STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075275	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grimes Center	1354 Chapel St New Haven, CT 06511

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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 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** 42117 Based on review of the clinical record, review of facility documentation and interviews for 3 of 3 residents (Resident #53, #58, and #70) reviewed for advanced directive, the facility failed to ensure the advanced directive form was completed. The findings include: 1. Resident #53 was readmitted to the facility on [DATE] with diagnoses which included dementia, end stage renal disease, and anxiety. The hospital discharge summary dated [DATE] did not identify a code status for Resident #53. A nurses' note dated [DATE] at 10:09 PM identified Resident #53 was admitted to the facility and was alert and oriented times 3. The resident representative was called identified he/she wanted Resident #53 to be a full code. The facility consent form for the administration or withdrawal of cardiopulmonary resuscitation (CPR) identified on [DATE] that 1 nurse had signed a telephone verbal consent from the resident's representative as a full code. The witness line was blank. Review of the nurse's notes dated [DATE]-[DATE] did not reflect that Resident #53 was asked about his/her wishes for the code status. A physician progress note dated [DATE] did not identify a code status. The APRN progress note dated [DATE] did not identify a code status. The quarterly MDS assessment dated [DATE] identified Resident #53 had intact cognition and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The care plan dated [DATE] identified advanced directives. Interventions included Resident #53 was a full code and to review advanced directives quarterly with the resident and/or family. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 6:50 AM identified the code status must be discussed on every admission and readmission with the resident or resident's representative that day or within the first 24 hours. The DNS indicated that if a resident had a BIMS of ,d+[DATE] that resident could sign the advanced directives themselves but if not cognitively intact then the charge nurse was responsible to call the resident representative. The DNS indicated that if the charge nurse calls a resident representative that 2 nurses or 1 nurse and 1 social worker must be present to discuss and receive the advanced directive wishes and the 2 staff must sign the advanced directive form. The DNS indicated if the charge nurse was not able to reach the resident representative that her expectation was there would be a nurses note to reflect that there was a call attempting to get the advance directives. The DNS indicated that if by the day after admission the charge nurse did not get in touch with the resident representative, the social worker would attempt to call and document the call. The DNS indicated if there was a telephone verbal consent for the code status she did not expect that the next time the resident representative visited or at the next quarterly care conference that the resident representative would sign the form. Interview with the ADNS on [DATE] at 7:10 AM indicated that a resident with a BIMS of 15 was able to make their own decisions. The ADNS indicated that Resident #53 had a conservator of person who was the resident representative. The ADNS indicated that on readmission or admission the charge nurse was responsible to get the advanced directives right away. The ADNS indicated if the charge nurse had to call a resident representative to get a code status 2 nurses must hear the resident representative's wishes for the code status on the phone and sign the document. After review of the clinical record, the ADNS indicated there was not a physician's order for the code status and the advance directive form for Resident #53 was only signed by one nurse and there was not any witness. The ADNS indicated there must be 2 nurse's signatures and did not know why it was not done correctly. 2. Resident #58 was readmitted to the facility on [DATE] with diagnoses which included a stroke, anxiety, and diabetes. The nurses note dated [DATE] at 11:00 PM identified Resident #58 was admitted from hospital and was alert and confused. Resident representative was called and requested Resident #58 be a full code. The facility consent form for the administration or withdrawal of cardiopulmonary resuscitation (CPR) form identified on [DATE] that 1 nurse had signed a telephone verbal consent from the resident's representative as a full code. The witness line was blank. A physician's order dated [DATE] directed Resident #58 was a full code. The quarterly MDS assessment dated [DATE] identified Resident #58 had moderately impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The care plan dated [DATE] identified advanced directives. Interventions included Resident #58 was a full code and to review advanced directives quarterly with the resident and/or family. Interview with the ADNS on [DATE] at 7:15 AM indicated that Resident #58 had a responsible party. After clinical record review, the ADNS indicated that the charge nurse had called the resident representative and received a verbal consent from the resident representative but did not have a witness. The ADNS indicated she would have expected a second person to witness and sign the form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #70 was admitted to the facility on [DATE] with diagnoses which included heart failure, schizophrenia, and diabetes. The hospital discharge summary dated [DATE] identified Resident #70 was a full code per the W-10 to the hospital but was not discussed with resident or resident representative. A physician's order dated [DATE] directed full code. The care plan dated [DATE] identified advanced directives. Interventions included Resident #70 was a full code and to review advanced directives quarterly with the resident and/or family. The nurse's note dated [DATE] at 9:44 PM identified Resident #70 was admitted to the facility and had a BIMS of 3 (BIMS of 3 means severely impaired cognition). Called the conservator and left a message. Review of the progress notes dated [DATE]- [DATE] did not identify any staff had attempted to speak with the conservator regarding the code status. Interview with the ADNS on [DATE] at 7:20 AM identified the administration or withdrawal of cardiopulmonary resuscitation (CPR) form was blank in Resident #70's chart. The ADNS indicated that Resident #70 was admitted from the hospital as a full code on [DATE] and the facility had not spoken with Resident #70's conservator. The ADNS indicated the conservator had visited but did not recall when. The ADNS indicated the charge nurse should have discussed the advanced directives when he/she had visited and documented the conversation. The ADNS indicated the code status should have been obtained within the first day or two following admission to the facility. Interview with the SW #1 on [DATE] at 7:30 AM indicated if a resident was admitted and is not cognitively intact nursing will inform her if they were unable to reach the residents representative. SW #1 indicated she will attempt to call and if she needs to, she will fax, scan, or email the residents representative regarding the advanced directives requesting they sign the form and send it back to the facility. SW #1 indicated that she should document any attempts to call someone but doesn't always document. SW #1 indicated the advanced directive should have been received by the resident or resident representative within ,d+[DATE] hours of the admission or readmission. SW #1 indicated that a resident is a full code until the resident or resident representative signs the advance directive form. SW #1 indicated that Resident 53's representative does come into the facility to visit and could sign the advanced directive form. SW #1 indicated that Resident #58, she did not see any social worker notes identifying social services got involved with the code status. SW #1 indicated that Resident #70, she had seen the resident representative and handed the advanced directive form to him/her but thought nursing would have followed up to get the form back. Review of the facility Advanced Directive and Physician Order Form Policy identified all residents upon admission to the facility will be asked their advanced directives. The advanced directive and physician order form will be completed. The physician order for code status will be transcribed by the nurse into the electronic medical record.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37293 Based on review of the clinical records ,review of facility documentation, and interviews for 3 of 5 residents (Resident #1, 18 and 71), reviewed for hospitalization , the facility failed to ensure the Office of the State Long-Term Care Ombudsman was notified when the residents were transferred to the hospital. The findings include. 1a. Resident #1 was admitted to the facility in February 2024 with diagnoses which included chronic kidney disease, myocardial infarction, and atherosclerotic heart disease. The nurse's note dated 2/17/24 at 1:48 PM identified Resident #1 was transferred to the hospital. The nurse's note dated 2/29/24 at 2:41 PM identified Resident #1 was readmitted to the facility. Review of the Action Summary dated 2/1/24 - 2/29/24 failed to reflect the Office of the State Long-Term Care Ombudsman had been notified when Resident #1 was transferred to the hospital on 2/17/24. b. The nurse's note dated 3/16/24 at 6:22 AM identified Resident #1 was transferred to the hospital. The nurse's note dated 3/28/24 at 3:39 AM identified Resident #1 was readmitted to the facility. Review of the Action Summary dated 3/1/24 - 3/31/24 failed to reflect the Office of the State Long-Term Care Ombudsman had been notified when Resident #1 was transferred to the hospital on 3/16/24. 2a. Resident #18 was admitted to the facility in September 2020 with diagnoses which included congestive heart failure, atrial fibrillation, and chronic kidney disease. The nurse's note dated 3/15/24 at 10:55 AM identified Resident #18 was transferred to the hospital. The nurse's note dated 3/20/24 at 8:47 PM identified Resident #18 was readmitted to the facility. Review of the Action Summary dated 3/1/24 - 3/31/24 failed to reflect the Office of the State Long-Term Care Ombudsman had been notified when Resident #18 was transferred to the hospital on 3/15/24. b. The nurse's note dated 3/28/24 at 12:13 PM identified Resident #18 was transferred to the hospital. The nurse's note dated 4/2/24 at 11:28 PM identified Resident #18 was readmitted to the facility. Review of the Action Summary dated 3/1/24 - 3/31/24 failed to reflect the Office of the State Long-Term Care Ombudsman had been notified when Resident #18 was transferred to the hospital on 3/28/24. 3. Resident #71 was admitted to the facility in November 2023 with diagnoses that included Wegener's granulomatosis, epilepsy, and chronic pain syndrome. The nurse's note dated 11/17/23 at 6:14 PM identified Resident #71 was transferred to the hospital. The nurse's note dated 12/27/23 at 11:01 PM identified Resident #71 was readmitted to the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Action Summary dated 11/1/23 - 11/30/23 failed to reflect the Office of the State Long-Term Care Ombudsman had been notified when Resident #71 was transferred to the hospital on 11/17/23. Interview with the Administrator on 4/8/24 at 9:00 AM identified she was not aware of the Action Summary was being sent out monthly but was not aware it was being sent incorrectly. Interview with the DNS on 4/8/24 at 9:10 AM identified SW #1 and the medical record staff were responsible for sending the Action Summary to the Office of the State Long-Term Care Ombudsman. Interview with the medical record staff on 4/8/24 at 10:39 AM identified she uploads the discharges to the hospital to the Office of the State Long-Term Care Ombudsman the first week of each month. The medical record person indicated she was not aware she was sending the incorrect Action Summary. Subsequent to surveyor inquiry SW #1 send the correction for the Action Summary dated 1/1/23 - 12/31/23 and 1/1/24 - 3/31/24 to the Office of the State Long-Term Care Ombudsman. Although requested, a facility policy was not provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, review of facility documentation, and interviews for 2 of 4 residents (Resident #40, Resident #37) reviewed for accidents, the facility failed to provide adequate supervision to prevent a fall resulting in a fracture and the facility failed to ensure appropriate observation and monitoring was conducted for a resident with multiple recurrent falls.The findings include: 1. Resident #40 was admitted to the facility with diagnoses which included schizophrenia, emphysema, bilateral lower extremity neuropathy, and multiple malignant neoplasms. The quarterly MDS assessment dated [DATE] identified intact cognition and required supervision with transfers, bed mobility, walking in room and corridor, dressing, toilet use, and personal hygiene. The care plan dated 3/23/23 identified Resident #40 was at risk for falls related to cancer diagnosis and anticipated decline in functional status with a progressive terminal disease. Interventions included to cue for safety awareness, keep environment safe, and remind to call for assistance. The Occupational Therapy Discharge Summary dated 3/23/23 identified Resident #40 was contact guard assistance with rolling walker or holding the tube feeding pole and assistance with peroneal hygiene for thoroughness. Resident #40 was discharged with recommendations of continue with independent ambulation and participation with activities of daily living. The Physical Therapy Discharge Summary dated 3/24/23 identified ambulation with rolling walker minimal assist of 1 sidestepping. Discharge recommendations continue ambulation with or without feeding tube pole for support and moderate independent mobility ad lib on nursing unit. The reportable event dated 4/29/23 at 2:55 PM indicated Resident #40 had an unwitnessed fall in the shower. Resident #40 indicated that he/she slipped and fell while in the shower on his/her left arm. Resident #40 complained of pain in left shoulder, had increased swelling, tenderness to touch, and was unable to move the left upper extremity. The physician was notified and directed the resident be transferred to the emergency room for an evaluation. The care plan dated 4/30/23 identified at risk for falls. Intervention directed to assist resident in the shower to prevent falls in the shower. The reportable event summary written by the DNS dated 5/3/23 identified Resident #40 had an unwitnessed fall in the shower. The emergency room x-ray report indicated an acute mildly displaced fracture at the proximal humerus. Resident #40 had reported he/she was in the shower and lost his/her balance and slipped and fell on to the left arm. Resident #40 had gotten him/herself up off the shower floor and ambulated to his/her room and notified the nurse of the fall and requested pain medication. Left cuff and collar sling in place and Resident #40 now is non weight bearing to the left upper extremity. Resident #40 is to follow up with orthopedics within 2 weeks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 4/8/24 at 10:27 AM indicated Resident #40 was independent with ambulation and the nursing assistant should help set Resident #40 up in the shower but was expected to stay in shower room with resident for safety in case the resident would fall because the floor gets wet from the water, or the shower chair could move when attempting to sit on it or get up. Interview and clinical record review with OT #1 on 4/8/24 at 10:45 AM indicated that she had worked with Resident #40 and discharged him/her on 3/23/23. OT #1 indicated Resident #40 could ambulate independently but was not evaluated if he/she could shower independently. OT #1 indicated that she would be responsible to evaluate a resident to see if the resident was safe to shower independently. OT #1 indicated her expectation was that when Resident #40 gets a shower that a nursing assistant stay with Resident #40. Interview with NA #3 on 4/9/24 at 10:30 AM indicated when she is assigned to Resident #40, she will bring him/her washcloths and towels and Resident #40 will ambulate to the shower room. NA #3 indicated after Resident #40 is set up she will leave him/her alone in the shower. NA #3 indicated when Resident #40 is done with the shower Resident #40 will ambulate independently back to his/her room pushing the IV/feeding tube pole. NA #3 indicated that all the nursing assistants just knew that Resident #40 was independent in the shower. NA #3 indicated she does not recall if it was on the nursing assistant care card for Resident #40 to shower alone NA #3 indicated she did not ask the nurse if it was okay to leave Resident #40 alone in the shower. NA #3 indicated on the day that Resident #40 had fallen and had to go to the emergency room she did not recall if she had escorted him/her that day to the shower prior to going on her break. NA #3 did recall she was at break at the time of the fall. Interview with APRN #1 on 4/9/24 at 12:47 PM indicated that for a resident to be independent and left alone in a shower that therapy would have to conduct an evaluation and clear the resident as independent in the shower. The facility was unable to provide documentation that Resident #40 was assessed by therapy to independently shower alone and have a physicians order to allow Resident #40 to shower alone. Although attempted, an interview with LPN #3and RN #3 were not obtained. 46040 2. Resident # 37 was admitted to the facility on [DATE] with diagnoses which included repeated falls, muscle weakness, and dementia. The admission MDS assessment dated [DATE] identified Resident # 37 had severely impaired cognition, was always continent of bowel and bladder, required extensive assistance from staff with bathing and moderate assistance with toileting and transfers. The MDS further identified Resident #37 had a history of falls in the month prior to admission to the facility and had at least one following admission to the facility. The care plan dated 11/11/23 identified Resident #37 was at risk for falls due to functional decline and a history of repeated falls. Interventions included offering frequent toileting, always use nonskid socks, and keep resident in sight. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility accident and incident (A&I) report dated 11/25/23 at 11:45 PM identified Resident #37 had an unwitnessed fall. The report identified that Resident #37 was found on the bathroom floor after self-transferring to the bathroom. Interventions identified that Resident #37 required a 1:1 sitter. Review of the clinical record failed to identify any documentation related to 1:1 monitoring observations of Resident #37 after the 11/25/23 unwitnessed fall. A facility A&I report dated 11/26/23 at 12:50 PM identified Resident #37 had an unwitnessed fall attempting to get up from a chair and fell to the floor on his/her right arm. Interventions included a X-ray of the right arm and that Resident required a 1:1 sitter. The care plan dated 11/26/23 identified Resident # 37 was at risk for falls due to functional decline and a history of repeated falls and included a new intervention of a need for a 1:1 sitter. Review of the clinical record failed to identify any documentation related to 1:1 monitoring observations of Resident #37 after the 11/26/23 unwitnessed fall. An APRN note dated 11/27/23 by APRN #1 identified that Resident #37's right arm x ray did not show any acute fracture, but that Resident #37 had a + Covid test and had been started on Paxlovid (a medication for Covid 19). The note further identified Resident #37 had a 1:1 sitter for safety interventions. Review of the clinical record identified multiple nursing notes which noted Resident #37 was on 1:1 monitoring due to repeated falls. The clinical record failed to identify any documentation related to 1:1 monitoring observations by any nursing staff at the facility conducted on Resident #37 from 11/27-12/7/23. A nurse's note dated 12/7/23 at 12:49 AM identified Resident #37 had a 1:1 sitter for safety. A facility A&I report dated 12/7/23 at 7:30 AM identified Resident #37 had an unwitnessed fall and was found sitting on the floor next to his/her bed. The interventions included continuing with a 1:1 sitter. Review of working daily staffing roster included with the A&I report failed to identify that any staff member was assigned to monitor Resident #37 at any time from 7:00 AM-11:00PM. Review of the clinical record failed to identify any documentation related to neurological monitoring completed following Resident #37's unwitnessed fall on 12/7/23. Review of the clinical record identified that Resident #37's monitoring was changed from 1:1 to every 30 minute checks on 1/4/24 and identified that Resident #37 had every 30 minute monitoring completed and documented on the form Every half hour checks for safety and care needs. Further review of the clinical record identified one additional monitoring form completed for Resident #37 dated 1/6/24. The clinical record failed to identify any additional documentation related to every 30 minute observations or monitoring completed for Resident #37 from 1/7-1/17/24. The nurse's note dated 1/17/24 at 12:56 AM identified Resident #37 was on every 30 minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility A&I report dated 1/17/24 at 10:00 AM identified Resident #37 had an unwitnessed fall. The A&I report identified that staff were providing care to the resident at approximately 10:00 AM and identified a bruised area to Resident #37's left shoulder and left outer eye. The report identified Resident #37 indicated he/she fell last night while attempting to use the bathroom. Interventions included an X-ray of the left shoulder and every 15 minute checks of the resident. The X ray report dated 1/18/24 identified Resident #37 had no acute changes to the left shoulder. Review of the clinical record failed to identify any documentation related to every 15 minute observations or monitoring completed following Resident #37's unwitnessed fall on 1/17/24. The clinical record also failed to identify every 15 minute observations or monitoring were completed on 1/18/24 and 1/19/24. Review of the clinical record identified documentation related to every 15 minutes and observation checks completed on Resident #37 beginning on 1/20/24. The documentation reviewed identified multiple days and timeframe's when no observations or monitoring were documented and included: 1/22/24: 7 AM-2:45 PM and 6 PM-10:45 PM 1/23/24: 7 AM-10:45 PM 1/24/24: 7:45 PM-9 PM 1/27/24: 9 AM-10:45 PM 1/29/24: 8 PM-10:45 PM 1/30/24: 7 AM-2:45 PM 1/31/24: 3 PM-10:45 PM 2/1/24: No documentation for this date 2/4-2/5/24: No documentation for these dates A facility A&I report dated 2/7/24 at 10:05 PM identified Resident #37 had an unwitnessed fall. The report identified that Resident #37 was found on the floor to the left side of his/her bed and no apparent injuries were identified. Interventions included continuing every 15 minute checks. Review of the clinical record identified documentation related to every 15 minute monitoring and observation checks were continued and completed on Resident #37 following the fall on 2/7/24. The documentation reviewed failed to identify any observations or monitoring were documented or completed for the following dates/times: 2/9/24: 7 AM-2:45 PM 2/10/24: 3 PM-10:45 PM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/13/24: 7 AM-2:45 PM 3/15/24: 2:15 PM-10:45 PM A facility A&I report dated 3/16/24 at 9:30 AM identified Resident #37 had an unwitnessed fall. The report identified that Resident #37 slid off his/her bed and hit his/her buttocks on the floor. Resident #37 reported he/she was attempting to walk to the bathroom. Interventions included continuing every 15 minute checks. Further review of the clinical record failed identify any documentation related to every 15 minute monitoring and observation checks were completed on 3/16/24 from 7 AM -2:45 PM. Review of the clinical record failed to identify any documentation related to neurological monitoring was completed following Resident #37's unwitnessed fall on 3/16/24. Review of the clinical record identified documentation related to every 15 minute monitoring and observation checks were continued and completed on Resident #37 following the fall on 3/16/24. The documentation reviewed failed to identify any observations or monitoring were documented or completed on 3/17/24 or 3/18/24. A facility A&I report dated 3/19/24 at 12:15 AM identified Resident #37 had an unwitnessed fall. The report identified Resident # 37 was found sitting on the floor next to his/her bed with no apparent injuries. Interventions included continuing every 15 minute checks and offer toileting when resident was awake. Review of the clinical record identified documentation related to every 15 minute monitoring and observation checks were continued and completed on Resident #37 following the fall on 3/19/24. The documentation reviewed failed to identify any observations or monitoring were documented or completed on 3/21/24 beginning at 3 PM. A facility A&I report dated 3/21/24 at 3:15 PM identified Resident #37 had an unwitnessed fall. The report identified Resident #37 was found sitting on the floor in his/her room with his/her back against a chair. Resident #37 reported that he/she had returned from the bathroom and attempted to sit in the chair but slid to the floor. Interventions included a 1:1 sitter. Review of the clinical record failed to identify any documentation related to neurological monitoring was completed following Resident #37's unwitnessed fall on 3/21/24. Review of the clinical record failed to identify documentation related to 1:1 observation and monitoring were initiated and completed on Resident #37 following the fall on 3/21/24 from 3:00 PM-10:45 PM. Further review of the clinical record identified that every 15 minute were done in place of 1:1 monitoring beginning 3/22/24 at 11 PM. The documentation reviewed failed to identify any observations or monitoring, including every 15 minute checks or 1:1 monitoring, were documented or completed for the following dates/times: 3/22/24: 7:15 PM-10:45 PM 3/23/24: 7 AM-10:45 PM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/24/24: no documentation for this date 3/25/24: 7 AM-10:45 PM 3/26/24: 7 AM-10:45 PM 3/27-3/28/24: no documentation for these dates 3/29/24: 12:30 PM-10:45 PM 3/30/24: no documentation related to monitoring or observations. Review of the monitoring form identified sitter/1:1 written at the 11 PM, 7 AM, and 3 PM time slots with a line and arrow drawn down the row of the respective subsequent 15-minute times with no additional documentation. 4/1-4/3/24: no documentation for these dates 4/4/24: Review of the monitoring form identified sitter/1:1 written at the 11 PM time slots with a line and arrow drawn down the row. 7 AM-2:45 identified 15 minute checks were completed. The documentation also identified a line and arrow and 1:1 sitter written in at the 3PM timeslot with an arrow to 9:15 PM. No additional line or note was identified from 9:30 PM-10:45 PM. 4/5/24: Review of the monitoring form identified sitter written at the 11 PM time slot with a line and arrow drawn down the row. 7 AM-10:00 AM identified 15 minute checks were completed and at 10:15 AM sitter was written into the time slot with a line and arrow drawn to 2:45 PM. No documentation was identified from 3 PM-10:45 PM. 4/6/24: no documentation related to monitoring or observations. Review of the monitoring form identified sitter/1:1 written at the 11 PM and 3 PM time slots with a line and arrow drawn down the row. No documentation was identified from 7 AM-2:45 PM. A daily nursing roster report dated 4/7/24 provided to the survey team upon entrance to the facility identified Resident #37 was on every 15 minute checks. Observation on 4/7/24 at 7:46 AM identified Resident #37 sleeping in bed in his/her room. During this observation, no staff member was identified in the room. During this observation, NA #1 was observed assisting another resident in the same hallway as Resident #37. Review of the clinical record identified Resident #37 was on 1:1 monitoring as a nursing measure on 4/7/24. Review of the daily staffing sheet for 4/7/24 identified NA #1 was assigned as the sitter for Resident #37's unit. Observation on 4/8/24 at 8:45 AM identified NA #1 in Resident #37's room. NA #1 was assisting Resident #299, Resident #37's roommate, with dressing. NA #1 was observed with her back turned to Resident #37, who was seated across the room in a chair. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/8/24 at 10:00 AM with RN # 2 (unit manager) and LPN #3, who was assigned to care for Resident #37, identified that Resident #37 had a nursing intervention in place for 1:1 monitoring and that providers at the facility did not place monitoring orders for residents. RN #2 identified that a sitter was listed on the daily nursing schedule to be assigned to residents who required 1:1 monitoring, but due to staffing issues, 1:1 monitoring could not always be provided. RN #2 identified that depending on staffing, monitoring for Resident #37 would fluctuate between 1:1 monitoring, every 15-minute checks, every 30 minute checks, or every hours. LPN #3 identified there was always a staff member checking in on Resident #37, even if it was not 1:1 and that when the sitter assigned to care for Resident #37 would go on break or lunch, that Resident #37 would not have a sitter assigned to cover this time, rather, staff would just go in and do frequent checks on the resident. RN #2 identified that Resident #299 had recently been put on 1:1 monitoring due to a recent fall, and that he/she was moved to the same room as Resident #37 to allow for one sitter to be assigned to both residents. RN #2 identified that the facility did not have the staffing for each resident to have a staff member assigned individually and that the staff member assigned to complete 1:1 monitoring for more than one resident was expected to also complete any ADL assistance, including assistance with toileting, daily care, personal hygiene, and transfers. Observation and interview with NA #1 on 4/8/24 at 1:15 PM identified that she was the primary day shift staff member assigned to complete 1:1 monitoring for Resident #37. NA #1 identified that while the schedule would identify her assignment as a sitter for Resident #37, this often changed due to short staffing due to call outs. NA #1 identified that she had been assigned to care for both Resident #37 and Resident #299 as a 1:1 and that any staff member in the facility would be assigned to care for both residents as a 1:1, and that would include all care that would be provided to both residents during the shift. NA #1 also identified that when she was assigned to care for Resident #37, she was also responsible to document her observations on the form for every 15 minute checks. NA #1 identified that prior to 4/8/24, she had not been assigned to complete any 1:1 monitoring or care for Resident #39 for over a week due to staffing and assignment changes, and had not been assigned to care for or provide monitoring for Resident #37 on 4/7/24. During this observation, NA #1 was observed sitting with both Resident #37 and #299 in the unit's resident dining room. (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 DNS on 4/8/24 at 2:24 PM identified that the facility policy did not require that frequent monitoring, whether it be hourly, every 30 minute, 15 minute, or 1:1 continuous monitoring, have a physician's order. The DNS identified that the facility would decide on the level of monitoring needed on a case by case basis and that the facility policy for residents with a history of falls allowed for purposeful rounding, which required staff to check on residents hourly, and that level of monitoring would change depending on the resident's needs. The DNS identified that if a resident was deemed to need 1:1 monitoring, this would have been determined based on her discussing the resident at the weekly risk management meeting with APRN #1. The DNS identified that she was aware of Resident #37's history of repeated falls and that he/she had been on 1:1 monitoring from 11/26/23-1/3/24, then changed to every 30 minute checks from 1/4-2/6/24, then every 15 minute checks from 2/7-3/20/24, and was currently on 1:1 monitoring. The DNS identified that 1:1 monitoring in the facility was to be conducted with one staff member and one resident, and that the assignment be 1 person to 1 person. The DNS also identified that neurological monitoring should be initiated and completed over 72 hours for any resident who was a poor historian and had an unwitnessed fall. The DNS identified that she reviewed the facility A&I reports as part of the risk meetings for the residents and that she was unsure why the documentation related to the neurological assessments for 12/7/23, 3/16/24, or 3/21/24 but that they should have been completed. The DNS identified she was not aware that the staff had adjusted Resident #37's monitoring based on staffing issues, or at times the monitoring intervention in place was not being carried out at all due to staffing issues. The DNS identified she did review Resident #37's case and history of falls weekly at-risk management but did not review staffing or the monitoring sheets to determine if that may be part of Resident #37's issue with repeated falls. The DNS identified that she would re-educate the staff on 1:1 monitoring and that Resident #37 should have only have one staff member assigned to him/her exclusively if he/she required 1:1 monitoring. The DNS was not able to explain how Resident #37 continued to have multiple falls while on enhanced monitoring. Interview with APRN #1 on 4/9/24 at 12:45 PM identified that she was aware of Resident #37's history of repeated falls and that he/she often required either 15 minute checks or 1:1 monitoring. APRN #1 identified that the monitoring was not a provider directed order in the resident's chart, but a nursing intervention, but that the level of monitoring was determined based on the resident's risk and discussion between her and the DNS, and at times also Resident #37's physician. APRN #1 identified that she was not aware that the monitoring put in place was altered based on the nursing staffing levels and was not being done at times, and identified staffing has been an issue everywhere. APRN #1 identified that her expectation would be that the monitoring level discussed with the DNS, whether it be every 15 minutes or continuous 1:1 monitoring, be carried out to ensure the resident's safety. The facility policy on falls directed that residents at risk for falls would have fall prevention and precautions implemented as appropriate and that all falls would be reviewed during at risk meetings, monthly, and as needed to identify trends and any common causes. The policy further directed that interventions would be utilized for patients that were fall risks, including purposeful rounding and at times may require a 1:1 sitter. The policy identified that as part of the fall prevention program, the facility staff would complete purposeful rounding, which included rounding on all residents of the facility hourly to determine if the residents required any assistance or needed any items (tissues, something to eat/drink, etc) to help with fall prevention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on neurological checks directed neurological checks should be completed on any resident with an unwitnessed fall who was unable to accurately verbalize if he/she hit his/her head. The policy further directed that for unwitnessed falls, check would be initiated and completed every 15 minutes for 2 hours, every 30 minutes for 2 hours, every hour for 4 hours, every 8 hours for 16 hours, and every shift for 3 days and should include date and time of the assessment, level of consciousness, vital signs, and pupil response.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 2 residents (Resident #17) reviewed for nutrition, the facility failed to ensure the dietitian had followed up on weight loss. The findings include: Resident #17 was admitted to the facility with a diagnosis which included Alzheimer's disease, dementia, dysphagia, and diabetes. The quarterly MDS assessment dated [DATE] identified Resident #17 had severely impaired cognition and required set up with meals. Resident #17's height was 70 inches, weighed of 236 lbs. and did not have a weight gain or loss. Resident #17 was on a therapeutic diet. The care plan dated 12/13/23 identified nutrition and dehydration risk with a weight gain this quarter ending on 12/13/23. Interventions included to provide diet as ordered. The dietitian quarterly progress note dated 12/13/2023 at 9:36 AM identified Resident #17's diet was no added salt and no concentrated sweets. On 12/11/23 residents' weight was 235.9 lbs. Resident continues to feed him/herself and oral intake is consistently documented at 75-100%, with no problems chewing or swallowing. Resident has diagnosis of dementia and new goal is for weight maintenance. A review of the clinical record failed to identify Resident #17 usual and/or ideal body weight. The care plan was revised on 12/13/23 to identify at risk for nutrition and dehydration related to dysphasia. Interventions included providing diet as ordered and Resident #17 will maintain weight of 236 lbs. plus or minus 5 lbs through next review. The Weight Summary Form identified Resident weight on 12/25/2023 at 8:55 PM was 239 lbs. A physician's order dated 1/3/24 directed to provide shower, body audit, and weight every Monday 3:00 PM -11:00 PM shift. The dietitian progress note dated 1/3/2024 at 12:03 PM identified Resident #17 was scheduled for a significant change due to a left ankle fracture. There is no change in residents' nutritional status related to this change. Care plan remains as outlined. The Weight Summary Form dated 1/8/24 identified Resident #17's weight was 224 lbs., a weight loss from 12/25/23 of 15 lbs. which represented a 6.3 % weight loss. Additionally, had an 11.8 lbs. representing a 5% weight loss from 12/11/23, and had an 18.6 lbs. weight loss representing a 7.7% weight loss since 10/9/23. Weight Summary Form dated 1/10/24 identified Resident #17's weight was 221.9 lbs., identified it was a 14 lb. and 6% weight loss since 12/11/23 and 18.6 lb. and 7.7% weight loss since 10/23/23. Weight Summary Form dated 1/23/24 identified Resident #17's weight was 220.6 lbs. identified it was an 18. 4 lbs. and 7.7% weight loss since 12/25/23. Weight Summary Form dated 2/12/24 identified Resident #17's weight was 219.5 lbs. identified it was a 19.5 lbs. and 8.2% weight loss since 12/25/23. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Dietitian on 4/8/24 at 12:00 PM, failed to provide documentation that she had assessed Resident #17 after the noted weight loss on 1/8, 1/10, 1/23, and 2/12/24 and brought it to the weekly meeting with the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. The Dietitian had assessed Resident #17 on 12/13/23 and then did not see Resident #17 until 3/8/24. Review of the facility Nutritional Care of Residents for Weight Loss and Gain Policy identified to assist in maintaining each resident as closely as possible to their ideal body weight. All residents will be assessed by the dietitian and the dietitian will define the ideal body weight for individual residents. When there is an unexplained weight loss or gain, nursing will reweigh the resident to check for accuracy of the weight. If there is a 5% weight loss in a month or a 10% weight loss in 6 months, the charge nurse shall notify the physician, the dietitian and the residents care plan will be updated with the new interventions to prevent any further unwanted weight loss. If there is a significant unplanned weight loss or gain the dietitian will assess the resident and will make appropriate recommendations to address the loss or gain. Review of the dietitian job description identified she was responsible for assessing resident's dietary needs through interviews, assessments, and collaboration with other team members.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observations, clinical record review, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #37) reviewed for accidents, the facility failed to ensure adequate nursing staff was available to provide close monitoring for a resident with multiple falls per facility policy. The findings include: Resident # 37 was admitted to the facility on [DATE] with diagnoses which included repeated falls, muscle weakness, and dementia. The admission MDS assessment dated [DATE] identified Resident # 37 had severely impaired cognition, was always continent of bowel and bladder, required substantial assistance from staff with bathing and moderate assistance with toileting and transfers. The MDS further identified Resident #37 had a history of falls in the month prior to admission to the facility and had at least one following admission to the facility. The care plan dated 11/26/23 identified Resident # 37 was at risk for falls due to functional decline and a history of repeated falls and included a new intervention of a need for a 1:1 sitter. Review of the clinical record and facility accident/incident reports identified Resident #37 had a total of 12 falls at the facility between 11/2/23-3/21/24. A daily nursing roster report dated 4/7/24 provided to the survey team upon entrance to the facility identified Resident #37 was on every 15 minute checks. Review of the clinical record identified Resident #37 was on 1:1 monitoring as a nursing measure on 4/7/24 Review of the daily staffing sheet for 4/7/24 identified NA #1 was assigned as the sitter for Resident #37's unit. Observation on 4/7/24 at 7:46 AM identified Resident #37 sleeping in bed in his/her room. During this observation, no staff member was identified in the room. During this observation, NA #1 was observed assisting another resident in the same hallway as Resident #37. Observation on 4/8/24 at 8:45 AM identified NA #1 in Resident #37's room. NA #1 was assisting Resident #299, Resident #37's roommate, with dressing. NA #1 was observed with her back turned to Resident #37, who was seated across the room in a chair. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/8/24 at 10:00 AM with RN # 2 (unit manager) and LPN #3, who was assigned to care for Resident #37, identified Resident #37 had a nursing intervention in place for 1:1 monitoring and that providers at the facility did not place monitoring orders for residents. RN #2 identified that a sitter was listed on the daily nursing schedule to be assigned to residents who required 1:1 monitoring, but due to staffing issues, 1:1 monitoring could not always be provided. RN #2 identified that depending on staffing, monitoring for Resident #37 would fluctuate between 1:1 monitoring, every 15-minute checks, every 30 minute checks, or every hour checks. LPN #3 identified there was always a staff member checking in on Resident #37, even if it was not 1:1 and that when the sitter assigned to care for Resident #37 would go on break or lunch, that Resident #37 would not have a sitter assigned to cover this time, rather, staff would just go in and do frequent checks on the resident. RN #2 identified that Resident #299 had recently been put on 1:1 monitoring due to a recent fall, and that he/she was moved to the same room as Resident #37 to allow for one sitter to be assigned to both residents. RN #2 identified that the facility did not have the staffing for each resident to have a staff member assigned individually and that the staff member assigned to complete 1:1 monitoring for more than one resident was expected to also complete any ADL assistance, including assistance with toileting, daily care, personal hygiene, and transfers. Observation and interview with NA #1 on 4/8/24 at 1:15 PM identified that she was the primary day shift staff member assigned to complete 1:1 monitoring for Resident #37. NA #1 identified that while the schedule would identify her assignment as a sitter for Resident #37, this often changed due to short staffing due to call outs. NA #1 identified that she had been assigned to care for both Resident #37 and Resident #299 as a 1:1 and that any staff member in the facility would be assigned to care for both residents as a 1:1, and that would include all care that would be provided to both residents during the shift. NA #1 also identified that when she was assigned to care for Resident #37, she was also responsible to document her observations on the form for every 15 minute checks. NA #1 identified that prior to 4/8/24, she had not been assigned to complete any 1:1 monitoring or care for Resident #37 for over a week due to staffing and assignment changes, and had not been assigned to care for or provide monitoring for Resident #37 on 4/7/24. During this observation, NA #1 was observed sitting with both Resident #37 and #299 in the unit's resident dining room. Interview with the DNS on 4/8/24 at 2:24 PM identified that the facility policy did not require that frequent monitoring, whether it be hourly, every 30 minute, 15 minute, or 1:1 continuous monitoring, have a physician's order. The DNS identified that the facility would decide on the level of monitoring needed on a case by case basis and that the facility policy for residents with a history of falls allowed for purposeful rounding, which required staff to check on residents hourly, and that level of monitoring would change depending on the resident's needs. The DNS identified that she was aware of Resident #37's history of repeated falls with current 1:1 monitoring. The DNS identified that 1:1 monitoring in the facility was to be conducted with one staff member and one resident, and that the assignment be 1 person to 1 resident. The DNS identified she was not aware that the staff had adjusted Resident #37's monitoring based on staffing issues, or at times the monitoring intervention in place was not being carried out at all due to staffing issues. The DNS identified she did review Resident #37's case and history of falls weekly at-risk management meeting but did not review staffing or the monitoring sheets to determine if that may be part of Resident #37's issue with repeated falls. The DNS identified that she would re-educate the staff on 1:1 monitoring, and that Resident #37 should have only have one staff member assigned to him/her exclusively if he/she required 1:1 monitoring. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 4/9/24 at 12:45 PM identified that she was aware of Resident #37's history of repeated falls and that he/she often required either 15 minute checks or 1:1 monitoring. APRN #1 identified that the monitoring was not a provider directed order in the resident's chart, but a nursing intervention, but that the level of monitoring was determined based on the resident's risk and discussion between her and the DNS, and at times also Resident #37's physician. APRN #1 identified that she was not aware that the monitoring put in place was altered based on the nursing staffing levels and was not being done at times and identified staffing has been an issue everywhere. APRN #1 identified that her expectation would be that the monitoring level discussed with the DNS, whether it be every 15 minutes or continuous 1:1 monitoring, be carried out to ensure the resident's safety. The facility policy on falls directed that residents at risk for falls would have fall prevention and precautions implemented as appropriate and that all falls would be reviewed during at risk meetings, monthly, and as needed to identify trends and any common causes. The policy further directed that interventions would be utilized for patients that were fall risks, including purposeful rounding and at times may require a 1:1 sitter. The policy identified that as part of the fall prevention program, the facility staff would complete purposeful rounding, which included rounding on all residents of the facility hourly to determine if the residents required any assistance or needed any items (tissues, something to eat/drink, etc) to help with fall prevention.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 5 residents (Resident #16) reviewed for unnecessary medications, the facility failed monitor targeted behaviors for antipsychotics use. The findings include: Resident #16 was admitted to the facility with diagnoses which included bipolar disorder, dementia, depressive episodes, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #16 had intact cognition, did not display physical or verbal behaviors towards others, no hallucinations or delusions, no rejection of care or wandering. Resident #16 receives antipsychotics and antidepressants in the last 7 days. The care plan dated 2/7/24 identified daily use of psychotropic medication related to bipolar disorder with anxiety and depression. Interventions included to administer medications as ordered, monitor for side effects including movement disorder, discomfort, hypotension, gait disturbance, constipation or cognitive/behavioral impairment, and physician to consider dose reduction when clinically appropriate. The psychiatric APRN progress note dated 2/15/24 indicated Resident #16 was on Zoloft and Zyprexa daily and Trazodone (start date unknown) twice a day as needed for 30 days. Resident #16 chooses to stay in bed and self-isolate at baseline. Resident #16 and staff deny any concerns for adverse reactions for psychotropic medications. A physician's order dated 2/21/24 directed to document on behavior monitoring flow sheet every shift. Olanzapine Oral Tablet 5 MG (Zyprexa an antipsychotic) give 5 mg by mouth at bedtime for depression, Sertraline HCl Oral Tablet (Zoloft an antidepressant) give 100 mg by mouth one time a day for depression. Additionally, Trazadone 25 mg (a sedative, original order dated 12/29/23) twice a day as needed for 60 days and then re-evaluate. The psychiatric APRN progress note dated 2/26/24 indicated to monitor behaviors of concern: disorganized behaviors, delusions, and restlessness. Resident #16 is currently hypomanic. The physician progress note dated 3/4/24 indicated Resident #16 was seen to help with dealing with grief of losing roommate. Resident #16 does not present an active delusion process. The progress note did not reflect the rationale to continue the use Trazadone 25mg as needed for 60 days. A physician's order dated 3/4/24 directed to give Trazodone HCl Oral Tablet (Trazodone HCl) give 25 mg by mouth twice a day as needed for anxiety/sleep for 60 Days and have APRN re-evaluate Trazodone order in 6o days. Interview with the DNS on 4/7/24 at 2:30 PM indicted that the licensed nurses must document every shift for targeted behaviors for Resident #16 on antipsychotic medication which id located in the electronic health record. (continued on next page)

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	075275	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grimes Center	1354 Chapel St New Haven, CT 06511

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 4/8/24 at 1:30 PM indicated that the behavior flow sheets that were provided contained the signatures of the nursing assistants and some from the nurses. Review of the flow sheets with the DNS indicated that for example on 3/11/24 the day and evening shift it was the nurse that documented but on 11-7 it was only the nursing assistant that signed off on the behaviors. The DNS indicated that the behaviors for Resident #16 was a computerized template and not targeted behaviors for Resident #16 specifically. The DNS indicated that it was supposed to be individualized for the behaviors that the resident exhibits. The psychiatric APRN progress note dated 4/9/24 indicated behaviors of concern to monitor for Resident #16 were delusions, hallucinations, paranoid, and restlessness. Review of the 3/1/24-4/8/24 identified the licensed nurses were signing off every shift on the physician order that they would document behaviors on the behavior monitoring flow sheet every shift. Review of the March 2023 behavior monitoring flow sheet there were 50 behaviors listed. The DNS and the Administrator identified Licensed nursing staff signed off on 60 shifts out of 93 opportunities for monitoring behaviors and the nursing assistants documented on 31 shifts. There were 2 days on the 11:00 PM -7:00 AM shifts missing signatures on 3/13/24 and 3/24/24. Review of the 4/1/24-4/8/24 behavior monitoring flow sheet the DNS and the Administrator identified the Licensed nursing staff signed off on 15 shifts out of 24 opportunities for monitoring behaviors and the nursing assistants documented on 7 shifts. There was 1 shift missing documentation on 4/1/24 on the 11:00 PM -7:00 AM shift. Review of the facility Antipsychotic Drug Use Indications Policy identified the facility was to utilize antipsychotic drugs to treat specific indications as endorsed by the Pharmacy and Therapeutics Committee. Antipsychotic drugs should not be used unless the clinical record documentation shows the resident has one or more of the following specific conditions as Schizophrenia, Schizoaffective disorder, Psychotic mood disorder, acute psychotic episodes, Tourette's disorder, Huntington's disease, and organic mental syndrome (including dementia) with associated psychotic and/or agitated features as defined as specific behaviors such as specific quantitative (number of episodes) and objectivity such as hitting, biting, kicking, scratching, documented by the facility which causes the resident to actually interfere with staff's ability to provide care and continuously crying out, screaming, yelling, pacing if these behaviors cause impairment in functional capacity and if they are quantitative and psychotic symptoms such as hallucinations, paranoia, and delusions exhibited as specific behaviors. All anti-psychotic and psychotropic medications that are ordered as needed are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

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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** 43032 Based on observation, facility documentation, facility policy and interviews, the facility failed to ensure the glucometer was sanitized after use and hand hygiene performed per policy and professional standards of care. The findings include: Resident #245 was admitted to the facility on [DATE] with diagnosis which included Type 2 Diabetes, muscle weakness, and congestive heart failure. The nursing assessment dated [DATE] identified Resident #245 was alert, forgetful, and confused and oriented to person and place. The care plan for Resident #245 dated 4/1/24 identified a focus on both nutrition and hydration with interventions that included to provide diet as ordered, and labs as ordered. The physician's orders dated 4/1/24 identified Resident #245's blood sugar should be monitored before meals and at bedtime, and to administer Lispro (insulin) via a sliding scale based upon blood sugar level. Observation on 4/7/24 at 7:45AM identified LPN #1 obtaining a blood sugar level for Resident #245. LPN #1 obtained a blood sugar of 187 mg/dl, exited the room wearing gloves and placed the glucometer on top of the medication cart. LPN #1 removed her gloves, discarded the lancet used to obtain the blood sugar in the appropriate container and performed hand hygiene, repositioned the glucometer with her recently sanitized left hand, entered the blood sugar into the computer and proceeded to open an alcohol swab to clean the top of the bottle of Lispro (insulin) to administer 2 units as ordered for administration without the benefit of hand hygiene. The surveyor stopped the administration prior to the insulin syringe being inserted for the insulin draw to inquire about hand hygiene. LPN #2 indicated she did not perform hand hygiene after touching the glucometer. LPN # 1 proceeded to go to the room across the hall to Resident #7 and # 246. She identified both were due for blood sugar monitoring prior to breakfast. LPN #1 inserted the glucometer strip into the glucometer and proceeded with unopened alcohol swabs and a lancet to enter the room. The Surveyor asked that she stop and inquired of her knowledge of facility policy for glucometer cleaning. She identified she did not know. LPN #1 returned to the cart stating she asked a coworker who advised her to use the Sani-Purple wipes which have a noted dwell time of 2 minutes. LPN #1 wiped the unit with the Sani-Purple wipe as she claims she was instructed to do and immediately proceeded to insert the lancet. The surveyor inquired about adequate dwell time to which LPN #1 was uncertain. LPN #1 called the supervisor, RN #1, who identified the policy to clean glucometer and perform hand hygiene are on the cart and proceeded share the policies with LPN #1. RN #1 advised LPN #1 that she should have napkins to position the glucometer on after wiping for the dwell time, and RN #1 secured napkins from another cart and instructed LPN #1 on the proper cleaning. LPN #1 cleaned the glucometer as instructed and noted per policy the dwell time is an additional 2 minutes for a total of 4 minutes before the glucometer is considered sanitized for subsequent use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 and the ADNS/Staff Development 4/9/24 at 9:30AM identified agency staff are briefed on facility policy upon initial entrance into the facility. The overview generally takes 1 hour to complete. She identified LPN #1 was educated on glucometer cleaning and the policy is also visible on all medication carts should there be a question. Interview with the DNS on 4/9/24 at 10:40AM identified all licensed agency staffing receive an overview of policies and procedures including glucometer cleaning upon entrance into the facility. LPN #1 should have followed the policy for glucometer cleaning to ensure the safety of the residents. Subsequent to surveyor inquiry, the facility initiated an inservice on Glucometer Disinfecting which states Staff should follow facility policy and steps for cleaning and disinfecting the glucometer before and after each use. The instructions for glucometer use located on the med carts included 28 steps with a dwell time of 2 minutes for the Purple Cap Wipes PDI and a bleach wipe dwell time of 4 minutes. The manufacturer's recommendations for this glucometer suggest the use of a germicidal bleach wipe, and a dwell time for 1 minute and allow to air dry for an additional minute for a total of 2 minutes. The policy for cleaning and disinfecting the glucometer includes after securing the blood sugar, disinfecting the glucometer (Sani-wipes or Purple Cap Wipes PDI-dwell time 2 minutes) after each use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 43032 Based on facility documentation review, and interviews, the facility failed to ensure a certified Infection Preventionist was employed by the facility. The findings include Review of RN #4 (Infection Control Nurse) certification documentation on 4/8/24 at 9:30 AM identified a certificate of achievement from Infection Control Training dated 4/4/22 and the course topics included: Introduction, Transmission, Prevention and Control, Hand Hygiene, Personal Protective Equipment, Environmental Controls, Sharps and Injection Safety, Occupational Health and Safety, Sepsis, Final Exam. The course was 4 hours long, and the certification expires after 2 years. RN #4 also identified she took also took several courses in the CDC/Infection Control Training site which was is 19 hours long and consists of 23 modules, however RN#4 did not complete the final exam associated with the CDC/Infection Control Training and as a result did not have a certificate of completion. The courses were taken June 2022. Interview and Infection Control curriculum review with RN #4 on 4/9/24 at 9:40 AM identified RN #4 completed many modules however 2 remained outstanding and she had never taken the test to secure a certificate of completion. Interview with the Administrator and DNS on 4/9/24 at 10:40 identified they were not aware the CDC course and final test were not completed. The DNS identified RN #4 was the only nurse certified for infection control since her hire date of June 2022. Subsequent to surveyor inquiry, RN #4 completed the 2 remaining modules, took the test and presented a certificate certifying completion of the CDC Infection Prevention Course and exam dated 4/9/24. The policy for the Infection Prevention and Control Program state the qualifications and job responsibilities of the Infection Preventionist are outlined in the Infection Preventionist job description which states the qualifications include the ability to demonstrate and to maintain the standards of care rendered in accordance with the State Agency, governing body of the facility and the State and Federal agencies.