 grabbed Resident #51's arm and hit him/her. Both residents then began to hit each other. The residents were immediately separated, and Resident #35 was placed on a 1:1 observation until he/she was transferred to a different unit and floor. Psych and social services to followed up with both residents and no injuries were noted on either resident. A nursing note dated 10/4/2024 at 1:53 AM written by RN #6 identified on 10/3/2024 about 7 PM, Residents #51 and #35 were involved in a physical altercation and the residents were immediately separated. Resident #35 indicated he/she hit Resident #51 first, and his/her flexed muscles. Resident #35 complained of right wrist pain, redness was noted to the right side of the face and a scratch was noted to right nose crease, right hand and wrist. APRN #1 notified, an x-ray was obtained of Resident #35's right wrist and results were negative. Review of LPN #11's written statement dated 10/3/2024 at 7:00 PM identified LPN #11 witnessed Resident #51 and #35 grabbing and hitting each other in the hallway. Staff intervened, both residents stopped, and they were separated. Review of NA #3's written statement dated 10/3/2024 without a timeframe identified NA #3 heard Resident #35 screaming, and NA #3 looked over and saw Resident #51 and #5 grabbing each other's arms. Although attempted, interview with LPN #11 and NA #3 was unable to be obtained during survey. Interview with the DON and Administrator on 10/29/2024 at 2:30 PM identified the incident involved a physical interaction between the residents. Interview further identified the facility did not substantiate the incident as abuse because the residents were confused. Review of facility Abuse Policy dated 3/20/2024 directed in part, abuse of residents 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 residents, family members or legal guardians, friends, or other individuals. 47900

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical record, review of facility policy and interviews for one of two sampled residents (Resident #59) reviewed for choices, the facility failed to ensure the implementation of the admissions policy when the resident was admitted to the facility. Resident #59 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder recurrent severe with psychotic symptoms, schizoaffective disorder, polyneuropathy, and extrapyramidal symptoms. The admission face sheet located in the electronic health record identified Resident #59 was conserved and indicated the conservator's contact information. The baseline care plan dated 6/18/24 identified Resident #59 was at risk for behaviors related to psychiatric disorders. Interventions included: encourage participation in behavioral program and recreational groups, residence on a secured unit, monitor behaviors, and provide mental health professional services as indicated The admission MDS assessment dated [DATE] identified Resident #59 was cognitively intact, had no behaviors, was independent with hygiene, dressing, eating, transfers and mobility. The assessment further identified Resident #59 was taking antipsychotic, antianxiety and antidepressant medication. Review of Resident #59's clinical record on 10/21/24 at 10:00 AM identified the following forms were not completed: the behavioral program unit resident review, behavioral health program individualized assessment of resident safety status and the behavioral program unit resident review. Further review failed to identify other admission consent forms outlined in the admission's checklist were completed. The record did contain a consent to voluntarily reside on a secured unit dated 6/18/24 that was signed by the resident and a witness. Review of the social services progress notes from 6/18/24 through 10/24/24 failed to identify that contact with Resident #59's conservator was attempted. Review of nurse's notes from 6/18/24 through 10/24/24 failed to identify that notification was made to Resident #59's conservator regarding the resident's admission to the facility. Observation on 10/21/24 at 11:07 AM identified Resident #59 resided on the secured unit in the facility. Interview on 10/22/24 at 2:00 PM with the Regional Clinical Director identified the facility consent admission paperwork is supposed to be completed by the RN supervisor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Hill Care Center	151 Hillside Ave Hartford, CT 06106

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 10/23/24 at 10:23 AM with SW #2 (designated social worker for the secured unit), identified that when a resident is conserved, the RN supervisor is responsible for reviewing and getting the admission forms signed by the resident's conservator. Following SW #2's review of the clinical record, she identified that the admission paperwork in the chart should include the completion of the following forms: advance directive, consent for treatment, and consent for residing on the secured unit. Interview on 10/23/24 at 10:46 AM with Resident #59's Conservator identified that she was unaware of Resident #59's admission to the facility and that the facility had not contacted her regarding admission paperwork or admission consent forms that required her attention. Interview on 10/23/24 at 10:57 AM with the DNS identified the facility had not contacted Resident #59's Conservator regarding the resident's admission to the facility and had not elicited the Conservator's permission's and consents required on admission. Additionally, she indicated that regardless of the resident's cognitive status, if the resident is conserved, the paperwork should be signed (completed) by the conservator. Interview on 10/24/24 at 10:14 AM with the MDS Coordinator identified that the Social Worker is responsible for obtaining the conservator's signature on the admission paperwork. Interview on 10/24/24 at 10:40 AM with SW#1, the Social Work Director, identified the admission paperwork is discussed with the resident, although, if the resident is conserved the paperwork gets emailed or faxed to the conservator. The Social Work Director was unable to identify that the conservator was contacted for admission signatures. The facility admission policy identified that the nurse is responsible for completing the admission documentation and it should be completed within 24 hours. The policy further identified the admission checklist identified consents to be signed on admission include the following: Consent to treat Vaccine Pneumonia/Flu Vaccine Covid Advance Directive Privacy Act Notification statement Receipt of Privacy Practices Use and Disclosure - Facility Directory Harvest Consent Supportive Care Consent Health Drive Consent (continued on next page)

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	SUD program if applicable (substance use disorder) Secure unit Residency if applicable GHMCC disclosure statement if applicable Additionally, the admission checklist identified the completion of the admission was the responsibility of all three shifts, not just the shift that the resident arrives on and directed to pass the checklist on from supervisor to supervisor.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for three of five sampled residents (Resident #30, Resident #31, Resident #32) reviewed for abuse, and one of two residents reviewed for choices, the facility failed to ensure that the residents' care plan was reviewed and revised following an incident of abuse and failed to ensure interdisciplinary care plan meetings were conducted following the completion of the admission and quarterly MDS. The findings include: 1. Resident #30's diagnoses included dementia, anxiety and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #30 had moderate cognitive impairment, had no behaviors, and was independent with personal hygiene and ambulation. The care plan dated 5/3/24 identified Resident #30 had an altercation with another resident with interventions that directed to assist in keeping the residents separated, encourage resident to voice his/her frustrations to staff and to have close observation levels applied as indicated. The care plan further identified Resident #30 was admitted to the behavioral health program located on the secured unit due to the diagnoses of schizophrenia and behaviors and symptoms such as delusions, verbal aggression, physical aggression, social disruptiveness, inappropriate acts towards others, sexually inappropriate comments towards staff with interventions that included resident would not be involved in altercations with others, provide increased attention/observation when needed and provide mental health professional services as indicated or ordered. The Reportable Event Report dated 6/3/24 identified at 9:30 AM LPN #7 witnessed Resident #32 throw a chair at Resident #30 hitting the resident on the right lower extremity resulting in a skin tear to the right ankle that measured 1.0 centimeter (cm) by 0.5 cm. The report further noted Resident #30 complained of pain to the left ankle. Resident #32 identified that he/she was annoyed that Resident #30 was walking up and down the hall singing. Resident #32 was placed on one-to-one observation until seen by psychiatry. The Reportable Event Report further identified Resident #32 was moved to a different unit with less stimulation and both residents were seen by the psychiatric service provider. Review of Resident #30's care plan failed to identify the resident-to-resident altercation that took place on 6/3/24 and failed to identify interventions put in place as a result of the altercation that resulted in an injury. Interview on 10/25/24 at 11:34 AM with the DNS, the Regional Nurse (RN #6) and the Regional Clinical Director failed to identify why Resident #30's care plan was not reviewed and/or revised to reflect the resident-to-resident altercation and interventions to address how to provide support and/or protection of Resident #30. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 10/25/24 at 11:34 AM identified that it was the responsibility of the Social Worker to develop and implement the care plan for both the victim and the perpetrator. The DNS further identified that it is the responsibility of the DNS and the Administrator to review the reportable event reports to ensure that the state agency was updated, investigation was completed, summary and care plan was completed. Interview with the Director of Social Services (SW #1) and SW #2 on 10/25/24 at 1:12 PM identified that it is the Social Worker's responsibility to update the resident's care plan following a resident-to-resident incident and to review and revise the psychosocial care plans quarterly and annually. SW #1 and SW #2 identified that both the victim and the perpetrator care plans would be updated. SW #1 further identified that Resident #30's care plan should have been updated to identify the date of the incident, the initials of the abuser, brief information about the altercation and what it was related to with interventions that were specific to the incident such as social worker one to one visits and psychiatric team for therapy. Additionally, interview with SW #2 on 10/25/24 at 2:55 PM identified that she had failed to address Resident #30's care plan following the incident with Resident #32. 2. Resident #31's diagnoses included vascular dementia, major depressive disorder and heart failure. The quarterly MDS assessment dated [DATE] identified resident #31 had severe cognitive impairment, had no behaviors, required maximal assistance with personal hygiene, and did not ambulate. The assessment further identified that Resident #31 utilized a wheelchair for ambulation. The care plan dated 4/24/24 identified Resident #31 was admitted to the behavioral health program located on the secured unit due to the diagnoses of dementia with behavioral disturbances, due to the following behaviors and symptoms of delusions, intrusions, social disruptiveness, and attempts to leave the unit. Interventions included monitor resident in common areas, provide increased attention/observation when needed, redirect when needed/direct and provide mental health professional services as indicated or ordered. The Reportable Event report summary identified Resident #31 was seated in his/her wheelchair in the hallway when Resident #32 walked by Resident #31 and struck the resident on the head unprovoked. The summary further identified that both residents were separated, Resident #31 did not sustain any injury while Resident #32 was place on one-to-one observation pending transfer to hospital, and upon return from the hospital was moved to another unit. Resident #31's care plan dated 3/27/24 was reviewed with the DNS, the Regional Nurse (RN #6) and Regional Clinical Director Nurse on 10/25/24 at 11:34 AM failed to identify the resident-to-resident altercation incident that occurred on 6/8/24 between Resident #30 and Resident #32. Interview with the DNS on 10/25/24 at 11:34 AM identified that it was the responsibility of the Social Worker to develop and implement the care plan for both the victim and the perpetrator. The DNS further identified that it was the responsibility of the DNS and the Administrator to review accidents and incident reports to ensure that the state agency was updated, investigation was completed, summary and care plan was completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Social Services (SW #1) and SW #2 on 10/25/24 at 1:12 PM identified that it was the Social Worker's responsibility to update the resident's care plan following a resident-to-resident incident and to review and revised the psychosocial care plans quarterly and annually. The SW #1 and SW #2 identified that both the victim and the perpetrator care plans would be updated. SW #1 further identified that the incident that occurred on 6/8/24 was the first resident to resident incident for Resident #31, hence the care plan would had identified that Resident #31 was treated in an abusive manner by peer (Resident #32) with goal to feel safe from risk of physical harm or mental anguish while receiving care at the facility, and the interventions would include psychiatric team for therapy, one to one visit with the social worker, provide counseling approaches that focus on comfort and satisfaction and to remove resident from individuals know to bother the resident. Interview with SW #2 on 10/25/24 at 2:55 PM identified that after reviewing Resident #31's care plan she failed to identify any mention or interventions implemented following the incident that occurred on 6/8/24 between Resident #31 and Resident #32. 3. Resident #32's diagnoses included alcohol induced dementia, anxiety disorder and adjustment disorder. The quarterly MDS assessment dated [DATE] identified Resident #32 had moderate cognitive impairment, had no behaviors, required moderate assistance with personal hygiene, dressing, independent with bed mobility, transfers and ambulation. The care plan dated 4/24/24 identified Resident #32 had a history of resident-to-resident altercations due to being unable to recognized appropriate boundaries with interventions that included if the resident was bothered by the presence of some to assist in keeping them separated, encourage resident to voice his/her frustrations to staff and to have resident seen by psychiatry for medication and symptom management. The care plan further identified Resident #32 at risk for psychosocial well-being due to chronic medical and/or psychological conditions with interventions that included nursing staff would refer to facility's social worker for any newly identified psychosocial or concerns as needed and would refer to the facility's contracted psychiatric consultants as needed for significant impaired coping or psychosocial complications. The Reportable Event dated 6/3/24 identified that at 9:30 AM Resident #32 threw a chair hitting Resident #30 on the right lower extremity which was witnessed by one of the charge nurses on the floor, LPN #7. When asked what occurred Resident #32 stated he was annoyed that Resident #30 was walking up and down the hall singing. The report further identified that Resident #30 was noted to have a skin tear to the right ankle that measured 1.0 centimeter (cm) by 0.5 cm and complained of pain to the left ankle. In addition, the report further identified that both residents were separated, Resident #32 was placed on one-to-one observation until the he/she was cleared by psychiatry. Resident #32' care plan dated 4/24/24 was reviewed with the DNS, the Regional Nurse (RN #6) and Regional Clinical Director Nurse on 10/25/24 at 11:34 AM failed to identify that resident had a room change related to the resident-to-resident altercation incident that occurred on 6/3/24 between Resident #30 and Resident #32. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Reportable Event report summary identified Resident #31 was seated in his/her wheelchair in the hallway when Resident #32 walked by Resident #31 and struck the resident on the head unprovoked. The summary further identified that both residents were separated, Resident #31 did not sustain any injury while Resident #32 was place on one-to-one observation pending transfer to hospital, and upon return from the hospital was moved to another unit. Resident #32's care plan dated 4/24/24 was reviewed with the DNS, the Regional Nurse (RN #6) and Regional Clinical Director on 10/25/24 at 11:34 AM failed to identify any resident-to-resident altercation incident that occurred on 6/8/24 between resident #31 and resident #32. Interview with the DNS on 10/25/24 at 11:34 AM identified that it was the responsibility of the Social Worker to develop and implement the care plan for both the victim and the perpetrator. The DNS further identified that it was the responsibility of the DNS and the Administrator to review accidents and incident reports to ensure that the state agency was updated, investigation was completed, summary and care plan was completed. Interview with the Director of Social Services (SW #1) and SW #2 on 10/25/24 at 1:12 PM identified that it was the Social Worker's responsibility to update the resident's care plan following a resident-to-resident incident and to review and revised the psychosocial care plans quarterly and annually. The SW #1 and SW #2 identified that both the victim and the perpetrator care plans would be updated. SW #1 identified that since this was not Resident #32's first resident to resident altercation that the date of the incident along with the initial of the resident would be added with the new interventions such as Resident #32 was sent to the hospital and room change to the exiting care plan. Interview with SW #2 on 10/25/24 at 2:55 PM identified that after reviewing Resident #32's care plan she failed to identify any mention or interventions implemented following the incident that occurred on 6/8/24 between Resident #31 and Resident #32 and the incident occurred on 6/3/24 did not include all the interventions that was implemented. Review of the Care Plan policy identified that the facility to develop a comprehensive person-centered plan of care for its residents that is consistent with residents' rights for them to attain and/or maintain their highest practicable level of physical, mental, and psychosocial well-being. 4. Resident #59 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, schizoaffective disorder, polyneuropathy, and extrapyramidal symptoms. The baseline care plan dated 6/18/24 identified Resident #59 was at risk for behaviors related to psychiatric disorders, with interventions that included: consult with conservator of person regarding the exercise resident's rights, encourage participation in behavioral program and recreational groups, residence on secured unit, monitor behaviors, provide mental health professional services as indicated, and the care plan noted that the resident/representative was involved and/or informed of the plan of care. The admission MDS assessment dated [DATE] identified Resident #59 was cognitively intact, had no behaviors, was independent with hygiene, dressing, eating, transfers and mobility. The assessment further identified the resident was taking antipsychotic, antianxiety and antidepressant medication. The resident also had a quarterly MDS assessment dated [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's clinical record failed to identify that an interdisciplinary team care plan conference meeting inclusive of the resident and/or the resident's responsible party took place between 6/18/24 and 10/24/24. Review of the and social service progress notes from 6/18/24 through 10/24/24 failed to identify documentation notification of Resident #39's admission to the facility was made to the resident's conservator and or that the conservator was invited to participate in the care plan process, it also failed to identify that the resident was included in the care planning process. Interview on 10/24/24 at 10:14 AM with the MDS Coordinator identified there had not been an interdisciplinary care plan meeting held for Resident #59 after the completion of the admission MDS or the quarterly MDS. 47900

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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** 47900 Based on observation, review of the clinical record, review of facility policy and interviews for one sampled resident (Resident #377) reviewed for antibiotic use, the facility failed to ensure admission orders were verified prior to administration and failed to ensure that a physician's orders directing the treatment and care a a central line catheter. The findings include: Resident #377 was admitted to the facility on [DATE], with diagnoses that included osteomyelitis, viral hepatitis C and major depressive disorder. The Nursing Admission assessment dated [DATE] identified Resident #377 was cognitively intact and had a peripherally inserted central catheter (PICC). Review of the Inter-Agency Referral Report (W-10) from the hospital dated 10/11/24 identified the following discharge medications: 1. Bisacodyl 5milligram (mg) Enteric Coated (EC) give 10mg by mouth daily as needed 2. Bisacodyl 10mg suppository rectally daily as needed 3. Ceftriaxone 1 gram give 2 grams intravenous daily 4. Folic Acid 1mg by mouth daily 5. Gabapentin 300mg, give 900mg by mouth three times daily 6. Milk of Magnesia 30 milliliters (ml) daily as needed 7. Melatonin 3mg by mouth at bedtime (nightly) as needed 8. Methocarbamol give 500mg by mouth four times daily 9. Nicotine 21mg/24 hour apply one patch daily 10. Nicotine Polacrilex 4mg gum by mouth every 2 hours as needed 11. Oxycodone 10mg by mouth every 8 hours 12. Glycolax 17gram by moth twice daily 13. Seroquel 100mg give 100mg by mouth at bedtime 14. Senokot-S 8.6-50 mg, give 2 tabs by mouth at bedtime (nightly) 15. Thiamine 100mg by mouth daily (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	16. Trazadone 50mg by mouth nightly as needed 17. Vancomycin in 0.9% sodium chloride give 1500 mg intravenous every 12 hours 18. Methadone 10mg/ml solution 130mg by moth daily 19. Epclusa 400-100 mg give one tablet daily 20. PICC line care 21. Flush non-valved when not in use daily 22. Intermittent access minimum 5ml normal saline (NS) pre -administration of medication minimum 5ml NS post administration 23. Volume before and after blood draw: 5ml NS pre-draw and 10 ml post-draw 24. Volume before and after blood product: 5ml NS pre transfusion 10 ml post transfusion 25. Heparin locking for non-valved PICC: 5ml 10unit/ml Heparin 26. Heparin locking for valved PICC: 5ml NS -DO not use Heparin The physician's orders in the physical chart failed to identify that the discharge medications listed on the W-10 were verified with the provider at the time of admission on 10/11/24 and that flushes and care of the central line catheter were ordered. Observation on 10/23/24 at 9:49 AM identified Resident #377 self-propelling his/her wheelchair in the hallway while antibiotic was infusing via PICC line with 2 lumen that had a clamp which indicates the catheter was a non-valve catheter. Review of Resident #377's Medication Administration record identified the following medications were administered on 10/11/24 to 10/13/24: 1. Ceftriaxone 1 gram give 2 grams intravenous daily 2. Vancomycin in 0.9% sodium chloride give 1500 mg intravenous every 12 hours 3. Folic Acid 1mg by mouth daily 4. Gabapentin 300mg, give 900mg by mouth three times daily 5. Methocarbamol 500mg by mouth 4 time daily 6. Seroquel 100mg give 100mg by mouth at bedtime 7. Thiamine 100mg by mouth daily (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Senokot-S 8.6-50 mg, give 2 tabs by mouth at bedtime (nightly) 9. Methadone 10mg/ml solution 130mg by moth daily 10. Tylenol 650mg by moth every six hours for pain or elevated temperature 11. Oxycodone 10mg by mouth every 8 hours as needed for pain 12. Trazadone 50mg by mouth nightly as needed for insomnia 13. Melatonin 3mg by mouth at bedtime (nightly) as needed for insomnia 14. Intermittent access minimum 5ml normal saline (NS) pre -administration of medication minimum 5ml NS post administration. 15. Change of the changing of the tubing every 24 hours 16. Change dressing weekly Interview with the Nursing Supervisor (RN #3) on 10/23/24 at 8:21 AM identified that Resident #377 arrived at the facility on the day shift. RN #3 identified that she received the hospital paperwork from the Infection Preventionist (IP) nurse and the ADNS was still in the facility. RN #3 identified that she did not verify the orders with the provider as she had received the paperwork from the IP nurse and the ADNS and thought they had verified the orders as she was just told to input the orders in the electronic medical record system. She indicated that she was assisting the 3:00 PM to 11:00 PM nursing supervisor as they were both agency staff and was new to the facility. RN #3 indicated that the communication was poor at the facility and that she was not told to write the orders on the paper physician's order sheet. Interview with APRN #1 on 10/23/24 at 9:48 AM identified she did not verify any orders for Resident #377 as she was not working on 10/11/24. The APRN #1 identified that she verified the orders on 10/14/24 and thought that was the date that the resident was admitted to facility as the physician's order sheet read new admission. Interview with the Infection Preventionist (LPN #2) on 10/23/24 at 10:02 AM identified she did not verify the admission orders when the resident arrived at the facility. LPN #2 identified that she only took the hospital discharge summary which was in the Methadone box so that she could pick-up the Methadone and bring to the facility on Saturday. Interview with the ADNS on 10/23/24 at 10:48 AM identified that she was in the building when Resident #377 arrived at the facility. The ADNS identified that she did not verify the admission orders on 10/11/24 as it was the responsibility of the nursing supervisor on duty to verify the orders. The ADNS identified that the DNS had reviewed the chart on 10/14/24 and identified that the admission orders were not written on the paper physician order sheet and asked her to follow-up. The ADNS indicated that she utilized the W-10 and review the orders and have APRN #1 verify the orders and sign the physician's order sheet on 10/14/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 10/24/24 at 10:19 AM identified that she had reviewed Resident #377 chart on 10/14/24 and identified that the orders were not written on the paper physician order sheet and asked the ADNS to follow-up. The DNS identified that there is a notice in the supervisor's office that indicates that all admission and re-admission orders must be put into the electronic medical record as well as written in the physical physician orders as well as on the paper medication administration record and the treatment administration record. Interview with APRN #2 on 10/25/24 at 10:56 AM identified that she was not working on 10/11/24. Interview with MD #1 on 10/25/24 at 3:31 PM identified that he is always on call but did not verify any orders for Resident #377 on 10/11/24. He identified that probably an on-call physician would have verified the order. MD #1 was asked when does the answering service started, which he responded at 5:00 PM. MD #1 was made aware that the resident arrived at the facility at 2:00 PM, then he responded that the on-call provider would have then not been called to verify the admission orders. Review of the Physician Orders Transcription policy identified that physician orders would be transcribed by a licensed staff and followed through in a manner consistent with quality standard of care practices. The policy further identified that admission orders will be transcribed from the W-10 or discharge order to the facility's physician's order sheet, followed by calling the attending physician to confirm orders, then add the date, time, and sign physician's name, your name and orders confirmed on the physician's order sheet. Review of the Central Line Catheter protocol identified the flushing protocol for non-valved catheters 5ml of NS before Medication administration and 5ml of NS after medication administration then 5ml of 10units/ml heparin flush. For unused lumen of PICC line non-valved catheter to be flushed every 12 hours each lumen with 5ml of NS then 5ml of 10units/ml heparin flush. Treatment protocol includes change tubing 24 hours of primary intermittent, change needless connection on admission, every week and as needed, change dressing every week and as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on observations, review of the clinical record, review of facility policy, and interviews for one sampled resident (Resident #70) reviewed for respiratory care, the facility failed to ensure a physician's order was in place directing the use of oxygen therapy for a resident utilizing oxygen. The findings included: Resident #70s diagnoses included end stage renal disease, chronic obstructive pulmonary disease, anxiety, and heart failure. The quarterly MDS assessment dated [DATE], identified Resident #70 was cognitively intact, required moderate assistance with transfers, toileting, personal hygiene, and identified that the resident utilized a wheelchair for mobility. The assessment did not indicate the use of oxygen. The care plan dated 8/31/24 identified Resident #70 was at risk for breathing problems related to chronic pulmonary disease, with interventions that included providing oxygen as needed to maintain oxygen levels. Elevating the head of the bed to prevent shortness of breath, and to monitor for any symptoms of difficulty breathing. Observation on 10/23/24 at 10:10 AM in Resident #70's room, identified oxygen was being administered at 2 liters via nasal cannula. The oxygen tubing was labeled, and dated 10/17/24, and appeared clean. Interview at the time of the observation with Resident #70, identified he/she utilized oxygen on a regular basis for shortness of breath. Interview on 10/23/24 at 10:39 AM with LPN #1 Unit/medication nurse 3rd floor identified that there should be an order for oxygen. Resident #70 usually uses the oxygen upon return from dialysis, and it used as needed. The oxygen order must have fallen off the medication administration record (MAR). The 11-7 nurse changes the oxygen tubing weekly, labels and dates the tubing. LPN #1 was unable to locate a physician's order for oxygen in the resident's medical record (paper chart, or in the electronic medical record) and an order was not located on either the MAR or on the treatment administration record (TAR). Subsequent to surveyor inquiry; observation on 10/24/24 at 1:06 PM with LPN #4 third floor unit/medication nurse, identified a new order dated 10/23/24 for oxygen 2 liters via nasal cannula every shift as needed, change oxygen tubing every week on Sunday 11-7 shift, and check oxygen levels (pulse oximetry) every shift. Orders had been transcribed onto the treatment administration record (TAR). Review of the Medication Order Transcription policy-Paper Systems, directed in part, that prescribers' medication orders will be accurately transcribed and executed in a timely manner to ensure accurate administration of all physicians' orders. Review of the Oxygen Administration policy dated 4/17/24, directed in part, to verify that there is a physician's order in place for this procedure or facility protocol.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of the clinical record, review of facility documentation, review of facility policy/procedure and interviews for one sampled resident (Resident #115) reviewed for pain, the facility failed to administer pain medication in a timely manner. The findings included: Resident #115's diagnoses included puncture wound without foreign body of the right thigh, and muscle weakness. The admission MDS assessment dated [DATE] identified Resident #115 was cognitively intact, had no behaviors, required set up or clean up assistance with eating, oral hygiene, utilized partial to moderate assistance with toileting, showers, personal hygiene and dressing. The assessment further identified Resident #115 utilized a wheelchair for mobility, and almost constantly was in pain with a rating of 10 in pain intensity on a scale of 0-10 with 10 being the most intense. The care plan dated 7/16/24 identified Resident #115 had pain related to a gunshot wound with interventions that included provide pain medication as ordered and observe effectiveness, for complaints of break through pain offer another one of the medications ordered for pain and offer to help find a comfortable position. Physician's order dated 7/18/24 directed Oxycodone 5mg tab by mouth every 6 hours as needed for pain for 1 week then Oxycodone 5mg tab by mouth every 8 hours for pain as needed. Physician's order dated 8/13/24 directed to start Ibuprofen 800mg by mouth every 8 hours as needed for 14 days. Review of facility documentation (interview form) dated 8/14/24 at 11:00 PM identified LPN #3 indicated she went to the break room around 10:45 PM and when she returned Resident #115 was waiting for medication and spoke to her using profanity. Review of facility documentation (interview form) dated 8/14/24 at 11:45 PM identified Resident #115 indicated he/she rang the call bell twice around 9:00 PM and spoke with the same NA#1 who said she had notified the nurse that he/she was wanted pain medication. After waiting over two and a half hours the nurse finally showed up after a fall out of bed onto the floor. The documentation further noted that LPN#3 conveyed she wasn't going to give the medication. A grievance form dated 8/14/24 identified Resident #115 asked LPN #3 after ringing the call bell twice and waiting for more than two hours, her response was that she was not giving the resident anything and to get it from the supervisor, and who did the resident think they were for telling her when to give medication, this grievance was turned into a reportable event. Interview form dated 8/15/24 at 2:37 PM from NA#1 indicated that she told the charge nurse twice that Resident#115 needed pain medication as the resident was ringing the call bell requesting medication, once around 7:30 PM and once around 8:30 PM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for the month of August 2024 identified no PRN Oxycodone 5mg or Ibuprofen 800mg was signed off as passed to Resident #115 on 8/14/24. Review of the Control Substance Disposition record for Oxycodone IR 5mg identified 1 tab was passed at 1:50 PM therefore the next dose could be passed 8 hours later meaning any time after 9:50 PM. The medication was signed off passed on 8/14/24 at 11:12 PM. Interview with Resident #115 on 10/21/24 at 10:15 AM indicated he/she was in severe pain on 8/14/24 and had told NA#1 twice to let the nurse know about the pain, once around 8:00 PM and a second time closer to 9:00 PM. Resident #115 identified he/she fell while trying to move to the bed due to the intense pain. Resident #115 identified that LPN#3 could not be located for a period and that NA#1 was trying to help locate the nurse to get him/her the medication. By the time LPN#3 was located Resident #115 admitted he/she was frustrated and was in severe pain. A formal grievance was written, and Resident #115 stated he/she never received a reply from the grievance, but that LPN #3 had been back to work on his/her unit. Interview on 10/24/24 at 11:04 AM with NA#1 identified the nurse that evening seemed annoyed and or frustrated as another patient had said a bandage was too tight and she told them she only gets paid for 8 hours and that she was not putting it on again. Resident #115 did ring the call bell twice once around 7:30 PM and once around 8:30 PM and each time she notified the nurse that he wanted his PRN pain medication, she seemed annoyed after the second time I told her. The third time Resident #115 rang the call bell NA#1 said she would find the nurse however could not locate the nurse for approximately 45 minutes to 1 hour. She went back to resident #115 and said LPN #3 must be on break. Resident #115 self-reported a fall after coming out of his/her room towards the nurses station towards the end of the shift when the nurse was getting back to the unit, however no one witnessed it. Interview on 10/24/24 at 11:19 AM with LPN #3 indicated that she was very busy that evening of 8/14/24 because there was a new admission, and that she did go off the floor towards the end of the night for a phone call. She knew Resident #115 could have received pain medication between 9-10pm, however said she wasn't aware from the NA#1 that he was in pain and no PRN medications were passed to Resident #115 on her shift on 8/14/24, including the Ibuprofen 800mg PRN. When she returned to the unit Resident #115 was very upset wanting medication and angry. She said she would not pass Resident #115 his/her medications because he/she was so angry, she requested the supervisor pass the requested medication. Interview with the DNS on 10/29/24 at 10:15 AM identified if a NA tells a nurse that a resident is in pain it is the nurse's responsibility to assess the pain and administer medications as ordered. Review of the Medication Administration and Documentation policy directed The Medication Administration Record (MAR) is the form onto which all medication orders are transcribed, from which medications are poured and administered and on which medication doses are charted. The MAR is a permanent part of the residents' record. Review of the Pain Management policy directed pain strategies to include as applicable, pharmacologic, and non-pharmacologic interventions.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observations, review of the clinical record, review of facility documentation, review of facility policy and procedures and interviews for one sampled resident reviewed for hospitalization , the facility failed to ensure access to emergency supply medication and failed to ensure the implementation of a system to account for the receipt, usage, disposition, and reconciliation. The findings include: 1. Resident #73's diagnoses included unspecified open wound left foot, anxiety disorder, and post-traumatic stress disorder. The admission MDS assessment dated [DATE] identified Resident #1 was cognitively intact, had no behaviors, required set up or clean up assistance with eating, toileting hygiene, and supervision with shower bathing and dressing. The assessment further identified the resident utilized a wheelchair for mobility Physicians order dated 10/18/24 directed Lorazepam 1mg by mouth every 4 hours as needed for anxiety. The nurse's note dated 10/18/24 at 3:16 PM identified Resident #73 was very aggressive. The nurse's note dated 10/18/24 at 10:28 PM identified Resident #73 punched the wall with his right hand and the APRN was notified, and an x-ray was ordered. The nurse's note dated 10/19/24 at 10:57 AM identified Resident #73 reported punching the wall on 10/18/24 as he/she was upset about his/her medications when he/she returned from the hospital. Review of the MAR for the month of October 2024 identified one dose of PRN Lorazepam signed for 10/18/24. No control drug receipt disposition for October 2024 for Lorazepam 1mg PRN for Resident #73 could be located in the facility. Interview on 10/21/24 at 10:40 AM with Resident #73 identified that the day the resident returned from the hospital 10/18/24 there was no Lorazepam 1mg PRN available for him/her when requested on second shift. It took 2-3 hours to get the medication, and it resulted in Resident #73 becoming agitated and punching the nurses station with his/her right hand. Review of the Omni-cell access list received from the ADNS identified LPN#9 and Supervising RN #5 did not have access to the Omni-cell access list. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/25/24 at 10:27 AM with LPN #9 identified she was the nurse on the unit that evening and the Lorazepam 1mg PRN was not available for Resident #73 to receive. The Supervisor RN #5 was notified and could not get into the E-box to get any because he was an agency nurse and was not granted access. Approximately 1-2 hours after Resident #73 requested the medication the supervisor RN#5 brought over the medication that he borrowed from another resident, however unsure whom. Interview with MD#1 on 10/24/24 at 12:11 PM identified he was not contacted regarding any medication issues upon return from the hospital for Resident #73 and was notified the following day while in the building. Interview with Supervisor RN#5 was attempted on 10/25/24 at 11:31 AM and a message was left. Interview with ADNS on 10/25/24 at 2:35 PM identified access can be added for nurses in the omni cell however currently no agency nurses had access to the omni cell for emergency medication. The ADNS identified she was on call this evening and never received a phone call with an issue from the Supervisor RN#5. Interview with the DNS on 10/25/24 at 2:45 PM identified the receipt and disposition for administration of the Lorazepam 1mg PRN for Resident #73 could not be located in the facility, and that if there was no access to the omni-cell that evening a stat medication order could have been called from pharmacy. Medications should never be borrowed from another resident in any instance. Review of the Electronic Interim Box policy directed the Director of Nursing to be responsible for developing and maintaining a confidential system for assigning access codes and system privileges for nursing personnel. Review of the medication unavailable policy directed that a nurse upon identification that is medication is unavailable they should notify the supervisor immediately. The Nursing Supervisor should check all areas where meds are stored to ensure medication is actually not available. Upon determining that the required medication is not available contact the pharmacy, inform the prescriber, attending; and if necessary, contact the pharmacy to advise of any new orders. 2. Interview on 10/24/24 at 1:30 PM with the ADNS identified the process for receiving medications into the facility. She identified the delivery slip is checked for accuracy by the supervisor, is signed and given back to the delivery person. There are not delivery slips kept in the facility. The medication and the Controlled Substance Disposition Record (CSDR) are brought to the respective units and counted, and the medication is placed in the narcotic box on the medication cart and the white copy of the CSDR is placed in a binder that is kept with the cart. The CSDRs are duplicate forms, and the yellow copy is placed in a bin in the reception office. The ADNS indicated the receptionist was responsible for the CSDRs after that and the ADNS was not aware the yellow CSDRs were placed in binders in the reception area. Additionally, the ADNS indicated that as the white CSDR sheets were completed on the units, the sheets were placed in the receptionist inbox and the receptionist was responsible for matching the sheets up. At this time the ADNS identified that a narcotic audit was when she went to the units and counted the controlled substances in the unit medication carts with the working nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/24/24 at 1:45 PM identified the reception area had a door accessible from the administration area of the facility. This door was not secured, and all employees of the facility had access to this area. The reception area also had a window with a sliding glass door that faced the entrance to the facility and was not secured. Additionally, there was a window sized opening on the wall directly across from the door, that was accessible to the hallway. The inbox where the yellow CSDR slips were present was on a shelf directly to the left of the window. Interview on 10/24/24 at 1:49 PM with the Regional Nurse and ADNS identified 20 yellow CSDR sheets that were taken out of the reception inbox and presented to the surveyor as the active controlled substances at use in the facility. Review of the CSDR sheets with medications in the facility identified the medications were all accounted for. After review, the Regional Nurse and the ADNS indicated that there were other controlled substances in use in the facility that did not have corresponding yellow CSDR sheets. Interview on 10/24/24 at 1:50 PM with the ADNS identified two binders that contained yellow CSDR sheets were located by the Regional Nurse. The ADNS indicated that the receptionist was responsible for filing the yellow sheets and that she had never looked at or taken the binders out of the reception area. The ADNS identified that she was responsible for the controlled substance audits and her interpretation of an audit was simply counting the medication carts with the nurses assigned to them. She identified that she had been the ADNS for two years and although she rounded twice monthly for the purpose of controlled substance audits, the carts were simply counted. Interview on 10/24/24 at 2:13 PM with Pharmacist #1 identified the facility was responsible for keeping track of the controlled substances and completing audits twice a month. The pharmacist identified the pharmacy had copies of the delivery slips and was able to provide the policies, contract, and delivery slips for the facility. Interview on 10/25/24 at 10:22 AM with the ADNS, subsequent to surveyor inquiry, identified the binders with the yellow CSDR sheets were being relocated to the ADNS office and would be under the ADNS control. Additionally, the ADNS identified that a facility audit was completed, and all controlled substances were accounted for. Interview on 10/25/24 at 12:16 PM with a representative from the DEA identified that a controlled substance audit would consist of comparing the delivery slips with the yellow CSDR sheets and the white CSDR sheets to ensure that every substance received in the facility was accounted for as being in use in the facility or had been destroyed by the facility. Additionally, it was identified that the yellow CSDR binders should not be kept in an accessible area of the facility, but under lock and key. Observation on 10/25/24 at 1:13 PM of the DNS and ADNS identified that neither person was able to obtain a controlled substance report from the Pyxis machine and indicated that the pharmacy consultant did the controlled substance audits when in the facility. Interview on 10/25/24 at 3:00 PM with the Pharmacy Consultant identified that she conducted audits and reorders of non-controlled substances, and that the facility was responsible for auditing the controlled substances. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy for storage of controlled substances accountability identified that staff will follow pharmacy policies as they relate to the receipt, storage, control and disposal of controlled substances. In addition to requirements outlined in pharmacy policies, controlled drug audits will be completed two times per month of the current inventory to ensure all controlled substances are reconciled. Review of the Pharmacy contract with the facility identified that controlled medications are restocked on an as needed basis as ordered by the Medical Director. Additionally, the contract identified the Director of Nursing Services, or their specified designee will generate a report of all controlled substance emergency stock transactions on a daily basis. This report would be reviewed, audited, and documented by the DNS for drug diversion at least weekly. Review of the pharmacy policy titled Receiving Controlled Substances identified controlled substance inventory sheets would be filed appropriately. The policy identified a hard-bound log book, or in accordance with facility policy, is utilized to track the controlled substance from delivery to disposition. 47489

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical record, review of facility policy/procedures and interviews for one of five sampled residents (Resident #78) reviewed for unnecessary medications, the facility failed to ensure the pharmacy recommendations were reviewed by the provider, and present in the resident clinical chart. Additionally, the facility did not have an established policy and procedure for processing of the pharmacy recommendations. The findings included: Resident #78's diagnoses included traumatic brain injury, vascular dementia and, anxiety disorder. The quarterly MDS dated [DATE] identified the resident had severely impaired cognition, did not exhibit inattention, disorganized thinking, or altered level of consciousness. The Care plan dated 9/13/24 identified Resident #78 was at risk for Behavioral Health and participated in the Behavioral Health Program related to depressive disorder, bi-polar, and anxiety. Interventions included placement on a secured unit, and to monitor for psychotropic medication side effects. Physician's orders dated 10/12/24 directed to administer 50 mg of Trazodone every night at bedtime, 1mg of Risperidone twice per day, 850 mg of Metformin once a day, 200 mg of Lamotrigine once a day, 0.1 mg Fludrocortisone once a day, 250 mg Divalproex Delayed Release once every 12 hours, 1mg of Clonazepam three times a day, 2.5 mg Bromocriptine once a day, 40 mg of atorvastatin once a day, and 100 mg of amantadine twice a day. Additional medications included over the counter medications. Review of the Pharmacy progress notes dated 3/3/26/24, 4/16/24, 7/22/24, and 9/25/24 identified the Pharmacy review was completed, and recommendations were made to the provider. Review of the clinical chart on 11/23/24 at 12:00 PM, included the paper chart and 2 electronic health records, failed to produce the above listed pharmacy reviews with the recommendations, and failed to contain lab results for the resident. Interview on 10/25/24 at 11:15 AM with the DNS and Regional Clinical Director identified the recommendations were not all in the charts at that time and the facility was in the process of redoing the process for the processing of pharmacy recommendations. They identified the process for pharmacy recommendations was as follows: 1. The recommendations are emailed to the DNS and ADNS. 2. Whomever is reviewing prints the recommendation, makes a copy and gives a copy to the APRN 3. The APRN will sign off on them and agree or disagree with the recommendations and give it back to the DNS. 4. The DNS makes a copy, keeps one copy and places the other into the resident chart. 5. The APRN makes changes, if needed, and the DNS checks for implementation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 10/25/24 at 1:31 PM with the Regional Clinical Director identified that the recommendations were reprinted and indicated they were not signed by the APRN. She identified that she was reviewing the charts to see if the recommendations were implemented. Pharmacy recommendations reviewed on 10/25/24 at 2:00 PM, after they were provided by the facility included the following: Drug Regimen Review dated 3/26/24 that indicated the resident was taking Metformin and the pharmacist was unable to locate recent HbA1C in the chart. Additionally, it was indicated that this test was recommended every 6 months. The Prescriber response was Agree; will do and was signed by the APRN 3/27/24. Drug Regimen Review dated 4/15/24 identified HBA1C was ordered on 3/27/24, results not located on chart. Please follow up and obtain a duplicate copy, or consider reordering, if necessary. The follow up comments indicated the test was re-ordered. This form was signed by an RN and dated 4/16/24. Drug Regimen Review dated 7/22/24 identified the resident was receiving Atorvastatin (Lipitor) for dyslipidemia. Unable to locate recent serum lipid profile in chart. Recommended 3 months after start then annually thereafter. Please consider ordering. This recommendation was not reviewed and not signed by the provider. Unable to locate blood test results. Drug Regimen Review dated 9/25/24 identified a 2nd request that indicated the resident was receiving Atorvastatin (Lipitor) for dyslipidemia. The consultant identified the serum lipid profile was not able to be located and recommended the serum be obtained 3 months after start and annually thereafter. Additionally, a second recommendation identified the resident was receiving Metformin and the HbA1C was unable to be located in the chart and recommended this test every 6 months. This review was not signed by the provider. Interview on 10/29/24 at 10:10 AM with APRN identified that the Drug Regimen Reviews are printed and placed in her inbox. The APRN indicated she addressed them and sometimes gave a verbal order or sometimes wrote on the Physician Order sheets. She identified that with the new electronic health record, the orders would be put directly into the resident's chart. Additionally, the APRN identified she was notified about the 7/22/24 and 9/25/24 Drug regimen reviews this day and had placed orders for a blood draw to obtain a lipid panel and an A1C or blood glucose test. The APRN identified there were no negative effects by delaying these tests. The facility policy for chart order and thinning/retention guidelines identified active residents' paperwork should be kept on the unit. Advance directives, consents to treat for the facility or psych group, and all care plans are permanent and should not be removed from the clinical chart. Pharmacy recommendations should include the current 1 year. The Consultant Pharmacist Service Agreement identified the pharmacy consultant shall be responsible for the performance of each resident's drug regimen review monthly, with reports of all findings or irregularities to the Director of Nursing for distribution to the attending Physician. Although requested the facility did not provide a policy that identified the procedure for processing the Drug Regimen Reviews.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of the clinical record, review of facility documentation, review of facility policy/procedure and interviews for one of two sampled residents (Resident #119) reviewed for dental, the facility failed to ensure the resident was seen by a dentist/hygienist. The findings include: Resident #119 was admitted to the facility in May of 2024 with diagnoses that included fracture of right femur, fracture of left tibia and fibula, depression and anxiety. The admission MDS assessment dated [DATE] identified Resident #119 was cognitively intact, required total dependence with oral hygiene, dressing, personal hygiene, transfers and did not ambulate. The assessment further identified that the resident had obvious or likely cavity or broken natural teeth. The care plan dated 6/11/24 identified Resident #119 required assistance with ADL's related to bilateral lower extremity fractures with interventions that included monitor resident's status for any changes, improvement, decline and report to MD and therapy, and allow resident to do as much of ADL's as he/she can. The nurse's note dated 6/22/24 at 3:45 PM identified Resident #119 complained of pain and discomfort to teeth. Review of the monthly physician's orders for June/2024 identified an order that directed that the resident be referred to dental for evaluation and Chlorhexidine 0.12 % solution to take 15 milliliters (ml) by mouth and swish for 30 seconds twice a day for a total of 14 days with origination date of 6/24/24 at 11:04 AM. Review of the monthly physician's orders for August/2024 identified an order that directed that the resident be referred to dental for evaluation and Chlorhexidine 0.12 % solution to take 15 milliliters (ml) by mouth and swish for 30 seconds and spit twice a day with origination date of 8/14/24 at 10:25 AM. Review of the clinical records failed to identify any dental or hygienist evaluation and/or notes that Resident #119 refused any dental visits. APRN #1's medical progress note dated 6/27/24 at 3:54 PM identified that resident's teeth were examined, which noted no discoloration, healthy gums, minimal gingivitis no fracture or chip tooth with a plan to follow up with dental. The nurse's note dated 8/13/24 at 11:07 PM identified Resident #119 complained of pain to teeth. APRN #1's medical progress note dated 8/14/24 identified resident complained of dental pain and was referred to dental on 6/24/24 but has not been seen yet. The progress noted further identified resident had missing teeth, and some gingivitis with a plan to refer resident to dental and start chlorhexidine 0.12 % solution to take 15ml by mouth and swish for 30 seconds and spit twice daily. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with the Charge Nurse LPN #5 on 10/23/24 at 9:30 AM identified when asked if Resident #119 had requested to see the dentist in which LPN #5 identified that the resident did request to see a dentist and was seen by APRN #1 who had written orders for mouthwash and to see the dentist. LPN #1 identified that she was on schedule at the when the orders were written for a dental consult, however, was not the nurse who noted the physician's order. LPN #5 further identified that it was the responsibility of the nurse who noted the order to contact the unit secretary via phone call or write the request on a paper and place it in her mailbox. After which, the unit secretary would then make and schedule the appointment for the resident. LPN #5 identified that she could not recall if the resident had seen the dentist or the hygienist. Request was made to the DNS for the contact information of the nurse who noted the physician's order on 6/24/24 for Resident #119, on 10/24/24 at 10:15 AM, the DNS indicated that the nurse was an agency staff and would provide the number, however, the facility failed to provide the contact information. Another request was made to the DNS on 10/25/24 at 8:11 AM and throughout the day which the DNS facility failed to provide the contact information and the facility indicated that were unable to contact the staff. Interview with Unit Secretary #1 on 10/23/24 at 12:14 PM identified that Resident #119 was not seen by the dentist or hygienist since being admitted to the facility. The Unit Secretary identified that she never received any request from nursing that Resident #119 had a referral for dental, as if she had received the request for the referral, it would have been made. She further identified that the process for sending referral to her was that the nurse on the unit would complete the consult form indicating the type of consultation needed then leave it in my mailbox located on the first floor and the nurses would also call or let me know directly. Unit Secretary #1 further identified that she had only received a request for podiatry early last week from nursing and checks her mailbox daily for any request. Interview with the Infection Preventionist (LPN #2) on 10/23/24 at 12:30 PM identified she had not received any request from nursing that Resident #119 needed a dental evaluation. LPN #2 further identified that she had completed a facility audit on dental, podiatry and vision, which identified that Resident #119 had not being seen by either of the providers from the outside company since admission. Interview with APRN #1 on 10/24/24 at 10:10 AM identified that she had written an order for Resident #119 for dental evaluation and mouth was on 6/24/24 and flag the order for the nursing to note the order. The APRN #1 was asked if she followed up on orders in which she responded that she does especially when the resident states it was not done and receives complain from nursing about the same issue. The APRN #1 identified that she did not receive any further complaints from staff, or the Resident #119 complaining of teeth pain and assumed it was resolved until August of 2024 when another complaint about tooth pain was made, then she made another referral for a dental evaluation and an order of the same mouthwash ordered in June. APRN #1 indicated that she had mentioned of the follow-up on dental evaluation in her notes in July but knew the company who does the evaluation may have not had seen the resident due to certain requirements. Interview with the DNS on 10/24/24 at 10:14 AM identified she was new to the facility, but the expectation was that the nurse who noted the physician's order for dental evaluation would ensure that the individual(s) responsible for making the appointment at the facility was made aware of the referral whether by phone or by completing the consult sheet. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the Dentist's and Dental Hygienist's service dates at the facility for the period of June 18, 2024, to October 17, 2024, identified that the Dentist visited the facility a total of 6 times and the Dental Hygienist visited the facility a total of 3 times to provide dental services. Interview with LPN #2 on 10/25/24 at 12:30 PM identified that Resident #119 was not seen by the Dentist nor the Dental Hygienist at any of their visits to the facility from June 2024 to present time. Review of the Oral Health Evaluation policy identified that a dental examination and evaluation would be performed by a qualified professional such as dentist, dental hygienist. Review of the Physician Orders-Transcription policy identified that physician would be transcribe by a licensed nurse and followed through in a manner consistent with quality-of-care practices. The policy and procedure further identified that the orders would be reviewed on the physician order sheet and transcribe onto the appropriate worksheets and the licensed staff signs off the order.

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F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	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** 48335 Based on observations during the kitchen tour, review of facility policy and interviews, the facility failed to ensure food items were appropriately labeled and dated when opened or stored and removed once expired. The findings include: Observations during a tour of the kitchen on [DATE] at 9:51 AM identified the following: 5 brown bags identified in the walk-in refrigerator, with no identifiable information, dates or resident names. Interview on [DATE] at 9:55 AM with the Food Service Director (FSD), indicated the brown bags were lunches prepared the evening before or early morning for dialysis resident's and should be labeled and dated and include each resident's name. Observations during a tour of the kitchen on [DATE] at 11:32 AM identified the following: 4 large bins, two containing white rice, one dated ,d+[DATE], and one without a date. One bin with powdered thickener for liquids, dated [DATE], and the remaining bin with a white powder (flour) was without a label or date. Interview on [DATE] at 11:36 AM with the FSD identified, all the bins should be labeled once opened or filled. The powdered thickener is good for 2 months once opened and is expired, and the flour is good, for one month once opened. The FSD removed the 4 bins from circulation and directed the kitchen staff to clean, and refill the bins, then label/date them per facility policy. Observation on [DATE] at 10:30 AM identified the 4 bins; 2 rice bins and one powdered thickener and one flour, were all labeled with food names and dated [DATE] when opened/filled. Review of the Food Storage and Marking policies dated [DATE], directed in part, that dry food items should have a date including the month, date and year, in which the product was delivered or a manufacturer's printed Best By/Use by date. The date marking system is a process to identify, how old foods are and when those foods must be discarded. Refrigerated, ready-to-eat, potentially hazardous foods opened or prepared, shall be clearly marked at the time of preparation to indicate the date of preparation. Ready-to-eat food items should be discarded within 72 hours of the date opened.

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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** 47489 Based on review of clinical records, review of facility policy and interviews for two of five sampled residents (Resident #59 and Resident #78) reviewed for unnecessary medications and for one of five sampled residents (Resident #32), reviewed for abuse, the facility failed to ensure resident medical records were complete, accurately documented and readily accessible. The findings include: 1. Resident #32's diagnoses included alcohol induced dementia, anxiety disorder and adjustment disorder. The quarterly MDS assessment dated [DATE] identified Resident #32 had moderate cognitive impairment, had no behaviors, required moderate assistance with personal hygiene, dressing, independent with bed mobility, transfers and ambulation. The physician's orders dated 6/3/24 directed to discontinue one to one constant observation and start every 15 minutes checks for 48 hours. The physician's order dated 6/11/24 directed every 15 minutes checks for 48 hours until 6/12/24 at 3:00 PM. The nurse's note dated 6/11/24 at 1:47 PM identified that Resident #32 remains on every 15 minutes checks until 6/12/24 at 3 pm. Review of the nurse's noted dated 6/11/24 at 11:01 PM and 6/13/24 at 11:10PM identified that Resident #32 continued every 15minute checks. A request was made to the facility on [DATE] throughout the day for the one-to-one observation and every 15 minutes check for Resident #32 for the incidents that occurred in June 2024, which the facility failed to provide. Another request was made on 10/24/24 at 8:11 AM to the DNS and at 8:15 AM to the ADNS. The DNS at 3:20 PM indicated that they were unable to locate the flowsheets. Another request was made on 10/25/24 at 11:31 AM for the for the one-to-one observation and every 15 minutes check for Resident #32 in which the facility only provided flowsheets dated from 6/3/24 to 6/9/24. Interview with the ADNS on 10/23/24 at 2:00 PM identified that one-to-one observation and every 15 minutes check sheets are stored in the physical chart. The ADNS reviewed the physical chart thoroughly with the surveyor and was unable to locate the flowsheets. The ADNs then indicated that she would check with the medical records department. Interview with NA #3 on 10/23/24 at 2:35 PM identified that when a resident is placed on one-to-one observation and every 15-minute checks the sheet is placed on a clipboard for the nurse aides to document after which the nurse would review the paperwork and place it in a binder. on the unit and file then in the resident's chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the charge nurse LPN #7 on 10/25/24 at 10:31 AM identified that after the on one-to-one observation and every 15-minute check the sheet was completed it was placed into a bin and in front of the binder on the unit for medical records to file in the resident's chart. Review of the Close Observation policy identified that initiation checks must be documented in an appropriate location in the clinical records. Review of the facility policy for chart order and thinning/retention guidelines identified active residents' paperwork should be kept on the unit. 2. Resident #59's was admitted to the facility on [DATE] and had diagnoses that included Major Depressive Disorder recurrent severe with psychotic symptoms, Schizoaffective Disorder, Polyneuropathy, and Extrapyramidal and movement disorder unspecified. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was cognitively intact, had no behaviors, was independent with all hygiene, dressing, eating, transfers antianxiety and antidepressant medication. The care plan dated 6/18/24 (this resident has not had an RCC to date) identified Resident #59 was at risk for behaviors related to psychiatric disorders and taking therapeutic psychotropic medications. Interventions to encourage participation in behavioral program and recreational groups, to reside on a secured unit, to monitor behaviors, and to provide Mental Health Professional services as indicated. Physician's orders dated October 2024 directed to administer clonazepam, an antianxiety medication, 0.5mg one time in the morning, clonazepam 1mg one time at bedtime, Escitalopram, an antidepressant medication, 20mg one time each day, mirtazapine, an antidepressant medication, 15mg once nightly, Quetiapine, an antipsychotic medication, 400mg once nightly. Review of social services progress notes dated 6/19/24 through 10/24/24 failed to identify contact made with Resident #59's conservators of person regarding completion of admission paperwork to include code status, consents for treatment, vaccinations, secured unit residency consent, and Psychiatric consent. Review of nursing progress notes dated 6/19/24 through 10/24/24 failed to identify any contact with the resident's conservator regarding admission to the facility. Review of the Resident's clinical chart on 10/22/24, which included the paper chart and two electronic health records, failed to contain conservator paperwork, signed copies of the admission paperwork, behavioral program unit resident review, and behavioral program participation agreement. Interview on 10/23/24 at 10:23 AM with SW#2 identified the RN supervisor was responsible to have the consent paperwork signed by the conservator on admission. Following her review of the clinical record SW#2 identified the admission paperwork, to include the advance directive, consent for treatment, consent for residing on a secured unit and behavioral unit assessments were not present in the resident's chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/24 at 10:40 AM with SW#1, Social Work Director, identified all assessments and admission paperwork should be present in the clinical chart. Subsequent to surveyor inquiry on 10/25/24 at 3:00 PM, SW#2 provided copies the consent to voluntarily reside on a secure unit dated 6/19/24 with verbal consent written in on the conservator signature line. SW#2 identified she had completed the admission paperwork the day after admission and had placed them in an individual file in SW#2's office. The paperwork provided included the behavioral program unit resident review, signed copies of the admission paperwork, and behavioral program participation review. She identified there should be copies in the clinical record. Additionally, she provided conservator paperwork from the court of probate that was signed by the judge 10/24/24. 3. Resident #78 was admitted to the facility 10/14/20. Diagnosis included Diffuse traumatic Brain injury without loss of consciousness, Vascular dementia unspecified severity with other behavioral disturbance, anxiety disorder due to known physiological condition. The quarterly MDS dated [DATE] identified the resident had severely impaired cognition, did not exhibit inattention, disorganized thinking, or altered level of consciousness. The Care plan dated 9/13/24 identified Resident #78 was at risk for Behavioral Health and participated in the Behavioral Health Program related to depressive disorder, bi-polar, and anxiety. Interventions included placement on a secured unit, and to monitor for psychotropic medication side effects. Physician's orders dated 10/12/24 directed to administer 50 mg of trazodone every night at bedtime, 1mg of risperidone twice per day, 850 mg of Metformin once a day, 200 mg of Lamotrigine once a day, 0.1 mg Fludrocortisone once a day, 250 mg Divalproex Delayed Release once every 12 hours, 1mg of Clonazepam three times a day, 2.5 mg Bromocriptine once a day, 40 mg of atorvastatin once a day, and 100 mg of amantadine twice a day. Additional medications included over the counter medications. Review of the Pharmacy progress notes dated 3/3/26/24, 4/16/24, 7/22/24, and 9/25/24 identified the Pharmacy review was completed, and recommendations were made to the provider. Review of the clinical chart on 11/23/24 at 12:00 PM, included the paper chart and 2 electronic health records, failed to produce the above listed pharmacy reviews with the recommendations, and failed to contain lab results for the resident. Interview on 10/25/24 at 11:15 AM with the DNS and Regional Clinical Director identified the recommendations were not all in the charts at that time and the facility was in the process of redoing the process for the processing of pharmacy recommendations. They identified the process for pharmacy recommendations was as follows: a. The recommendations are emailed to the DNS and ADNS. b. Whomever is reviewing prints the recommendation, makes a copy and gives a copy to the APRN c. The APRN will sign off on them and agree or disagree with the recommendations and give it back to the DNS. d. The DNS makes a copy, keeps one copy and places the other into the resident chart. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The APRN makes changes, if needed, and the DNS checks for implementation. Interview on 10/25/24 at 1:31 PM with the Regional Clinical Director identified that the recommendations were reprinted and indicated they were not signed by the APRN. She identified that she was reviewing the charts to see if the recommendations were implemented. The facility policy for chart order and thinning/retention guidelines identified active residents' paperwork should be kept on the unit. Advance directives, consents to treat for the facility or psych group, and all care plans are permanent and should not be removed from the clinical chart. Pharmacy recommendations should include the current 1 year. The Consultant Pharmacist Service Agreement identified the pharmacy consultant shall be responsible for the performance of each resident's drug regimen review monthly, with reports of all findings or irregularities to the Director of Nursing for distribution to the attending Physician. 47900

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 47900 Based on review of facility documentation, review of facility policy and interviews, reviewed for the infection control and prevention program, the facility failed to ensure that the annual water management plan meeting was conducted. The findings include: Review of the facility Water Management Plan for 2023 to 2024 with the Director of Maintenance on 10/24/24 at 2:23 PM failed to identify that the facility had a water management meeting to review the updated and revised plan provided by the company that was contracted by the facility to manage the facility's water management plan. Review of the safety committee meeting minutes dated 5/29/24 identified that the water management meeting (quarterly) was schedule to be completed on 7/12/2024. Interview with the Director of Maintenance on 10/24/24 at 3:27 PM identified that it was the policy of the facility to have an annual meeting to discuss and review the water management plan revision and update provided by the contracted company. The Director of Maintenance identified that the meeting was not done as he lost track of time, as the meeting was to be held in July. Interview with the Administration on 10/25/24 at 1: 54 PM identified that the water management was not completed, as it was the practice that in the safety committee meeting minutes, the minutes would have identified what was discussed regarding the water management plan based on his experience in working for this company. Review of the Annual Water Management Plan Revision and Updates dated 7/12/23 and 7/11/24 that was provided to the facility by the contracted company identified that the water committee shall meet and review the water management plan, record the topics discussed and record meeting minutes with signatures of attendees, which meeting minutes are conducted by the facility. Review of the Water Management Plan policy identified that environmental assessments shall be updated annually.