STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075274	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Danbury	107 Osborne Street Danbury, CT 06810

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 residents (Resident #34) who expressed the desire to self-administer medications, the facility failed to complete a self-administration assessment and obtain a physician's order, according to facility policy, to ensure the resident was safe to self-administer medications. The findings include: Resident #34 was admitted to the facility in September 2024 with diagnoses that included hyperkalemia, end stage renal disease requiring dialysis, and chronic obstructive pulmonary disease. The admission MDS dated [DATE] identified Resident #34 had intact cognition. Resident #34 required maximum assistance with toileting, dressing, and personal hygiene. The nurses note dated 2/20/25 at 3:44 PM identified Resident #34 was changing rooms and wanted to be present during moving of personal belongings. The care plan dated 2/25/25 identified Resident #34 has end stage renal disease. Interventions included communication to dialysis regarding weights, medications, diet, lab results, etc. Additionally, Resident #34 has COPD with interventions to provide medications as needed. The monthly physician's orders dated 4/1/25 to 4/30/25 directed to administer Lokelma powder packet 5 grams give 3 packets equaling 15 grams at 6:00 PM, DuoNeb 0.5mg-2.5mg in 3 ml vial in inhalation machine use 4 times a day, and Albuterol/Ventolin HFA 90 mcg aerosol inhaler take 2 puffs every 6 hours as needed. Observation on 5/4/25 at 8:40 AM identified the Albuterol inhaler was visible on the bedside table. Additionally, Resident #34 has 3 packets of Lokelma on top of the dresser and the top dresser draw that was open completely contained 2 - 4 Lokelma packets and multiple vials of nebulizer treatments. Resident #34 indicated he/she uses the Ventolin inhaler prior to receiving the nebulizer treatments and when he/she feels short of breath. Resident #34 indicate that the nurse gave him/her the inhaler to use when he/she needed. Resident #34 indicated that he/she takes one packet of 5 grams of Lokelma and mixes it in a cup of water with every meal and has done that independently since he/she was admitted into the facility. Resident #34 indicated that he/she gets the packets from the nurses. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 5/5/25 at 7:44 AM indicated that there currently weren't any residents in the facility that self-administer any medications or inhalers. The DNS indicated that if someone could do self-administration, the resident would have to be assessed, and it would be done on paper, and the physician would have to agree and give the orders for that specific medication, and resident would receive a lock box for the medication. The DNS indicated that Resident #34 does not have a self-administration assessment done and is not permitted to self-administer any medications since admission until now. Interview with Resident #34 with the DNS present on 5/5/25 at 7:55 AM indicated that his/her Ventolin inhaler and the Lokelma packets were visible by standing at the foot of the bed. Resident #34 indicated that he/she uses the Ventolin inhaler when he/she needs it and before his/her nebulizer treatments because he is not going to wait 30 minutes for the nurse when he/she is having difficulty breathing and the inhaler is from the facility pharmacy. Resident #34 indicated that he/she has been using the inhaler independently since admission in September 2024 when it runs out the nurses will give him/her another one from the medication cart and he/she takes 1 packet of Lokelma 3 times a day with each meal. Resident #34 indicated that the nurses give it to him/her and he/she mixes it in a cup of water and has been doing it independently in the facility since admission. Resident #34 identified he did not have a lock box for the medications. The interview with RN #1 (corporate) on 5/5/25 at 8:19 AM indicated she has removed all the medication from Resident #34's bedside, and she will do a self-administration assessment with Resident #34 and if appropriate she will notify the physician and get physician's order for self-administration, get a lock box for the medications, and revise the care plan. RN #1 indicated that the admission nurse should have done a self-administration assessment or when the resident requests to do self-administration of any medications. RN #1 indicated that the LPN can do the self-administration observation because it is in EMR as an observation but if it was an assessment it would have to be done by an RN. The nurses note dated 5/5/25 at 11:40 AM identified Resident #34 requests self-administration of Lokelma, Budesonide, Albuterol and Ventolin inhaler. Notified APRN and he approved of self-administration. Resident #34 was educated by writer and APRN on medication administrations safety. Resident able to name medications, dosage, strength, frequency/schedule and purpose of medications. Resident #34 verbalized understanding of education and competency. Locked drawer and key provided to Resident #34 for medication storage safety. Review of the facility Medication at the Bedside identified nurses are not to leave any medications at the resident's bedside unless there is a physician's order stating may leave at bedside. The risks are harmful to the residents from omitting the dose, doubling a dose later, or mixing the medication. Additionally, other residents are at risk due to sharing, rummaging, or being medicated by the residents who kept the medication at their bedside. When a resident is requesting to keep medications at the bedside the facility is obligated to complete a self-administration observation, obtain an order from the provider, care plan that medication(s) can be left, and document it in the medical record. All medications must be secured and always locked when not in use. Although requested, a facility policy for resident self-administration of medication(s) was not provided.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #34 and 59) reviewed for code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops), the facility failed to ensure the resident's wishes for code status were honored. The findings include: 1. Resident #34 was readmitted to the facility in [DATE] with diagnoses that included end stage renal disease, abnormal weight loss, protein-calorie malnutrition, opioid dependance, bipolar, major depression, chronic obstructive pulmonary disease, hyperkalemia. The admission physician's order dated [DATE] directed full code status (full code directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency). The admission MDS dated [DATE] identified Resident #34 had intact cognition, and required maximum assistance with toileting, dressing, and personal hygiene. The care plan dated [DATE] identified Resident #34 had full code status. Interventions included making staff aware of his/her code status and social services to review code status with the resident quarterly and as needed. Interview with Resident #34 on [DATE] at 7:00 AM indicated that at the hospital he/she was a full code and wanted to continue as full code. Resident #35 indicated that no one at the facility since admission in [DATE] had talked to or educated him/her on code status or has had him/her sign any forms for a code status. Interview with the DNS on [DATE] at 7:20 AM indicated the charge nurse or supervisor should educate and have the resident sign for a code status on the day of admission. The DNS indicated there was an old form for full code status and then a second form for DNR status, but as of [DATE] there is a new form including both. The DNS indicated when a resident is found unresponsive and has no heart rate, the charge nurse would stay with resident, and have another nurse check the computer first then the chart whichever is easier to get or verify the code status. After clinical review, the DNS indicated that there was no code status designation in the medical record and that Resident #34 had not signed a code status form. 2. Resident #59 was admitted to the facility in [DATE] with diagnoses that included cystitis, multiple sclerosis, and diabetes. The annual MDS dated [DATE] identified Resident #59 had moderately impaired cognition. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated [DATE] directed to advise resident or resident appointed health care representative to provide copies to the facility of any updated advance directives. Resident #59 has on record full code status. A Do Not Resuscitate Form identified Resident #59 had discussed the concept of a DNR with MD #1 and the staff at the facility, and knowingly and voluntarily requested DNR status. This means that no CPR measures will be administered at facility if cardiac or respiratory arrest occurs. The form was signed by Resident #59 and LPN #10 on [DATE] and MD #1 on [DATE]. The monthly physician's order dated [DATE] to [DATE] directed Resident #59 be full code status. The quarterly care conference notes dated [DATE], [DATE], [DATE], [DATE], [DATE] did not reflect that code status was discussed in the meeting or what Resident #59's wishes were. The census form identified Resident #59 went to the hospital on [DATE] and returned to the facility on [DATE]. The monthly physicians order dated [DATE] to [DATE] identified Resident #59 was full code status. The care plan dated [DATE] identified Resident #59's code status was full code and to perform CPR. Interview with LPN #14 on [DATE] at 12:28 PM indicated that she was Resident #59's charge nurse today from 7:00 AM until 3:00 PM and if Resident #59 had no pulse and was not breathing, she would check the face sheet list in the EMR on the medication cart for the code status, which lists Resident #59 as a full code, so she would start CPR. Interview RN #10 (supervisor) on [DATE] at 12:36 PM indicated that she works every weekend and today was working 16 hours from 7:00 AM until 11:00 PM as the supervisor. RN #10 indicated if a resident was to code she would look in the computer first and if close to the nurse's station the paper chart. RN #10 indicated when she arrived at the unit, if the charge nurse informed her Resident #59 was a full code she would immediately go to Resident #59 check for a pulse and if the resident had no pulse she would start CPR. RN #10 indicated if the charge nurse did not know the code status, she would look in the EMR under the face sheet for the code status and it identifies Resident #59 is a full code. After clinical record review, RN #10 indicated that Resident #59 was admitted and signed a full code on [DATE] but then Resident #56 signed a code status of DNR on [DATE] and MD #1 signed it on [DATE]. RN #10 indicated that she would have to follow the most current code status of a DNR. Interview with LPN #10 on [DATE] at 1:01 PM indicated she discussed the code status with Resident #59 on [DATE] and Resident #59 signed that his/her wish was to be a DNR, and she signed as the witness. LPN #10 indicated she then leaves the signed DNR form it in the APRN and physician book for the APRN or physician to sign it. After reviewing the form, she indicated that MD #1 had signed the DNR form on [DATE] and it was the responsibility of the nurse that was on duty on [DATE] to put in the EMR as the physician order for the DNR code status. LPN #10 indicated she did not know why that did not happen. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on [DATE] at 7:20 AM indicated that the nurse or supervisor on admission or readmission was responsible, upon arrival to the facility, to have the resident or resident's representative sign the code status or call the resident representative for a code status if not present. The DNS indicated that prior to [DATE] there were 2 separate forms, one for a full code and one for a DNR. The DNS indicated that if a resident was found not breathing and no pulse the nurse would check resident for a pulse and if breathing and stay with the resident and have another nurse check the computer for the code status and then the chart, whichever is easier to get the code status. After clinical review, the DNS indicated the most recent is a DNR signed by the Resident #59 on [DATE], the nurse that signed as the witness LPN #10 should have called the APRN or physician to change the order from a full code to a DNR on [DATE] and then leave in the communication book for MD #1 to sign. The DNS indicated the EMR identified Resident #59 as a full code. Even though Resident #59's wish was to be a DNR. The DNS indicated that she would get this corrected. Although attempted, an interview with APRN #3 was not obtained. Review of the facility Advance Directive Policy identified upon admission the resident will be provided with written information concerning the right the right to refuse or accept medical treatment. Advanced directives are written instructions recognized by state law relating to the provisions of health care when the resident is incapacitated. The resident has the right to refuse a resident will not be treated against his/her own wishes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #37) reviewed for pressure ulcers, the facility failed to ensure that the physician and resident representative were notified following a newly identified skin issue. The findings include: Resident #37 was admitted to the facility on [DATE] with diagnoses that included hemiplegia of the left side, insulin dependent diabetes, and dementia. A physician's order dated 4/5/23 directed to complete weekly skin checks on Wednesdays on the 3:00 PM - 11:00 PM shift and to complete a weekly skin observation if any new areas were identified. The quarterly MDS dated [DATE] identified Resident #37 had moderately impaired cognition, was always incontinent of bowel and bladder and required staff to provide moderate assistance with toileting, dressing, and bathing. The care plan dated 11/5/24 identified that Resident #37 had a potential for alteration in skin integrity. Interventions included complete skin assessments of the body upon admission, weekly, and as needed. The interventions also included reporting any changes in skin status to the physician. A Braden Scale (Braden Scale is a tool used to assess a resident's risk of developing a pressure ulcer) dated 12/15/24 identified Resident #37 was at moderate risk to develop pressure ulcers. A nurse's note dated 12/15/24 at 4:47 AM, by the Prior DNS, identified that she was working on the 11:00 PM - 7:00 AM shift to assist a nurse aide with completion of competencies and that Resident #37 was part of the assignment. The Prior DNS identified that while performing incontinent care, she discovered a non-blanchable area of redness on Resident #37's sacrum that measured 2cm x 1.3cm x 0.0cm. The Prior DNS identified she performed a head-to-toe assessment and no other non-blanchable areas were present. The Prior DNS identified she would put interventions into place including a specialty low air loss (LAL) mattress, turn and positioning schedule, toileting/incontinent care schedule, and application of barrier paste. The Prior DNS also identified she would discuss Resident #37's wheelchair cushion with the rehab department. Review of the 12/2024 TAR identified a treatment order for application of house barrier ointment after each incontinent episode every shift and as needed was implemented on 12/15/24. A nurse's note dated 12/15/24 at 9:58 AM identified that the Prior DNS identified she spoke with the therapy department, who were no longer working with Resident #37 but confirmed that Resident #37 had a ROHO cushion in place. The DNS identified she would be initiating a physical therapy (PT)/occupational therapy (OT) evaluation screening. Review of the clinical record failed to identify any documentation that a PT/OT evaluation screening was requested or completed on or after 12/15/24. Review of the clinical record failed to identify a specialty LAL mattress was implemented on or after 12/15/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any additional documentation related to additional assessments of the non-blanchable area on the sacrum identified on 12/15/24. Review of the clinical record failed to identify any documentation related to notification to Resident #37's physician or resident representative regarding the newly identified non blanchable area on the sacrum on or after 12/15/24. Review of the 12/2024 TAR identified Resident #37's weekly skin check signed off on 12/18/24 on the 3:00 PM - 11:00 PM shift. Further review of the clinical record failed to identify any observation documentation of Resident #37's sacrum. A nutrition note dated 12/19/24 at 2:33 PM identified that Resident #37 was seen for a non-blanchable area of redness to the sacrum identified on 12/15/24. Recommendations included initiation of a carbohydrate-controlled diet for improved blood sugar control and initiation of Proheal 30ml to aid in wound healing. A nurse's note dated 12/19/25 at 7:37 PM by RN #11 (Agency) identified that Resident #37 was seen by the dietitian for concerns about a non-blanchable area of redness on the sacrum on 12/15/24. The identified recommendations included initiating a carbohydrate-controlled diet for improved blood sugar control and starting Proheal (a protein supplement used to add in wound healing) twice daily to aid in wound healing. The note further identified the orders were implemented in Resident #37's record. Review of the 12/2024 TAR identified an order for Proheal 30ml twice daily which was started on 12/19/24 to be given twice daily at 9:00 AM and 5:00 PM. Review of the clinical record failed to identify any additional documentation or interventions related to the non-blanchable area on the sacrum after 12/19/24. Interview with LPN #3 (Regional Corporate LPN) on 5/5/25 at 11:00 AM identified she was unable to locate any additional documentation related to further assessments of Resident #37's non-blanchable sacral area following the initial documentation on 12/15/24. LPN #3 identified that Resident #37 had an order for a weekly skin check. LPN #3 identified that the facility policy was that the skin checks were signed off on the TAR weekly and only issues that were identified were documented as a skin observation. LPN #3 identified that Resident #37's physician or APRN should have been notified of the new skin issue as well as Resident #37's resident representative and the non-blanchable skin area should have been followed and assessed at least weekly once it was identified. Interview with APRN #2 on 5/7/25 at 9:05 AM identified she was not notified of the non-blanchable sacral area identified by the prior DNS on 12/15/24. APRN #1 identified that while the interventions implemented by the Prior DNS appeared to be appropriate, if she had been notified, she would have assessed the area or requested that the RN who works with her and alternates visits to the facility to assess the area and notify her of the findings. APRN #2 identified that a non-blanchable area to the sacrum as identified in the Prior DNS's note would possibly have been a pressure ulcer, but she would have needed to assess the area to be sure however she was not notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 5/7/25 at 9:10 AM identified she was the facility wound nurse on 12/15/24. LPN #1 identified she had not been notified regarding the non-blanchable area on Resident #37's sacrum identified on 12/15/24. LPN #1 identified that the process for any newly identified skin area that could potentially be a pressure injury included adding the resident to the upcoming weekly wound rounds so that the wound physician could assess and determine the next steps in treatment. LPN #1 also provided a weekly wound round list dated 12/18/24. Review of the 12/18/24 weekly wound round list failed to identify any documentation that Resident #37 was added to the list to be seen by the wound physician. Review of the 24-hour nursing report sheets from 12/15/24 - 12/20/24 failed to identify any additional documentation related to the non-blanchable area on the sacrum. Although attempted, an interview with the Prior DNS was not obtained. Although attempted, an interview with RN #11 was not obtained. The facility policy on change in a resident's condition or status directed that a significant change of condition included a major decline or improvement in the resident status that required interdisciplinary review and or revision to the care plan and impacted more than one area of the residence health status. The policy directed that prior to notifying the physician or health care provider, the nurse would make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the interact S bar communication form. The policy also directed that the nurse would notify the resident's attending physician or physician on call when there was a significant change to the residents' physical emotional or mental condition. The policy also directed that except in medical emergencies notifications would be made within 24 hours of a change occurring in the resident's medical mental condition or status. The policy directed that unless otherwise instructed by the resident, the nurse would also notify the resident representative when there was a significant change in the residence physical mental and psychosocial status.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #79 and 87) reviewed for abuse, the facility failed to ensure the residents were free from verbal and physical abuse by another resident. The findings include: 1a. Resident #79 had diagnoses that included dementia and mild neurocognitive disorder with behavioral disturbance. The quarterly MDS dated [DATE] identified Resident #79 had severely impaired cognition and was independent with ambulation. The care plan dated 3/4/25 identified Resident #79 had behavioral symptoms related to dementia, inappropriate behaviors towards staff and other residents, agitation, and verbal behaviors. Interventions included psychiatry for increased aggression and approach resident in a calm manner. b. Resident #91 had diagnoses that included dementia and history of traumatic brain injury. The quarterly MDS dated [DATE] identified Resident #91 had memory problems with continuous inattentiveness and disorganized thinking and was independent with ambulation and toileting. The care plan dated 12/26/24 identified Resident #91 behavioral symptoms including wandering and intrusiveness. Interventions included encouraging diversional activities and encourage to walk with staff when possible. Physician's orders dated 3/1/25 directed independent ambulation on the unit without an assistive device. A reportable event form dated 3/4/25 identified at 5:00 PM, Resident #79 and Resident #91 were walking in the hallway, and Resident #79 said to Resident #91 that he/she was going to (kick his/her a**). Resident #91 said stop and put his/her right hand around Resident #79's neck slightly and pinned Resident #79 against the wall for two seconds. No injuries were sustained. Resident #91 was placed on 1:1 enhanced monitoring. The physician, police and resident representative were notified and Resident #91 was subsequently transferred to the emergency department. A late entry nurses note dated 3/5/25 at 5:15 PM completed by LPN #9 identified Resident #79 was observed walking in the hallway in front of Resident 91 and then stopped. Resident #91 asked Resident #79 to move. Resident #79 stated he/she was not going to move and to f*** off. Resident #91 grabbed Resident #79 around the neck, loosely. LPN #9 was immediately able to release and remove Resident #91's hand. No injury was noted. Both residents were separated without further issue. Psychiatric evaluation dated 3/6/25 identified Resident #79 was unable to remember the event. Medication adjustments were made to address behaviors with ongoing monitoring in place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79's care plan was further revised to attend recreational activities between 3:00 PM and 5:00 PM, to use distraction techniques and remove potential triggers. Resident #91's care plan was revised to include moving to a separate floor and to monitor hallway dynamics for known behaviors and intervene if needed. An interview with NA #1 on at 5/6/25 8:18 AM identified she was working during the 3:00 PM to 11:00 PM shift on 3/4/25 but was not assigned to Resident #79 or Resident #91. NA #1 indicated it was a busy night on the dementia unit. Residents were sundowning (a term used to describe increased agitation and restlessness in the late afternoon/early evening for those with dementia). NA #1 had just walked up to the nurse's station when she observed Resident #91 walk past her in the hall, pacing as he/she normally does. Resident #79 was also in the hall approximately 10 feet away from the nurse's station, standing with other residents, yelling out and using profanities. NA #1 further identified she was unclear of what was being said as the profanities were not directed at anyone particular and not unusual for Resident #79. NA #1 heard screaming, turned around and observed Resident #91 with his/her hands just below the base of Resident #79's neck. NA #1 and the nurse, LPN #9 quickly intervened. Resident #91 released after approximately 10 seconds. Other staff also intervened, and both residents were separated. NA #1 identified Resident #91 had never previously been involved in any other resident to resident altercations that she was aware of. An interview and facility documentation review with the Administrator on 5/6/25 at 2:19 PM identified prior to this incident, Resident#91 had not displayed any aggressive behaviors towards other residents and has not since. The Administrator further identified the interdisciplinary team initiated a plan of correction for licensed, nurse aides and all agency staff in response to the resident-to-resident altercation. However, the education provided was limited to staff on duty between 3/4/25 through 3/6/25 and was not inclusive of all staff working from 3/6/25 forward. The Administrator alleged correction of past noncompliance with continued biweekly audits in place monitoring combative behaviors. The Administrator indicated she would expect that all residents be free from abuse. A review of the facility policy for abuse directs the facility to provide protection for the health, welfare and rights of each resident to prevent abuse defined as the willful infliction of injury. Attempts to interview LPN #9 were unsuccessful. A plan of correction with an alleged compliance date of 3/6/25 was initiated following the resident-to-resident altercation. Actions taken included immediate separation of residents with Resident #91 moving to a separate floor, medical and behavioral response with ongoing support services. Care plans were updated to include triggers and de-escalation strategies, increased monitoring and staff awareness, cues, enhanced documentation of mood and behavior. Resident #91 was placed on 1:1 monitoring during waking hours and every 15 minute checks while in his/her room post hospital discharge until stability was observed. Education was provided to licensed and nurse aide staff for recognizing early signs of agitation or conflict and managing interpersonal interactions, promote respectful communication, preventing conflict and support emotional wellbeing. A Quality Assurance and Performance Improvement (QAPI) was initiated to track behavior and monitor trends and trigger proactive interventions. Education was limited only to staff on schedule between 3/4/25 and 3/6/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.a Resident #1 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder and dementia. The quarterly MDS dated [DATE] identified Resident #1 had intact cognition, reported feeling down, depressed, or hopeless 2 - 6 days over the last 2 weeks, and did not exhibit physical or verbal behavioral symptoms directed towards others. The care plan dated 3/4/25 identified Resident #1 had symptoms/needs related to depression. Interventions included maintaining a calm environment and setting limits and expectations for behavior. The nurse's note dated 3/10/25 identified at 2:55 AM the nurse reported that the Resident #1 was wailing and said he/she wanted to kill him/herself. The writer confirmed the statements were true with Resident #1, he/she answered yes but refused to answer additional questions. The APRN was notified and an order to transfer the resident to the emergency department for evaluation was obtained. Resident #1 was transferred to the emergency department at 3:30 AM via stretcher, accompanied by 3 EMS staff members. The nurse's note dated 3/10/25 at 4:48 AM identified that Resident #1 was transferred back from the emergency department. The facility staff sent Resident #1 back to the emergency department with the paramedic because the resident was not sent with clearance papers from the psychiatric provider. The nurse's note dated 3/10/25 at 5:49 AM identified that Resident #1 was sent back from the emergency department at 5:22 AM with clearance paperwork that he/she was not a danger to self or others. The resident was treated with Trazadone 50mg in the emergency department with recommendations to follow up with attending physician per emergency department recommendation. The emergency department paperwork dated 3/10/25 identified Resident #1 was evaluated on 3/10/25 and did not appear to be a threat to him/herself or others, and at this time it was recommended that the patient could return to his/her current living conditions and resume the maintenance of his/her current medications. b. Resident #87 was admitted to the facility on [DATE] with diagnoses that included arthrodesis status and spondylolisthesis. The admission MDS dated [DATE] identified Resident #87 had intact cognition and required moderate assistance with walking 10 feet. The care plan dated 2/25/25 identified Resident #87 had complaints of acute back pain related to back surgery. Interventions included handling the resident gently and trying to eliminate any environmental stimuli. The nurse's note dated 3/10/25 at 8:22 AM identified Resident #87 notified the writer that Resident #1 threw a remote control at him/her while he/she was in bed. The remote control hit Resident #87 on the left side of the face and the resident sustained a 5cm x 2cm bruise. No open area was observed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The reportable event form dated 3/10/25 identified that Resident #1 and Resident #87 were roommates. Resident #1 was transferred to the emergency department for suicidal ideation on 3/10/25 at 3:30 AM. Shortly after returning to the facility, Resident #1 was in his/her room, the nurse aide passed by and heard Resident #1 talking to him/herself, and then Resident #1 left and went to the lounge. After a couple of minutes Resident #1 returned to the room, went into bed, and continued to talk to him/herself. Resident #87 reported that Resident #1 was unhappy most of the day on 3/9/25. Resident #87 also said that Resident #1 kept repeating that another resident was telling everyone he/she had money. Resident #87 said he/she tried to ignore Resident #1, and on the early morning of 3/10/25 another resident came into their room, and Resident #87 offered the other resident some chips, and when Resident #1 saw the other resident, he/she appeared to be upset, and started saying to Resident #87, that's why you became pregnant, and have 15 children, and they are *profanity used*. Resident #87 said he/she then reported what Resident #1 was saying to the nurse, Resident #87 left the room, and later returned to the room to have labs drawn, and as Resident #87 sat on the bed, Resident #1 threw the remote-control hitting Resident #87 on the side of the face. Resident #87 then yelled out for the nurse, and the staff came immediately, removed Resident #87 out of the room, and Resident #1 was transferred to the hospital. Interview with Resident #87 on 5/4/25 at 10:00 AM identified that on the evening of 3/9/25 Resident #1 was starting to have some behaviors, and then on 3/10/25 between midnight and 2:00 AM, Resident #1 started saying he/she was going to kill him/herself, and then Resident #1 was transferred to the hospital. Resident #87 indicated that Resident #1 returned from the hospital about an hour or 2 later, began pacing the hallways, and had awoken other residents, one of which was a male resident that wandered into their room asking for a snack. Resident #87 indicated that Resident #1 returned to their room as the male resident was exiting the room with a snack, Resident #1 returned to his/her bed, and started yelling at Resident #87 that he/she was a *profanity used*, had *profanity used* children, and that he/she hoped Resident #87 would die. Resident #87 indicated that he/she was trying to ignore Resident #1, and then Resident #1 threw a remote control, from a 3 - 4-foot distance, striking Resident #87 on the side of the head, behind the left ear. Resident #87 indicated that he/she left the room immediately and Resident #103 (who lived directly across the hall) witnessed the event and started calling for help. Resident #87 identified that he/she was assessed by a nurse, declined going to the hospital for further evaluation, and requested an immediate room change; Resident #1 was transferred back to the hospital. Interview with Resident #1 on 5/4/25 at 10:50 AM identified that he/she had gotten along with his/her old roommate; it just didn't work out. Resident #1 indicated that while he/she tries not to get into arguments with other residents, he/she was not sure that he/she has friends at the facility. Interview with the Administrator on 5/5/25 at 1:08 PM identified that the incident between Resident #1 and Resident #87 was an isolated incident and after completing their investigation, the facility was not able to substantiate abuse, as Resident #1 did not intentionally try to hurt Resident #87. Resident #1 was feeling slighted that Resident #87 had shared chips with another resident. The Administrator indicated that just prior to the alleged incident, Resident #1 was evaluated at the hospital, after making suicidal remarks, and had received psychiatric clearance that he/she was safe to return to the facility and did not pose a threat to him/herself or others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Supervisor (RN #7) on 5/06/25 at 9:59 AM indicated that she did not have her notes in front of her but from what she could remember on 3/10/25, Resident #1 was having behavior issues, and he/she stated that he/she wanted to kill him/herself. RN #7 indicated that she sent Resident #1 to the emergency department around midnight for talk of suicidal ideation, and the hospital sent Resident #1 back to the facility about 30 minutes later, with no papers indicating that he/she had been cleared by a psychiatric provider. RN #7 further indicated that she sent Resident #1 back to the hospital for psychiatric clearance; Resident #1 was then sent back to the facility, after approximately 30 minutes, with the paperwork that he/she was cleared and did not pose a risk to her/himself or others. RN #7 identified that she re-assessed Resident #1 upon admission and he/she was not agitated at that time. Approximately an hour later the floor nurse notified her that Resident #1 threw a remote control at Resident #87. RN #7 indicated that she identified a small bruise during her assessment of Resident #87's head. RN #7 further indicated that she tried to make Resident #87 comfortable, but he/she indicated that he/she was fine, and Resident #1appeared calm and was returned to the hospital. Interview with the Charge Nurse (LPN #6) on 5/06/25 at 11:11 AM identified that he did not have his notes in front of him, but from what he could recall on 3/10/25, he checked Resident #1's vital signs when he/she returned from the hospital, and Resident #1 was calm and did not appear agitated. LPN #6 indicated that, sometime later, while he was providing care to another resident, he heard yelling and loud talking from many residents. LPN #6 indicated that he went to see why residents were yelling, he saw Resident #87 being assisted out of his/her room (could not recall by whom), and when he asked what had happened Resident #87 reported to him that Resident #1 threw a remote control at his/her head. LPN #6 could not recall if he looked at Resident #87's head, but he notified the Nursing Supervisor. LPN #6 identified he recalled that something triggered Resident #1 to become agitated, but he could not recall what the trigger was. Interview with Resident #103 (intact cognition) on 5/7/25 at 8:25 AM identified that a few months ago (could not recall the exact day or time of day), Resident #1 was sent out to the hospital for emotional reasons and then came back to the facility. Resident #103 further indicated that, at that time, Resident #1 and #87's room was directly across the hall, and he/she had been sitting in his/her wheelchair and could see their room. Resident #103 identified that approximately half hour to one hour after Resident #1 returned to the facility, he/she heard Resident #1 expressing her/himself loudly and started to say nasty things to Resident #87. Resident #103 identified that he/she saw Resident #1 pick up an object and throw it, hitting Resident #87 right at the back of his/her head, Resident #1 had good aim. Resident #103 indicated that he/she began yelling for help, and Resident #87 was assisted out of the room. The Abuse, Neglect, and Exploitation policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations, and defines willful as the individual must have acted deliberately, not that the individual must have intended to inflict harm or injury. The policy further directs that the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, and misappropriation of resident property, and exploitation that achieves, in part, identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #46 and Resident 50) reviewed for hospitalization, the facility failed to provide written notice of the bed hold policy to the resident representative when the resident was transferred to the hospital. The findings include: 1. Resident #46 had diagnoses that included congestive heart failure and dementia. The resident census identified the following hospital transfers for Resident #46: Resident #46 was transferred to the hospital on 3/10/25 and returned to the facility on 3/15/25. Resident #46 was transferred to the hospital on 3/19/25 and returned to the facility on 3/22/25. Review of the clinical record failed to identify that written notice of the bed hold policy had been provided to the resident/representative at or following the time of the transfers on 3/10/25 and 3/19/25. An interview with the Administrator on 5/5/25 at 10:54 AM identified it was the nursing staff responsibility to ensure the bed hold policy was provided to the resident/resident representative at the time of the hospital transfer. An interview and clinical record review with RN #5 on 5/05/25 at 11:00 AM identified her role as a nursing supervisor normally scheduled for the 7:00 AM to 3:00 PM shift included to ensure the bed hold policy was completed and provided to the resident representative at the time of a hospital transfer. RN #5 further identified the bed hold policy form was not completed for Resident #46 as an oversight. Additionally, the bed hold policy was not included as part of the transfer packet. 2. Resident #50 had diagnoses that included hypoxia and Alzheimer's disease. The resident census identified the following hospital transfers for Resident #46: Resident #50 was transferred to the hospital on 2/26/25 and returned to the facility on 3/1/25. Resident #50 was transferred to the hospital on 3/26/25 and returned to the facility on 3/29/25. Review of the clinical record failed to identify that written notice of the bed hold policy had been provided to the resident/representative at or following the time of the transfers on 2/26/25 and 3/26/25. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	An interview with the Administrator on 5/5/25 at 10:54 AM identified it was the nursing staff responsibility to ensure the bed hold policy was provided to the resident/resident representative at the time of the hospital transfer. An interview and clinical record review with RN #5 on 5/05/25 at 11:00 AM identified her role as a nursing supervisor normally scheduled for the 7:00 AM to 3:00 PM shift included to ensure the bed hold policy was completed and provided to the resident representative at the time of a hospital transfer. RN #5 further identified the bed hold policy form was not completed for Resident #46 as an oversight. Additionally, the bed hold policy was not included as part of the transfer packet. The facility's Bed-Hold and Returns policy directs that prior to a transfer, written information will be given to the resident and the resident representative that explains in detail: a. The rights and limitations of the resident regarding bed-holds. b. The reserve bed payment policy as indicated by the state plan (Medicaid residents). c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. The details of the transfer (per the Notice of Transfer).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #34) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to incorporate the PASARR recommendations from the Level 2 determination into the resident's assessment and plan of care. Notice of PASARR dated 7/16/24 identified Resident #34 had a diagnosis of depression, anxiety, and Bipolar. Resident #34 was not on any antidepressants, mood stabilizers, antipsychotics, or other health medications prescribed currently, or other mental health medications prescribed currently or within the last 6 months. Resident #34 received a Level 2 approval with no specialized services needed. The PASARR did not reflect Resident #34 had opioid dependance. Resident #34 was admitted to the facility on [DATE] with diagnoses that included anxiety, opioid dependance, bipolar, depression, and psychotic disorder. A physician's order dated 9/20/24 directed to give Buprenorphine-Naloxone (Suboxone - medication for opioid dependance) 8-12 mg tablet sublingual at bedtime daily. The care plan dated 10/10/24 identified Resident #34 had a substance abuse problem and depression. Interventions included psychiatric consultation as ordered. The admission MDS dated [DATE] identified Resident #34 had intact cognition, and no behavior. Notice of PASARR Level 1 screen dated 12/24/24 identified Resident #34's PASARR was submitted for review. Resident #34 has a diagnosis of major depression, bipolar disorder, and opioid dependency. The outcome identified a Level 2 must be conducted based on the information submitted. Notice of PASARR level 2 outcome dated 1/6/25 identified Resident #34 had a Level 2 approval with recommendations. Resident #34 has a diagnosis of substance abuse disorder for opioids. Recommendations included to provide services and support through the nursing home including a support group for recovery from substance abuse (AA, AN, etc.) and mental health counseling. The care plan dated 2/25/25 identified Resident #34 has a substance abuse problem. Interventions included educating resident, resident friends, and family to not bring controlled substances to the dialysis center and not have visitor's at dialysis treatments. Interview with SW #1 on 5/5/25 at 2:18 PM indicated that Resident #34 was admitted with a Level 2 PASARR, and had a 30-day exemption to file for another PASARR from date of admission. SW #1 indicated that she did not submit the PASARR by 10/20/24. SW #1 indicated she submitted the PASARR late on 12/24/24 for another Level 2, which would be done onsite. SW #1 indicated that someone had come to the facility to evaluate Resident #34 and the facility received the Level 2 approval on 1/6/25. SW #1 indicated that she did not review Resident #34's Level 2 PASARR to see if there were any recommendations. SW #1 indicated that she was responsible to make sure all PASSAR recommendations are followed. SW #1 indicated that the facility does not offer support group for recovery from substance abuse (AA, AN, etc.). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SW #1 indicated that she was not aware that Resident #34 had recommendations for support groups for recovery until now, so she did not speak with Resident #34 to see if he/she was interested in attending. SW #1 indicated that if she had read the recommendations, she would have tried to find Resident #34 a support group for recovery in the community. Additionally, SW #1 indicated she was responsible to do a care plan for any PASARR Level 2 and any recommendations but she had not updated Resident #34's care plan related to the PASSAR recommendations. The social worker note dated 5/6/25 at 6:50 PM identified Resident #34 was interested in attending NA support group meeting and had been attending them prior to admission in this facility. The social worker note dated 5/6/25 at 7:07 PM identified she was able to locate a NA meeting in the community and would follow up in the morning. The social worker note dated 5/7/25 at 8:57 AM identified Resident #34 was interested in attending the NA/AA meetings virtually if unable to attend in community and left a message with the NA number in the community to see if NA facility was wheelchair accessible. The interview with the Administrator on 5/7/25 at 7:30 AM indicated that SW #1 was responsible to update the PASARR within the 30 or 60-day time frame that PASARR had given. The Administrator indicated that she was not aware SW #1 had submitted the level 2 PASARR late for Resident #34. The Administrator indicated that the social worker was responsible to do a PASARR care plan and including any PASARR recommendations and follow up on the recommendations to make sure they were done. The Administrator indicated that SW #1 did not inform her that Resident #34 had recommendations for NA support group services. Review of the Resident Assessment and Coordination with PASARR Program Policy identified the facility coordinates assessments with the preadmission screening and resident review PASARR program under Medicaid to ensure that individuals with mental disorder, intellectual disabilities, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to the facility will be screened for serios mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. PASARR level 1 initial pre-screen is completed prior to admission. If level 1 is negative, the process ends. A positive level 1 screen necessitates a PASARR level 2 evaluation prior to admission. A PASARR level 2 is a comprehensive evaluation by the appropriate state designated authority, that determines the appropriate setting for a resident and recommends any specialized services and/or rehabilitation services that a resident would need. If a resident had an exemption from admission and remained in the facility for longer than 30 days, the facility must screen the individual using the states level 1 process. The level 2 resident review must be completed within 40 calendar days of admission. The social services director is responsible for tracking each residents PASARR screening status, and referring to the appropriate authority. Recommendations, such as specialized services, from PASARR level 2 determine and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interview for 1 of 5 residents (Resident #13) reviewed for PASARR, the facility failed to notify the state designated authority when Resident #13 received a new mental health and intellectual disability diagnosis. The findings include: Resident #13 was admitted to the facility in [DATE] with diagnoses that included stroke and age-related cognitive decline. Review of the PASARR dated [DATE] identified the reason for screening as Resident #13's approval had expired and the resident needs additional time in the nursing facility. Resident #13 is expected to stay for long term care with a start date of [DATE]. Resident #13 had an admitting diagnosis of metabolic encephalopathy, diabetes, and hyperlipidemia. Resident #13 requires medication management and assistance with ADLs. Determination date [DATE] Resident #13 received long term care approval based on submitted information but if medical condition improves resident may be discharged if safe. The psychiatric APRN note dated [DATE] identified Resident had a diagnosis of mood disorder due to physiological condition and will be treated with Zyprexa (antipsychotic medication) 2.5mg for disorder and delusions. Resident #13's diagnosis form identified on [DATE], Resident #13 received a diagnosis of psychotic disorder with delusion. The care plan dated [DATE] identified Resident #13 receives psychotropic medications. Interventions included to complete an AIMS (AIMS is a diagnostic tool designed to assess and monitor involuntary movement disorders, most commonly used to screen for and monitor tardive dyskinesia (TD), a condition characterized by repetitive, jerky movements often resulting from long-term use of antipsychotic medications) every quarter, assess behavioral symptoms and attempt a gradual dose reduction as indicated to give the lowest dose possible. The quarterly MDS dated [DATE] identified Resident #13 had moderately impaired cognition and required extensive assistance with personal hygiene and transfers, had a diagnosis of anxiety and depression and received antipsychotic and antidepressant medications for the last 7 days or since admission. A physician note dated [DATE] identified Resident #13 returned from the hospital for cutting him/herself with a butterknife. The hospital recommended to increase the Zyprexa to 7.5 mg at bedtime. The psychiatric licensed social worker note dated [DATE] identified Resident #13 had a diagnosis of mild intellectual disabilities. The psychiatric APRN note dated [DATE] identified Resident #13 had psychosis with memory impairment. Resident #13 is on antipsychotics and is at high risk for relapses and exacerbation, so no gradual dose reduction attempted at this time. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated [DATE] directed to administer Zyprexa (antipsychotic medication) 15 mg daily for diagnosis of psychotic disorder. The psychiatric evaluation and consultation dated [DATE] identified Resident #13 was seen for diagnosis of psychotic disorder with delusions, dysthymic disorder, and mild intellectual disability-neuropathy. A physician order dated [DATE] directed to administer Zyprexa (antipsychotic medication) 10 mg twice a day for diagnosis of psychotic disorder. The quarterly MDS dated [DATE] identified Resident #13 had moderately impaired cognition and required extensive assistance with personal hygiene and transfers and had a diagnosis of anxiety, depression, and psychotic disorder. The interview with SW #1 on [DATE] at 2:10 PM indicated that she was responsible to do the PASARRs and if a resident receives a new psychiatric diagnosis she is responsible to update the state designated authority. SW #1 indicated if a resident already had a Level 2 PASARR and received a new diagnosis she would not have to update PASARR because the resident already has a Level 2 PASARR. SW #1 indicated that Resident #13 already has a Level 2 PASARR dated [DATE] so because Resident #13 already has long term care approval, she was not required to update the state designated authority when Resident #13 received a new diagnosis of psychotic disorder with delusions in [DATE], or intellectual disabilities in [DATE]. SW #1 indicated Resident #13 already receives psychiatric services. SW #1 indicated that during 2023 and into 2024 there was a lack of communication between the psychiatric group and herself. SW #1 indicated that she will call the state designated authority to see if the resident requires a new PASSAR. Interview with SW #1 on [DATE] at 12:49 PM indicated she called the state designated authority who informed her that Resident #13 does not have a Level 2 PASARR, and that when a resident receives a new psychiatric diagnosis the state designated authority must be updated so they can evaluate if the resident requires any new specialized services. Interview with the Administrator on [DATE] at 7:30 AM indicated that SW #1 was responsible to update the state designated authority within the 30 or 60 days when there was a new diagnosis of psychotic disorder with delusions and mild intellectual disabilities. Interview with the Psychiatric APRN (APRN #3) on [DATE] at 8:56 AM indicated Resident #13 was currently receiving Seroquel (antipsychotic) for the psychotic disorder with delusions, but she was not sure how long Resident #13 had that diagnosis. APRN #3 indicated that Resident #13 has a diagnosis of mild intellectual disabilities but does not know when Resident #13 received that diagnosis. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Assessment Coordination with PASARR Program Policy identified the facility coordinates with the PASARR program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the States Medicaid rules for screening. Level 1 initial prescreening is completed prior to admission. A negative level 1 permits admission unless there is a change for a possible serious mental health disorder or intellectual disability arises after admission. A level 2 a comprehensive evaluation by the appropriate state designated authority (not the facility) determines whether a resident has MD, ID, or related condition, determines the appropriate setting for residing, and recommendations for any specialized services and/or rehabilitation services the resident needs. The Social Services Director is responsible for keeping tracks for all PASARR's. The social worker is responsible for tracking, making referrals, care planning, and updating PASARR with any changes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #91) reviewed for abuse, the facility failed to ensure interventions, including enhanced monitoring, were in place for a resident with a documented history of combative behavior towards staff, who later acted as the aggressor in a resident-to-resident physical altercation. The findings include: Resident #91 had diagnoses that included dementia and history of traumatic brain injury. The quarterly MDS dated [DATE] identified Resident #91 had memory problems with continuous inattentiveness and disorganized thinking and was independent with ambulation and toileting. The care plan dated 12/26/24 identified Resident #91's behavioral symptoms included wandering and intrusiveness. Interventions included encouraging diversional activities and encouraging the resident to walk with staff when possible. a. Psychiatric consult dated 1/17/25 identified Resident #91 was combative at times, refused to shower and attempted to hit staff when offering showers. A low dose of Trazadone 12.5mg (an antidepressant) every shift as needed (PRN) was ordered for combative behaviors before offering ADLs for 14 days. Further, continue to monitor Resident #91's mood and behavior. b. Psychiatric consult dated 1/29/25 identified a request was made to evaluate Resident #91 as soon as possible due to very combative, aggressive behaviors during care. Further, Resident #91 had been chasing the nurse aides with objects and pencils. LPN #2 reported continued combative behaviors, and that Trazadone had not been effective. Labs and an electrocardiogram were ordered along with an increase in Olanzapine (antipsychotic used to treat psychiatric disorders) from 5mg to 7.5mg daily with ongoing recommendations to monitor Resident #91's mood and behavior. c. Psychiatric consult dated 2/5/25 identified nursing staff reported Resident #91 continued to be combative, hitting staff, refusing care and was unable to be redirected despite an increase in Olanzapine and use of PRN Trazadone. Lorazepam 1mg twice daily and 1mg every eight hours was ordered PRN for 14 days with discontinuation of the PRN Trazadone and continued monitoring of Resident #91's mood and behavior. A reportable event form dated 3/4/25 identified at 5:00 PM Resident #79 and Resident #91 were ambulating in the hallway. Resident #79 stated to Resident #91 that he/she was going to kick his/her a**. Resident #91 said Stop and put his/her right hand around Resident #79's neck slightly and pinning Resident #79 against the wall for two seconds. No injuries were sustained. Resident #91 was placed on 1:1 enhanced monitoring. The physician, police and resident representative were notified and Resident #91 was subsequently transferred to the emergency department. An interview with the Administrator on 5/6/25 at 2:19 PM identified she was unaware of Resident #91's combativeness towards staff but would expect the nursing supervisor and DNS to discuss behaviors and the care plan be revised to address combative behaviors towards staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and clinical record review with APRN #3 on 5/6/25 at 3:14 PM identified she provided routine psychiatric support services to Resident #91 beginning on 1/10/25. APRN #3 identified she had not witnessed combative behaviors firsthand from Resident #91 however, would document behaviors based on staff reports before evaluating each resident. APRN #3 confirmed, based on her documentation, LPN #2 reported combative behaviors towards staff. Medication adjustments, lab tests and other diagnostic testing had been ordered in response to those reports, however, Resident #91 had not been responsive. APRN #3 identified she has requested staff to initiate non pharmacologic interventions to address Resident #91's behaviors and would expect staff to track all instances of combativeness towards staff in the care planning process. An interview and clinical record review with LPN #2 on 5/07/25 at 9:13 AM identified a nurse aide, formerly employed by the facility, whose name she could not recall, had reported Resident #91's combative behavior towards staff. LPN #2 reported the concerns to APRN #3 but could not recall if the information was ever reported to the nursing supervisor. Although requested, a policy for revisions to the care plan based on change of condition were not provided. A review of the policy for Behavioral Assessment and Monitoring directed the interdisciplinary team to document improvements or worsening of behavioral symptoms, mood or function for any resident being treated for altered behavior or mood and that interventions will be adjusted based on impact of behavior and other symptoms.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #7) reviewed for unnecessary medications, the facility failed to follow the physician's orders for lab monitoring following the start of a new medication, and for Resident #46 the facility failed to obtain physician's orders for the use of oxygen post hospitalization. The findings include: 1. Resident #7 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease (COPD), major depressive disorder with psychotic features, and dementia. Review of the clinical record identified that Resident #7 was hospitalized from [DATE] - 2/28/25 due to behavioral health issues including worsening agitation and aggression. Review of the W-10 dated 2/28/25 identified Resident #7 had new medications including Depakote 250mg twice daily (a seizure and mood stabilizing medication) to stabilize mood. A physician's order dated 2/28/25 directed to administer Depakote 250mg twice daily at 9:00 AM and 9:00 PM. Review of a pharmacy psychoactive medication use recommendation dated 3/3/25 identified Resident #7 was admitted on Depakote and there was no recent serum valproic acid level in the chart. Recommendations included to consider obtaining lab work to check the level. The admission MDS dated [DATE] identified Resident #7 had severely impaired cognition, was always incontinent of bowel, occasionally incontinent of bladder, and was dependent on staff assistance with eating, bathing, and toileting. A psychiatric APRN note dated 3/7/25, by APRN #3, identified that she reviewed Resident #7's labs, was unable to locate a recent valproic acid level (used to monitor the serum level of Depakote in the blood), and ordered the valproic acid level as requested by the pharmacy. An APRN order dated 3/7/25 directed to obtain a valproic acid level on 3/10/24. Review for the March 2025 MAR identified that the order for valproic acid level was signed off as completed on 3/10/25 during the 7:00 AM - 3:00 PM shift. The care plan dated 3/11/25 identified that Resident #7 had a history of cognitive loss due to dementia. Interventions included administering medications as ordered. A psychiatric APRN note dated 4/3/25, by APRN #3, identified that she reviewed the valproic acid level done for Resident #7 on 3/5/25 and the level was within normal limits. Review of the clinical record failed to reflect a valproic acid level for Resident #7 on 3/5/25 or 3/10/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 5/5/25 at 11:00 AM identified she was unable to locate any valproic acid levels for Resident #7 since readmission on [DATE]. LPN #3 identified she had contacted the lab and there was no record of any lab requests or specimens for Resident #7 regarding a valproic acid level. Interview with APRN #3 on 5/7/25 at 8:47 AM identified that she ordered the valproic acid level to be done on 3/10/25 and reviewed the valproic acid level for Resident #7 on 4/3/25. APRN #3 identified it was her practice that when she reviewed lab results for a resident, she also took a picture of the lab results which she saved, to go along with the documentation in the visit note. During the interview, APRN #3 attempted to locate the photo of the valproic acid level but after several minutes she identified she was unable to locate the photo. Upon review of the clinical record and documentation related to the 3/7/25 order date and the 3/10/25 draw date for the valproic acid level, and information obtained from the facility that the valproic acid level had not been obtained, APRN #3 identified she was unsure what happened or why she documented that she had reviewed the valproic acid level results for Resident #7. APRN #3 identified that for residents who were started on Depakote for behavioral health issues, valproic acid levels were drawn within one to two weeks of initiation of the medication, and if the levels were within normal limits, she would then check the levels every six months and as needed to ensure that the levels were not high and in the toxic range. APRN #3 identified that she would reorder the valproic acid level to be done and ensure the level was obtained and documented correctly. Although requested, a policy on psychotropic medications was provided. The policy on behavioral assessment and monitoring directed that residents would have minimal complications associated with the management of altered or impaired behavior, and that the facility would comply with regulatory requirements related to the use of medications to manage behavioral changes. The policy also directed that interventions would be adjusted based on the impact on behavior and other symptoms including any adverse consequences related to treatment. The policy on lab results and diagnostic testing directed that the physician would identify, and order diagnostic and lab testing based on the resident's needs, and facility staff would process test requisitions and arrange for tests, and the laboratory, diagnostic radiology provider, or other testing sources would report test results to the facility. The policy on charting and documentation directed that all services provided to the resident would be documented in the residence medical record and the medical record should facilitate communication between the interdisciplinary team regarding the residence condition and response to care. The policy further directed that the documentation in the medical record would be objective, complete, and accurate. 2. Resident 46 had diagnoses that included congestive heart failure and dementia. The quarterly MDS dated [DATE] identified Resident #46 had severely impaired cognition, was independent with bed mobility and transfers, and did not require oxygen therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 2/14/25 identified Resident #46 had a diagnosis of congestive heart failure and dementia. Interventions directed to administer medications and provide cues/supervision for ADL's. A nurses note dated 3/10/15 at 9:45 AM identified Resident #46's recorded oxygen saturation (amount of oxygen in the blood) was 80% (normal 95% - 100%), and the resident was short of breath and anxious. Resident #46 was placed on 4 liters of oxygen via nasal cannula with additional orders for stat (as soon as possible) labs, covid/flu/RSV swabs, chest x-ray and DuoNeb (bronchodilator) now and every six hours. A nurse's note dated 3/10/25 at 10:26 AM identified Resident #46 received DuoNeb with little effect. The APRN was notified and a new order received to send Resident #46 to the emergency department for further evaluation. The hospital Discharge summary dated [DATE] identified Resident #46's discharge diagnosis included respiratory failure, sepsis and pneumonia. Resident #46 required oxygen at 5 liters during hospitalization with recommendations to wean off oxygen as tolerated with a goal to maintain levels between 92% and 94%. A review of the admission physician's orders dated 3/15/25 failed to include orders for oxygen. A review of nurse's notes dated 3/15/25 through 3/17/25 identified Resident #46 was maintained on oxygen at 4 liters/minute via nasal cannula with an oxygen saturation between 94% and 98%. The APRN progress note dated 3/17/25 at 7:15 AM identified Resident #46's hypoxia had improved, and the resident no longer required the use of supplemental oxygen. Nurse's notes dated 3/17/25 through 3/19/25 at 3:15 AM identified Resident #46 continued on oxygen at 4 liters/minute via nasal cannula, was occasionally removing the oxygen and was in no acute distress. A nurse's note dated 3/19/25 at 1:47 PM identified at 12:42 PM Resident #46 was minimally responsive with an oxygen saturation of 80% on 4 liters of oxygen via nasal cannula. Resident #46 was placed on a nonrebreather and the oxygen saturation increased to 98%. The APRN was called to assess and Resident #46 and was ordered to be sent to the emergency department for further evaluation. An interview with RN #1 on 5/05/25 at 1:14 PM and 5/14/25 at 11:33 PM identified the admitting nurses were responsible for reviewing the hospital discharge summary with the provider to determine which orders were continue on admission. Resident #46 still required the use of oxygen upon readmission as part of hospital recommendations and the order was not transcribed on admission. The DNS indicated based on documentation, Resident #46 continued to receive oxygen until the error was identified on 3/22/25 upon return from his/her second hospitalization. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with APRN #5 on 5/14/25 at 12:25 PM identified the nurse would normally review and transcribe the orders on admission and he would review all orders the following day. APRN #5 identified he did not note nor transcribe the orders for oxygen as recommended by the hospital discharge summary as an oversight but acknowledged Resident #46 still required oxygen on readmission. APRN #5 further identified that although his progress note dated 3/17/25 identified Resident #46 no longer required oxygen, that was an entry error. APRN #5 indicated Resident #46 still required and was regularly receiving oxygen. A review of the policy for transcribing medication orders directed for oxygen, the rate, flow, route and rationale must be specified on the physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #13) reviewed for accidents, the facility failed to ensure the resident was transferred per the physician's orders resulting in a fall, for 1 resident (Resident #27) reviewed for smoking, the facility failed to ensure the resident was supervised and redirected when necessary to smoke in a safe manner, and the facility failed to ensure that smoking materials were accounted for, equipment in the smoking area was inspected at least monthly, and smoking materials were secured. The findings include: 1. Resident #13 was admitted to the facility in November 2021 with diagnoses that included edema, diabetes, anxiety, diabetic neuropathy, urge incontinence, obesity. The care plan dated 9/19/24 identified Resident #13 was at risk for frequent falls. Interventions included a left leg brace and right sneaker while out of bed. A physician's order dated 12/13/24 directed to transfer with a standard walker and assistance of 2 people while wearing a right sneaker and a left cam boot. The quarterly MDS dated [DATE] identified Resident #13 had moderately impaired cognition was frequently incontinent of bowel and always incontinent of bladder and required maximum assistance for toileting. A reportable event form dated 12/16/24 at 9:00 PM indicated that Resident #13 was in the bathroom with NA #4 who was assisting Resident #13 in the bathroom. NA #4 stated Resident #13's knees got weak, and the resident fell, but did not hit his/her head. Resident #13 had no injuries noted. The witness was NA #4. Interview with LPN #7 on 5/5/25 at 10:29 AM indicated she was outside Resident #13's room and heard a commotion in the bathroom. As she entered, NA #4 was lowering Resident #13 to the floor. LPN #7 indicated she did not recall if NA #4 had used a gait belt. LPN #7 indicated that the RN supervisor, NA #4, and herself used the mechanical lift to get Resident #13 off the floor. Interview with the DNS on 5/5/25 at 12:25 PM indicated the expectation was that NA #4 would have reviewed the resident care card prior to doing the transfer and follow the physician's order for transfers, which included assistance of 2 people. The DNS indicated if the nurse aide had any concerns, she should have spoken with the nurse to clarify. Review of investigation for the fall on 12/16/24, the DNS indicated that NA #4 did a transfer with only 1 assistance, however, she did not see anything regarding if the gait belt, cam boot, or right sneaker were on at the time of the fall. The DNS indicated that it was the facility policy that the nurse aides use a gait belt when transferring a resident. The DNS indicated that there was a physician order for Resident #13 to transfer with a standard walker and assistance of 2 people while wearing a right sneaker and a left cam boot. The DNS indicated based on the investigation NA #4 transferred the resident alone when she should have had 2. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 5/7/25 at 10:50 AM indicated she was informed that Resident #13 was required only 1 person for transfers. The Administrator indicated that she did not realize that Resident required 2 at that time per the physician's order. The Administrator indicated that if she was aware Resident #13 required the assist of 2, and that NA #4 had done the transfer alone and did not follow the care card and plan of care, she would have been educated and had done a written discipline with NA #4 at that time. Although attempted, an interview with NA #4 was not obtained. Review of the Falls Management Policy identified the facility will identify hazards and resident risk factors and implement interventions to minimize falls. Each resident is assisted in attaining and maintaining his/her highest practical level of function by providing the resident with adequate supervision, assistive devices, and/or functional programs to minimize the risk for falls. The licensed nurse will assess residents for fall risk upon admission, re-admission, quarterly, annually, and with a significant change in condition. The interdisciplinary team will review all resident falls within 24 - 72 hours at the morning meeting to evaluate and investigate the circumstances and probable cause for the fall and modify the plan of care to minimize repeat falls and update the resident care card and care plan. 2. Resident #27 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, nicotine dependence, and iron deficiency anemia. A physician's order dated 9/26/24 directed that Resident #27 may go outside to smoke as per facility guidelines. A smoking assessment dated [DATE] identified that Resident #27 was a current smoker and had been educated on the smoking policies and procedures for the facility. Review of the clinical record failed to identify any additional smoking evaluations for Resident #27 after 11/4/24. The quarterly MDS dated [DATE] identified Resident # 27 had moderately impaired cognition, was always continent of bowel and bladder, required set with meals and dressing and was independent with toileting. The care plan dated 3/14/25 identified Resident #27 wished to smoke and would be assessed for the supervised smoking program. Interventions included educating the resident on safe smoking practices and monitoring safety during smoking. Interview with Resident #27 on 5/4/25 at 10:40 AM identified that the facility provided two smoking times at 11:00 AM and 6:00 PM, the facility secured the resident smoking materials, and that a staff member accompanied Resident #27 to an outside patio during smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/4/25 at 10:55 AM identified that Resident #27 requested to be able to smoke on the outside patio. NA #7 was observed speaking to RN #10, who was inside of the RN supervisor's office requesting keys to the locked smoking cabinet. NA #7 was observed entering the employee locker room directly next to the RN supervisor's office and opening a locked cabinet which contained a plastic caddy which contained 2 packs of cigarettes. After looking through the caddy, NA #7 identified she was unable to locate the lighter that was normally contained in the caddy. NA #7 placed the plastic caddy on top of the cabinet next to the cabinet keys and left the unit. The plastic caddy was observed unattended in the employee locker room from 11:00 AM to 11:04 AM when this surveyor notified LPN #3 (regional corporate LPN) who was on the unit. Observation and interview with LPN #3 on 5/4/25 at 11:04 AM identified that the smoking materials should not be left unsecured anywhere on the unit and that the lighter with the smoking materials should always be accounted for. LPN #3 identified that the lighter was likely to be still with a staff member from the 3:00 PM - 11:00 PM shift the day prior since that would have been the last smoking time however she was not sure of this and would need to investigate. Interview with NA #7 at 11:05 AM identified she was unsure where the other lighter went. Observation of Resident #27 and NA #7 on 5/5/25 beginning at 11:10 AM identified that NA #7 was seated in the immediate vicinity of Resident #27. Resident #27 was not within reach of a metal ash receptacle. Resident #27 was observed seated on a rollator walker flicking cigarette ash onto the cement patio. Resident #27 was positioned directly in front of a wooden bench and wood mulch for the duration of the smoking time. During this observation, NA #7 did not attempt to educate or redirect Resident #27 to use the metal ash receptacle located approximately 2 feet from Resident #27. Resident #27 was observed discarding the cigarette butt into the metal ash receptacle after finishing the cigarette. NA #7 assisted Resident #27 back into the building at 11:21 AM. During this observation, the wood mulch located next to Resident #27 was wet due to an active rainstorm. Observation of the smoking area on 5/4/25 at 11:22 AM identified that the fire extinguisher in the smoking area had no documentation of a monthly inspection record tag since 10/2024, approximately seven months prior. The patio area was also noted to have a large wooden barrel planter that contained a mixture of soil, and a partial covering of wood mulch also observed to have multiple cigarette butts (a total of 7) located inside the planter. Interview with the Director of Maintenance (covering regional) on 5/4/25 at 11:45 AM identified that the facility fire extinguishers were to have a visual inspection check to ensure that the extinguishers were charged and ready to use at least monthly, and that the maintenance staff would sign the tag on the extinguisher. The Director of Maintenance identified he was only covering the building for the day due to the regular Director of Maintenance being out but that it was the procedure to sign the tag directly, and he would have to investigate any policies or logs in the maintenance office. Interview with LPN #3 on 5/4/25 at 12:00 PM identified she was assisting with staff development in the facility until a staff development nurse was hired. A request was made for education documentation and in-services related to smoking supervision for NA #7. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Maintenance (covering regional) on 5/4/25 at 12:08 PM identified that he was unable to locate any documentation related to policies on fire extinguisher checks or monthly logs for the smoking area fire extinguisher and identified that the tag on the extinguisher served as the log. Interview with LPN #3 on 5/6/25 at 1:30 PM identified that the facility did not have any documentation related to education or in-services prior to 5/4/25. LPN #3 identified that the facility had recently undergone a change of ownership in 10/2024, and prior to the change, the facility allowed smoking, but following the change, smoking was prohibited. LPN #3 identified Resident #37 was one of 2 residents who were grandfathered in to continue to have supervised smoking. LPN #3 identified that following the observations on 5/4/25, she began in-service education on smoking supervision and safety with all facility nursing staff and initiated an audit tool to ensure that all smoking materials were accounted for and secured following each smoking time. LPN #3 also identified that the missing lighter from the smoking caddy on 5/4/25 had not been located. Review of the in-service education dated 5/4/25 identified staff were educated on safe handling and storage of smoking materials. The education identified that all smoking materials must be strictly managed in accordance with facility policy and state regulations. Guidelines identified in the education included securing all smoking materials after each smoking time, not leaving smoking materials including cigarettes, lighters or cart keys unattended, keeping the smoking cart locked at all times, reporting any missing items immediately to the charge nurse and facility administration, and monitoring residents behavior during smoking sessions and intervening if any unsafe behavior was observed. Further review of the in-service education also included a staff notice smoking safety reminder which identified that all smoking materials must be secured and to ensure that this smoking area was free of clutter and safe from fire hazards, and that all supervised smoking events should be documented per facility policy. Review of a smoking competency education dated 5/6/25 for NA #7 and completed by the DNS identified that NA #7 had met competencies including education on gathering smoking materials from the locked smoking cart, safely assisting residents to the assigned smoking area 20 feet away from the building, monitoring residents who smoke for the entire time without distractions, and ensuring cigarettes were properly extinguished and placed in an approved receptacle. Interview with the DNS on 5/7/25 at 11:15 AM identified she was aware of the issues identified related to Resident #37's supervised smoking and smoking materials. The DNS identified that Resident #37 should have been using the metal ash receptacle in the smoking area as there could have been a fire if the wood mulch had been dry and Resident #37 flicked ash into this area. The DNS identified education and in service had been initiated with staff. The policy on smoking for residents directed that the facility should establish and maintain safe resident smoking practices. The policy further directed that metal containers with self-closing cover devices were available in the smoking area and ashes would be emptied only and designated receptacles. The policy also directed any resident who had been grandfathered in would be reevaluated quarterly, upon a significant change in condition physical or cognitive, and as determined by staff.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #34) reviewed for a specialized medical procedure, the facility failed to ensure consistent monitoring and documentation of intake and output for a resident on fluid restriction. The findings include: Resident #39 was admitted to the facility in February 2025 with diagnoses that included end stage renal disease, and fluid overload. The care plan dated 2/28/25 identified Resident #39 had a diagnoses of end stage renal disease and received dialysis. Interventions included dialysis on Mondays, Wednesdays, and Fridays. Review of the intake and output record for March 2025 identified staff failed to document the resident's intake and the resident failed to meet the 1,000 ml/day fluid restriction 26 of 93 occasions. The initial nutrition assessment dated [DATE] at 12:36 PM identified Resident #39 was on a renal diet with 1, 000 ml/day fluid restrictions. Intake by mouth has been good since admission. Recommendations included to honor resident preferences. Fluid breakdown: 1,000 ml/day. Nursing: 520 ml, Dietary: 480 ml (total), breakfast - 240 ml, lunch 120 ml, dinner 120 ml. The admission MDS dated [DATE] identified Resident #39 had intact cognition, was independent with eating, and was receiving specialized services. Review of the education form dated 3/12/25 for fluid intake and output monitoring procedure identified an in-service was provided to the nursing staff. Review of the intake and output record for April 2025 identified staff failed to document the resident's intake and the resident failed to meet the 1,000 ml/day fluid restriction 25 out of 90 occasions. The care plan dated 4/17/25 identified Resident #39 had low fluid intake related to fluid restriction of 1,000 ml daily due to end stage renal disease and dialysis. Interventions included nurse aides, nursing, and food service will follow fluid restrictions at medication pass, mealtimes every shift. The physician's order dated 5/1/25 directed a fluid restriction of 1,000 ml/24 hours. The physician's orders dated March 2025, April 2025, and May 1 - 6, 2025 failed to direct the breakdown of the amount of fluid Resident #39 could consume from nursing and dietary in a 24-hour period. Review of the intake and output record for May 1 - 6, 2025 staff failed to document the resident's intake and the resident failed to meet the 1,000 ml/day fluid restriction 6 out of 18 occasions. Subsequent to surveyor inquiry a physician's order dated 5/7/25 was obtained for the breakdown of the amount of fluid Resident #39 could consume from nursing and dietary in a 24-hour period. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #5 dated 5/7/25 at 8:25 AM identified all nurse aides document intake and output in the computer for residents that are on intake and output. NA #5 indicated the nurse aides do not use paper for documenting intake and output. NA #5 indicated she is assigned to Resident #39 most of the time and when she is assigned to Resident #39, she documents the resident intake and output in the computer. Interview with NA #6 dated 5/7/25 at 10:20 AM identified all nurse aides document intake and output in the computer for residents that are on intake and output. NA #6 indicated nurse aides do not use paper for documenting intake and output. Interview with LPN #3 (Regional Clinical Support) dated 5/7/25 at 11:00 AM identified she was aware of the facility not following the intake and output policy. LPN #3 indicated she had provided education on 3/12/25 regarding fluid intake and output monitoring procedures to the nursing staff. LPN #3 indicated she was not aware Resident #39 was not meeting the fluid restriction per physician's order. LPN #3 indicated the nurse aides, and the licensed nurses are responsible for documenting the intake and output each shift. Interview with the DNS on 5/7/25 at 11:15 AM identified she was aware of nursing staff were not following the intake and output policy. The DNS indicated the facility had educated the nursing department in March 2025 regarding intake and output. The DNS indicated she was not aware Resident #39's intake and output were not being filled out completely by each shift. The DNS indicated she was not aware of the fluid restriction physician's order was not being followed. Interview with RN #9 (Registered Nurse at dialysis center) on 5/7/25 at 11:25 AM identified Resident #39 was on a 1,000 ml a day fluid restriction. RN #9 indicated in reviewing the resident's record, there was no evidence that the facility had notified the dialysis center that the resident intake and output were inconsistently monitored. RN #9 indicated Resident #39 fluid intake and output should be monitored. Interview with MD #1 on 5/8/25 at 11:52 PM identified he was not aware the facility was not following the physician's order and the specialized treatment center order for fluid restriction. MD #1 indicated his expectation would be that the nurses follow the physician's order. Interview with APRN #5 on 5/8/25 at 12:47 PM identified he was not aware the facility was not following the physician's order. APRN #5 indicated his expectation would be that the nurses followed the physician's order especially when the resident is receiving specialized treatment. Although attempted, an interview with the dietitian was not obtained. Review of the facility intake measurements policy identified the purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy. Inform the resident and his or her family and visitors that the resident is on intake and output. Record the fluid intake as soon as possible after the resident has consumed the fluids. At the end of your shift, total the amounts of all liquids the resident consumed. Record all fluid intake on the intake and output record in cubic centimeters (ml's).

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy, and interviews for 1 of 3 certified nurse aide personnel files reviewed, the facility failed to complete annual employee performance reviews at least every twelve months. The findings include: Review of NA #10's personnel file identified her date of hire as 2/10/15. The last performance review was on 8/3/20, 5 years ago. An interview with the Administrator on 5/6/25 at 9:13 AM identified it was the responsibility of the DNS and ADNS to ensure the completion of annual evaluations. Frequent turnover in staffing likely contributed to the evaluation not being completed annually. The Annual Employee Evaluation policy directs all employees' job performance be evaluated annually based on their hire date or facility - defined cycle and applies to all full time, part time and per diem employees across all departments.

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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** Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure that a discrepancy for a controlled medication was investigated and resolved in a timely manner, failed to ensure that an individual use medication was labeled and dated, and failed to ensure that the controlled drug change of shift audits were completed. The findings include: 1. Observation of the electronic medication cabinet on 5/6/25 at 10:40 AM with RN #8 (agency nursing supervisor), located in the 2nd floor nursing supervisor's office, identified an alert on the sign on screen which identified You have one unresolved discrepancy on this cabinet. Interview with RN #8 at that time identified she was unable to resolve the discrepancy alert displayed on the medication cabinet as the facility did not allow any agency staff the ability to access the medication cabinet. RN #8 identified she worked at the facility sporadically but had noted that the discrepancy alert had been in place since her last shift at the facility on 5/2/25, 4 days ago. Interview with RN #5 (3rd floor nursing supervisor) on 5/6/25 at 11:07 AM identified that she had attempted to resolve the discrepancy in electronic medication cabinet but did not have access to do so, and it was the responsibility of the DNS to resolve any discrepancies related to the electronic medication cabinet. Observation and interview with the DNS on 5/6/25 at 11:25 AM identified she was responsible for investigating and resolving any discrepancies related to the electronic medication cabinet. The DNS identified she became aware of the discrepancy with the electronic medication cabinet earlier in the morning of 5/6/25 and had not observed any discrepancy alert prior. The DNS and RN #5 were then observed signing into the electronic medication cabinet, and the DNS was observed completing a controlled drug audit which identified there was a discrepancy related to a narcotic count of Oxycodone 10 mg which occurred on 4/16/25 with the last count entered as 27 tabs and the electronic medication cabinet alerting that the count should have been 28 tabs. Further, the DNS and RN #5 completed the count of the Oxycodone 10mg and identified 28 tablets which resolved the discrepancy. Interview with the DNS immediately following this observation identified that she was unable to identify the last time she accessed the electronic medication cabinet for any reason. A review of the medication cabinet electronic controlled substance transaction log from 4/16/25 - 5/6/25, 20 days, identified that the DNS did not access, sign into, inventory any controlled substances during that time frame. The facility policy on the BD PYXIS station cabinet medication policies and procedures for Connecticut directed that at a minimum, a bimonthly inventory would be performed on all controlled substances stored in the medication cabinet by the director of nursing along with the designated representative. The bimonthly controlled substance inventory would be maintained at the facility for a minimum of three years. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on schedule II-controlled substance medications directed that schedule II-controlled substance medications included drugs with acceptable medical use but with high abuse potential. The policy further directed that the director of nurses was designated by the facility to be responsible for the control of such drugs and medications. The facility policy on shift-to-shift narcotic counts directed that the purpose of the policy included detecting and addressing discrepancies immediately. The policy further directed that any discrepancies must be reported immediately to the supervisor, DNS or designee and that the facility staff should document actions taking and resolving any discrepancies. 2. Observation of the 2 [NAME] medication cart with LPN #8 on 5/6/25 at 10:56 AM identified a 1.5 fluid oz bottle of [NAME] care saline nasal spray inside of a clear plastic cup. The bottle did not contain any resident identifying information. Further observation identified upon LPN #8 lifting the bottle from the plastic cup, a small torn piece of paper was located at the bottom of the cup which identified 225 D but failed to identify any additional information regarding who the saline nasal spray belonged to. Interview with LPN #8 immediately following this observation identified that it was the policy of the facility to label and date any multi dose over the counter use medications and she was unsure why the bottle was located in the medication cart and could not confirm that the current occupant of room [ROOM NUMBER] D was the resident who the nasal spray belonged to. Subsequent to survey or inquiry, LPN #8 was observed disposing of the saline nasal spray. Interview with the DNS on 5/7/25 at 11:15 AM identified that all medications used for residents should be labeled appropriately with the resident's name and the date the medication was opened. Although requested, the facility failed to provide a policy on the use of over the counter medications. The policy on the storage of medications directed that the facility store all drugs and biologicals in a safe, secure, and orderly manner. The policy directed that nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy also directed that discontinued, outdated, or deteriorated drugs or biologicals were to be returned to the dispensing pharmacy or destroyed. 3. Review of the controlled drug/change of shift audit forms dated May 2025 for the 2nd floor medication carts identified the following: The 2 East medication cart-controlled drug/change of shift audit form failed to identify any controlled drug/change of shift count completed for 5/1/25 during the 11:00 PM - 7:00 AM (off going nurse and oncoming nurse), 7:00 AM - 3:00 PM (oncoming nurse and off going nurse), 3:00 PM - 11:00 PM (oncoming nurse and off going nurse). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/2/25 11:00 PM - 7:00 AM (off going nurse). 5/3/25 11:00 PM - 7:00 AM (oncoming nurse). 5/4/25 11:00 PM - 7:00 AM (off going nurse). 5/5/25 7:00 AM - 3:00 PM (oncoming nurse), 7:00 AM - 3:00 PM (off going nurse), 3:00 PM - 11:00 PM (oncoming nurse), 3:00 PM - 11:00 PM (off going nurse), 11:00 PM - 7:00 AM (oncoming nurse). 5/6/25 11:00 PM - 7:00 AM (off going nurse), 7:00 AM - 3:00 PM (oncoming nurse). The 2 [NAME] medication cart-controlled drug/change of shift audit form failed to identify any controlled drug/change of shift count completed for: 5/1/25 11:00 PM - 7:00 AM (off going nurse), 3:00 PM - 11:00 PM (off going nurse), 11:00 PM - 7:00 AM (oncoming nurse). 5/2/25 11:00 PM - 7:00 AM (off going nurse), 3:00 PM - 11:00 PM (oncoming nurse), 3:00 PM - 11:00 PM (off going nurse). 5/3/25 3:00 PM - 11:00 PM (oncoming nurse), 3:00 PM - 11:00 PM (off going nurse), 11:00 PM - 7:00 AM (oncoming nurse). 5/4/25 11:00 PM - 7:00 AM (off going nurse). 5/5/25 11:00 PM - 7:00 AM (off going nurse). Interview with the DNS on 5/6/25 at 11:25 AM identified that the facility licensed nursing staff were responsible to complete a controlled substance count and sign off controlled drug/change of shift audit form following each shift and coming onto each shift. A request was made to the DNS to provide all controlled drug/change of shift audit forms for 2025 for the facility. Review of the controlled drug/change of shift audit forms dated 12/24 and 2/2025 - 4/2025 provided by the DNS, identified multiple missing change of shift audits for controlled drugs. Review of the single 12/2024 audit form provided for the 2 [NAME] medication cart identified 25 of 155 missing controlled substance shift audits. Review of the 2/2025 audit forms for the 2 [NAME] medication cart identified 19 of 140 missing controlled substance shift audits; 2 East medication cart identified 21 of 140 missing controlled substance shift audits; and the 3 East medication cart identified 14 of 140 missing controlled substance shift audits. The 2/2025 3 [NAME] audit form was not provided. Review of the 3/2025 audit forms for the 2 [NAME] medication cart identified 23 of 155 missing controlled substance shift audits; 2 East medication cart identified 26 of 1155 missing controlled substance shift audits; and the 3 East medication cart identified 12 of 155 missing controlled substance shift audits. The 3/2025 3 [NAME] audit form was not provided. (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 4/2025 audit forms for the 2 [NAME] medication cart identified 19 of 150 missing controlled substance shift audits; 2 East medication cart identified 19 of 150 missing controlled substance shift audits; the 3 East medication cart identified 39 of 150 missing controlled substance shift audits; and 3 [NAME] medication cart identified 47 of 150 missing controlled substance shift audits. Although requested, the facility failed to provide any additional controlled drug/change of shift audit forms for 12/2024, 1/2025, 2/2025 or 3/2025. The policy on shift to shift narcotic counts directed to ensure strict accountability and security for all controlled substances through a shift-to-shift narcotic count and that the process helped prevent medication diversion, insured accurate documentation, and promoted resident safety. The policy further directed at the beginning of each shift, a licensed nurse from the outgoing shift and a licensed nurse from the incoming shift must jointly conduct a controlled substance count. The policy further directed the counts must occur prior to the transfer of shift responsibilities and that the licensed nurses were to count each controlled medication in the narcotics storage areas including medication cards medication rooms or locked drawers, verify the counts against the controlled substance proof of use sheets, blister packets, or unit dose packaging. The policy further directed that the staff were to ensure the medication count matched the documented balance and confirm that all doses were administered, wasted, or returned were correctly documented. The policy also directed the documentation must include both nurses initialing and signing the narcotic count log for the shift, reporting any discrepancies immediately to the nursing supervisor, DNS, or designee, and document actions taken to resolve any discrepancies. The policy also directed that the DNS or designee would conduct random audits of narcotic counts at least monthly and audit findings would be documented and corrective actions would be taken if necessary. The policy also directed that failure to comply with the policy may result in disciplinary action up to and including termination and reporting to the appropriate state licensing board.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #37) reviewed for pressure ulcers, the facility failed to document weekly assessments and/or healing of a newly identified non-blanchable area of redness on the sacrum. The findings include: Resident #37 was admitted to the facility on [DATE] with diagnoses that included hemiplegia of the left side, insulin dependent diabetes, and dementia. A physician's order dated 4/5/23 directed to complete weekly skin checks on Wednesdays on the 3:00 PM - 11:00 PM shift and to complete a weekly skin observation if any new areas were identified. The quarterly MDS dated [DATE] identified Resident #37 had moderately impaired cognition, was always incontinent of bowel and bladder and required staff to provide moderate assistance with toileting, dressing, and bathing. The care plan dated 11/5/24 identified that Resident #37 had a potential for alteration in skin integrity. Interventions included complete skin assessments of the body upon admission, weekly, and as needed. The interventions also included reporting any changes in skin status to the physician. A Braden Scale (Braden Scale is a tool used to assess a resident's risk of developing a pressure ulcer) dated 12/15/24 identified Resident #37 was at moderate risk to develop pressure ulcers. A nurse's note dated 12/15/24 at 4:47 AM, by the Prior DNS, identified that she was working on the 11:00 PM - 7:00 AM shift to assist a nurse aide with completion of competencies and that Resident #37 was part of the assignment. The Prior DNS identified that while performing incontinent care, she discovered a non-blanchable area of redness on Resident #37's sacrum that measured 2cm x 1.3cm x 0.0cm. The Prior DNS identified she performed a head-to-toe assessment and no other non-blanchable areas were present. The Prior DNS identified she would put interventions into place including a specialty low air loss (LAL) mattress, turn and positioning schedule, toileting/incontinent care schedule, and application of barrier paste. The Prior DNS also identified she would discuss Resident #37's wheelchair cushion with the rehab department. Review of the 12/2024 TAR identified a treatment order for application of house barrier ointment after each incontinent episode every shift and as needed was implemented on 12/15/24. A nurse's note dated 12/15/24 at 9:58 AM identified that the Prior DNS identified she spoke with the therapy department, who were no longer working with Resident #37 but confirmed that Resident #37 had a ROHO cushion in place. The DNS identified she would be initiating a physical therapy (PT)/occupational therapy (OT) evaluation screening. Review of the clinical record failed to identify any documentation that a PT/OT evaluation screening was requested or completed on or after 12/15/24. Review of the clinical record failed to identify a specialty LAL mattress was implemented on or after 12/15/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any additional documentation related to additional assessments of the non-blanchable area on the sacrum identified on 12/15/24. Review of the clinical record failed to identify any documentation related to notification to Resident #37's physician or resident representative regarding the newly identified non blanchable area on the sacrum on or after 12/15/24. Review of the 12/2024 TAR identified Resident #37's weekly skin check signed off on 12/18/24 on the 3:00 PM - 11:00 PM shift. Further review of the clinical record failed to identify any observation documentation of Resident #37's sacrum. A nutrition note dated 12/19/24 at 2:33 PM identified that Resident #37 was seen for a non-blanchable area of redness to the sacrum identified on 12/15/24. Recommendations included initiation of a carbohydrate-controlled diet for improved blood sugar control and initiation of Proheal 30ml to aid in wound healing. A nurse's note dated 12/19/25 at 7:37 PM by RN #11 (Agency) identified that Resident #37 was seen by the dietitian for concerns about a non-blanchable area of redness on the sacrum on 12/15/24. The identified recommendations included initiating a carbohydrate-controlled diet for improved blood sugar control and starting Proheal (a protein supplement used to add in wound healing) twice daily to aid in wound healing. The note further identified the orders were implemented in Resident #37's record. Review of the 12/2024 TAR identified an order for Proheal 30ml twice daily which was started on 12/19/24 to be given twice daily at 9:00 AM and 5:00 PM. Review of the clinical record failed to identify any additional documentation or interventions related to the non-blanchable area on the sacrum after 12/19/24. Interview with LPN #3 (Regional Corporate LPN) on 5/5/25 at 11:00 AM identified she was unable to locate any additional documentation related to further assessments of Resident #37's non-blanchable sacral area following the initial documentation on 12/15/24. LPN #3 identified that Resident #37 had an order for a weekly skin check. LPN #3 identified that the facility policy was that the skin checks were signed off on the TAR weekly and only issues that were identified were documented as a skin observation. LPN #3 identified that Resident #37's physician or APRN should have been notified of the new skin issue as well as Resident #37's resident representative and the non-blanchable skin area should have been followed and assessed at least weekly once it was identified. Interview with APRN #2 on 5/7/25 at 9:05 AM identified she was not notified of the non-blanchable sacral area identified by the prior DNS on 12/15/24. APRN #1 identified that while the interventions implemented by the Prior DNS appeared to be appropriate, if she had been notified, she would have assessed the area or requested that the RN who works with her and alternates visits to the facility to assess the area and notify her of the findings. APRN #2 identified that a non-blanchable area to the sacrum as identified in the Prior DNS's note would possibly have been a pressure ulcer, but she would have needed to assess the area to be sure however she was not notified. (continued on next page)

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	075274	A. Building B. Wing	05/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 5/7/25 at 9:10 AM identified she was the facility wound nurse on 12/15/24. LPN #1 identified she had not been notified regarding the non-blanchable area on Resident #37's sacrum identified on 12/15/24. LPN #1 identified that the process for any newly identified skin area that could potentially be a pressure injury included adding the resident to the upcoming weekly wound rounds so that the wound physician could assess and determine the next steps in treatment. LPN #1 also provided a weekly wound round list dated 12/18/24. Review of the 12/18/24 weekly wound round list failed to identify any documentation that Resident #37 was added to the list to be seen by the wound physician. Review of the 24-hour nursing report sheets from 12/15/24 - 12/20/24 failed to identify any additional documentation related to the non-blanchable area on the sacrum. Although attempted, an interview with the Prior DNS was not obtained. Although attempted, an interview with RN #11 was not obtained. The facility policy on pressure ulcers/skin breakdown directed that the facility would help prevent and manage pressure ulcers consistent with established guidelines. The policy further directed that the nursing staff and practitioner would assess and document an individual's significant risk factors for developing pressure ulcers; For example, immobility and medical instability, and that the physician would help to identify the type and characteristics of any identified ulcer and help identify and define any complications related to pressure ulcers. The policy further directed that the physician would help identify factors contributing or predisposed residents to skin breakdown and would help clarify the status of relevant medical issues including the impact of comorbid conditions on healing and existing wounds.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #163) reviewed for infection control, the facility failed to ensure a resident with an indwelling medical device was placed on enhanced barrier precautions (EBP). The findings include: Resident #163 was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease and dependence on renal dialysis. A physician's order dated 4/15/25 directed to observe permcath (an indwelling medical device used as a vascular access for dialysis) site every shift. Monitor for signs and symptoms of infection. The physician's orders failed to identify a directive for the use of EBP. The nurse's note dated 5/2/25 at 8:03 PM identified Resident #163 was readmitted to the facility, was alert and oriented, had a permcath to the right chest, dressing was intact, dry and no signs of infection noted. This writer was able to verify the medications with the APRN. The skin was intact, with no open areas noted. The care plan dated 5/4/25 identified Resident #163 was at risk for complications related to dialysis. Interventions included monitoring for signs and symptoms of bleeding at the port site and applying pressure, as needed. Review of the facility's Enhanced Barrier Precautions list failed to identify Resident #163 required the employment of EBP. Interview with LPN #8 on 5/7/25 at 10:00 AM identified Resident #163 had not been placed on enhanced barrier precautions. LPN #8 indicated that Resident #163 received dialysis, at an outpatient clinic, through a permcath in his/her right upper chest wall. LPN #8 further indicated that she had not used PPE while providing care to Resident #163, and she would have to check with the Infection Preventionist to see if Resident #163 should be placed on EBP, but she thought he/she probably should be on EBP. LPN #8 identified there was no sign on Resident #163's door indicating that he/she was on EBP. Interview with the Infection Preventionist (LPN #1) on 5/7/25 at 10:04 AM identified Resident #163 was not placed on EBP. LPN #1 indicated that she would check to see if Resident #163 belonged on enhanced barrier precautions because the resident has a permcath. Interview and clinical record review with the DNS on 5/7/25 at 10:10 AM identified that Resident #163 receives dialyses through a permcath, and the resident should be on EBP. The DNS indicated Resident #163 should have an order for enhanced barrier precautions and there should also be signage on his/her door identifying that he/she is on EBP and directing staff to use PPE during care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Enhanced Barrier Precautions policy directs EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. EBPs are indicated (when contact precautions do not otherwise apply) for residents with chronic wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 of 8 residents (Resident #1, 7, 13 and 82) reviewed for pneumococcal vaccinations, the facility failed to ensure that pneumococcal vaccines were offered timely. The findings include: 1. Resident #1 was admitted to the facility in April 2025 with diagnoses that included dementia, diabetes, and hyperlipidemia. The quarterly MDS dated [DATE] identified Resident #1 had moderately impaired cognition. Additionally, pneumococcal vaccine was not up to date and was not offered. The Preventative Health Record for Resident #1 did not reflect a pneumococcal vaccine status. Interview with LPN #1 (Infection Preventionist Nurse) on 5/6/25 at 10:20 AM indicated that Resident #1 has a conservator, and she had offered all the vaccines except the pneumococcal. LPN #1 indicated that she must have missed it because it was not on the same form as the other 3 vaccines. 2. Resident #7 was admitted to the facility in January 2025 with diagnoses that included dementia, chronic obstructive pulmonary disease, and adult failure to thrive. The quarterly MDS dated [DATE] identified Resident #7 had severely impaired cognition and was not up to date with the pneumococcal vaccine. The Preventative Health Record for Resident #7 did not reflect a pneumococcal vaccine status. Interview with LPN #1 on 5/6/25 at 10:22 AM indicated that Resident #7 has a resident representative. LPN #1 offered the pneumococcal 23 in June of 2023, and it was declined, but she did not offer or educate about the other pneumococcal vaccines at that time. LPN #1 indicated that when someone refuses a vaccine, she is responsible to go back a year later and reoffer that vaccine again. LPN #1 indicated that she does not know why she had not reoffered the pneumococcal 23. LPN #1 indicated that she only offered pneumococcal 23 in the facility and does not offer the other pneumococcal vaccines. 3. Resident #13 was readmitted to the facility in March 2025 with diagnoses that included diabetic, stroke, and hypothyroidism. The quarterly MDS dated [DATE] identified Resident #13 had moderately impaired cognition. Additionally, Resident #13 was not up to date with pneumococcal vaccines, it was offered but declined. The Preventative Health Record for Resident #13 did not reflect a pneumococcal vaccine status. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 5/6/25 at 10:25 AM indicated that Resident #13 has a resident representative. LPN #1 had offered the pneumococcal 23 on 5/23/23, and it was declined, but she did not offer or educate about the other pneumococcal vaccines since then. LPN #1 indicated that when someone refuses a vaccine, she is responsible to go back within a year and reoffer and educate about the vaccine again. 4. Resident #82 was admitted to the facility in March 2024 and readmitted in February 2025 with diagnoses that included respiratory syncytial virus, diabetes, and hyperlipidemia. The quarterly MDS dated [DATE] identified Resident # 82 had intact cognition. Additionally, Resident #82 was up to date with the pneumococcal vaccines. The Preventative Health Record for Resident #82 did not reflect a pneumococcal vaccine status. Interview with LPN #1 on 5/6/25 at 10:43 AM indicated did not offer the pneumococcal vaccine because Resident #82 was [AGE] years old. LPN #1 indicated that she did not ask the physician or the APRN if Resident #82 would be eligible due to comorbidities like diabetes due to the residents age. Interview with LPN #1 (Infection Preventionist) on 5/6/25 at 10:45 AM indicated that she was responsible to get the resident's history for vaccines and then educate and offer the vaccines to the resident or the resident's representative on admission and readmission. Interview with MD #1 on 5/6/25 at 11:35 AM indicated if Resident 1, 7, 13, or 82 or their resident representative wanted the pneumococcal vaccine and signed the consent form, he would write the order to give administer the vaccine based on CDC guidelines. MD #1 indicated that he would order the pneumococcal vaccine to be given to Resident #82 due to the residents health status despite the age of [AGE] years old, which is a guide. MD #1 indicated that these residents were eligible and could have received the pneumococcal vaccine. Interview with LPN #3 (corporate) on 5/6/25 at 12:30 PM indicated the expectation was the infection preventionist makes sure all residents are offered vaccines and tracks the vaccines. LPN #3 indicated that the facility is to offer the Prevnar 20 first because it is one dose needed following the CDC guidelines. Review of the facility Pneumococcal Vaccines Policy identified all residents will be offered pneumococcal vaccines to aid in preventing pneumonia and pneumococcal infections. Prior to admission or upon admission resident's will be assessed to receive the pneumococcal vaccine series and then offered the vaccine series on admission to the facility unless medically contraindicated or the resident already been vaccinated. Before receiving the pneumococcal vaccine, the resident or resident representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. See current vaccine information on the CDC website. Provisions of education will be documented in the residents EMR. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Center for Disease Control and Prevention (CDC) recommendations at the time of vaccination.