STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075293	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson House	1 John H Stewart Dr Newington, CT 06111

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #87 and Resident #353) reviewed for transmission-based precautions, the facility failed to ensure privacy related to having the posted isolation sign identify the type of infection/reason for the resident's isolation. The findings include: 1. Resident #87's diagnoses included current herpes zoster/shingles, chronic obstructive pulmonary disease and congestive heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #87 was cognitively intact and required partial to moderate assistance with toileting, transfers, and bed mobility. The Resident Care Plan dated 1/3/25 indicated a rash related to herpes zoster and antiviral medication for a diagnosis of shingles. Interventions included treatments and medications as ordered and to inform medical staff as needed. A physician's order dated 1/23/25 directed contact precautions, place a contact precaution sign on the door, highly transmissible active infection that cannot be contained, and Resident #87 must be in room alone and without a roommate. An observation on 1/27/25 at 10:00 AM identified Resident #87's room had a sign with a large red circle, a white hand inside the circle and text that indicated NO ENTRY to persons who HAVE NOT HAD: the varicella/chicken pox vaccine or chicken pox. Please visit the Nurses Station. Resident #87 was observed inside of the room and seated in the bedside recliner. Interview with Resident #87 on 1/27/25 at 1:15 PM identified that although he/she understood why the isolation sign was on the door, he/she did not like it and thought the sign should be removed. Resident #87 indicated he/she was going to speak to the nurse about removing the sign from the door. Interview with Person #2 on 1/27/25 at 1:17 PM identified that he/she did not like that there was an isolation sign on the door and that it made it look like the room was quarantined. Person #2 indicated she was going to speak to the nurse about having the isolation sign removed. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 1/28/25 at 10:00 AM identified that the door to Resident #87's room had an isolation sign on the door with a large red circle, a white hand inside the circle and text that indicated NO ENTRY to persons who HAVE NOT HAD: the varicella/chicken pox vaccine or chicken pox. Please visit the Nurses Station. Resident #87 was observed inside of the room and seated in the bedside recliner. 2. Resident #353's diagnoses included current herpes zoster/shingles, pancytopenia and thrombocytopenia. The admission Minimum Data Set assessment dated [DATE] identified Resident #353 was cognitively intact and required substantial/maximal assistance with bed mobility and was dependent with transfers and toileting. The Resident Care Plan dated 1/13/25 indicated Resident #353 was at risk for impaired skin integrity related to severe protein malnutrition. Interventions included conduct a systemic skin inspection on shower day and provide treatment to impaired skin integrity and rashes as ordered. A physician's progress note dated 1/17/25 at 1:51 PM identified a unilateral left upper back/posterior left shoulder area with erythematous, blotchy rash with tiny vesicles noted in a dermatomal pattern, highly suspect for herpes zoster. The progress note indicated isolation precautions and antiviral medication were ordered. Observations on 1/22/25 at 11:15 AM and 1/23/25 at 1:30 PM identified the door to Resident #353's room had an isolation sign with a large red circle, a white hand inside the circle and text that indicated NO ENTRY to persons who HAVE NOT HAD: the varicella/chicken pox vaccine or chicken pox. Please visit the Nurses Station. Resident #353 was observed inside of the room and seated in the bedside recliner. Interview with the Infection Preventionist (RN #7), on 1/27/25 at 12:17 PM identified the isolation signs observed on the door of Resident #87 and Resident #353's rooms indicating NO ENTRY to persons who HAVE NOT HAD: the varicella/chicken pox vaccine or chicken pox were placed there according to the facility policy and that the same signage is utilized at all of the company's locations. RN #7 identified that, although the isolation sign indicated varicella/chicken pox in the text, the isolation sign did not divulge Resident #87 and Resident #353's actual diagnoses of shingles. Futher, RN #7 was unable to explain how a visitor with a medical background would remain unaware of the resident diagnosis since specific infections were posted on the isolation sign. RN #7 was unable to identify conditions/diagnoses other than varicella/chicken pox to which these particular precautions would apply, therefore not maintaining Resident #87 and Resident #353's privacy. Interview with Resident #353 on 1/28/25 at 9:49 AM identified that although he/she knew why the isolation sign was on his door, he/she had to explain to his many visitors what his/her condition was and why the sign was there. Resident #353 indicated he preferred the sign was no longer on his door. Review of the facility policy, Contact/Airborne Precautions for Herpes Zoster (Shingles), undated, directed that a patient with localized shingles (lesions confined to one area and can be covered) would be placed on Standard Precautions with No Entry signage on the door. Non-immune staff should not enter the room if possible. The policy further directed that ideally the patient with shingles should be placed in a single room if available. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, Enhanced Barrier Precautions, undated, directed that Standard Precautions were a set of infection control practices used for all residents regardless of their diagnosis and infection status. Review of the facility policy, Precautions for Shingles, dated 6/1/24, directed when Standard Precautions are required, ideally the patient with shingles should be placed in a single room if available and a No Entry shingles sign shall be posted.

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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. 51101 Based on clinical record reviews, review of the Resident Assessment Instrument (RAI) Manual, facility policy, and interviews for 2 of 4 sampled residents (Resident #49 and Resident #89) reviewed for resident assessment, the facility failed to complete a Quarterly Minimum Data Set (MDS) assessment in a timely manner. The findings include: 1. Resident #49's diagnoses included dementia and spinal stenosis. On 1/27/25 at 10:43 AM review of MDS submissions with MDS Coordinator #2 (LPN #1) identified a quarterly MDS assessment was completed on 8/16/24, but failed to complete further MDS assessments. Additionally, MDS Coordinator #2 identified a quarterly MDS assessment should have been completed in November 2024 (72 days past due). 2. Resident #89's diagnoses included chronic systolic heart failure and type 2 diabetes mellitus. On 1/27/25 at 10:43 AM review of MDS submissions with MDS Coordinator #2 (LPN #1) identified a quarterly MDS assessment was completed on 8/28/24, but failed to complete further MDS assessments. Additionally, MDS Coordinator #2 identified a quarterly MDS assessment should have been completed in November 2024 (60 days past due). Further interview with MDS Coordinator #2 (LPN #1) identified that although Resident #49 and #89 appeared on the November 2024 MDS calendar as being due for assessment completion, she did not know the reason they were not completed. As per the RAI OBRA required assessment summary the facility has 3 months to complete a Quarterly MDS assessment.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 51101 Based on record review, staff interview and Resident Assessment Instrument (RAI) policy for 4 of 4 sampled residents (Resident's #49, #52, #89, and #96) reviewed for late Minimum Data Set (MDS) transmittals, the facility failed to ensure MDS' were transmitted timely. The findings include: Interview and transmittal review of MDS' on 1/27/25 at 10:23 AM with MDS Coordinator #1 (RN #5) identified the following: 1. Resident #49 was admitted to the facility in February 2023. a. An annual MDS assessment was completed on 2/20/24, but not transmitted until 3/11/24 (5 days past due). b. A quarterly MDS assessment was completed on 8/16/24, but not transmitted until 9/19/24 (19 days past due). 2. Resident #52 was admitted to the facility in October 2021. a. A quarterly MDS assessment was completed on 6/20/24, but not transmitted until 8/15/24 (42 days past due). b. A quarterly MDS assessment was completed on 12/17/24, but not transmitted until 1/23/25 (23 days past due). 3. Resident #89 was admitted to the facility in September 2023. a. A quarterly MDS assessment was completed on 5/30/24, but not transmitted until 6/25/24 (12 days past due). b. An annual MDS assessment was completed on 8/28/24, but not transmitted until 9/16/24 (6 days past due). 4. Resident #96 was admitted to the facility in September 2024. a. An admission MDS assessment was completed on 9/10/24, but not transmitted until 9/30/24 (6 days past due). b. A quarterly MDS assessment was completed on 12/10/24, but not transmitted until 1/23/25 (30 days past due). Additional, MDS Coordinator #1 identified she was a newer employee and was catching up when she was hired. Additionally, she stated they were behind in transmitting MDS' due to other MDS Coordinators having time off. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	According to the Resident Assessment Instrument (RAI) manual, a quarterly assessment must be electronically submitted within 14 days of the MDS completion date.

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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** 51756 Based on observations, review of clinical records, facility documentation, facility policy and interviews for 2 of 5 residents (Resident #9 and Resident #64) reviewed for unnecessary medications, the facility failed to follow professional standards for medication administration. The findings include: 1. Resident #9 was admitted to the facility in August of 2022 with diagnoses that included infection and inflammatory reaction due to internal right knee prosthesis (chronic infection of knee replacement), peripheral vascular disease, and Factor VIII disorder (increase bleeding disorder). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 as being cognitively intact and required maximum assistance with personal hygiene, dressing, showering and totally dependent for toileting and independent with eating. The Resident Care Plan dated 1/2/25 identified behavioral symptoms with interventions to administer medications per physician orders and monitor for any side effects or adverse reactions and may have artificial tears and Ayr saline nasal spray at bedside to self-administer. Physician's orders dated August 2022 through 1/3/25 identified Resident #9 was not on Insulin (had no physician orders for Insulin). A nurse's note dated 1/22/25 at 5:33 PM and written by Registered Nurse (RN) #6 identified Person #1 phoned the facility to inform nursing staff that Resident #9 reported that Licensed Practical Nurse (LPN #2/an agency nurse) entered Resident #9's room to administer an Insulin injection into his/her abdomen. Additionally, the nursing note identified LPN #2 prepared Resident #9's abdomen with an alcohol wipe for injection and then asked Resident #9 his/her name. Resident #9 asked LPN #2 what he/she was doing, and then LPN #2 proceeded to leave the room. RN #6 explained to Person #1 that LPN #2 was sent home, and the staffing agency was contacted. Facility documentation titled Near Miss Report Form and completed by RN #6 identified that on 1/22/25, LPN #2 attempted to administer Insulin subcutaneously (beneath the skin) to Resident #9's abdomen until Resident #9 questioned what he/she was doing. LPN #2 proceeded to leave the room. RN #6 updated the staffing agency of the incident, and that LPN #2 could no longer return to the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #9 on 1/27/25 at 11:00 AM indicated that LPN #2 walked into Resident #9's room, pulled up his/her shirt, started to wipe down his/her stomach and took a cap off a pen containing medication (Insulin). Resident #9 stated he did not recognize LPN #2 and did not think he/she had ever seen LPN #2. Resident #9 proceeded to ask LPN #2 what he/she was doing and what was LPN #2 going to give him/her. LPN #2 responded that he/she was going to give Resident #9 Insulin and Resident #9 stated he/she informed LPN #2 that he/she did not take Insulin. LPN #2 responded by asking Resident # 9 his/her name at that time (but not before attempting to inject Insulin to Resident #9). Resident #9 informed LPN #2 that his/her name was on the door and asked LPN #2 if he/she checked the door prior to coming in the room. Resident # 9 indicated that LPN #2 responded that he/she had to leave. Resident #9 verbalized that if he/she received the Insulin could have had a bad reaction. Resident #9 indicated that he/she proceeded to call Person #1 to update on what had transpired and Person #1 contacted the facility. Resident #9 indicated that LPN #2 never asked his/her name when entering the room nor did LPN #2 check Resident #9's name bracelet on his/her wrist. On observation during interview, Resident #9's name bracelet was on his/her right wrist and appeared to be slightly worn, indicating he/she had been wearing it awhile. Resident #9 indicated that the name bracelet had been on since he/she was admitted to the facility in 2022 and he/she has never removed the name bracelet (yet LPN #2 had not verified his/her name bracelet to ensure the right resident was receiving an injectable medication). Interview with LPN #2 on 1/27/25 at 1:15 PM via the telephone indicated that he/she went into Resident #9's room and placed all medications on Resident #9's over bed table. LPN #2 stated that Resident #9 was not wearing a name bracelet, so he/she proceeded to ask Resident #9 his/her name. According to LPN #2, instead of providing his/her name, Resident #9 asked what the injection pen was for. LPN #2 informed Resident #9 that the pen contained Insulin and indicated that just because he/she entered the room with the Insulin pen did not mean Resident # 9 was going to receive it. LPN #2 stated that he/she informed Resident #9 that he/she needed to know his/her name and indicated to Resident #9 that the Insulin was not for him/her. LPN #2 denied raising Resident #9's shirt and wiping his/her abdomen with alcohol. LPN #2 indicated that Insulin was for another male resident that was eating in the dining room (yet LPN #2 was in Resident #9's room). LPN #2 indicated that many residents were not wearing name bracelets (all residents had name bracelets on during survey). LPN #2 stated he/she was feeling ill and shortly after RN #6 informed LPN #2 around 5:30 PM that he/she needed to leave the facility related to the Insulin incident and due to feeling ill. Interview with RN #6 on 1/27/25 at 2:30 PM indicated that Person #1 phoned the facility on 1/22/25 and spoke to her to report that LPN #2 attempted to administer Insulin to Resident #9 prior to supper without properly identifying Resident #9. RN #6 stated she was already going to assess LPN #2 since she had been sick (vomiting) in the bathroom and was planning to send LPN # 2 home. RN #6 stated after the Insulin incident, LPN #2 needed to leave and not return. RN #6 indicated that she contacted the ADNS and the staffing agency to inform them of the incident and that LPN #2 had left the facility around 5:30 PM. RN #6 indicated that she was informed that there was a medication error with another resident who did not receive the correct dose of medication from LPN #2 on 1/22/25. 2. Resident #64 was admitted to the facility in August 2024 with diagnoses that included dementia with behavioral disturbances, anxiety, and depression. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #64 as being cognitively impaired with inattention and disorganized thinking and required moderate assist for personal hygiene, dressing, showering, toileting and eating. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 12/3/24 identified behavioral symptoms as a focus issue and to administer medications as ordered, monitor effectiveness, avoid over stimulation, provide 1 to 1 as needed and provide and follow consistent and familiar routines. A physician's order dated 1/22/25 directed to administer Klonopin (a medication for anxiety) 0.5 mg (milligrams) at 5:00 PM and Klonopin 0.5 mg every 12 hours as needed for restlessness or agitation. A Reportable Event Form dated 1/22/24 at 4:06 PM indicated that LPN #2 administered Klonopin 0.25 mg instead of Klonopin 0.5 mg to Resident #64 as ordered at 5:00 PM. A nursing note dated 1/23/25 at 8:30 AM identified that Person #2 was notified of a medication error. An interview with LPN #2 on 1/27/25 at 1:15 PM revealed that she was not aware of making any type of medication errors and that she had no idea what the facility was referring to. Interview with the ADNS on 1/28/25 at 9:30 AM identified that LPN #2 had made a medication error regarding Resident #64's Klonopin on 1/22/25, that the appropriate documentation for medication errors had been completed and the staffing agency had been notified by the ADNS on 1/23/25 regarding LPN # 2's medication error. A review of Medication Administration Policy directed, in part, to bring medication cart to an area adjacent to resident room, read order entirely, remove medications from the drawer and read label 3 times (when removing from drawer, before pouring and after pouring). Identify resident by reading the wristband. A review of Medication Error policy date 7/1/24 directed, in part to prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time of administration. b. Right resident and right documentation. If a medication error occurs the nurse assess and examines the resident's condition and notifies the health care practitioner. The nurse reports the incident to the appropriate supervisor and completes the incident or occurrence report.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #29) reviewed for pressure ulcers, the facility failed to properly document a change in skin condition and notify the provider and for 1 of 4 sampled residents, (Resident #57) reviewed for accidents, the facility failed to implement a physician's order for the application of padded side rails. Additionally, for 1 of 1 sampled resident (Resident #63) reviewed for choices, the facility failed to schedule an appointment with a specialist per provider recommendations and resident request, and for 1 of 3 residents (Resident #87) reviewed for general concerns, the facility failed to schedule a hematology consult per physician's order. The findings include: 1. Resident #29's diagnoses include pressure ulcer of sacral region, Type 2 Diabetes, and heart failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 was cognitively intact, and was dependent with personal hygiene and rolling left and right. A Resident Care Plan (RCP) dated 1/1/25 identified Resident #29 had a Stage 4 pressure injury at the coccyx level with an intervention to turn and reposition every two hours, conduct systematic skin inspections, and report any signs of further skin breakdown. An Advanced Practice Registered Nurse (APRN) order dated 1/2/24 directed wound care and a dressing change be performed once a day on the Stage 4 coccyx pressure ulcer. A Wound Assessment completed by Registered Nurse (RN) #11 and dated 1/25/25 at 2:58 PM identified a new pressure ulcer to Resident #29's gluteal crease. RN #11 failed to document the size of the wound, document the condition of the skin, indicate that a provider was notified to order a treatment, or document a progress note about the new wound. An interview with RN #9 (the nurse entering Resident #29's room to complete a wound treatment) on 1/27/25 at 10:58 AM identified she was unaware of the newly documented pressure ulcer to Resident #29's gluteal crease. An interview with the Nurse Manager (RN #4) on 1/27/25 at 11:11 AM identified that per policy, new skin integrity problem areas should be measured, documented, and the provider contacted for treatment. RN #4 failed to identify the wound was documented in a progress note, wound book, or APRN communication book. Further, she failed to identify the reason the wound was not assessed/documented on. Subsequent to surveyor inquiry, a wound care evaluation was completed on 1/27/25 at 11:42 AM by APRN #1. The area was determined not to be a pressure ulcer due to the area being blanchable, and APRN verbal orders were obtained on 1/27/25 at 11:42 AM directing Triad Cream to the gluteal fold (no frequency identified). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Skin Integrity Policy identified that if there is a change in skin integrity, a Medical Doctor (MD) should be notified. Documentation should include a description of the wound and surrounding tissue, a description of the surrounding skin, drainage, and APRN notification of worsening condition if applicable. 2. Resident #57's diagnoses included cognitive decline, osteoarthritis, and acute embolism and thrombosis (blood flow blockage) of the deep veins in the lower extremities. The annual Minimum Data Set assessment dated [DATE] identified Resident #57 was cognitively intact, had limited range of motion on both sides of the lower extremities, and was totally dependent on staff for bed mobility and transfers. The Resident Care Plan dated 12/26/24 identified Resident # 57 was at risk for bruising and bleeding related to anticoagulant therapy and was also at risk for impaired skin integrity. Interventions included staff to provide a safe environment with no sharp edges, to monitor for active signs of bleeding, apply side ride pads, and to check for placement of rail pads each shift (3 times a day). The physician's orders in effect from 1/21/25 through 1/28/25 directed the application of side rail pads and staff were to check for placement each shift. Observation on 1/21/25 at 10:31 AM identified Resident #57 was awake, sitting upright in a chair. There were 2 blue side rail pads leaning against the wall, in the corner of the room, behind Resident #57's chair. Observation on 1/22/25 at 9:01 AM identified Resident #57 was awake and sitting upright in bed with a tray table across the bed. Resident #57 stated he/she just woke up. There were 2 side rails in the up position without the benefits of side rail pads. There were 2 blue side rails pads in the corner of the room, propped up against the wall. Observations on 1/24/25 at 5:58 AM and 7:58 AM identified Resident #57 in bed without the benefit of padded side rails on the 2 bed rails that were in the up position. Two blue side rail pads were noted in the corner of the room propped up against the wall. Observation and interview with RN #9 and NA #2 on 1/27/25 at 11:02 AM identified Resident #57 was sitting upright in a chair near the window in the corner of the room. RN #9 indicated that the blue pads in the corner of the room were side rail pads. NA #2 indicated that Resident #57 required the bed rail pads placed only when he/she was in bed because he/she bruised very easily. RN #9 took the blue pads and indicated she would have to reach out to the Maintenance Department to get new side rail pads because the blue side rail pads that were in Resident #57's room did not fit the new beds which had been obtained by the facility. RN #9 did not know what the policy was, but indicated it was the NA's responsibility to ensure the side rail rail pads were applied to the bed. Interview with the ADNS on 1/28/25 at 10:30 AM indicated the facility changed Resident #57's bed sometime over the summer. The ADNS was not aware the side rail pads did not fit the bed and would need to follow-up with maintenance. The ADNS indicated Resident #57 was at risk for bruising and bleeding if the side rail pads were not applied. (continued on next page)

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Jefferson House	1 John H Stewart Dr Newington, CT 06111

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Safety Policy directed, in part, that bed rail protection is implemented for residents with seizure activity and any others requiring such intervention as designated in the care plan. 3. Resident #63 was admitted to the facilities Short-Term Care Unit on 9/19/24 with diagnoses that included chronic congestive heart failure (CHF), presence of an implanted defibrillator, left bundle branch block, and cardiomyopathy. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was cognitively intact, required maximal assistance with personal hygiene, and was dependent on chair/bed-to-chair transfers. The Resident Care Plan (RCP) dated 10/10/24 identified Resident #63 was at risk for decreased activity tolerance and shortness of breath related to CHF, cardiomyopathy, cardiac defibrillator, and atrial fibrillation. Interventions included adjusting the intensity of activities, monitoring of weight, and Cardiology follow-up as needed. An In-House Cardiology APRN note dated 10/14/24 at 9:54 AM directed follow-up with Resident #63's Cardiologist within 7 to 10 days of his/her transfer from the Short-Term Rehabilitation Unit to the Long Term Care Unit and recommended telemonitoring for CHF. The APRN note further stated that In-House Cardiology was signing off from Resident #63's care and his/her care should be managed with the CHF Protocol. Resident #63 was transferred to the facilities Long Term Care Unit on 11/29/24. A physician's order (from the facilities physician) dated 12/12/24 directed the Automatic Implanted Cardioverter Defibrillator (AICD) monitor to be plugged in at the bedside at all times. An interview with Resident #63 on 1/22/25 at 10:07 AM identified that he/she had requested to see his/her own Cardiologist and had not seen them as requested. Resident #63 expressed concern that he/she was told he/she could only see In-House providers and that did not include his/her own Cardiologist. An interview with Registered Nurse (RN) #2 on 1/27/25 at 12:40 PM identified that the facility physician was the person responsible for placing an order for a resident to see a specialist and nurses were responsible for tracking resident's appointments on a unit calendar. RN #2 failed to locate documentation that Resident #63 had been evaluated by his/her Cardiologist after Cardiologist APRN recommendations and admission to Long Term Care from the Short-Term Care Unit. An interview with the Nursing Supervisor (RN #4) on 1/27/25 at 12:56 PM identified that a follow-up visit with Resident #63's Cardiologist should have been scheduled (per APRN recommendations) after the resident's discharge from the Short-Term Care Unit but could not identify the reason the appointment was not made. An interview with the Unit Secretary/Scheduler on 1/28/25 at 9:40 AM identified she was not aware Resident #63 requested to see his/her Cardiologist and thus did not schedule an appointment. She further identified that she was usually notified in writing by a nurse manager when an appointment needed to be scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse Supervisor (RN #8) on 1/28/25 at 9:48 AM identified she was unaware that Resident #63 requested and needed to see a cardiologist (per APRN note from 10/14/24) and did not direct the Unit Secretary/Scheduler to make an appointment. RN #8 indicated that Resident #63 was planned to be discharged home but instead was transferred to the Long-Term Care Unit. She further noted that when a resident was transferred from Short Term Care to Long Term Care, they were no longer able to receive services from the In-House Cardiologist and that information should have been relayed between nurses during hand-off. An interview with the Unit Secretary on 1/28/25 at 9:48 AM identified that Resident #63 had attempted to schedule his/her own Cardiology appointment on 1/7/25 but canceled the appointment his/herself due to lack of transportation. The Unit Secretary stated she was unaware Resident #63 tried to independently schedule a Cardiology appointment until this morning when she called the Cardiology office and was given that information. She further noted the Cardiology office stated Resident #63's pacemaker and AICD had not been interrogated (a standard procedure performed by a Cardiologist to ensure a pacemaker is functioning properly and to retrieve stored usage data from the pacemaker itself, ensuring optimal pacing therapy is provided to a patient) since 1/2/24. An interview with Person #4 from Resident #63's Cardiology Office on 1/28/25 at 11:41 AM identified that Resident #63 should have been evaluated by his/her Cardiologist after his/her last facility In-House Cardiology visit on 10/14/24. She further noted that lack of timely follow-up by Resident #63 could result in potential heart failure exacerbation. Subsequent to surveyor inquiry a physician's order dated 1/28/25 directed staff to contact Resident #63's Cardiologist to schedule an appointment for his/her AICD. Review of the Physician Order Monitoring Policy identified that all resident medical records will be reviewed on a daily basis. The nurse will review each record and ensure that all orders have been implemented. 4. Resident #87's diagnoses included protein deficiency anemia, iron deficiency anemia and folate deficiency anemia. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was cognitively intact and was independent with eating. Additionally, the MDS identified Resident #87 required supervision with toileting and personal hygiene and was independent with eating. The Resident Care Plan dated July 2024 identified Resident #87 was at risk for impaired nutritional status related to a diagnosis of protein deficiency anemia. Interventions included to monitor and report labs as ordered. A lab result collected on 9/3/24 and reported on 9/11/24, indicated a low albumin level and an abnormal protein band. The blood work results further identified a significantly elevated lambda light chain and a low [NAME]/lambda ratio. A physician's progress note dated 9/11/24 noted a review of recent blood work with abnormal results which needed further investigation and a hematology consult was to be scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 9/11/24 directed to schedule a hematology consult to evaluate Resident #87's abnormal blood work results. Interview and record review with the Unit Secretary/Scheduler on 1/27/25 at 10:37 AM identified that she was not aware that a hematology consult had been ordered by the physician on 9/11/24 and was unable to locate a record that the physician ordered hematology consult had been scheduled for Resident #87. Additionally, the Unit Secretary/Scheduler indicated that the nurse should have seen the order in the electronic system and when it was transcribed by the nurse it should have been written in the appointment book. The Unit Secretary/Scheduler identified that although she checks the appointment book regularly, she would not have known Resident #87 needed a hematology consult because it was not written in the appointment book. Subsequent to surveyor inquiry on 1/27/25 at 10:40 AM, the Unit Secretary/Scheduler indicated that she had contacted the hematology office and left a message with the office to schedule a new patient appointment for Resident #87. Interview and record review with the Registered Nurse Supervisor (RN #8) on 1/27/25 at 10:45 AM, identified that the physician order dated 9/11/24 for a hematology consult was placed under general orders in the electronic record, nursing should have seen it and transcribed it from there. Additionally, RN #8 indicated when the 11:00 PM to 7:00 AM nurse completed an audit of the orders for 9/11/24, the previously untranscribed order for the hematology consult should have been picked up, transcribed and put into the appointment book at that time. RN #8 indicated that nursing should have written the request for the hematology consult in the appointment book and without doing so, the Unit Secretary would not have known about or scheduled the needed appointment for Resident #87. Interview with MD #1 (the ordering physician) on 1/27/25 at 1:00 PM identified that he ordered the hematology consult on 9/11/24 after he reviewed abnormal blood work results for the resident. MD #1 indicated that he wrote the order for the hematology consult as a physician's order and in his progress note and that the order should have been transcribed and followed through by nursing. MD #1 identified that, although Resident #87 appeared relatively asymptomatic, the abnormal blood work results indicated he/she should have been seen by a hematologist to determine if he/she needed additional testing or treatment, especially because of the resident's various anemia diagnoses. MD #1 further indicated that failure to schedule the hematology consult could have led to a potential worsening of Resident #87's condition. Review of the facility's, Physician Order Monitor policy, undated, directed to ensure that all physician orders are noted and implemented as ordered. The policy further directed that all resident medical records will be reviewed daily and all audits will be completed by the 11:00 PM to 7:00 AM licensed staff on each nursing unit. The nurse should review each record and note that all orders have been implemented. 51182 52073

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observations, interviews and record review for 1 of 1 sampled residents (Resident #39), reviewed for positioning, the facility failed to offload heels for a resident at risk for pressure ulcers and for 1 of 3 sampled residents (Resident #8) reviewed for pressure ulcer injury, the facility failed to provide the necessary treatment to prevent the redevelopment of a pressure ulcer. The findings include: 1. Resident #8's diagnoses included rheumatoid arthritis, contracture of both knees, contracture of right thigh muscle, spinal stenosis, and osteoarthritis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #8 was cognitively intact, had limited range of motion on both sides of the lower extremities, and was totally dependent on staff for turning and transferring. The Resident Care Plan dated 12/20/24 identified Resident #8 was at risk for impaired skin integrity related to limited bed mobility, weakness and a history of right heel redness and skin tears. Interventions included treatment to areas of impaired skin integrity as ordered. A nursing note dated 1/10/25 indicated a Stage 2, fluid filled blister, to the right heel measuring 5.5 centimeters (cm) by 6 cm which was tender to touch (a Stage 2 pressure injury is a partial-thickness skin loss that appears as an open wound, blister, or scrape). A pressure ulcer risk assessment dated [DATE] identified that Resident #8 had a Braden Score of 13 which indicated Resident #8 had a moderate risk for developing a pressure ulcer. A nursing note dated 1/25/25 indicated Resident #8's right heel blister had healed. A physician's order in effect on 1/27/25 directed the application of skin prep to both heels and reddened areas, twice a day at 9:00 AM and 9:00 PM. Observation, interview, and review of the clinical record with RN #2 and RN #9 on 1/27/25 at 9:44 AM identified both RN's turned Resident #8 in preparation for his/her treatment. RN #2 washed Resident #8's feet with soap and water then patted them dry. RN #2 was observed to apply a small amount of [NAME] healing dry skin moisturizer to Resident #8's right and left feet. RN #2 indicated that Resident #8's prescribed wound care treatment consisted of cleaning his/her right heel with soap and water and then applying the Resident's personal cream. During a clinical record review of the physician's orders with RN #2, she noted that she had failed to provide the physician directed appropriate treatment. RN #2 indicated that she would try to find skin prep and would return to provide the correct physician prescribed treatment to Resident #8. Interview on 1/27/25 at 10:02 AM with Register Nurse Supervisor (RN) #4 indicated that she would have expected the nurse to use skin prep as directed by the physician's order. RN #4 identified that Resident #8's personal dry skin moisturizer was not the same as what was ordered (skin prep) and would not provide the same protection against the redevelopment of the pressure injury. RN #4 stated that she would have expected a nurse would know to follow the physician's orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Integrity: Protocol, Promotion and Maintenance of Skin Integrity Policy, directed, in part, that residents having pressure ulcers receive the necessary treatment and services to promote healing, prevent infections, and prevent new ulcers from developing. Treatment modalities should be chosen according to the wound stage and drainage. Treatment choice is either preventative or the stage of the wound. Treatment requires orders from NP/PA or MD. 2. Resident #39's diagnoses included osteoarthritis, osteoporosis and hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 had moderate cognitive impairment, and required substantial/maximal assistance from staff for upper body dressing, rolling from left to right and moving from sitting to lying in bed. Additionally, the MDS identified Resident #39 was at risk for developing pressure ulcers and pressure injuries. The Resident Care Plan dated 12/24/24 identified Resident #39 was at risk for skin breakdown and pressure ulcers due to non-ambulatory status related to osteoarthritis, valgus deformity of the knees, gait abnormality and osteoporosis. Interventions included in part, to perform systematic skin inspections every shower day and as needed, report any signs of skin breakdown, and to keep heels elevated while in bed. A physician's order dated 12/20/24 directed to off load heels every shift while lying in bed, and document if refused. The Patient/Resident Care Card located in Resident #39's bathroom directed to off load heels in bed. Observations on 1/21/25 at 10:52 AM, 1/21/25 at 1:12 PM and 1/22/25 at 9:09 AM identified Resident #39 lying in bed, legs outstretched with a flat pillow placed under the calves which did not afford his/her heels to be off of the bed (heels were lying directly on the bed). An interview and observation with Registered Nurse (RN) #3 on 1/23/25 at 8:59 AM identified the facility policy on off-loading heels was that heels should not be touching the bed, and Nurse Aides were responsible for elevating the heels by utilizing a pillow, green boots or a positioning wedge. Additionally, observation of Resident #39 with RN #3 identified that the positioning of the heels was not considered offloaded because the pillow was too flat, and the heels were touching the bed. Subsequent to surveyor inquiry RN #3 off loaded Resident #39's heels by placing a thicker pillow under her/his calves so that the heels were not lying on the bed. An interview and care card review with Nurse Aid (NA) #1 on 1/23/25 at 9:08 AM identified she did not know what off-load heels meant, but instructions on care were identified on care cards located in resident bathrooms. Review of the care card in Resident #39's bathroom directed to offload heels in bed under positioning, however NA #1 could not identify what that meant or what was expected to carry out that care. Subsequent to surveyor inquiry RN #3 educated NA #1 about off-loading heels. Review of the Skin Integrity: Protocol for prevention and maintenance of skin integrity promotion/maintenance; prevention and treatment of pressure ulcers and wounds Policy directed in part that a resident without a pressure ulcer does not develop a new pressure ulcers, and that preventative measures will be instituted to relieve heel pressure by rising heels off the bed by using multiple pillows. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	52073

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on the tour of the Dietary Department, interviews, review of facility policy and facility documentation, the facility failed to ensure that beard restraints were worn appropriately, perform hand hygiene when appropriate, ensure open food items were properly closed/dated and not near debris on the floor and failed to discard expired food items. The findings include: During observations of meal service on [DATE] at 11:45 AM with the Director of Food Services, the following was identified: 1a. Dietary Aide #1 (DA) was observed at the tray line placing plated food on residents' trays wearing a beard restraint that covered only the lower half of his facial hair with the sides of his beard exposed. Subsequent to surveyor inquiry, the Director of Food Services (who was also observing the meal service) informed DA #1 that his beard was exposed around the beard restraint and that his beard restraint needed to be readjusted. DA #1 proceeded to walk away from the plating area, removed his gloves, removed his beard restraint and reapplied it attempting to readjust the beard restraint. DA #1 then washed his hands, applied new gloves, and then returned to the serving area and resumed placing the plated food on the trays. DA #1's beard restraint still did not fully cover his beard with facial hair half exposed on the sides. DA # 1 stated to the Director of Food Services that he was not able to fully cover the beard as the beard restraint would not cover the sides of his face. DA #1 continued with plating food on the residents' trays with his facial hair exposed. b. The Executive Chef was observed to be plating food items from the steam table (chicken or hamburger on a bun with lettuce and tomato, rosemary potatoes and green beans) wearing a beard restraint that only covered half of his facial hair, with the sides of his beard exposed. Subsequent to surveyor inquiry, the Director of Food Services informed the Executive Chef at 11:54 AM that his beard restraint did not fully cover his facial hair. The Executive Chef proceeded to go to the sink area, removed his gloves, readjusted his beard restraint, washed his hands, and applied new gloves. He then returned to his station of plating food but the beard restraint still did not cover his facial hair with the sides and lower cheek facial hair being exposed. The Director of Food Services informed him that his beard was still not fully covered. The Executive Chef proceeded to attempt to readjust his beard restraint while at the steam table without the benefit of walking away from the area or performing appropriate hand hygiene including washing his hands and changing his gloves after touching his face. The Executive Chef continued to plate food with facial hair exposed and with the same gloves. c. At 11:57 AM, observation of the Executive Chef noted he walked away from the steam table and proceeded to the grill area. Hamburgers were cooking on the grill that were partially cooked and still raw on one side. The Executive Chef was observed to touch a raw hamburger with his gloved hands and flipped another hamburger with a spatula. He then proceeded and turned around to the preparation station and removed a hamburger bun from the package without the benefit of removing his gloves and washing his hands after touching the raw meat and before touching the hamburger bun. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Executive Chef on [DATE] at 10:20 AM indicated that he was aware that his beard restraint was not properly covering his facial hair on [DATE] when serving. He indicated that before serving he sometimes adjusts the beard restraint as it can be uncomfortable and forgets to put it back in place when he starts to serve meals. He also indicated that he should have changed gloves and washed his hands after he touched his face and after touching the raw hamburger. Additionally, he stated that he immediately was aware that he cross contaminated when he touched the raw hamburger and then touched the hamburger roll. The Executive Chef indicated he has been educated on the proper use of beard restraints, hand hygiene, glove use and cross contamination after handling raw meat. He stated that there was a lot going on and it just slipped his mind when these incidents occurred. 2. A tour of the large dry goods storage area (located in the basement) at 12:30 PM with the Director of Food Services, the following was identified: a. A bag of 50-pound flour that was ,d+[DATE] full, was partially opened without the benefit of a label of the date opened or discard/expiration date. On the floor next below the bag of flour there was a pile of swept debris. The floor had been swept without the benefit of discarding the debris on the floor. Interview with the Director of Food Services at the time of observation identified that the bag of flour should have been secured and dated and the debris on floor should have been discarded in the trash. In addition, a 20-pound bag of corn meal with less than one third used was on a shelf that was left partially opened without the benefit of a label of the date opened or discard/expiration date. The Director of Food Services indicated that the bag was not properly closed, and he would secure it or put it in a plastic container and label and date the corn meal. b. Metal shelves contained a ,d+[DATE] full, 21 ounce container of Everything Bagel spice with an expiration of [DATE] (14 months old), a Japanese Seven spice container with an expiration date of [DATE] (21 months old) that was two thirds filled and a Harissa Spice with expiration date of [DATE] (21 months old) that was two thirds full. There were (8) 32-ounce containers of plant-based coconut milk that expired February 2024 (11 months old). The Director of Food Services indicated that these products had not been in use and should have been removed from the shelves and discarded. A review of Uniform Dress Code policy dated ,d+[DATE] directed, in part, associates working with food wear approved restraints and refrain all facial hair with a beard net restraint. A review of Food Handling Guidelines policy dated ,d+[DATE] directed, in part, food shall be protected against cross-contamination by appropriately separating types of raw animal products from other foods and hands should be scrubbed following appropriate hand washing techniques according to facility policy between food preparation tasks, between tasks and before putting on clean gloves. A review of Disposable Glove use policy dated ,d+[DATE] directed, in part, that disposable gloves must be changed, and hands washed when the gloves are dirty or ripped and when moving from one task to another. A review of posted sign titled, Main Storage Room Standard Expectation, posted on the inside door of the in the main dry storage area, directed, in part, clean up all spills and trash from the floor. This task is to be conducted by each staff member who enters and uses the Main storage room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food and Storage Supply policy dated ,d+[DATE] directed, in part, to date and rotate items, first in and first out. Discard food past the used-by date or expiration date. Cover, label and date unused portions and open packages. Use the Medadvantage/Freshdale labeling system or complete all section on a [NAME] orange label.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48950 Based on staff interview and review of Payroll Based Journal (PBJ) submissions for Quarter 1 (October 1, 2024 through December 31, 2024) and Quarter 2 (January 1, 2024 through March 31, 2024) the facility failed to ensure the PBJ data was submitted on time. The findings include: PBJ submissions for Quarter 1 of 2024 and Quarter 2 of 2024 identified the facility as a 1-star rating and excessively low weekend staffing metric was suppressed for the facility for Quarter 1 and Quarter 2 of 2024. On 1/28/25 at 2:21 PM an interview with Administrator identified that the staff member who was responsible for submitting the PBJ reports had left and then came back per diem, she did not submit the PBJ on time for Quarter 1 and therefore Quarter 2 was also triggered. The Administrator further identified that she was responsible at this time for reporting the PBJ and no further issues have been identified. Review of the Mandatory submission of staffing information based on payroll data in a uniform format. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, review of the clinical record, facility policy, and staff interviews for 5 of 5 residents (Resident #10, #32, #66, #73, and #83) reviewed for blood glucose testing, the facility failed to clean and disinfect a glucometer device per the manufacturer's instructions for use. 1. Resident #10's diagnoses included Type 2 Diabetes, Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). A physician's order dated [DATE] directed to obtain a blood glucose level every Tuesday at 6:00 AM. A chart review identified that Resident #10 had blood glucose checks performed per physician order on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had moderately impaired cognition, required maximal assistance with his/her personal hygiene, and was dependent with chair/bed-to-chair transfers and rolling left and right. The Resident Care Plan (RCP) dated [DATE] identified Resident #10 was at risk for episodes of hyperglycemia and hypoglycemia from diabetes and included interventions of monitoring his/her glucose, obtaining blood glucose levels three times a day and as needed, and monitoring for signs and symptoms of hyperglycemia and hypoglycemia. 2. Resident #32's diagnoses included Type 2 Diabetes, Alzheimer's disease, and Stage 3 chronic kidney disease. A physician's order dated [DATE] and currently in effect directed to obtain a blood glucose level every Thursday at 6:00 AM. The significant change MDS assessment dated [DATE] identified Resident #32 had severely impaired cognition, required moderate assistance with eating, and was independent with chair/bed-to-chair transfers and rolling left and right. The RCP dated [DATE] identified Resident #32 was at risk for episodes of hyperglycemia and hypoglycemia from diabetes and included interventions of monitoring blood glucose as ordered, and monitoring for signs and symptoms of hyperglycemia and hypoglycemia. A chart review identified that Resident #32 had blood glucose checks performed per physician order on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. 3. Resident #66's diagnoses included Type 2 Diabetes, Stage 3 chronic kidney disease, and hemiplegia and hemiparesis. A RCP dated [DATE] failed to identify a risk for episodes of hyperglycemia and hypoglycemia from diabetes or implement any interventions. (continued on next page)

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	075293	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson House	1 John H Stewart Dr Newington, CT 06111

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] identified Resident #66 was cognitively intact, required maximal assistance with upper body dressing and rolling left and right, and was dependent with a change in position from sitting to lying. A physician's order dated [DATE] directed to obtain a blood glucose level one time a day on Monday, Wednesday, and Friday at 6:00 AM. A chart review identified that Resident #66 had blood glucose checks performed per physician order on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. 4. Resident #73's diagnoses included Type 2 Diabetes, dementia, and heart failure. The MDS assessment dated [DATE] identified Resident #73 had moderately impaired cognition, and required maximal assistance for personal hygiene, chair/bed-to-chair transfers, and rolling left and right. A chart review identified that Resident #66 had blood glucose checks performed per physician order on [DATE], and [DATE]. The RCP dated [DATE] identified Resident #73 was at risk for episodes of hyperglycemia and hypoglycemia from diabetes and included interventions of monitoring blood glucose as ordered, and monitoring for signs and symptoms of hyperglycemia and hypoglycemia. A physician's order dated [DATE] directed to obtain a blood glucose level one time a day on Monday, Wednesday, and Friday at 6:00 AM. 5. Resident #83's diagnoses included Type 2 Diabetes, atrial fibrillation, and hyperlipidemia. A physician's order dated [DATE] directed to obtain a blood glucose level once a day every three days at 6:00 AM. The quarterly MDS assessment dated [DATE] identified Resident #83 was cognitively intact, required maximal assistance for personal hygiene, and required moderate assistance for chair/bed-to-chair transfers and achieving a sit to stand position. The RCP dated [DATE] identified Resident #83 was at risk for episodes of hyperglycemia and hypoglycemia from diabetes and included interventions of monitoring blood glucose as ordered, and monitoring for signs and symptoms of hyperglycemia and hypoglycemia. A chart review identified that Resident #83 had blood glucose checks performed per physician order on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. An observation of the glucometer's usage on [DATE] at 5:20 AM identified that Registered Nurse (RN) #1 was cleaning a glucometer with disinfectant wipes that expired on [DATE] (4 months ago). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with RN #1 on [DATE] at 5:20 AM identified that the glucometer was used to take blood glucose measurements for multiple residents on the facility's unit. RN #1 further identified the expired wipes were used for disinfection purposes daily and the responsibility to ensure the wipes used were not expired was the responsibility of the nurse using them. RN #1 failed to identify why the disinfectant wipes had not been removed from the medication cart when they expired and why she did not check the expiration date before using the wipes. RN #1 further stated the policy of the facility was to remove expired disinfection products from use and dispose of them. An interview on [DATE] at 5:37 AM with the Nursing Supervisor (RN #13) identified the disinfectant wipes used to clean the facility's glucometer expired on September of 2024. RN #13 identified it was the responsibility of the nurse using the wipes to ensure the wipes were not expired. RN #13 failed to identify why the disinfectant wipes had continued to stay in circulation for use for over 4 months after their expiration. Subsequent to surveyor inquiry, the disinfectant wipes were removed from the medication cart for disposal and a new container of disinfectant wipes was placed in the medication cart to be used for glucometer cleaning. An interview with the Disinfectant's Professional Customer Care Center on [DATE] at 9:11 AM identified the disinfectant wipes should be disposed of no later than the expiration date listed on the packaging. The Care Center indicated the greater the time that passes after the expiration date of the product, the less effective the product will be. The Care Center could not guarantee the expired product was providing proper disinfection and sanitizing of equipment and recommended its immediate disposal. An interview with the Nurse Manager (RN #4) on [DATE] at 8:59 AM identified 5 residents (Resident #10, #32, #66, #73 and #83) had received blood glucose testing using the glucometer from the cart with the expired disinfectant. Review of the Glucometer Disinfection Policy identified that glucometers should be disinfected according to manufacturer instructions before and after each use to prevent the transmission of Hepatitis A, Hepatitis B, and the Human Immunodeficiency Virus (HIV). Review of the Expired Cleaning Supply Disposal Policy identified that nurses are responsible for monitoring cleaning supplies on their carts and products should be removed before or at their expiration date.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on tour of the nourishment rooms and interviews, the facility failed to ensure that 3 sinks in 4 nourishment rooms were maintained in a clean and sanitary manner. The findings included: Observations and interviews on 1/23/25 at 10:35 AM with Director of Environmental Services and Administrator revealed the following: a. The first floor [NAME] nourishment room cabinet under the sink was locked with a zip tie and a green substance was noted on the bottom of the cabinet. Interview with the Director of Environmental Services at that time indicated that it should not have a green substance on the bottom and the green substance must be coming from the pipes. b. The first floor [NAME] North nourishment room door was unlocked, the sink was noted with a container under the pipe that was collecting water with small black particles on the bottom of the cabinet. The Director of Environmental Services turned on the faucet which revealed a slow leak coming from the pipe under the cabinet. He indicated that the particles on the bottom were most likely debris and rust. He stated the leak would be fixed and area under the sink cleaned. Interview with the Administrator at time of discovery indicated that nothing should be under the sink and items were removed. The small kitchenette area adjacent to the large kitchen had a small sink that was unlocked with small black spots on the bottom of the cabinet. The Director of Environmental Services indicated that the area would be cleaned and locked. c. The second floor [NAME] nourishment room cabinet under the sink had some black debris, rust and a mouse trap. The Director of Environmental Services indicated on interview during observation that the area needed to be cleaned, could not identify the last time the sink was checked and it should not be maintained in this manner. Interview with Environmental Services Assistant on 1/23/25 at 11:30 AM revealed that he was not doing any repairs under the sinks in the nourishment rooms at this time and that he did not receive a verbal request for work or a ticket issued for work requests. Interview with the Administrator on 1/23/25 at 11:40 AM indicated that there was no preventive maintenance in place for under the sinks, but she would be initiating a preventive maintenance plan. The Administrator indicated that staff was able to put in a work request with computerized system called Workhub which produces a work request ticket. She was unable to provide any work tickets related to repairs needed under the sinks. Interview with RN #7 on 1/28/25 at 10:00 AM revealed Environmental Rounds are done monthly with the Director of Environmental Services and the Assistant. She indicated that they do not check under the sinks as they are usually zip tied closed. She stated that she does not remove the zip ties to check under the sink as she does not have spares to replace them. (continued on next page)

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Although requested, a facility policy for maintenance and care for under the sinks was not provided as the Administrator stated there was no policy available.