STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075290	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Center	200 Leeder Hill Dr Hamden, CT 06517

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47457 Based on review of facility documentation and interviews, the facility failed to provide staff support to ensure the residents right to organize and participate in resident groups (resident council) was honored. The findings include: Review of the Resident Council Meeting binder identified that the last resident council meeting was held on 11/29/23, over a year ago. The binder failed to identify resident council meeting minutes from December 2023 through November 2024. During the Resident Council interview on 12/3/24 at 9:05 AM with Residents #3, 4, 11, 12 and 16, Resident #12 identified that he/she would previously attend a monthly resident council meeting regularly, but the group had not met for a long time. Resident #12 could not recall when he/she had last attended a resident council meeting but indicated that it was a good idea for the residents to all sit together and share ideas. Resident #12 identified that he/she would like to continue to participate in resident council meetings. Interview with the DNS on 12/3/24 at 2:33 PM identified that the resident council had not met since their social worker had left the facility, about a year ago. The DNS indicated that after the prior social worker had left, the facility had not had a social worker to run the meeting. Interview with the Administrator on 12/4/24 at 9:50 AM identified that the former social worker headed up resident council, and he had left his position mid-December of 2023, and it appeared that resident council meetings were not held since. The Administrator indicated that it was an oversight that another facility staff member was not designated to assist with organizing resident council meetings. The Administrator further indicated that due to the small size of resident unit, staff members communicated with residents daily and addressed their needs individually, and no patterns had been identified in resident's concerns. The Administrator identified that a new social worker was hired and was starting on 12/4/24, and that a resident council meeting would be scheduled for later this month. Although requested a Resident Council policy was not provided.

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

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

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(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 - Some	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, facility documentation, facility policy, and interviews for 4 of 5 residents (Resident #14, 174, 175, and 176) 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 that code status was reviewed with the resident or resident representative, upon admission and as needed, to ensure the residents choices were was honored. The findings include: 1. Resident #14 was admitted to the facility in [DATE] with diagnoses that included Alzheimer's dementia, chronic kidney disease, and hypertension, A physician's order dated [DATE] directed in the event of cardiopulmonary arrest, do not resuscitate (DNR) and RN to pronounce death. The quarterly MDS dated [DATE] identified Resident #14 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff assistance with dressing, bathing, and toileting. The care plan dated [DATE] identified Resident #14 had impaired cognitive function and impaired thought processes related to dementia. Interventions included to communicate with the resident representative regarding the resident's needs. A physician's order dated [DATE] directed Resident #14 had advance directives that included do not hospitalize (DNH), A physician's order dated [DATE] directed Resident #14 to have a hospice consult and care. Review of the clinical record failed to identify a signed advanced directive form, a care plan related to Resident #14's advance directives choices or documentation that staff had a discussion regarding advance directives with the resident representative. Interview with the DNS on [DATE] at 8:15 AM identified that she was aware there were issues with advance directive forms being completed for residents of the facility. The DNS identified that the advance directive form should have been signed and completed by the resident or resident representative within 48 hours of admission, and that for Resident #14, the form should have been reviewed again with Resident #14's resident representative with the order for hospice. The facility policy on advance directives directed that when any interdisciplinary team member had a discussion with a resident representative regarding advance directives, the conversation would be documented. The policy further directed that the appropriate advance directive paperwork would be placed in the advance directive section of the resident's medical record, and that the resident's code status would be reviewed at every resident care plan meeting to ensure all information was accurate and current. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #174 was admitted to the facility in [DATE] with diagnoses that included lumber fracture and hypertension. The admission assessment dated [DATE] identified Resident #174 was alert and oriented to person, place, and time. The baseline care plan dated [DATE] failed to reflect the residents wishes for a code status. Review of the nurse's notes dated [DATE] to [DATE] failed to reflect that staff had discussed and ascertained Resident #174's wishes for code status and/or documented that discussion in the medical record. Review of the physician orders dated [DATE] to [DATE] failed to reflect a code status. The physician admission note dated [DATE] failed to reflect the physician had discussed and ascertained Resident #174's wishes for code status and/or documented that discussion in the medical record. Interview with the DNS [DATE] at 7:35 AM identified that the admission charge nurse or supervisor was responsible to put the code status in the physician orders using the code status from the hospital and that the code status should have been addressed with Resident #174 within 48 hours of admission and be verified with the physician. Further, the DNS indicated Resident #174 was and able to sign his/her own code status form. After surveyor inquiry, the Resuscitation Status Form dated [DATE] was signed by Resident #174 and MD #1 to reflect that Resident #174 was to receive CPR (cardiopulmonary resuscitation) and a physician's order dated [DATE] at 7:55 AM (7 days after admission) directed Resident #174 to be a full code. Interview with MD #1 on [DATE] at 10:18 AM indicated that when a resident comes from the hospital that she uses the code status from the hospital on admission. MD #1 indicated that on admission she had confirmed the admission orders for Resident #174 and had seen Resident #174 on Thanksgiving Day just to do the admission, but she did not see or discuss the code status. MD #1 indicated she signed the code status form today [DATE] because it was left in her communication book. 3. Resident #175 was admitted to the facility in [DATE] with diagnoses that included pelvic fractures and atrial fibrillation. The hospital transportation form dated [DATE] identified Resident #175 was a Do Not Resuscitate (DNR) as of [DATE] per hospital physician. The admission assessment dated [DATE] at 10:43 PM identified Resident #175 was alert and oriented to person, place, and time. Review of the nurse's notes dated [DATE] to [DATE] failed to reflect that staff had discussed and ascertained Resident #175's wishes for code status and/or documented that discussion in the medical record. The baseline care plan dated [DATE] failed to reflect a code status (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated [DATE] directed Resident #175 was a DNR. The physician admission note, written by MD #2 dated [DATE] failed to reflect a discussion regarding code status. Review of the clinical record on [DATE] at 7:30 AM identified that Resuscitation Status Form was blank and there was no signed advanced directive form in chart. Interview with the DNS on [DATE] at 10:12 AM indicated that although Resident #175 could sign the form him/herself, the Resuscitation Status Form was not completed and had not been addressed with Resident #175. The DNS indicated that the code status should have been addressed by a nurse or MD #2 within 48 hours of the admission. Interview with Resident #175 on [DATE] at 11:30 AM indicated that he/she had discussed his/her wishes regarding code status with staff at the hospital, but no staff at the facility had discussed it with him/her. Resident #175 indicated that he/she wanted to be a DNR. The Resuscitation Status Form dated [DATE] (7 days after admission) identified Resident #175 and MD #2 signed Resident #175 was a do not resuscitate (DNR). 4. Resident #176 was admitted to the facility in [DATE] with diagnoses that included Crohn's disease, hypertension, and anxiety. The hospital discharge summary dated [DATE] identified Resident #176 was a full code. Review of the nurse's note dated [DATE] to [DATE] failed to reflect that staff had discussed and ascertained Resident #176's wishes for code status and/or documented that discussion in the medical record. Physician's admission orders dated [DATE] until [DATE] (13 days) directed Resident #176 was a full code. Review of the admission History and Physical, by MD #1 dated [DATE] failed to reflect a discussion regarding code status. The baseline care plan dated [DATE] failed to reflect a code status. Review of a progress note dated [DATE], [DATE] by MD #1 failed to reflect a discussion regarding code status. Review of the clinical record on [DATE] at 7:30 AM and 11:00 AM failed to reflect a signed Resuscitation Status Form in the clinical record by either Resident #176 or MD #2. Interview with MD #1 on [DATE] at 10:18 AM indicated that she had seen Resident #176 many times but did not discuss code status with the resident. MD #1 indicated that Resident #176 was responsible for him/herself and could sign the Resuscitation Status Form. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #176 on [DATE] at 2:40 PM indicated that his/her wish was to be a DNR. Resident #176 indicated that since he/she was admitted to the facility no one had asked or discussed his/her wishes for code status and if they did, he/she would have informed the staff that he/she requested DNR. Resident #177 indicated that his/her PCP in the community was aware that his/her wishes were to be a DNR prior to going to the hospital and he/she believed that the hospital was aware that he/she wanted to be a DNR. Interview with the DNS on [DATE] at 2:50 PM indicated that Resident #176 was able to sign his/her own Resuscitation Status Form and that there was not a signed Resuscitation Status Form in the clinical record. The Resuscitation Status Form dated [DATE] directed DNR signed by Resident #176. A physician order dated [DATE] at 4:04 PM directed DNR. Interview and review of the clinical records with RN #3 on [DATE] at 7:10 AM indicated that Residents #174, #175, and #176 did not have signed Resuscitation Status Forms in their clinical records. RN #4 indicated that on admission the charge nurse is responsible to get an order from the physician for an code status based on the hospital discharge paperwork until the nurse or physician can go over the code status forms with the resident or resident representative. RN #4 indicated that all residents were to have a Resuscitation Status Form signed by the resident or resident representative and the primary physician within the first couple of days from admission. RN #4 indicated that a full code was a green piece of paper and a DNR was a red piece of paper that would be easily found in the front of every resident's medical record. RN #4 indicated that it was color coded and kept on paper in the front of the medical record so in the event of emergency, it would be quick to find. RN #4 indicated that she did not know why Residents #174, #175, and #176 did not have it completed because these residents could sign form themselves. Interview with the DNS [DATE] at 7:35 AM identified the code status should have been addressed with the residents or resident representatives within 48 hours of admission and the Resuscitation Status Form would be signed by the physician and placed in the resident's medical chart and scanned into the electronic medical record. The DNS indicated that the admission nurse should have used the code status from the hospital and verified it with the covering physician at the facility until the resident had been educated, informed, and the resident or resident representative had signed either for a full code or DNR form. Review of the Advanced Directive Policy last review date [DATE] identified that all resident's will have documented advanced directives in their medical records. When any staff member has a conversation with a resident who is cognitively intact and their own decision maker regarding advanced directives such as a DNR or comfort measures, treatment, etc.- this conversation is to be documented. The attending physician will write orders for resident's code status based on the resident's wishes. The appropriate code status paperwork will be placed in the Advanced Directive Section on the medical record. 46040

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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** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #8) reviewed for unnecessary medications, the facility failed to immediately notify the hospice provider and the resident representative when the resident had complaints of new severe wrist pain. The findings include: Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident # 8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The care plan also identified Resident #8 has a terminal diagnosis related to end stage dementia. Interventions included to observe closely for signs of pain, administer pain medication as ordered, and notify the physician of breakthrough pain. Review of the August 2024 physician's orders directed to assess Resident #8 for pain every shift (original date 9/13/22) and administer Acetaminophen (a pain relief medication) 325 mg - 2 tablets every 4 hours for general discomfort as needed (original date 10/7/22). The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order directed to obtain an x-ray and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM. Review of the clinical record failed to reflect the resident representative or hospice provider had been made aware of the residents swollen right wrist with tenderness and severe pain. A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture. Review of the clinical record failed to identify any additional monitoring, assessments, or documentation of Resident #8's right wrist injury by any facility staff after 8/13/24. (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 and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury, contact the physician, initiate an investigation, and contact Resident #8's resident representative. LPN #2 identified that during his assessment of Resident #8's right wrist, he observed that Resident #8 was crying out. Interview with RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified on 8/12/24 and 8/13/24 she was out of work and provided a review of her timesheet that identified such. RN #4 identified that during this time there were several RNs covering her leave, however, there was not a consistent nurse scheduled to cover during her absence. RN #4 identified that LPN #2 should have reported Resident #8's right wrist injury to the covering RN supervisor, who should have done an assessment and contacted the physician to report the injury as well as Resident #8's hospice physician. RN #4 also identified that the nursing staff should have notified Resident #8's resident representative, and an investigation should have been initiated and conducted to determine the cause of the right wrist injury and Resident #8's pain should have been addressed by LPN #2. Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues related to Resident #8's right wrist prior to surveyor inquiry. The DNS identified LPN #2 should have notified the RN supervisor, who then should have completed a full assessment and contacted the physician to report the injury as well as Resident #8's hospice physician and Resident #8's resident representative. The DNS further identified an investigation should have been initiated and conducted to determine the cause of Resident #8's right wrist injury, and the injury should have been reported to the state agency as the facility was not aware of how the injury occurred. The DNS identified that Resident #8's pain should have been assessed, addressed and monitored once the pain and wrist injury were identified. The DNS identified that the clinical record should also have accurate documentation related to the right wrist injury. Although attempted, an interview with Person #1 (Resident #8's resident representative) was not obtained. The facility policy on change of condition directed that licensed nursing staff would document any change in condition in the electronic medical record (EMR). The policy further directed upon a change in condition of the resident, licensed staff would notify the physician, and direction would be given to the nurse regarding the physician orders. The nurse would document any new orders in the EMR as well as write a note of the physician notification, and the resident representative would be notified as well and documented with a corresponding note. The facility policy on Resident Rights directed that the facility must consult the resident's physician and notify the resident representative within 24 hours for any significant change in the resident's physical status.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 8) reviewed for unnecessary medications, the facility failed to notify the state agency, according to established timeframes, when the resident complained of new severe wrist pain of unknown origin. The findings include: Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order directed to obtain an x-ray and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM. A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture. Review of reportable event forms for Resident #8 failed to identify a reportable event form had been initiated related to Resident #8's swollen right wrist tenderness and severe pain on 8/12/24. Review of the state agency reportable event portal failed to identify a reportable event form related to Resident #8's swollen right wrist tenderness and severe pain on 8/12/24 had been reported. Review of the clinical record and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury and initiate an investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues related to Resident #8's right wrist prior to surveyor inquiry. The DNS identified LPN #2 should have notified the RN supervisor, who then should have completed a full assessment. The DNS further identified that an investigation should have been initiated and conducted to determine the cause of Resident #8's right wrist injury, and the injury and investigation should have been reported to the state agency as the facility was not aware of how the injury occurred Although requested, the facility failed to provide a policy related to reporting injuries of unknown origin to the state agency. The facility policy on A&I-Injury of unknown origin directed that it was the policy of the facility to completely investigate any resident injury of unknown origin to ensure that safe care and treatment of the residents was maintained, and that all staff should report any bruise, skin tear, or injury of unknown origin to their supervisor immediately so that the appropriate investigation and documentation would take place.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 8) reviewed for unnecessary medications, the facility failed to investigate an injury of unknown origin. The findings include: Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order directed to obtain an x-ray and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM. A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture. Review of reportable event forms for Resident #8 failed to identify a reportable event form had been initiated related to Resident #8's swollen right wrist tenderness and severe pain on 8/12/24. Review of the state agency reportable event portal failed to identify a reportable event form related to Resident #8's swollen right wrist tenderness and severe pain on 8/12/24 had been reported. Review of the clinical record and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury and initiate an investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues related to Resident #8's right wrist prior to surveyor inquiry. The DNS identified LPN #2 should have notified the RN supervisor, who then should have completed a full assessment. The DNS further identified that an investigation should have been initiated and conducted to determine the cause of Resident #8's right wrist injury, and the injury and investigation should have been reported to the state agency as the facility was not aware of how the injury occurred The facility policy on A&I-Injury of unknown origin directed that it was the policy of the facility to completely investigate any resident injury of unknown origin to ensure that safe care and treatment of the residents was maintained, and that all staff should report any bruise, skin tear, or injury of unknown origin to their supervisor immediately so that the appropriate investigation and documentation would take place. The policy further directed that the procedure would include all staff should report any resident injury to their supervisor/charge nurse immediately, and the supervisor/charge nurse would complete the injury of unknown origin investigation form with as much information as possible. The policy also directed any supporting documentation, employee statements, and other notes would be attached to the investigation, and that the supervisor/charge nurse on duty would be responsible for initiating an investigation determine the probable cause of the injury and this would include, but not be limited to, interviewing staff members, obtaining written statements, reviewing the medical record to determine if there were any documented behaviors that may have caused/contributed to the injury, etc, and any suspicion of resident abuse, neglect, or mistreatment would be reported to the DNS/ADNS or Administrator immediately. The policy also directed an interim care plan would be initiated, the DNS/ADNS would review the completed form to determine if additional investigation was warranted, and the A&I report and completed investigation would be reviewed with the Medical Director and Administration.

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interview for 1 resident (Resident #10) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to notify the appropriate state-designated authority that the resident had a new diagnosis of psychotic disorder with delusions. The findings include: Resident #10 was admitted to the facility in August 2020 with diagnoses that included Parkinsons Disease, depression, anxiety, and dementia. Notice of PASARR Level 1 Screen dated 8/21/20 identified Resident #10 had a diagnosis of anxiety disorder, depression (mild or situational), and dementia but did not have a diagnosis of psychotic disorder or delusional disorder. PASARR outcome dated 8/21/20 identified Level 1 was negative because there was no Level 2 condition. The quarterly MDS dated [DATE] identified Resident #10 had moderately impaired cognition and had a diagnosis of anxiety, depression, and dementia but did not have a diagnosis of psychotic disorder with delusions. The psychiatric APRN progress note dated 6/7/21 identified a diagnosis of psychotic disorder with delusions as an active disorder at that time. The annual MDS dated [DATE] identified Resident #10 had moderately impaired cognition and had a diagnosis of anxiety, depression, and dementia, but did not have a diagnosis of psychotic disorder. Review of the medical record in the medical diagnosis section identified that on 9/27/22, the prior MDS coordinator, RN #2, had added the diagnosis of psychotic disorder with delusions back dated to 6/7/21. The quarterly MDS dated [DATE] identified Resident #10 had moderately impaired cognition, and a diagnosis of anxiety and dementia and the added diagnosis of psychotic disorder. Interview with RN #2 on 12/2/24 at 1:15 PM indicated that when a resident has a new antipsychotic medication she would look back in the physician and psychiatric progress notes for a diagnosis. RN #2 indicated that when she finds the new diagnosis she places it on the current MDS and then adds it into electronic medical record on the diagnosis list. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the prior social worker, SW #1 on 12/3/24 at 9:01 AM indicated that he was the prior SW here at the facility and he left the position a little over a year ago in December of 2023. SW #1 indicated that he was responsible for the PASARR's for new admissions and if a resident received a new diagnosis, he would be responsible to update the appropriate state-designated authority. SW #1 indicated if a resident had a new diagnosis, he would depend on the facility staff to notify him. SW #1 indicated that he was responsible to do the updates, as needed, from June of 2021 until December 2023 for Resident #10. SW #1 indicated that if it was reported to him that Resident #10 had a new diagnosis of psychotic disorder with delusions on 6/7/21 he would have notified the appropriate state-designated authority at that time with a Level 2 referral, but he was not aware of the new diagnosis. Interview with the DNS on 12/4/24 at 11:30 AM indicated that there was not a facility policy for PASARR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy and interview for 5 residents (Resident #20, 12, 3, 8 and 124) the facility failed to ensure the residents received treatment and care in accordance with professional standards and physicians orders. For Resident #20, reviewed for edema, the facility failed to ensure that weights, ordered to be obtained every other day were consistently obtained. For Resident #12, the facility failed to follow the physician's order to apply compression stockings daily. For 1 of 4 residents (Resident #3), reviewed for accidents, the facility failed to ensure that neurological checks and post fall assessments were completed after the resident had multiple unwitnessed falls with reported head strikes. For 1 of 5 residents (Resident #8), reviewed for unnecessary medications, the facility failed to complete an RN assessment after the resident was found to have an injury of unknown origin and pain. For 1 of 4 residents (Resident #124) reviewed for accidents, the facility failed to ensure neurological assessments and follow-up assessments were completed, per the facility policy, following 2 unwitnessed falls. The findings include: 1. The Hospital Discharge Summary dated 11/16/24 identified Resident #20 was on Lasix (a diuretic) for chronic leg edema. Resident #20 was admitted to the facility on [DATE] with diagnoses that included femur fracture, chronic leg edema, and chronic peripheral venous insufficiency. A physician's order dated 11/16/24 directed to administer Lasix 10 mg (diuretic) once a day on Monday, Wednesday, and Friday. The Admission History and Physical, done by MD #1 dated 11/18/24 identified Resident #20 had statis dermatitis of both legs. A physician's order dated 11/18/24 at 3:31 PM directed to obtain weights every other day during the 7:00 AM to 3:00 PM shift. The admission MDS dated [DATE] identified Resident #20 had moderately impaired cognition and required maximum assistance to roll side to side in bed, to go from a lying to sitting position and for transfers from bed to wheelchair. The care plan dated 11/26/24 identified Resident #20 had chronic bilateral lower extremity edema. Interventions included to monitor weights as ordered and provide the assist of 1 with a rolling walker. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weight summary record identified the following. Weight on 11/18/24 was 159.4 lbs. No weights were obtained on 11/20/24 or 11/22/24. Weight on 11/25/24 was 160.2 lbs. A weight was not obtained on 11/27/24. Weight on 11/29/24 was 151.6 lbs., a 8.6 lbs. weight loss. Weight on 12/2/24 was 148.8 lbs. Review of the nurse's progress notes dated 11/18/24 to 12/3/24 did not reflect the resident had refused to have his/her weight obtained every other day as per the physician order. Interview with RN #4 (7:00 AM to 3:00 PM supervisor) on 12/4/24 at 7:59 AM indicated that she does not recall why MD #1 had given her the order for every other day weights for Resident #20 on 11/18/24 and she did not write a nurses note. RN #4 indicated that the nurse aides were responsible to get the weights at the directive of the charge nurse who was responsible to sign off and document the weight in the MAR. RN #4 indicated that Resident #20 would not have refused any weights and if the resident had refused it would have been documented on the MAR. After review of the clinical record, RN #4 indicated that she did not know why the weights were not being obtained. RN #4 indicated that if the physician order was not followed that she should have been informed so she could have notified the physician. Interview with the DNS on 12/4/24 at 8:53 AM indicated the nurse aide was responsible to get the weight every other day and the nurses were responsible to document the weight and initial that it had been obtained on the MAR. The DNS indicated that Resident #20 was on Lasix for leg edema, and she thinks maybe that's why MD #1 wanted Resident #20 on every other day weights so she could adjust the Lasix to prevent fluid overload, but she did not find any documentation for a rationale. The DNS indicated that her expectation was the nurses would follow the physicians order for the weights and if they did not follow the physicians order, the physician should have been notified. After clinical record review, the DNS noted there were missing weights and the physician order was not followed. Interview with MD #1 on 12/4/24 at 11:40 AM indicated that she had ordered the weights scheduled for every other day for Resident #20 because Resident #20 was on the medication Lasix and had the history of bilateral leg edema. MD #1 indicated that she would have expected the nurses to follow the physician order for weights and if the nurses did not get the weight she should have been informed. Further, if Resident #20 had gained or lost weight, the nurse should have updated her. MD #1 indicated that Resident #20 was sedentary and just sits all day so it was important to monitor the fluid by obtaining weights. Although requested, a facility policy for following physician orders was not provided. 43032 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #12 was admitted to the facility in November 2018 with diagnoses that included schizophrenia, hereditary lymphedema, and Parkinson's disease. The annual MDS dated [DATE] identified Resident #12 had intact cognition, utilized a walker or wheelchair for mobility, and had impairment on both the upper and lower extremities. The care plan dated 11/29/24 identified a focus on nutrition/unintended weight gain with interventions to provide and serve diet as ordered, and a focus on chronic bilateral edema with interventions for staff to provide assistance with putting on and removing compression stockings. A physician's order dated 12/1/24 directed to apply compression stockings to bilateral lower extremities every 12 hours, on in the morning prior to getting out of bed and off at bedtime. Thigh high compression socks 20 - 30mmHg every morning and at bedtime for bilateral lower edema. Observation on 12/2/24 at 7:35 AM identified Resident #12 was seated in his/her wheelchair with non-skid socks on feet, and without the benefit of the compression stockings. Resident #12 indicated at that time the staff rarely put the compression stockings on him/her. Observation on 12/2/24 at 2:15 PM identified Resident #12 was seated in his/her recliner without the benefit of the compression stockings. Observation on 12/3/24 at 7:45 AM identified Resident #12 without the benefit of the compression stockings. Resident #12 indicated at that time a strong desire to have the compression stockings on daily. Interview with Resident #12 on 12/3/24 at 9:05 AM during the Resident Council meeting identified concerns with the nurse's not following physician's orders as they related to the application of his/her compression stockings on daily bases. Interview with the charge nurse, LPN #2, on 12/3/24 at 2:15 PM identified although Resident #12 has an order for compression stockings, staff do not always put them on. LPN #2 further identified that the resident refuses, however, failed to identify documentation of refusals in the electronic medical record. Although observations on 12/1 and 12/2/24 identified Resident #12 did not have the compression stockings applied, review of the electronic medical record dated 12/1/24 and 12/2/24 identified documentation that the compression stockings had been applied. LPN #2 further stated that any resident refusal for care should be documented in the clinical record and the physician notified. Interview with the DNS on 12/3/24 at 2:45 identified it is her expectation that nurses follow the physician's order and if the resident refuses to document the refusal and notify the physician. Interview and review of the clinical record with MD #1 on 12/4/24 at 12:10 PM identified it is her exexpectation that she be notified if Resident #12 refuses the compression stockings. 46040 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #3 was admitted to the facility in October 2022 with diagnoses that included Alzheimer's dementia, unsteadiness on feet, and syncope and collapse. The annual MDS dated [DATE] identified Resident #3 had intact cognition, was always continent of bowel and bladder and required partial staff assistance with dressing, bathing, and was independent with toileting. The MDS also identified Resident #3 has a history of falls and required use of a walker with ambulation. The care plan dated 11/3/23 identified Resident #3 was at high risk for falls due to deconditioning with a history of falls. Interventions included ensuring the call light was within reach, encourage use of the call light, and the resident needed prompt response to all requests for assistance. A reportable event form dated 12/13/23 identified Resident #3 had an unwitnessed fall and reported striking his/her head against a recliner during the fall. A nurse's note dated 12/13/23 at 7:34 PM identified Resident #3 had a fall at 4:00 PM after losing his/her balance and struck his/her head on a recliner in his/her room. The note further identified Resident #3 complained of discomfort to the back of the head, and that no open areas or bruising were noted. Review of the clinical record failed to identify any documentation related to neurological monitoring or post fall assessments that were initiated or completed for Resident #3's fall with head strike on 12/13/23. A reportable event form dated 10/30/24 identified Resident #3 had an unwitnessed fall on that date. A nurse's note dated 10/30/24 at 2:10 PM identified Resident #3 had an unwitnessed fall and was founding lying on the bathroom floor of his/her room and neurological checks were initiated. Review of the clinical record failed to identify any documentation related to neurological monitoring or post fall assessments for Resident #3 following the unwitnessed fall on 10/30/24. A reportable event form dated 11/19/24 identified Resident #3 had an unwitnessed fall on that date. The report identified a hematoma to the right back side of his/her head after the fall. A nurse's note dated 11/19/24 at 2:48 PM by RN #4 identified Resident #3 had an unwitnessed fall and was found lying on the floor in front of the bathroom in his/her room. The note further identified that Resident #3 reported pain to the right side of the back of the head and identified he/she hit his/her head on the floor. The note identified Resident# had a small bump that could be felt and that a neurological check was within normal limits. Review of the clinical record failed to identify any documentation related to additional neurological monitoring or post fall assessments for Resident #3 following the fall with head. A request for all neurological checks and post fall assessment documentation was made to the DNS on 12/3/24 at 6:00 AM. (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 RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified that she completed Resident #3's assessment on 11/19/24 but would need to look into the neurological checks and post fall assessment documentation. RN #4 identified that it was the policy of the facility to complete neurological checks following any fall with head strikes. Subsequent to surveyor inquiry to the DNS and RN #4 on 12/3/24, additional documentation was provided on 12/3/24 at 12:57 PM. RN #1 provided an in-service signature sheet dated 11/1/24 for a topic Fall Charting which identified that nursing staff should do neurological checks on all unwitnessed falls. Interview with RN #1 immediately following review of the in-servicing document identified that there had been issues with nursing staff completing neurological checks and assessments for residents with unwitnessed falls and the in service was to provide education that all nurses should ensure that these were done. Interview with the DNS on 12/4/24 at 8:15 AM identified she was aware there were issues with assessments and neurological checks following unwitnessed falls for residents of the facility, and that these also were to be done for any resident who had a reported or confirmed head strike. The DNS identified that the facility had changed documentation systems in the last 2 years, and this change along with a use of paper and computer charting may have been the issue, however the policy was that post fall assessments and neurological checks should be done per the facility policy for 72 hours after the event. Although requested, the facility failed to provide any policy related neurological monitoring. Although requested, the facility failed to provide a copy of the neurological assessment flowsheet. The facility policy on fall management system directed that any fall with a potential or actual head injury would include follow up neurological checks which would be documented on the neurological assessment flow sheet for 72 hours. The policy further directed for any fall, follow up assessment and documentation would be conducted at a minimum of every shift for 72 hours. 4. Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident #8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The care plan also identified Resident #8 has a terminal diagnosis related to end stage dementia. Interventions included to observe the resident for signs of pain, administer pain medication as ordered, and notify the physician of breakthrough pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order for an x-ray had been placed and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM. Review of the clinical record failed to identify any additional documentation related to Resident #8's right wrist injury by LPN #2 on 8/12/24, including any interventions related to Resident #8's reports of severe pain. Further, the clinical record failed to identify any documentation related to an RN assessment of Resident #8's right wrist injury on 8/12/24. A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture. Review of the clinical record failed to identify any additional monitoring, assessments, or documentation of Resident #8's right wrist injury by any facility nursing staff after 8/13/24. Review of the clinical record and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury, contact the physician, initiate an investigation, and contact Resident #8's resident representative. LPN #2 identified that during his assessment of Resident #8's right wrist, he observed that Resident #8 was crying out. LPN #2 identified initially he provided Resident #8 a dose of acetaminophen; however, following review of the clinical record, LPN #2 identified he was unable to recall what interventions were put into place for Resident #8 and this would have been addressed by RN #4 during her assessment. Interview with RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified on 8/12/24 and 8/13/24 she was out of work and provided a review of her timesheet that identified such. RN #4 identified that during this time there were several RNs covering her leave, however, there was not a consistent nurse scheduled to cover during her absence. RN #4 identified that LPN #2 should have reported Resident #8's right wrist injury to the covering RN supervisor, who should have done an assessment and contacted the physician to report the injury as well as Resident #8's hospice physician. RN #4 also identified that the nursing staff should have notified Resident #8's resident representative, and an investigation should have been initiated and conducted to determine the cause of the right wrist injury and Resident #8's pain should have been addressed by LPN #2. Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues related to Resident #8's right wrist prior to surveyor inquiry. The DNS identified LPN #2 should have notified the RN supervisor, who then should have completed a full assessment and contacted the physician to report the injury as well as Resident #8's hospice physician and Resident #8's resident representative. The DNS further identified that Resident #8's pain should have been assessed, addressed and monitored once the pain and wrist injury were identified. The DNS identified that the clinical record should also have accurate documentation related to the right wrist injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although attempted, an interview with Person #1 (Resident #8's resident representative) was not obtained. Although requested, the facility failed to provide a policy related to RN assessments. The facility policy on change of condition directed that licensed nursing staff would document any change in condition in the electronic medical record (EMR). The policy further directed upon a change in condition of the resident, licensed staff would notify the physician, and direction would be given to the nurse regarding the physician orders. The nurse would document any new orders in the EMR as well as write a note of the physician notification, and the resident representative would be notified as well and documented with a corresponding note. The facility policy on pain management directed that nursing would maintain an adequate comfort level for all residents which included an evaluation of pain that would be completed upon admission, post fall, upon a change in condition, and as needed. 47457 5. Resident #124 was admitted to the facility in August 2021 with diagnoses that included malignant neoplasm of the left breast, secondary malignant neoplasm of axilla and upper limb lymph nodes, Alzheimer's disease, and difficulty in walking. The significant change in status MDS dated [DATE] identified Resident #124 had moderately impaired cognition, required supervision or touching assist with sitting to standing, chair/bed-to-chair transfers, and toilet transfers, and had sustained falls with no major injury since the prior assessment. The care plan dated 6/29/23 identified Resident #124 was at moderate risk for falls related to a history of falls, gait/balance problems, unaware of safety needs - often does not call for staff assist with transfers/mobility in his/her room. Interventions included educating Resident #124 on the importance of calling and waiting for assistance with transfers, educating the resident, family, and caregivers about safety reminders and what to do if a fall occurs, and following the facility's fall protocol. The nurse's note dated 9/21/23 at 10:11 PM identified that at 7:00 PM this RN was called into Resident #124's room to assess. Resident #124 was lying on the floor on his/her back and stated that he/she was trying to go to the bathroom and fell backwards. Resident #124 was complaining of left hip pain, and upon assessment he/she was unable to straighten the lower left extremity and during range of motion was grimacing in pain. Neurological assessments were initiated and were within normal limits. Resident #124 was assisted off the floor by 3 staff members into bed. The physician was notified, and the physician spoke directly to the family for a decision on sending Resident #124 to the emergency department or managing him/her at the facility. The family decided to have resident remain at the facility, orders for a portable x-ray of the left hip and pelvis were obtained, start Lovenox (an injectable anticoagulant for the prevention of blood clots), maintain bedrest for 24 hours or until x-ray results are back, and change PRN (as needed) Oxycodone to 10mg by mouth every 3 hours PRN for pain. Awaiting x-ray results, at this time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 9/21/23 at 11:08 PM identified Resident #124's x-ray results were negative for fracture or dislocation. The nurse's noted dated 9/23/23 at 7:03 PM identified this RN was called by staff to resident's room, Resident #124 was observed lying on the bathroom floor on his/her right side, supporting self on right elbow. The wheelchair was in the bathroom doorway with the wheels locked, when asked why he/she did not call for assist, Resident #124 replied, I can do this. Post fall RN assessment: alert and oriented to person, situation, place, and time, denies hitting head during fall. Assisted to wheelchair with an assist of 2 with safety belt. Range of motion at baseline for resident, no complaints of increased discomfort related to fall, no apparent injury observed. The nurse's note dated 9/23/23 at 7:33 PM identified this RN was notified by staff of another fall for Resident #124, first fall 30 minutes prior. Resident #124 was observed lying on the floor on his/her right side, behind the headboard of the bed, resident stated that he/she got out of bed to get a warmer robe from the closet and did not call for assistance, call light visible and accessible, on the bedrail. Post fall RN assessment: alert and oriented times 4, denies hitting head during fall. Range of motion at baseline for resident, complains of discomfort to lateral aspect of left lower leg, sustained skin tear at the site during fall, and Resident #124 stated, his/her leg caught the corner of the bed. Family notified of falls #1 and #2, and the on-call physician was notified via a message to the answering service. The clinical record failed to identify neurological assessments completed per the facility policy following Resident #124's 2 unwitnessed falls on 9/23/23. The Neurological Checks flowsheet dated 9/21/23 identified that neurological assessments were completed on 9/23/23 on the following shifts: 11:00 PM - 7:00 AM and 3:00 PM - 11:00 PM and on 9/24/23 on the 11:00 PM - 7:00 AM shift. Review of the nurse's notes dated 9/23/23 through 9/26/23 failed to identify nursing assessments were completed on the following shifts: 9/23/23 from 11:00 PM - 7:00 AM, 9/25/23 from 7:00 AM - 3:00 PM, and 9/25/23 from 3:00 PM - 11:00 PM. The nurse's note dated 9/26/23 at 3:20 PM identified that Resident #124 complained of more severe pain today status post fall. Some mild swelling noted to left hip. Physician updated and new order to obtain repeat x-ray of left hip. Resident representative visiting with resident, concerned regarding increased pain, upon assessment Resident #124 was crying and indicated the pain is the most severe it has been. Discussion with family and physician, decision was made to send resident to the emergency department for evaluation. The Emergency Medicine Resident Note dated 9/26/23 identified Resident #124 had a past medical history of dementia, congestive heart failure, hypertension, chronic obstructive pulmonary disease, arthritis on morphine pump, who was [NAME] from a subacute nursing facility due to hip and back pain for a few days. Patient first fell on [DATE] and had a head strike, but did not lose consciousness. He/she complains of hip pain but had negative x-ray results on 9/21/23, after the fall. However, he/she fell twice again and fell on his/her hip, this time without head strike and did not lose consciousness. He/she is baseline wheelchair bound for 3 years and is not complaining about hip pain (laterally unclear due to dementia) and low midline back pain. Course: 4:31 PM left hip x-ray shows left femoral neck fracture with marked varus angulations and foreshortening. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 12/3/24 at 7:33 AM failed to identify documentation to reflect that neurological assessments and nursing assessments were completed per the facility's fall policy, following Resident #124's 2 unwitnessed falls on 9/23/23. The DNS indicated that there was progress notes dated 9/24/23 and 9/25/23 that indicated neurological checks were at baseline, but she would have expected the nurse to either have written a timed nurse's note which included the neurological assessments or to have restarted a new neurological check flowsheet after the unwitnessed falls on 9/23/23. The DNS further indicated that neurological checks should have been based on the timeline outlined in the facility's policy. The DNS identified that she would also expect that a nurse's note would be written at least daily or per the facility's policy. The Fall Management System policy directs the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Any fall that involves a potential/actual head injury will include follow-up neurological checks. Neurological checks will be documented on the Neurological Assessment Flowsheet for 72 hours and follow-up assessment and documentation will be conducted for a minimum of every shift for 72 hours.

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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** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #1), reviewed for accidents, the facility failed to ensure the resident was transferred according to the physician's order (Sara lift with 2 staff) which resulted in the resident having to be lowered to the floor. The findings include: Resident #1 was admitted to the facility in June 2023 with diagnoses that included presence of left artificial knee joint, cardiac pacemaker, and atrial fibrillation. A physician's order dated 6/21/23 directed to use a Sara lift (mechanical lift used to lift and transfer) with the assistance of 2 staff for transfers to/from the wheelchair. The care plan dated 6/21/23 identified Resident #1 had limited mobility related to history of multiple surgeries to the bilateral lower extremities, was non-ambulatory and wheelchair bound at baseline. Interventions included transfers with the Sara lift and assist of 2 staff. The admission MDS dated [DATE] identified Resident #1 had intact cognition and required extensive 2-person assistance with transfers. The fall risk evaluation dated 6/29/23 identified Resident #1 was at low risk for falls. The August 2023 monthly physician's orders directed to transfer Resident #1 via a Sara lift with the assistance of 2 staff to/from the wheelchair (original date 6/21/23). The nurse's note dated 8/14/23 at 10:15 AM identified RN #4 was notified that Resident #1 was lowered to the floor during a transfer. RN #4 indicated that NA #3 transferred Resident #1 by herself after Resident #1 told NA #3 that he/she could be transferred with one staff. RN #4 indicated during the transfer Resident #1 became weak and needed to be lowered to the floor. No injuries were noted from the fall. Resident #1 was able to move all extremities at baseline. Resident #1 was assisted back to bed with assistance of 4 staff. The physician was present and updated. The reportable event form dated 8/14/23 at 10:15 AM identified Resident #1 was transferred with the assistance of 1 staff via stand pivot and was lowered to the floor during the transfer. An RN assessment was completed, there was no complaint of pain or distress, and the physician was notified. Report had been given to NA #3 prior to the start of shift regarding Resident #1's plan of care and she was provided with a printed copy. Will follow up with agency regarding NA #3 not following the plan of care. The fall risk evaluation dated 8/14/24 identified Resident #1 was at moderate risk for falls. Review of a statement written by NA #3 dated 8/14/23 identified Resident #1 told NA #3 that he/she can assist NA #3 with the transfer to the bathroom. NA #3 indicated she began transferring Resident #1 out of the bed to the wheelchair by herself, and as soon as Resident #1 stood up the resident started going down and she lowered Resident #1 to the floor and alerted the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement written by RN #4 dated 8/14/23 identified she was called to Resident #1's room and observed Resident #1 was lying on the floor. RN #4 indicated NA #3 attempted to transfer Resident #1 by herself and the resident became weak, and NA #3 lowered the resident to the floor. RN #4 indicated NA #3 was from the agency. RN #4 indicated at the start of the shift she had given NA #3 a thorough report on each resident that was on her assignment and was also provided with a written care guide. RN #4 indicated she educated NA #3 that she should have followed Resident #1's plan of care and should have gone to the nurse for any questions or clarification. The physician note dated 8/15/23 identified he was asked to see Resident #1 who had been lowered to the floor after an unsuccessful attempt to transfer with assist of one when Resident #1 usually transfers with a mechanical lift with no obvious injuries. The physician note dated 8/16/23 identified he received a call that Resident #1's left ankle was slightly swollen and painful with recommendations for an x-ray of the affected ankle. Report came in this afternoon which identified a non-displaced fracture of the distal tibia and loosening of the fibula/tibial screw. Recommendation to keep Resident #1 non-weight bearing and call orthopedic in the morning for advice. The reportable event form dated 8/16/23 at 5:30 PM identified Resident #1 sustained a fall during a transfer on 8/14/23 with no pain or injuries noted at the time of the incident. On 8/16/23 Resident #1 developed pain in the left foot and an x-ray of the area identified a nondisplaced fracture of the left distal tibial with loosening of the fibula/tibial screw. The event resulted in a serious injury or significant change in condition. The summary report dated 8/17/23 identified Resident #1 required a stand lift with assist of 2 for transfers out of bed to wheelchair. On 8/14/23 the agency nurse aide that was assigned to Resident #1 was provided with a verbal report and a copy of the resident care guide which included the residents transfer status. Resident #1 informed NA #3 that he/she could be transferred with the assist of one. NA #3 failed to follow the plan of care. On 8/16/23 Resident #1 developed left ankle pain and edema, an x-ray was ordered, and the result was a nondisplaced left distal tibial fracture with loosening of the fibula/tibial screw. New orders included to transfer the resident via Hoyer lift with assist of 2 and follow up with orthopedic for further interventions. On 8/17/23 the agency was updated that the nurse aide was no longer able to work at the facility. The nurse's note dated 8/17/23 at 11:14 AM identified the orthopedic physician indicated he was unable to give any advice/recommendation since he hasn't seen Resident #1 in several years. The nurse's note dated 8/17/23 at 11:45 AM identified the physician was notified with a new order to send Resident #1 to the hospital for evaluation. The nurse's note dated 8/17/23 at 8:34 PM identified Resident #1 returned to the facility at 7:00 PM, no surgical intervention was needed at this time per the orthopedic team. A splint was placed to left lower extremity with non-weight bearing to left lower extremity, continue with Xarelto (anticoagulant medication) for deep vein thrombosis prevention and follow up with orthopedic in 1 - 2 weeks. The nurse's note dated 8/31/23 at 1:26 PM identified Resident #1 returned from orthopedic appointment. Resident #1 is to continue non-weight bearing to left lower extremity. A short leg cast was applied to the lower left extremity. (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 review of the clinical record with the DNS on 12/4/24 at 11:00 AM identified while conducting the investigation NA #1 stated she transferred Resident #1 by herself. The DNS indicated NA #1 should have followed Resident #1's plan of care, the physician order, and had the assistance of 2 staff with the transfer from the bed to the wheelchair. The DNS indicated NA #3 was educated by RN #4 regarding following the plan of care, and the care guide prior to providing care that day to Resident #1. The DNS indicated NA #3 stated that Resident #1 told her that the transfer could be done with one person. Interview with RN #4 on 12/4/24 at 11:30 AM identified on 8/14/23 at the beginning of the shift she had given NA #3 a verbal report on every resident that was assigned to her, and the care guide to the residents. RN #4 indicated that NA #3 should have followed Resident #1's plan of care and if she had any questions she should have asked the charge nurse on the unit. Interview with MD #1 on 12/4/24 at 11:53 AM identified she was on the unit at the time resident was observed on the floor on 8/14/23. MD #1 indicated the nurse aide should have followed the physician's order to use the Sara lift with assistance of two when transferring the resident. Interview with NA #3 on 12/4/24 at 2:08 PM identified she is from the agency. NA #3 indicated the charge nurse and RN #4 did not give her report on her assignment or provide her with an assignment sheet on Resident #1 prior to the incident. NA #3 indicated on 8/14/23 around 10:15 AM she heard Resident #1 yelling for help. NA #3 indicated she went to Resident #1's room and the resident asked to go to the bathroom. NA #3 indicated Resident #1 was alert, oriented and Resident #1 stated to her that she can transfer him/her by herself. NA #1 indicated she helped Resident #1 out of bed to a standing position by herself and that is when Resident #1 started going down and she helped the resident to the floor and notified the nurse immediately. NA #3 indicated she did not ask the staff how the resident transferred prior to moving the resident. NA #1 indicated after the incident one of the facility staff gave her an assignment sheet and explained that Resident #1 required a Sara lift with assistance of 2 staff for transfers. Review of the facility safe resident transfer policy identified upon admission and as necessary, residents will be screened by therapy to determine the best and safest means of transfer and ambulation for both the residents' and staff members' safety. Review of the facility falls management system policy identified the facility will provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. Additionally, all residents fall in the facility are analyzed and trended through the Quality Improvement Interdisciplinary process to maintain a safe environment. At the time of admission, each resident is assessed using the falls risk assessment to determine his/her risk for sustaining a fall. A falls risk assessment that represents a high risk for falls and requires the development of a care plan with interventions implemented designed to prevent falls. When a resident sustains a fall, assessment will include investigation using the fall investigation worksheet to determine probable cause factors. When a resident sustains a fall, a Registered Nurse completes an assessment for injury. The attending physician and family/responsible party are notified of the fall and the resident status. Follow-up assessment and documentation will be conducted for a minimum of every shift for 72 hours.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident # 8) reviewed for unnecessary medications, the facility failed to assess and manage complaints of new severe wrist pain. The findings include: Resident #8 was admitted to the facility in December 2018 with diagnoses that included Alzheimer's dementia, hypertension, and failure to thrive. Review of the clinical record identified Resident #8 had been under hospice care since 6/9/21 due to late-stage severe Alzheimer's dementia. The annual MDS dated [DATE] identified Resident # 8 had severely impaired cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with toileting, bathing, and dressing. The care plan dated 6/26/24 identified Resident #8 had impaired cognitive function and impaired thought processes related to dementia. Interventions included communicating using consistent, simple and directive sentences. The care plan also identified Resident #8 has a terminal diagnosis related to end stage dementia. Interventions included to observe closely for signs of pain, administer pain medication as ordered, and notify the physician of breakthrough pain. Review of the August 2024 physician's orders directed to assess Resident #8 for pain every shift (original date 9/13/22) and administer Acetaminophen (a pain relief medication) 325 mg - 2 tablets every 4 hours for general discomfort as needed (original date 10/7/22). The nurse's note dated 8/12/24 at 3:09 PM by LPN #2 identified that Resident #8 had a swollen right wrist with tenderness and severe pain. The note also identified that a physician's order directed to obtain an x-ray and the results were negative. Further review of the nurse's note identified it was documented as a late entry on 8/13/24 at 3:13 PM. Review of the August 2024 MAR identified Resident #8's pain was documented as zero (no pain) on 8/12/24 during the 7:00 AM - 3:00 PM shift by LPN #2. Additionally, the MAR also failed to identify any documentation related to administration of pain medications on 8/12/24 during the 7:00 AM - 3:00 PM shift. Review of the clinical record failed to identify any additional documentation related to Resident #8's right wrist injury by LPN #2 on 8/12/24, including any interventions that were taken related to Resident #8's reports of severe pain. Review of the clinical record failed to identify any documentation related to an RN assessment of Resident #8's right wrist injury on 8/12/24. A radiology report dated 8/13/24 at 1:33 PM identified Resident #8 had an x-ray of the right wrist that showed joint space narrowing with no fracture. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any additional monitoring, assessments, or documentation of Resident #8's right wrist injury by any facility staff after 8/13/24. Review of the clinical record and interview with LPN #2 on 12/3/24 at 11:40 AM identified that he was the nurse assigned to care for Resident #8 on 8/12/24 and 8/13/24. LPN #2 identified while he did not remember entering the note related to Resident #8's right wrist injury as a late entry, he did remember the injury itself. LPN #2 identified that on 8/12/24, Resident #8 had been complaining of wrist pain and when LPN #2 observed Resident #8's right wrist, he observed it to be visibly swollen and uneven in comparison to Resident #8's left wrist. LPN #2 identified that he reported the injury to RN #4, and she would have been the one to enter a full assessment of Resident #8's wrist injury, contact the physician, initiate an investigation, and contact Resident #8's resident representative. LPN #2 identified that during his assessment of Resident #8's right wrist, he observed that Resident #8 was crying out. LPN #2 initially identified he provided Resident #8 a dose of acetaminophen; however, the August MAR failed to reflect that Acetaminophen had been administered. Further, LPN #2 identified he was unable to recall what interventions were put into place for Resident #8 and this would have been addressed by RN #4 during her assessment. Interview with RN #4 (RN Supervisor 7:00 AM - 3:00 PM) on 12/3/24 at 12:33 PM identified on 8/12/24 and 8/13/24 she was out of work and provided a review of her timesheet that identified such. RN #4 identified that during this time there were several RNs covering her leave, however, there was not a consistent nurse scheduled to cover during her absence. RN #4 identified that LPN #2 should have reported Resident #8's right wrist injury to the covering RN supervisor, who should have done an assessment and contacted the physician to report the injury as well as Resident #8's hospice physician. RN #4 also identified that the nursing staff should have notified Resident #8's resident representative, and an investigation should have been initiated and conducted to determine the cause of the right wrist injury and Resident #8's pain should have been addressed by LPN #2. Interview with the DNS on 12/4/24 at 8:15 AM identified that she was not aware of any issues related to Resident #8's right wrist prior to surveyor inquiry. The DNS identified LPN #2 should have notified the RN supervisor, who then should have completed a full assessment and contacted the physician to report the injury as well as Resident #8's hospice physician and Resident #8's resident representative. The DNS further identified an investigation should have been initiated and conducted to determine the cause of Resident #8's right wrist injury, and the injury should have been reported to the state agency as the facility was not aware of how the injury occurred. The DNS identified that Resident #8's pain should have been assessed, addressed and monitored once the pain and wrist injury were identified. The DNS identified that the clinical record should also have accurate documentation related to the right wrist injury. Although attempted, an interview with Person #1 (Resident #8's resident representative) was not obtained. The facility policy on pain management directed that nursing would maintain an adequate comfort level for all residents which included an evaluation of pain that would be completed upon admission, post fall, upon a change in condition, and as needed, and the pain assessment would include verbal and nonverbal cues. The policy also directed that the treatment plan for managing a resident's pain would be individualized to meet their needs and preferences including an interdisciplinary approach with pharmacological and non-pharmacological interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46040 Based on observation, review of facility documentation, facility policy and interview, the facility failed to ensure that hot and cold food temperatures for meals were obtained and documented appropriately. The findings include: During a tour of the facility kitchen with Dietary Director #1 on 12/2/24 at 9:30 AM identified the following. Review of the food service temperature logs for 11/2024 identified that multiple dates were missing temperatures or were completely blank. Initial review of the food temperature logs for 11/19/24 - 11/30/24 identified breakfast food temperature logs with hot food temperatures documented with no dates (month/day/year) annotated on the logs, no cold food items with any recorded temperatures from 11/19/24 - 11/29/24, and completely blank areas for the following meals: 11/19/24 - no breakfast logs available for review; no food temperatures for lunch items. 11/24/24 - no logs available for review for any meals. 11/26/24 - no breakfast logs available for review; no food temperatures for dinner items. 11/27/24 - no breakfast logs available for review; no food temperatures for lunch items. 11/28/24 - no breakfast logs available for review; no food temperatures for lunch items. 11/29/24 - no breakfast logs available for review; no food temperatures for dinner items. 11/30/24 - no breakfast logs available for review; no food temperatures for dinner items. Further review of breakfast logs identified that the meal items listed were identical (oatmeal/farina/scrambled eggs/pancakes/French toast) for all temperatures records. Further review of additional logs for 9/24 and 10/24 also identified multiple days with incomplete food temperature logs with missing temperatures for main and alternate meals. Review of the logs also failed to identify any documentation related to any cold food items. Interview with Dietary Director #1 immediately following this review identified that he was not aware that the food temperatures were not being logged with every meal and that he would expect that the staff were doing this. Dietary Director #1 identified he would educate that staff regarding the need to ensure that food was provided at the proper temperatures. An initial request was made to Dietary Director #1 for copies of the food temperature logs for all meals served to the facility residents from 9/1/24 - 12/1/24 immediately following these observations by the end of the day on 12/2/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up request was made on 12/3/24 at 2:00 PM to Dietary Stock Clerk #1, who identified that Dietary Director #1 had completed making copies of the food temperature logs but she was unable to identify where they were located and that she would notify him that the documents were still needed. Following a 3rd attempt made on 12/4/24 to obtain the food temperature logs on 12/4/24 at 7:00 AM, Dietary Stock Clerk #1 identified Dietary Director #1 was not scheduled to work on that date but had put aside the copies of the logs previously requested. Dietary Stock Clerk #1 provided multiple food temperature logs, including the logs previously reviewed by this surveyor. Review of the logs provided identified the logs had been altered, with meal temperatures added for the dates previously reviewed by this surveyor. In addition, the breakfast logs previously reviewed that were not identified by date, now included multiple dates added, including 11/19/24 - 11/30/24. Interview with Dietary Stock Clerk #1 immediately following these observations identified she was only told where the copies were located but was unable to identify why the documents were altered or who had altered them. Interview with Dietary Director #2 (Chef Manager) on 12/4/24 at 9:49 AM identified that he was aware of the issues with food temperature logs and that his associates at the facility had misunderstood the issues with the logs, and that the logs had been filled in after the initial review with Dietary Director #1. Dietary Director #2 declined to identify who filled out the logs or how the temperatures were obtained after the meals had already been served weeks to months prior to the review, or how the breakfast dates were recorded when the logs included identical meals with no dates previously. Dietary Director #2 identified the logs would be completed with all meals going forward, and that the facility had provided in servicing to the dietary staff, provided a copy of an in-service document, and identified that the facility did not have a policy related to food temperature logs. Review of an undated in-service document for Food Temperature logs identified that all food temperature logs must be filled out before the start of each meal service and at any other time if required. Subsequent to surveyor inquiry, interview and document review with Dietary Director #2 on 12/4/24 identified the facility did have a policy related to food temperatures and that he was unaware that the policy existed until the inquiry by this surveyor. The facility policy on food temperatures directed that all food production staff were responsible for recording and maintaining proper food temperatures at the tray line and/or point of service dining areas. The policy further directed that the food temperature log would be used to record temperatures for each meal, and all hot and cold food temperatures were be recorded at the start and end of each meal. The policy further directed that tempter logs would be maintained in the dietary department per the record retention policy.