STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075292	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at New Britain	400 Brittany Farms Rd New Britain, CT 06053

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on observation, review of facility policy and interviews for one sampled resident (Resident #166) observed self-administering medications, the facility failed to ensure the resident was assessed for self-administration of medications. The findings include: Resident #166's diagnoses included chronic obstructive pulmonary disease, heart failure and chronic pain. The resident medication self-assessment forms dated 10/27/23 & 1/4/24 indicated Resident #166 expressed no desire to self-administer medications. The quarterly MDS assessment dated [DATE] identified Resident #166 was cognitively intact and was dependent for transfers, showering, toileting and required set up for meals. The care plan dated 2/29/24 identified a self-care deficit related to decreased strength and endurance, with interventions that included nursing assistants (NA's) to ensure foods are cut into bit sized pieces during each meal tray set up. Observation on 5/7/24 at 10:04 AM identified Resident #166 in bed by the window, with the privacy curtain drawn halfway between he/she and his/her roommate. The resident's overbed table was in front of the resident and it contained a medicine cup with numerous pills visible in the cup. Interview on 5/7/24 at 10:05 AM with Resident #166 identified that the nurses sometimes leave the medications with him/her to self-administer. Resident #166 further explained he/she would never throw the medications away or not take them and proceeded to self-administer the medications contained within the medicine cup. Observation on 5/7/24 at 10:06 AM identified LPN #2 was across the hall from Resident #166's room in a resident's room with the medication cart placed in front of her. The privacy curtain obstructed the view of Resident #166 from the hallway. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/7/24 at 10:08 AM with LPN #2 identified that the facility policy is that medications should not be left at the bedside, nurses are expected to remain at the bedside and wait for the resident to take their medications. LPN #2 identified she was near Resident #166's room on this opposite side of the hallway. She further noted that she could peek in on Resident #166 to make sure he/she took the morning medications. In addition, LPN #2 identified that Resident #166 preferred that the nurses not hover and requested privacy. LPN #2 then leaned over and came from behind the medication cart to observe if Resident #166 had taken the medications. All morning medications that were left at the bedside were verified with LPN #2. Review of the medication administration record (MAR) with LPN #2 identified she had poured the following medications into the medicine cup: 1. Amlodipine 5mg daily for high blood pressure. 2. Aspirin 81mg delayed release tablet once daily. 3. Duloxetine HCL 20mg cap once daily for chronic pain related to adjustment disorder with Depression. 4. Gabapentin 300mg daily for diabetic neuropathy related to diabetes. 5. Isosorbide ER 60mg daily for high blood pressure. 6. Multivitamin one tab daily for vitamin deficiency. 7. Tylenol 325mg tabs totaling two tabs (650mg) twice daily for pain related to osteoarthritis. 8. Apixaban 5mg twice daily to prevent clots. 9. Carvedilol 3.125mg twice daily for high blood pressure. 10. Pantoprazole Sodium 40mg twice daily to decrease stomach acid. Review of the physician's orders for May/2024 did not identify an order that directed Resident #166 could self-administer medications. Interview on 5/8/24 at 10:59 AM with the DNS identified that during medication administration the resident should be within the nurse's view so that the nurse can visualize the resident consuming the medication. The DNS further noted that the nurse cannot leave the resident until the medications are consumed and medications should not be left at the bedside. A second interview with the DNS on 5/9/24 at 8:44 AM identified Resident #166 was unable to self-administer medications and noted that he/she had been sick and debilitated when admitted . She further noted that it might be time to re-evaluate the resident for self-administration of medications and noted self-administration assessments are completed upon admission, readmission and quarterly. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Administering Medications policy established that a resident may self-administer their own medications, only if the attending physician in conjunction with the interdisciplinary care team has determined that they have the decision-making capacity to do so safely.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #126), the facility failed to ensure the physician's order and the resident's signed Advance Directives were congruent. The finding includes: Resident #126 's diagnoses included pulmonary fibrosis, asthma, and chronic cough. The physician's order dated [DATE] directed Resident #126's code status was Full Code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR (cardiopulmonary resuscitation). Review of the clinical record identified an Advanced Directive form dated [DATE] that noted Resident #126 had elected a code status of Do No Resuscitate (DNR), which means that a person has decided not to have CPR attempted on them if their heart or breathing stops. The quarterly MDS assessment dated [DATE] identified Resident #126 had intact cognition and was independent with most activities of daily living apart from requiring supervision and set up assistance. Resident #126's care plan dated [DATE] identified the resident had a code status of DNR with interventions that included honor advanced directives through the next review date. Interview with LPN #2 on [DATE] at 1:27 PM identified that when determining a resident's code status, she first checks the physician's orders in the electronic medical record (EMR) and then checks the resident's physical clinical record for the advanced directives to make sure they match. After checking Resident #126's status, she noted that there was an order in the EMR for full code dated [DATE] and the signed advanced directives form in the physical medical record dated [DATE] noted a status of DNR. LPN #2 further noted that if a code occurred (the resident stopped breathing, and or was without pulses), she would follow the physician's order or advanced directive form with the most recent date. Additionally, LPN #2 identified that the advanced directives form should be reviewed and signed within twenty-four hours of a resident's admission or readmission to the facility. Interview on [DATE] at 1:46 PM with the DNS identified that all of the physical clinical records have a red sleeve denoting where the advanced directives are located. She further noted that when a resident is admitted or readmitted advanced directives are reviewed with the resident, family, or conservator within twenty-four hours. She further noted that it sometimes takes longer to get the advanced directives signed by the family or conservator and in those instances the resident would be designated a full code until the advanced directives were reviewed and signed. Additionally, the DNS identified that they would be conducting a facility wide audit to check for any other discrepancies. Interview with Resident #126 on [DATE] at 3:02 PM identified she/he wished to maintain the status of DNR that was elected on the advanced directives that she/he had signed on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, a physician's order dated [DATE] directed a code status of DNR. Review of the Advanced Directives policy dated ,d+[DATE]established that upon admission to the facility, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directives.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46117 Based on clinical record review, facility policy review, and interviews for one of four sampled residents (Resident #87) reviewed for nutrition, the facility failed to notify the physician and resident representative regarding a significant weight loss. The findings include: Resident #87's diagnoses included type 2 diabetes mellitus, hypertension, anxiety, vascular dementia, and paranoid schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #87 had severe cognitive impairment, required set up assistance for eating, was non-ambulatory, had a height of 67 inches, a weight of 174 pounds, and did not have weight loss in the past six months. The annual MDS assessment dated [DATE] identified Resident #87 had severe cognitive impairment, required supervision for eating inclusive of verbal cues and touching assistance, was non-ambulatory, had a height of 67 inches, a weight of 174 pounds, did not have weight loss in the past six months, and had a mechanically altered therapeutic diet. Resident #87's care plan dated 11/15/23 identified a potential nutritional risk related to dysphagia, type 2 diabetes, dementia, and schizophrenia. Care plan interventions included: monitor weights as ordered, provide, and serve diet as ordered, monitor and document signs and symptoms of dysphagia, and monitor for significant weight loss: 3 pounds (lbs.) in 1 week, greater than 5 percent in 1 month, greater than 7.5 percent in 3 months, and greater than 10 percent in 6 months. Review of the clinical record identified weight records that noted Resident #87 weighed 174.2 pounds (lbs.) on 7/9/23. Further review of the clinical record identified no recorded weights from August 2023 through December 2023. The quarterly MDS assessment dated [DATE] identified Resident #87 had severe cognitive impairment, required supervision with eating, extensive assistance with all activities of daily living, had a weight of 157 pounds, was not on a physician prescribed weight loss regimen and experienced a weight loss of 5% in the past month or 10% in the past six months, and was on a mechanically altered therapeutic diet. Review of physician's orders from July/2023 through February/2024 identified orders that instructed to obtain monthly weights on the 7-3 shift on the 10th day of the month. The weight and vital summary record identified Resident #87 weighed 152 pounds on 1/12/24, indicative of a 13 percent weight loss within a six-month time period. Further review identified Resident #87 was re-weighed on 1/12/24 at 2:40 PM with a resulting weight of 156.6 pounds (weight loss of 10.1 percent from 7/9/23). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Dietician #2's nutritional evaluation dated 1/30/24 identified Resident #87 triggered for significant weight loss of greater than 10 percent from the previous recorded weight, and food intake was 50 percent to 100 percent per meal according to the nursing documentation. The evaluation further noted that additional food items would be provided on the resident's tray for optimal food intake and noted that Resident #87's nutrition may decline related to dementia. Review of the nursing progress notes from 1/12/24 through 1/31/24 failed to identify Resident #87's physician and responsible party(ies) were notified of the significant weight loss. Interview and clinical weight record review with RN #1 (wound nurse but covering unit manager) on 5/8/24 at 10:00 AM identified that the dietician was responsible for assessing residents for weight loss. The charge nurse was responsible for recording the weights in the electronic medical record and the unit manager would ensure that there was a weight recorded in the resident's clinical record. There would also be a physician's order directing the frequency of weights. RN #1 could not locate monthly weights from August 2023 through December 2023. She also identified that nursing notifies the dietician, physician, and resident representative of significant weight loss, and it should be documented in the nursing progress notes. In addition, she could not recall whether or not she was aware of Resident #87's significant weight loss. Interview with the DNS on 5/9/24 at 2:15 PM identified that in regards to the monitoring of weights and weight loss in the facility, it is discussed in morning report and there is also an at-risk meeting twice a week. After reviewing Resident #87's clinical record, the DNS could not find documentation to identify that the physician and resident representative had been notified of the resident's significant weight loss. Interview with Dietician #2 on 5/10/24 at 9:45 AM identified Resident #87 triggered for a significant weight loss when she did the nutritional evaluation on 1/30/24. She also noted that she was aware Resident #87 did not have any documented monthly weights from August 2023 through December 2023 and identified that she sent an email to all unit managers and the DNS regarding the missing weights. She further identified that she added extra food items such as pudding, ice cream, and apple sauce on his/her meal tray related to the significant weight loss. In addition, she identified that she had not notified the physician and resident representative(s) of the weight loss because it was nursing's responsibility. Interview with APRN #1 on 5/10/24 at 11:00 AM identified he expects nursing to notify him of a weight loss. He further noted that once he was made aware he reviews the resident's weight loss, goals of care, and provides a plan of care. He recently started in his position of APRN for the facility and was not aware of Resident #87's significant weight loss. The Weight Assessment and Intervention policy identified that the multi-disciplinary team strived to prevent and intervene for undesirable weight loss to the residents. The resident's weight is recorded in each resident's medical record. The threshold for a significant unplanned weight loss would be greater than 5 percent in 1 month, greater than 7.5 percent in 3 months, and greater than 10 percent in 6 months. If weight loss was verified, nursing would notify the dietician, physician, and family.

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record reviews, and interviews for three sampled residents (Residents #25, #104, and #170) reviewed for resident assessments, the facility failed to ensure quarterly MDS assessments were completed and submitted within prescribed timing parameters. The finding includes: Resident #25 had an admission MDS assessment dated [DATE](this date references the assessment reference date) with a completion date of 12/13/23 (the completion date indicates the completion of the MDS). Resident #25 had a quarterly assessment dated [DATE] (the quarterly should be no later than 92 days following the previous comprehensive MDS assessment), the deadline for the completion date of the MDS was 3/23/24. The actual completion date of the MDS was 5/2/24 making the completion of the MDS 40 days late. Resident #104 had an annual MDS assessment dated [DATE] with a completion date of 12/20/23 (eleven days late). Resident #104 had a quarterly assessment dated [DATE], the deadline for the completion date of the MDS was 3/11/24. The actual completion date of the MDS was 5/8/24 making the completion of the MDS 58 days late. Resident #170 had an admission MDS assessment dated [DATE] with a completion date of 11/27/23. Resident #170 had quarterly MDS assessment dated [DATE], the deadline for the completion date of the MDS was 3/12/24; however, the actual completion date of the quarterly assessment 5/2/24 (51 days late). Interview with LPN #1(MDS Coordinator) on 5/8/24 at 10:25 AM identified she is responsible for the completion of the MDS assessments. She further identified that she is aware that the MDS assessment is to be completed within 14 days of the assessment reference date. In addition, she acknowledged that she was late in completing and submitting the quarterly MDS assessments for Residents #25, #104, and #170. LPN #1 noted that for a time there were only two MDS Coordinators for the facility and she could not catch up The Resident Assessment Instrument 3.0 user manual identified that the resident's assessment must be completed no later than the set ARD + 14 calendar days to be considered timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for two sampled residents (Resident #81 and #160) receiving anticoagulant medication, the facility failed to ensure the care plan included interventions to address the possible side effects and the monitoring that should accompany the use of an anticoagulant. The findings include: 1. Resident #81's diagnoses included acute embolism and thrombosis (disruption of the blood flow in veins and arteries), fractured left femur, and chronic diastolic congestive heart failure. The quarterly MDS assessment dated [DATE] identified Resident #81 had severe cognitive impairment, required maximal assistance with personal hygiene, toileting, was non-ambulatory, and utilized anticoagulant medication (blood thinner) that the assessment noted to be a high-risk medication. The physician's orders for May/2024 directed to administer Apixaban/Eliquis (a blood thinner used to prevent blood clots) 5 milligram (mg) one tablet by mouth every 12 hours. The origination date of the order was 2/23/21 (meaning the resident has been on this medication continuously since that date) According to Eliquis.com, the use of the medication poses a bleeding risk, in that it increases the risk of bleeding and can cause serious, potentially fatal bleeding. Resident #81's care plan dated 3/12/24 identified an alteration in musculoskeletal status related to left femur fracture with an intervention to administer anticoagulant medication as ordered. Further review of the care plan failed to identify the interventions related to the use of the Apixaban and the possible side effects related to the use of an anticoagulant and the increased risk of bleeding. Interview with the MDS Coordinators (LPN #1 and RN #3) on 5/10/24 at 12:25 PM identified Resident #81's care plan did not address interventions to address the possible side effects of anticoagulant therapy. RN #3 further identified that their corporate office directed them to develop anticoagulant care plans only for residents taking Coumadin and Lovenox medications. In addition, LPN #1 identified it was the responsibility of the MDS Coordinator and the nursing staff to ensure the care plan is comprehensive and updated as necessary. Interview with the DNS on 5/10/24 at 10:00 AM identified that residents who are prescribed anticoagulant medication should have a care plan in place for anticoagulant therapy. The DNS added it was not the sole responsibility of the MDS coordinator but nursing as well in developing and updating care plans as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Comprehensive Person-Centered Care Plan policy identified that the facility is to develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. It further identified that the comprehensive care plan is designed to incorporate risk factors associated with identified problems and recognized standards of practice for problem areas and conditions. Additionally, the policy identified that the care planning/interdisciplinary team is responsible for periodic review and updating of the care plans. 2. Resident #160's diagnoses included chronic embolism and thrombosis (disruption of the blood flow in veins and arteries), end stage renal disease, renal dialysis, and hyperlipidemia. The quarterly MDS assessment dated [DATE] identified Resident #160 had moderately impaired cognition, required maximal assistance with personal hygiene, was ambulatory, and utilized anticoagulant medication (blood thinner) that the assessment noted to be a high-risk medication Resident #160's care plan dated 3/19/24 identified a potential skin impairment related to fragile skin with an intervention that included to monitor for alteration in skin integrity related to subcutaneous anticoagulant use. Further review of the care plan failed to identify sides and symptoms to monitor for as a result of the resident being on anticoagulant therapy. A physician's order dated 3/31/24 through 5/30/24 directed Apixaban (a blood thinner used to prevent blood clots) 2.5 milligram (mg) one tablet by mouth every 12 hours related to chronic embolism and thrombosis. According to Eliquis.com, the use of the medication poses a bleeding risk, in that it increases the risk of bleeding and can cause serious, potentially fatal bleeding. Interview with the MDS Coordinator (LPN #1) on 5/9/24 at 3:10 PM identified Resident #160's care did not include a care plan that focused on anticoagulant therapy, but noted the resident should have had one. LPN #1 further identified that when the care plan was reviewed, interventions addressing the side effects to monitor could have been developed and implemented. LPN #1 added that it was the responsibility of both MDS and nursing to update and revise care plans as needed. Interview with the DNS on 5/10/24 at 10:00 AM identified that residents who are prescribed anticoagulant medication should have a care plan in place for anticoagulant therapy. The DNS added it was not the sole responsibility of the MDS coordinator but nursing as well in developing and updating care plans as needed. Interview with the Unit Manager/Supervisor (RN #2) on 5/10/24 at 1:10 PM identified that Resident #160 should have a care plan developed for anticoagulant therapy if the resident is taking any anticoagulant medication. RN #3 failed to identify why Resident #160 did not have a care plan developed for anticoagulant and that it was the responsibility of both nursing and MDS to create and to update care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Comprehensive Person-Centered Care Plan policy identified that the facility is to develop individualized comprehensive care plan for each resident that includes measurable objectives and timetables to [NAME] the resident's medical, nursing, and mental and psychological needs. It further identified that the comprehensive care plan is designed to incorporate risk factors associated with identified problems and recognized standards of practice for problem areas and conditions. The policy further identified that the care planning/interdisciplinary team is responsible for periodic review and updating of the care plans.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 47402 Based on observations, review of clinical records, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #42) reviewed for positioning and range of motion, the facility failed to ensure a physician's order was in place for the use of splints and for one sampled resident (Resident #213) who had orders for a compounded medication, the facility failed to ensure expired medication was not administered to the resident. The finding include: 1. Resident #42 was readmitted to the facility in January of 2024 with diagnoses that included quadriplegia, stiffness of unspecified joint, aphasia, and gastrostomy. The quarterly MDS assessment dated [DATE] identified Resident #42 had severe cognitive impairment, required maximal assistance with toileting, was dependent on staff for personal hygiene, transfers, was non-ambulatory, and had range of motion limitations of bilateral upper and lower extremities. The care plan dated [DATE] identified Resident #42 had the potential for impairment to skin integrity related to immobility, bilateral elbow splints and bilateral hand splints, with an intervention to apply bilateral hand splints. The care further identified a self-care deficit related to limited range of motion with an intervention for staff to place bilateral hand splints during morning (AM) care and remove them during PM care. A review of Resident #42's physician's order for the period of January/2024 through May/2024 failed to identify an order for bilateral hand splints. Resident #42's nurse aide care card instructed staff to apply bilateral hand splints during AM care and remove during PM care. Observation on [DATE] at 12:00 PM identified Resident #42 seated in a wheelchair wearing a hand splint to his/her left hand, the right hand was unadorned. Observation on [DATE] at 2:35 PM identified Resident #42 seated in a wheelchair, there was no splints applied to either hand. Observation with the Charge Nurse (LPN #5) on [DATE] at 12:58 PM identified Resident #42 seated in a wheelchair wearing a hand splint to his/her left hand and the right hand was unadorned. Interview with LPN #5 on [DATE] at 12:58 PM identified Resident #42 should have physician's orders directing the use of hand splints. After reviewing the orders, LPN #5 identified there were no orders in place regarding the use of hand splints. LPN #5 further identified that splints are applied by the NA's and nurses are responsible for checking the splint application and skin integrity. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on [DATE] at 1:03 PM identified she applied the splint to the resident's left hand, but the right-hand splint was not functioning. NA #1 further noted that she notified occupational therapy on [DATE] and was awaiting a replacement. Interview with the Unit Manager/Supervisor (RN #2) on [DATE] at 1:30 PM identified residents who utilize splints should have a physician's order addressing its usage based on the occupational therapist's recommendation. RN #2 further noted she reviewed Resident #42's physician's orders from January through [DATE] and was unable to identify a physician's order for splints. In addition, RN #2 identified that Resident #42 was readmitted to the facility in January and the orders for the splint were not added but noted the resident had an order for the splint previously. Interview with the Assistant Director of Rehab (OT #1) on [DATE] at 1:27 PM identified they were notified on [DATE] that the right-hand splint could not be located. OT #1 further noted that a physician's order confirming the recommendation made by the occupational therapist for splint usage should be in place. Interview with the Charge Nurse (LPN #6) on [DATE] at 11:55 PM identified she observed Resident #42 intermittently wearing bilateral hand splints but did not check to see if a physician's order was written for the splint usage. A second interview with OT #1 on [DATE] at 12:30 PM identified Resident #42 was last seen by the occupational therapy department in September of 2023 and was discharged from therapy in October of 2023. OT #1 further noted that a physician's order is required for splint usage to prevent skin breakdown and irritation. Additionally, OT #1 provided the OT discharge summary dated [DATE] which identified recommendations for remove bilateral elbow splints in with AM care and apply with PM care and to apply bilateral hand splints with AM care and remove with PM care. Interview with the DNS on [DATE] at 10:00 AM identified that a resident should have a physician's order when utilizing a splint. The DNS noted that all orders are discontinued when residents are transferred to the hospital and should be reviewed with the physician and reordered as required upon the resident's return to the facility. Review of the Assistive Devices and Equipment policy identified that the facility will maintain and supervise the use of assistive devices and equipment for residents. 2. Resident #213's diagnoses included protein calorie malnutrition, gastro-esophageal reflux disease (GERD) without esophagitis, and end stage renal disease. The admission MDS assessment dated [DATE] identified Resident #213 had intact cognition and was dependent for eating, oral hygiene, toileting, showering/bathing, and dressing. The Resident Care Plan dated [DATE] identified the resident has a nutritional problem or related to advanced age, therapeutic diet, mechanically altered diet, fluid restriction, food allergy, tube feeding supplementation diet, poor by mouth intake, increased nutritional needs. Interventions directed to monitor weight, skin, labs, and oral intake per protocol or as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's orders for May/2024 (the origination date of the order was [DATE]) identified an order for Lansoprazole oral suspension 3mg/ml with instructions to administer 10 ml via G-tube one time a day for GERD. Observation of the medication storage room with LPN #4 on [DATE] at 6:59 AM identified Lansoprazole Suspension for Resident #213 with an expiration date of [DATE] written prominently on the bottle in black pen. This medication was discarded into the return to pharmacy by LPN #4 at this time. Review of Resident #213's MAR for [DATE] identified Lansoprazole Suspension was administered daily as ordered from [DATE] to [DATE]. Review of the Point Click Care audit detail report for the Lansoprazole suspension for the month of May for Resident #213 identified the medication was clicked off administered on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. 10 days following the medication expiration date. Interview with LPN #4 on [DATE] at 7:00 AM identified the Lansoprazole oral suspension was expired for Resident #213 and should be sent back to the pharmacy and re-ordered and that it should not be in use. Interview with LPN #3 on [DATE] at 11:56 AM identified she administered Lansoprazole oral suspension to Resident #213 on [DATE]. When asked to locate the medication administered to the resident, LPN #3 checked the medication cart and the medication storage room, and the medication was not found. In addition, LPN #3 identified she must have made an error and had not administered the medication as ordered. She further noted that she was going to contact the pharmacy to get a refill of the Lansoprazole. Subsequent to surveyor inquiry LPN #3 struck out administration of Lansoprazole for Resident #213 at 11:59 AM on [DATE]. Interview with the Pharmacist on [DATE] at 12:11PM identified that efficacy following expiration date depends on what the medication is compounded with, and Lansoprazole was compounded with sterile water and Sodium Bicarbonate. He noted the medication was last filled on [DATE] and was good for 14 days following the fill date. In addition, he noted the Lansoprazole would lose efficacy once expired and the expectation is that the medication is used until the expiration date and should have been discarded after [DATE]. Further, the Pharmacist noted that the turnaround time for ordered medication is within 24 hours. Interview with the DNS on [DATE] at 12:50 PM identified she was aware of the medication not being available on the floor and that medications should not be in use following their expiration date. Review of the Administering Medications policy directed medications must be administered in accordance with the orders, including any required time frame. The individual administering the medications must check the label THREE (3) times to verify the right medication, right dosage, right time, right method (route) of administration before giving the medication. The expiration date must be checked prior to administering. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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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** 17723 Based on review of clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #213) who had physician orders for a compounded medication, the facility failed to ensure the medicaion was administered as ordered. Resident #213's diagnoses included protein calorie malnutrition, gastro-esophageal reflux disease (GERD) without esophagitis, and end stage renal disease. The admission MDS assessment dated [DATE] identified Resident #213 had intact cognition and was dependent for eating, oral hygiene, toileting, showering/bathing, and dressing. The Resident Care Plan dated 3/20/24 identified the resident has a nutritional problem or related to advanced age, therapeutic diet, mechanically altered diet, fluid restriction, food allergy, tube feeding supplementation diet, poor by mouth intake, increased nutritional needs. Interventions directed to monitor weight, skin, labs, and oral intake per protocol or as needed. The physician's orders for May/2024 (the origination date of the order was 3/21/24) identified an order for Lansoprazole oral suspension 3mg/ml with instructions to administer 10 ml via G-tube one time a day for GERD. Observation of the medication storage room on 6/8/24 at 6:59 AM identified Lansoprazole Suspension for Resident #213 with an expiration date of 4/30/24 written prominently on the bottle in black pen. This medication was discarded into the return to pharmacy by LPN #4 at this time. Review of Resident #213's MAR for May 2024 identified Lansoprazole Suspension was administered daily as ordered from 5/1/24 to 5/10/24. Review of the Point Click Care audit detail report for the Lansoprazole suspension for the month of May for Resident #213 identified the medication was clicked off administered on 5/8/24 at 8:07 AM by LPN #11, on 5/9/24 at 8:18 AM by LPN #11, and on 5/10/24 at 8:34 AM and struck out at 5/10/24 at 11:59 AM by LPN #3. Interview with LPN #3 on 5/10/24 at 11:56 AM identified she administered Lansoprazole oral suspension to Resident #213 on 5/10/24. When asked to locate the medication administered to the resident, LPN #3 checked the medication cart and the medication storage room, and the medication was not found. In addition, LPN #3 identified she must have made an error and had not administered the medication as ordered. She further noted that she was going to contact the pharmacy to get a refill of the Lansoprazole. Interview with the DNS on 5/10/24 at 12:50 PM identified she was aware of the medication not being administered but was signed for as administered. The DNS identified that medications not passed should not be signed for in the MAR. (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 Administering Medications policy directed medications must be administered in accordance with the orders, including any required time frame. The individual administering the medications must check the label THREE (3) times to verify the right medication, right dosage, right time, right method (route) of administration before giving the medication. The expiration date must be checked prior to administering. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility policy review, and interviews for one of four sampled residents (Resident #87) reviewed for nutrition, the facility failed to ensure the dietician assessed the resident for weight loss timely and failed to obtain the resident's monthly weight in accordance to facility policy. The findings include: Resident #87 's diagnoses included type 2 diabetes mellitus, hypertension, anxiety, vascular dementia, and paranoid schizophrenia. Review of Resident #87's weight records identified a weight of 174.2 pounds on 7/9/23, further review identified no documented weights from August 2023 through December 2023. The Resident Care Plan (RCP) dated 11/15/23 identified Resident #87 had a potential nutritional risk related to dysphagia, type 2 diabetes, dementia, and schizophrenia. Care plan interventions directed to monitor resident weight as ordered, provide, and serve diet as ordered, monitor/document signs and symptoms of dysphagia, and monitor for significant weight loss: 3 pounds (lbs.) in 1 week, greater than 5 percent in 1 month, greater than 7.5 percent in 3 months, and greater than 10 percent in 6 months. Resident #42's weight record identified Resident #87 was weighed on 1/12/24 at 9:06 AM with a weight of 152 pounds. (weight loss of 13 percent from 7/9/23). Further weight record reviewed identified Resident #87 had a re-weigh on 1/12/24 at 2:40 PM with a weight of 156.6 pounds (weight loss of 10.1 percent from 7/9/23). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 had severe cognitive impairment and required limited assistance with eating and extensive assistance with bed mobility, toileting, hygiene, transfer, and non-ambulatory. Further review of the resident assessment identified Resident #87 had an unplanned weight loss and was receiving a therapeutic mechanically altered diet. Dietician #2's nutritional evaluation dated 1/30/24 identified Resident #87 triggered for significant weight loss of greater than 10 percent from the previous recorded weight, food intake was 50 percent to 100 percent at meals according to nursing documentation. The evaluation further noted that added food items would be provided on the tray for optimal food intake and noted Resident #87's nutrition may decline related to dementia and the registered dietician would continue to monitor and evaluate as needed. The physician's order dated 4/1/24 with origination date of 10/29/21 directed to obtain a monthly weight on 7-3 shift 10th day of the month. The physician's order dated 4/1/24 with origination date of 10/25/23 directed to provide carbohydrate-controlled diet, ground texture food consistency and thin liquid. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical weight record review with RN #1 (wound nurse but covering unit manager) on 5/8/24 at 10:00 AM identified that the dietician was responsible for assessing resident for weight loss. The charge nurse was responsible for recording the weights in the electronic medical record and the unit manager would ensure that there was a weight recorded in the resident clinical record. There would also be a physician's order on how frequently the resident required a weight. RN #1 could not identify why Resident #87 had no weight recorded from August 2023 through December 2023, but she identified that facility had a vacancy for the unit manager, and she or the DNS was covering for being the unit manager during that time period. Interview with Dietician #1 on 5/9/24 at 11:10 AM identified that she was responsible for assessing residents for a weight loss and identified that the facility process was to run a daily weight report that highlights residents with weight loss in 30 days and/or 180 days. She further noted that weight loss is also discussed in the morning report. She identified that a significant weight loss would be greater than 5 percent in 30 days and greater than 10 percent in 180 days. In addition, the dietician also ran a report that identified missing weights at least once a month. She further identified that missing weights would not appear on the weight loss report. Interview with the DNS on 5/9/24 at 2:15 PM identified that the department heads discuss any potential weight loss in morning report and there is also an at-risk meeting twice a week for any resident with a weight loss. She confirmed that Resident #87 had a physician's order for a monthly weight. She also reviewed Resident #87's weight record and noted there were no monthly weights recorded from August 2023 through December 2023. Additionally, she identified that all weights should be entered in the electronic medical record so the resident weight would be included in the weight loss report otherwise, any missing weight would not be reflected in the weight loss report. She was unsure why Resident #87's weight loss had been missed. Interview with Dietician #2 on 5/10/24 at 9:45 AM identified Resident #87 triggered for a significant weight loss when she did the nutritional evaluation on 1/30/24. She also was aware that Resident #87 had no monthly weight recorded from August 2023 through December 2023. She noted that she sent an electronic mail monthly to all unit managers and the DNS regarding the monthly missing weight for Resident #87. She identified that the nursing department was responsible for ensuring the weight was obtained and recorded in the electronic medical record. She also identified that she added extra food items such as pudding, ice cream, and apple sauce on the tray related to significant weight loss. The Weight Assessment and Intervention policy identified that the multi-disciplinary team would strive to prevent and intervene for undesirable weight loss to the residents. The resident's weight would be recorded in each resident's medical records. The threshold for a significant unplanned weight loss would be greater than 5 percent in 1 month, greater than 7.5 percent in 3 months, and greater than 10 percent in 6 months.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47402 Based on review of personnel files, review of facility policy, and interviews for two of three sampled nurse aides (NA #1 and #3) the facility failed to complete annual performance evaluations. The findings include: Interview with HR #1 on 5/10/24 at 8:50 AM identified that performance evaluations could be located for 2022 and 2023 for NA#1 (hired on 8/10/12) and NA#3 (hired on 7/7/99), and that typically they would be completed by the unit manager, however, there has been some turnover recently so annual reviews of the NA's have not been completed. Interview with the DNS on 5/10/24 at 10:00am identified there were no annual evaluations only annual competencies that were being completed and that in the policy entitled Competency of Nursing Personnel it directed evaluations to be done at any time interval determined by the Nursing Administration for reasons of performance issues and/or attendance. No policy speaking to the requirement of annual performance review of NA's could be provided when requested.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observation, facility policy and interviews for one of three sampled medication rooms the facility failed to store medications appropriately. The findings include: Observation on [DATE] at 6:44am of Station 4 medication room with LPN #4 identified Ipatropium Bromide/Albuterol Sulfate 0.5mg & 3mg/3ml Rx#10754244 for Resident #16 was stored that expired , d+[DATE]. Observation on [DATE] at 6:50am of Station 4 medication room with LPN#4 identified Ipatropium Bromide/Albuterol Sulfate 0.5mg & 3mg/3ml Rx#10903962 for Resident #394 stored that expired ,d+[DATE]. Observation on [DATE] at 6:53 am of Station 4 medication room with LPN#4 identified Ipatropium Bromide/Albuterol Sulfate 0.5mg & 3mg/3ml Rx# 10754244 for Resident #16 was stored that expired , d+[DATE]. Observation on [DATE] at 6:55am of Station 4 medication room with LPN#4 identified Ipatropium Bromide/Albuterol Sulfate 0.5mg & 3mg/3ml Rx# 10728345 stored that expired ,d+[DATE]. Observation on [DATE] at 6:57am of Station 4 medication room with LPN#4 identified Albuterol Sulfate inhalation 0.083% 2.5mg/3ml Rx#10445440 that expired ,d+[DATE]. Observation on [DATE] at 6:59am of Station 4 medication refrigerator with LPN#4 identified Lansoprazole suspension compounded medication 3mg/ml for Resident #213 that expired on [DATE]. Interview with LPN#4 on [DATE] at 7:00am identified the medications were indeed expired and that it was everyone's job to go through the medications regularly to see if they were expired, and that they should be sent back to pharmacy and placed in a red pharmacy return bin if they are expired. Review of the MAR for [DATE] on [DATE] identified Lansoprazole had been signed off administered to Resident #213 on [DATE]st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 10th of 2024. Interview with Pharmacist #1 on [DATE] at 12:11pm identified that efficacy following expiration date depends on what the medication is compounded with, this medication (Lansoprazole) was compounded with sterile water and sodium bicarbonate. It was last filled on [DATE] and is good for 14 days following the fill date. The medication would lose efficacy once expired. No further refills had been filled. There was none noted in the system to go out today [DATE]. No electronic refill request could be located once identified it was expired. The expectation is that the medication is only used until the expiration date, and that it should have been re-ordered for the resident and discarded after [DATE]. Once the medication is re-ordered the facility should have received it within 24 hours. Review of the medication storage policy directed the facility should not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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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** 47900 Based on observation, review of facility documentation, review of facility policy, and interviews, for 2 of 3 residents (Resident #42 and Resident #230) reviewed for infection surveillance, the facility failed to identify and maintain records of residents with known MDRO colonization and failed to appropriately cohort residents with a known MDRO colonization. The findings include: Resident #42's was admitted to the facility with diagnoses that included hemiplegia, MRSA, C-diff, aphasia, and gastrostomy. The quarterly MDS assessment dated [DATE] identified Resident #42 cognitive skills for daily decision making was severely impaired, required maximal assistance with toileting hygiene, bathing and dependent on care personal hygiene, transfers, and non-ambulatory. The care plan dated 4/15/24 identified Resident #42 had a history of MRSA and C-diff colonization with interventions that included: monitor for sign and symptom of C-diff and monitor or report to MD as needed for sign or symptom of MRSA infection every shift. A physician's order dated 4/25/24 directed for Enhance Barrier Precautions to be maintained at all times every shift for gastrostomy tube. Resident #230's was admitted to the facility with diagnoses that included type 2 diabetes mellitus, urinary tract infection, and acute posthemorrhagic anemia. The admission MDS assessment dated [DATE] identified Resident #230 had moderately impaired cognition, required maximal assistance with toileting hygiene, transfers, personal hygiene, dressing, and moderate assistance with mobility. A review of the care plan dated 3/26/24 for Resident #230 failed to identify any history of a MDRO colonization. Review of the Hospital Discharge Summary dated 3/5/24 identified Resident #230 had ESBL E.coli and was treated with the final day of therapy completed on the day of discharge. Review of the History and Physical progress note dated 3/6/24 written by MD #1 identified that Resident #260 hospital course for a diagnosis of ESBL E.coli-right pyelonephritis for which resident completed 4 days of meropenem (antibiotic). Observation on 5/6/24 at 12:00 PM identified that both Resident #42 and Resident #230 were presently sharing a room. Review of the facility's current Enhanced Barrier and MDRO log with the DNS and the Infection Preventionist Nurse (LPN #8) on 5/8/24 at 8:34 AM failed to identify that Resident #42 had a history/colonization of MRSA and C-diff, and that Resident #230 had a history/colonization of ESBL. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS and LPN #8 on 5/8/24 at 8:34 AM identified that Resident #42 did not use the bathroom, hence why Resident #230 was placed in the same room. The DNS then identified that Resident #230 had ESBL and both residents probably should not have been placed in the same room. The DNS further indicated that the bed board did not reflect the MDRO's history of Resident #42 and #230 and will update accordingly. They added that the admission cooperate nurse completed the bed board indicating the MDRO's, and the IP would be responsible for the MDRO's log. LPN #8 indicated that she started working as the IP nurse in September of 2023 and that she was responsible for updating the MDRO log. LPN #8 further added that it was the practice of the facility to update the MDRO log daily after reviewing: admission records, laboratory testing results, and after daily morning facility report. The DNS and LPN #8 added that they review hospital discharge summary, laboratory testing result and receives a thorough nurse-to-nurse report from hospitals and other acute care settings to obtain the resident's MDRO status. The DNS identified residents with the same infections should be cohort in the same room or with a resident that would be a low risk of acquiring the infection per the facility's policy. Review of the Multidrug-Resistant Organisms policy identified that the appropriate precautions will be taken when caring for residents with known or suspected to have a MDRO. The policy further identified that when single rooms are not available, cohort residents with the same MDRO in the same room, and if not possible cohort with a resident who was at low risk for acquisition of MDRO's and are likely to have a short length of stay.