STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075307	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestelm Health and Rehabilitation Center	534 Town St Moodus, CT 06469

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #45) reviewed for activities of daily living (ADL), the facility failed to notify the physician of a change in condition. The findings include: Resident #45 was admitted in February of 2021 and had diagnoses that included chronic obstructive pulmonary disease (COPD), anxiety, and pneumoconiosis (chronic lung disease) due to asbestos and other mineral fibers. A physician's order dated 9/18/24 directed Resident #45 receive a regular diet at dysphagia level 2 (mechanically altered) texture, thin liquids, pureed vegetables, no rice, a 2 handled mug with concave lid and meal items served in individual bowls. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 was severely cognitively impaired and required setup or clean-up assistance with eating, was dependent for personal hygiene, and required substantial/maximal assistance with transfers. The Resident Care Plan (RCP) dated 9/26/24 identified Resident #45 was at risk for alteration in nutrition related to dementia and he/she was without teeth (missing dentures since 9/16/21 that the responsible party decided not to replace). Interventions included observation of Resident #45's tolerance to the diet texture, a regular diet with dysphagia level 2 (ground) texture, and for staff to refer to the speech therapist as needed. An Interdisciplinary Referral and Rehabilitation Screen Request form submitted by Licensed Practical Nurse (LPN) #3 dated 10/23/24 identified the reason for the referral was resident choking on meats observed over two days and further identified Resident #45 was screened by the speech therapist on 10/25/24. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Speech Therapy Evaluation and Plan of Treatment dated 10/25/24 at 8:45 AM identified Resident #45 had been referred by nursing after Resident #45 had severe coughing and spitting up during oral intake of ground meat. The evaluation further identified Resident #45 had no teeth and during trials of ground textures, experienced oropharyngeal dysphagia (swallowing problem occurring in the mouth and/or throat) characterized by little to no chewing, food residue on the tongue and inner cheeks and 2 instances of an observed cough. During trials with puree texture, Resident #45 did not chew, however, there were no signs or symptoms of airway compromise. Recommendations included skilled speech therapy services for management of Resident #45's dysphagia and to downgrade to a full puree texture diet due to reduced chewing and observed signs and symptoms of oropharyngeal dysphagia. A Dietary Communication Slip dated 10/25/24 identified Resident #45 had a diet change from dysphagia level 2 (mechanically altered/ground) with thin liquids to dysphagia level 1 (puree) with thin liquids. Review of Nurse progress notes from 10/2/24 through 10/29/24 failed to identify documentation Resident #45 had had trouble swallowing, coughed while eating, choked on meats, spit up food while eating, or coughed at any time during the shift. Interview with LPN #3 on 11/26/24 at 1:53 PM identified that on 10/23/24 a nurse aide (NA) requested her to the Dining Room because Resident #45 was coughing and spitting up while swallowing meat from his/her meal. LPN #3 identified she instructed the NA to stop Resident #45 from eating the meat and LPN #3 went to the kitchen and requested a new meal without meat. LPN #3 identified she watched Resident #45 eat a few bites of the new meal and after observing him/her eating without coughing or spitting up, left Resident #45 with the NA. LPN #3 indicated she then completed a Speech Therapy Referral form and a new diet slip requesting a diet without meat textured food until further notice. LPN #3 could not identify why she did not document the incident in a progress note and could not recall if she notified the supervisor or provider of Resident #45 coughing with his/her meal. LPN #3 further identified she observed Resident #45 take a few bites of the alternate meal she requested but did no further monitoring after that. Interview with the Director of Nursing Services (DNS) on 11/26/24 at 2:50 PM identified that LPN #3 failed to write a progress note about Resident #45 coughing while eating, failed to update the supervisor and provider, and failed to monitor Resident #45 for signs and symptoms of aspiration. The DNS further identified that when filling out the speech screen referral, LPN #3 should have documented coughing rather than choking unless it was verified that Resident #45 was choking which would have required immediate emergency intervention. Interview with APRN #1 on 11/26/24 at 3:03 PM indicated he was not notified of Resident #45 having difficulty swallowing on 10/23/24, and he did not see notations in his records relating to the incident. APRN #1 identified that if he were notified, he would have inquired about Resident #45's baseline swallowing status and diet order and determined if a change in diet was required at that time. APRN #1 further identified he would have ordered a speech screen, monitoring for signs and symptoms of aspiration and if signs or symptoms of aspiration were identified, ordered a chest x-ray. Review of the Change in Condition policy directed, in part, that changes in a resident's baseline condition were monitored by nursing staff members, assessed by the Registered Nurse (RN), reported to the attending physician/APRN to determine a course of action, reported to the family representative, and documented in a progress note in the resident's medical record.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50167 Based on observations, interviews, and facility policy, the facility failed to inform residents of how to complete a grievance, failed to ensure forms were available and accessible to residents and visitors and failed to maintain the results of grievances for three years. The findings include: Observations on 11/20/24 at 11:50 AM identified the grievance folder and a suggestion box were hung on a wall at the end of a hallway on the subacute unit, not easily accessible to any residents, especially to those residents who utilize wheelchairs, secondary to the level hung on the wall. The grievance folder was empty with no available forms inside. Review of the facility's grievance binder on 11/21/24 at 10:00 AM noted to have no completed grievance forms for the year 2023 and 2024. Interview with the Administrator on 11/21/24 at 10:30 AM indicated the facility did not have any grievances, instead, the facility received complaints which were then resolved, therefore, the facility had no grievances for the years on 2023 and 2024. She further indicated that her definition of a grievance was a complaint which was unresolved. During a Resident Council meeting on 11/22/24 at 10:30 AM, 12 cognitively intact residents (Resident #44, Resident #41, Resident #3, Resident #57, Resident #21, Resident #62, Resident #37, Resident #27, Resident #9, Resident #13, Resident #43, Resident #47), were unaware of how to complete a grievance form and were unaware of where the forms were located. Review of the policy titled Grievance Policy and Procedure directed, in part, the Grievance Officer will acknowledge the grievances as promptly as possible, and written decisions will be issued to the residents and others as necessary. The Grievance Committee will maintain a tracking file on each grievance. All Grievances will be maintained for a period of three years.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the clinical record, facility policy, and interview for 3 of 3 sampled residents, (Resident #45, Resident #58, and Resident #61), reviewed for change of condition, the facility failed to submit significant change in status (SCSA) Minimum Data Set (MDS) assessments for a decline in more than two functional ability areas. The findings include: 1. Resident #45 was admitted to the facility in February of 2021 and had diagnoses that included dementia, chronic obstructive pulmonary disease (COPD), and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 was severely cognitively impaired, used a manual wheelchair (w/c), was independent with wheeling 50 feet (ft) with 2 turns in the w/c, and was independent with wheeling 150 ft in the w/c. Resident #45 required supervision or touching assistance with eating, bed mobility, walking 10 ft, and walking 50 ft with 2 turns. Resident #45 required partial/moderate assistance with oral hygiene, upper body dressing, personal hygiene, going from sitting to standing, and transfers. Resident #45 required substantial/maximal assistance with putting on/taking off footwear. The MDS assessment further identified Resident #45 received physical therapy (PT) and occupational therapy (OT) which began on 6/17/24. The quarterly MDS assessment dated [DATE] identified Resident #45 was severely cognitively impaired, used a manual w/c, required supervision or touching assistance with wheeling 50 ft with 2 turns in the w/c, and required supervision or touching assistance with wheeling 150 ft in the w/c. Resident #45 required setup or clean-up assistance with eating. Resident #45 required partial/moderate assistance with bed mobility and walking 10 ft. Resident #45 required substantial/maximal assistance with oral hygiene, upper body dressing, going from sitting to standing, transfers, and walking 50 ft with 2 turns. Resident #45 was dependent for putting on/taking off footwear and personal hygiene, and no longer walked 150 ft. The MDS assessment further identified Resident #45 received PT which began 9/17/24, speech therapy (ST) which began 8/18/24, and Resident #45 had not received OT since 7/11/24. A decline in 14 functional mobility areas were identified when compared with the previous quarterly MDS assessment. The Resident Care Plan (RCP) dated 9/26/24 identified Resident #45 was a fall risk related to dementia, use of psychotropic medications, and independent ambulation (Resident #45 fell on [DATE] self-ambulating in the hallway). Interventions included to encourage and assist Resident #45 to the exercise activity program, obtain a medical work-up as needed for changes in condition, monitor for changes in gait, and Resident #45 was to be upright in the manual w/c with a full lap tray and pommel cushion for positioning with referral to the rehabilitation department with any change in status. The RCP further identified Resident #45 had impaired activities of daily living (ADL) function related to dementia. Interventions included assistance with dressing, grooming, hygiene, showers/bathing, and for a PT/OT evaluation with treatment as needed per provider order(s). (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview and clinical record review of Resident #45's MDS assessments with Registered Nurse (RN) #2 on 11/26/24 at 12:53 PM and 2:30 PM identified the clinical record failed to reflect documentation of an SCSA being submitted. RN #2 identified that she had not submitted a SCSA because it had been determined that Resident #45's decline was due to progression of dementia. After the MDS assessment information for 6/20/24 and 9/20/24 was reviewed and identified a decline in 14 areas of functional mobility, RN #2 stated that she hadn't realized Resident #45 had declined in areas other than ambulation and therefore a SCSA should have been completed and submitted. 2. Resident #58 was admitted in January of 2023 and had diagnoses that included traumatic hemorrhage of the cerebrum, diabetes, and hemiplegia affecting the left nondominant side. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), used a manual wheelchair, and required setup or clean-up assistance with eating. Resident #58 required substantial/maximal assistance with oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and bed mobility. Resident #58 did not receive physical therapy (PT) and/or occupational therapy (OT) this quarter. The quarterly MDS assessment dated [DATE] identified Resident #58 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), used a manual wheelchair, and required supervision or touching assistance with eating. Resident #58 was dependent for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and bed mobility. Resident #58 did not receive PT this quarter, but received OT from 8/6/24 to 9/16/24 A significant decline in cognition and a decline in 9 functional mobility areas was identified when compared with the previous annual MDS assessment. The Resident Care Plan (RCP) dated 10/11/24 identified Resident #58 had impaired cognition related to a stroke and impaired decision making. Interventions included observation of cognitive status for changes in orientation, memory, recall, comprehension, and decision-making ability and for administration of medications as ordered. The RCP further identified Resident #58 had impaired activities of daily living (ADL) function related to brain hemorrhage, left side hemiplegia, mobility deficit, and self-care deficit. Interventions included a PT/OT evaluation with treatment as needed per provider order(s) and for placement of Resident #58 into an adaptive w/c with headrest, pommel cushion, left sided half lap tray and left footrest in place at all times with right footrest in place for transport and when w/c was reclined. 3. Resident #61 was admitted to the facility in April of 2023 and had diagnoses that included dementia, macular degeneration, and osteoarthritis. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and used a walker and manual wheelchair. Resident #61 was independent with bed mobility, lying to sitting on side of bed, going from sitting to standing, chair and toilet transfers, walking 10 feet (ft), walking 50 ft with 2 turns, and walking 150 ft. Resident #61 required setup or clean-up assistance with oral hygiene and personal hygiene and supervision or touching assistance with toileting hygiene, going from sitting to lying down, and tub/shower transfers. Resident #61 required partial/moderate assistance with showering and upper body dressing, and substantial/maximal assistance with lower body dressing and putting on/taking off footwear. The MDS assessment further identified Resident #61 received occupational therapy (OT) starting on 3/22/24. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 1) and used a walker and manual wheelchair. Resident #61 required partial/moderate assistance with oral hygiene, toileting hygiene, going from sitting to lying, going from lying to sitting on the side of bed, and shower transfers. Resident #61 required substantial/maximal assistance with showering, upper and lower body dressing, putting on/taking off footwear, personal hygiene, going from sitting to standing, and chair and toilet transfers. Resident #61 was dependent with walking 10 ft, walking 50 ft with 2 turns, and walking 150 ft. The MDS assessment further identified Resident #61 received OT starting on 6/19/24 and physical therapy (PT) starting on 6/26/24. A decline in 15 functional mobility areas was identified when compared with the previous annual MDS assessment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and used a walker. Resident #61 no longer used the wheelchair, and was independent with bed mobility, going from sitting to lying, going from lying to sitting on the side of bed, going from sitting to standing, chair transfers, walking 10 Ft, and walking 50 ft with 2 turns. Resident #61 required supervision or touching assistance with toilet transfers, showering, and walking 150 ft. The MDS assessment further identified Resident #61 received OT 6/19/24 through 7/16/24 and PT 6/26/24-7/23/24. An improvement in 12 functional mobility areas was identified when compared with the previous quarterly MDS assessment. The Resident Care Plan (RCP) dated 9/26/24 identified Resident #61 had impaired activities of daily living (ADL) function related to dementia and a mobility deficit. Interventions included to monitor for declines in ADL function and mobility and refer for rehabilitation as needed and Resident #61's activity level was independent with a 2 wheeled walker and required assistance of 1 staff member for toileting. The RCP further identified Resident #61 was at risk for falls related to dementia and environmental changes. Interventions included to monitor for changes in gait and Resident #61 required assistance of 1 staff member for toileting. Interview and clinical record review of Resident #61's MDS assessments with Registered Nurse (RN) #2 on 11/26/24 at 12:53 PM and 2:30 PM identified the clinical record failed to reflect documentation of an SCSA being submitted for Resident #61's decline or improvement in 2 or more functional mobility areas. Subsequent to surveyor inquiry the Resident Assessment Instrument (RAI) manual definition of SCSA was reviewed and RN #2 acknowledged understanding of the 14-day requirement for submission of an SCSA but stated she had not realized that a SCSA should have been submitted for improvement in 2 or more areas of Resident #61's functional mobility.

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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. 50179 Based on clinical record review, facility documentation and staff interviews, the facility failed to provide medication administration education to a temporary agency staff nurse before starting work to meet professional standards of practice to prevent a significant medication error. The findings include: A Reportable Event Form dated 10/11/24 identified that Resident #1 received Resident #14's medications in error which included the following medications: Amlodipine 5 milligrams (mg) (lowers blood pressure), Aspirin 81mg (NSAID), Depakote 250mg (anticonvulsant), Cymbalta 120 mg (antidepressant), Gabapentin 800mg (anticonvulsant), lacosamide 100mg (antoconvulsant), Keppra 500 mg (anticonvulsant), Metoprolol 25mg (lowers blood pressure), Movantik 25mg (treats opioid induced constipation), Docusate (stool softener), Simethicone (gas relief), Vitamin D (supplement) and Vitamin B12 (supplement). Interview with LPN #1 on 11/25/24 at 1:47 PM identified that she was assigned to administer morning medications to Resident #1 on 10/11/24. LPN #1 identified that she went into the wrong room and administered Resident #14's medications to Resident #1 in error. LPN #1 identified that Resident #1 was not wearing a name identification bracelet. LPN #1 further identified that she called Resident #1 by the wrong name, Resident #1 did not respond to the name, but she assumed that she had the correct resident and administered the medications. LPN #1 identified that after administering medications to Resident #1, she realized that she administered medications to the wrong resident secondary to Resident #1 not having an ordered medical device which she would have needed to monitor. LPN #1 reported the medication error when she realized she administered medications to the wrong resident. LPN #1 identified that APRN #1 assessed Resident #1 and verbally instructed her to monitor Resident #1 every 2 hours for respiratory distress, lethargy, change in vital signs and to notify him of any change in vital signs. LPN #1 identified that Resident #1's systolic blood pressure dropped by 15 to 20 mmHg within the first two hours, which she reported to the DNS and APRN #1. Additionally, LPN #1 reported that she did not receive any form of medication administration re-education prior to continuing with her medication pass. LPN #1 indicated that she asked the DNS if she should write a statement and a progress note in the clinical record, regarding the medication error, but the DNS declined and stated he would complete the medication error statement, and a progress note for the incident. LPN #1 identified that she failed to follow the 5 rights of medication administration while administering medications to Resident #1 because she did not use any resident identifier to confirm she was administering medications to the right resident. LPN #1 identified that she should have verified the picture on electronic medical record or confirmed resident identity with another staff member when she realized Resident #1 had no name identification bracelet. Interview with the Human Resources Director (HRD) on 11/25/24 at 2:58 PM identified that the facility utilizes agency staff to fill vacant shifts. The HRD identified that prior to the initial shift worked at the facility, the agency staff would acknowledge and sign that they have received, read, and understood the facility Orientation for Pool Staff document. The document included facility policy information for Mission and Values, Confidentiality, Infection Control, Abuse and Neglect, Corporate Compliance, On-Site Hazards, Hazardous Materials, General Safety, Health Requirements, Identification, Patient's Rights, Weapons and Code of Conduct. (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 the DNS on 11/26/24 at 10:59 AM identified that the facility does not provide orientation for agency nurses to include medication administration competency. The DNS indicated that LPN #1 was educated on the 5 rights of medication administration prior to continuing with medication administration on the day of the medication error but was unable to provide documentation that medication administration re-education was provided. The DNS provided documentation that facility staff nurses were educated on medication administration after the medication error incident, but did not implement any form of education for agency staff nurses related to medication administration and did not add the medication administration policy to the facility Orientation for Pool Staff document which is reviewed with agency nurses before working a shift in the fcaility.

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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** 50167 50250 Based on observation, review of the clinical record, facility policy and interviews for 15 of 70 residents (Resident #4, Resident #6, Resident #22, Resident #28, Resident #30, Resident #32, Resident #33, Resident #39, Resident #41, Resident #45, Resident #48, Resident #58, Resident #65, Resident #69, Resident #326) reviewed for preventative weekly body audits, the facility failed to perform preventative weekly body audits according facility policy and physician orders. The findings include: 1. Resident #4 was admitted to the facility in November of 2020 and had diagnoses that included cerebrovascular disease, abnormal posture, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), was at risk for developing pressure injuries and had moisture associated skin damage (MASD) with skin treatments. Resident #4 was dependent for bed mobility and transfers. The Resident Care Plan dated 10/11/24 identified Resident #4 was at risk for pressure injuries related to impaired mobility and incontinence. Interventions included to complete a weekly body audit on shower day, turn and reposition on rounds, and to monitor skin integrity during morning and evening care. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 4/8/21) which directed to perform a weekly body audit on Fridays during the 7 AM to 3 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/4/24) which directed to apply barrier cream every shift for MASD and a provider order (start date of 11/16/24) which directed to cleanse the open area to Resident #4 ' s sacrum with normal saline and apply Silvadene (topical antimicrobial) followed by a clean dressing every morning. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/11/24, 10/18/24, 11/1/24, and 11/22/24. There was no body audit performed for Resident #4 for 21 days from 10/4/24 through 10/25/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:15 PM and identified that Resident #4 had no skin issues or abnormalities. The Weekly Body Audit failed to identify MASD or an open area to the sacrum correlating to the active treatment orders in place. 2. Resident #6 was admitted to the facility in August of 2019 and had diagnoses that included congestive heart failure, rheumatoid arthritis, and anemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual Minimum Data Set assessment dated [DATE] identified Resident #6 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), had abnormal posture, dementia, was at risk for developing pressure injuries and had skin treatments. Resident #6 was dependent for bed mobility and transfers. The Resident Care Plan dated 11/20/24 identified Resident #6 was at risk for pressure injuries related to severely impaired mobility and total functional incontinence. Interventions included to ensure Resident #6 had only 2 layers between his/her skin and the mattress, to turn and reposition during rounds, and to perform a weekly body audit on the scheduled shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 10/3/19) which directed to complete a weekly body audit on Fridays during the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 5/26/24) which directed to apply barrier cream to reddened buttocks 2 times a day and as needed after every incontinent episode. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/4/24, 10/18/24, 11/8/24, and 11/22/24. There was no body audit performed for Resident #6 for 14 days from 11/1/24 through 11/15/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:18 PM and identified that Resident #6 had no skin issues or abnormalities. The Weekly Body Audit failed to identify redness to the buttocks correlating to the active treatment orders in place. 3. Resident #22 was admitted to the facility in October of 2024 and had diagnoses that included a repair of a left femur fracture, muscle weakness, and anemia. The admission Minimum Data Set assessment dated [DATE] identified Resident #22 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), was at risk for developing pressure injuries, had a surgical wound, and had skin/wound treatments. Resident #22 required substantial/maximal assistance for bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 10/28/24 identified Resident #22 was at risk for pressure injuries related to impaired mobility, incontinence and bony prominences. Interventions included to monitor for pain on or near bony prominences and pressure points, reposition in chair on rounds, and to complete a weekly body audit on shower day. The RCP further identified Resident #22 was at risk for infection related to a surgical incision to the left hip. Interventions included to document drainage, appearance of site, and signs and symptoms of infection. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 10/15/24) which directed to complete a weekly body audit on Tuesday ' s during the 7 AM to 3 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. (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 Order Summary report dated 11/26/24 included a provider order (start date of 10/18/24) which directed to monitor an area surrounding a surgical incision to the left lower extremity and report abnormal findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/22/24, 11/5/24, 11/12/24, 11/19/24, and 11/26/24. There was no body audit performed for Resident #22 for 17 days from 11/9/24 through 11/26/24. Subsequent to surveyor inquiry, a Weekly Body Audit was performed on 11/26/24 at 5:21 PM and identified Resident #22 had no documented skin issues or abnormalities. The Weekly Body Audit failed to identify documentation of a surgical incision/healed incision to the left hip correlating to the active treatment order in place. 4. Resident #28 was admitted to the facility in February of 2021 and had diagnoses that included peripheral vascular disease (PVD), diabetes, and lymphedema. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #28 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), was at risk for developing pressure injuries and had skin treatments. Resident #28 required substantial/maximal assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 9/16/24 identified Resident #28 was at risk for pressure injuries related to impaired mobility and incontinence. Interventions included protective skin barrier with incontinent care and staff assistance to change positions in bed on rounds. The RCP further identified Resident #28 was at risk of bruises, skin tears, and skin alterations related to PVD, lymphedema and a history of cellulitis. Interventions included to moisturize legs and arms daily with morning care and to complete a weekly body audit on shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 7/28/24) which directed to apply house stock barrier cream to the buttocks every shift for skin integrity. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/5/24) which directed to complete a weekly body audit on Fridays during the 7 AM to 3 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified Weekly Body Audits were not completed on 10/1/24, 10/8/24, 10/22/24, 11/8/24, and 11/22/24. There was no body audit performed for Resident #28 for 17 days from 10/29/24 through 11/15/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:10 PM and identified Resident #28 ' s skin was clean, dry and intact. 5. Resident #30 was admitted in July of 2018 with diagnoses that included vascular dementia, osteoarthritis left shoulder, contracture right hand, and abnormal posture. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 was severely cognitively impaired and required an assist of 2 for eating, oral hygiene, toileting hygiene, showering, and upper and lower body dressing. The Resident Care Plan (RCP) dated 9/19/24 identified Resident #30 was at risk of bruises and skin tears related to dementia and fragile skin and was at risk for pressure injuries related to impaired mobility and incontinence. Interventions included to inspect skin daily with morning and evening care, to monitor skin pressure points, and perform weekly body audits on the shower day. A review of the October 2024 and November 2024 Treatment Administration Record (TAR) identified a Physician's order that directed to perform a body audit on Thursday's during the 3 PM to 11 PM shift and complete a weekly body audit form. The order was documented as completed for 11/7/24, 11/14/24, and 11/21/24. A review of Resident #30's clinical record identified the last body audit performed was on 10/31/24. Interview with RN #3 on 11/25/24 at 11:06 AM identified the last weekly body audit completed for Resident #30 was on 10/31/24, and nursing in the evenings was responsible to complete. Interview with the Director of Nursing (DNS) on 11/25/24 at 11:16 AM identified there were no weekly body audits completed for the month of November for Resident #30 and that nursing was responsible to complete. 6. Resident #32 was admitted to the facility in February of 2021 and had diagnoses that included Parkinson ' s disease and impulse disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #32 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), had muscle weakness, was at risk for developing pressure injuries and had skin treatments. Resident #32 required partial/moderate assistance with bed mobility and substantial/maximal assistance with transfers. The Resident Care Plan dated 11/07/24 identified Resident #32 was at risk for pressure injuries related to impaired mobility. Interventions included to avoid positioning Resident #32 on reddened areas and non-blanchable areas, to reposition in his/her chair on rounds, and to complete a weekly body audit on shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/08/24) directed to complete a weekly body audit on Fridays with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/11/24, 10/18/24, 11/1/24, 11/8/24, and 11/22/24. There was no Weekly Body Audit performed for Resident #32 for 21 days from 10/25/24 through 11/15/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:23 PM and identified Resident #32 had no documented skin issues or abnormalities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #33 was admitted to the facility in April of 2022 and had diagnoses that included Chronic Obstructive Pulmonary Disease, Dementia, Muscle Weakness, and Unsteadiness on Feet. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 as moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 10), required set up assistance for eating, and was dependent for toileting and transfers. The Resident Care Plan dated 9/23/24 identified Resident #33 was at risk for pressure injuries related to impaired mobility and incontinence. Interventions included to keep skin clean, dry, and moisturized, utilization of a pressure reducing mattress, repositioning in chair during rounds, and weekly body audit on shower day. Review of the clinical record identified documentation for weekly body audits were not completed on 5/4/24, 5/18/24, 5/25/24, 6/8/24, 6/22/24, 9/14/24, 10/12/24, and 10/19/24. An Order Summary document dated 11/25/24 included a provider order (start date of 4/13/24) that directed to provide a body audit weekly on shower day. Instructions directed to complete a weekly body audit form every Saturday, inspect for altered skin integrity, changes in moles or abnormalities of skin, and report findings to MD/APRN. Interview and clinical record review with the Director of Nursing (DNS) on 11/25/24 at 11:15 AM identified that the unit nurse is responsible for completing weekly body audits and that they should have been completed for Resident #33 per physician order and facility policy. Additionally, the DNS was unable to locate documentation or explain why body audits for Resident #33 were not completed on the following dates: 5/4/24, 5/18/24, 5/25/24, 6/8/24, 6/22/24, 9/14/24, 10/12/24, and 10/19/24. 8. Resident #39 was admitted to the facility in May of 2021 and had diagnoses that included Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, emphysema, essential hypertension, and restless leg syndrome. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 as moderately cognitively impaired (brief interview for mental status (BIMS) score of 11), required set up assistance for eating, substantial/maximal assistance for toileting, personal hygiene, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #39 was at risk for potential/actual alteration in skin, bruising and skin tears related to the aging process. Interventions included inspect skin daily with morning and evening care, observe for signs and symptoms of infection, and weekly body audits on shower day. Review of the clinical record identified documentation for weekly body audits were not completed on 4/12/24, 4/19/24, 5/3/24, 5/17/24, 5/24/24, 5/31/24, 6/14/24, 6/28/24, 7/12/24, 7/19/24, 7/26/24, 8/23/24, 9/6/24, 9/13/24, 10/18/24, 10/25/24, 11/1/24, and 11/8/24. Additional clinical record review identified there was no documentation of refusals in progress notes or the RCP. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with RN #7 on 11/25/24 at 12:30 PM, identified that weekly body audits should be done weekly on shower days. RN #7 identified that the unit nurse is responsible for completing weekly body audits and that the process includes NA ' s notifying the nurse of when a shower is provided, and the nurse completing the body audit during that time. RN #7 was unable to explain why body audits were not being completed weekly as ordered. An Order Summary document dated 11/26/24 included a provider order (start date of 6/4/21) that directed to provide a body audit weekly. Instructions directed to complete a weekly body audit form every Saturday, inspect for altered skin integrity, changes in moles or abnormalities of skin, and report findings to MD/APRN. Interview with the Director of Nursing (DNS) on 11/26/24 at 10:30 AM, identified that the unit nurse is responsible for completing weekly body audits. The DNS was unable to explain why body audits were not being completed weekly as ordered and identified that weekly body audit orders and the facility policy for weekly body audits should have been followed. Review of the Weekly Body Audit completed on 11/26/24 at 4:23 PM identified that Resident #22 had no documented skin issues or abnormalities. 9. Resident #41 was admitted to the facility in September of 2021 and had diagnoses that included polyosteoarthritis, polyneuropathy, and chronic pain. The annual Minimum Data Set assessment dated [DATE] identified Resident #41 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and independent with bed mobility and transfers. The Resident Care Plan (RCP) dated 11/6/24 identified Resident #41 was at risk for pressure injuries related to impaired mobility. Interventions included to turn and reposition on rounds and complete a weekly body audit on shower day. The RCP further identified Resident #41 was at risk for bruises and skin tears related to the aging process and dry flaky skin. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/30/22) which directed to complete a weekly body audit on Tuesdays during the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/1/24, 10/15/24, 10/29/24, 11/12/24, and 11/19/24. There was no body audit performed for Resident #41 for 19 days from 11/7/24 through 11/26/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:15 PM and identified Resident #41 ' s skin was clean, dry and intact. 10. Resident #45 was admitted to the facility in February of 2021 and had diagnoses that included polyneuropathy, osteoarthritis, and lumbosacral radiculopathy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 was severely cognitively impaired, had dementia, was at risk for developing pressure injuries and had skin treatments. Resident #45 required partial/moderate assistance with bed mobility and substantial/maximal assistance with transfers. The Resident Care Plan (RCP) dated 9/26/24 identified Resident #45 was at risk for pressure injuries related to dementia, potential for declines in mobility, and incontinence. Interventions included a pressure reducing mattress and completion of a weekly body audit on shower day. The RCP further identified Resident #45 was at risk for bruises, skin tears, and alterations in skin related to dementia, fragile skin and the aging process. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 4/12/24) which directed to complete a weekly body audit on Thursdays during the 7 AM to 3 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/3/24, 10/24/24, 11/7/24, and 11/21/24. There was no body audit performed for Resident #45 for 14 days from 10/31/24 to 11/14/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:19 PM and identified Resident #45 had no documented skin issues or abnormalities. 11. Resident #48 was admitted to the facility in October of 2021 and had diagnoses that included osteoarthritis, muscle weakness, and mild protein-calorie malnutrition. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #48 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2), had dementia, was at risk for developing pressure injuries and had skin treatments, required substantial/maximal assistance with bed mobility and transfers. The Resident Care Plan (RCP) dated 9/23/24 identified Resident #48 was at risk for pressure injuries related to dementia, incontinence, and decline in mobility. Interventions included to keep skin clean, dry and moisturized and to complete a weekly body audit on shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 3/5/24) which directed to complete a weekly body audit on Thursdays during the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/17/24, 11/14/24, and 11/21/24. There was no body audit performed for Resident #48 for 19 days from 11/7/24 to 11/26/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:17 PM and identified Resident #48 had no documented skin issues or abnormalities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Resident #58 was admitted to the facility in January of 2023 and had diagnoses that included hemiplegia and hemiparesis of the left side following a stroke, muscle weakness, and abnormal posture. The annual Minimum Data Set assessment dated [DATE] identified Resident #58 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), was at risk for developing pressure injuries, had nonsurgical dressings and skin treatments, required substantial/maximal assistance with bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 10/11/24 identified Resident #58 was at risk for pressure injuries related to diabetes, impaired mobility and incontinence. Interventions included to keep skin clean, dry and moisturized and to provide a pressure reducing cushion in reclining chair. The RCP further identified Resident #58 was at risk for bruises and skin tears related to behaviors, dementia, and fragile skin. Interventions included to observe Resident #58 ' s position in his/her wheelchair and to complete a weekly body audit on shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 1/17/24) which directed to complete a weekly body audit on Tuesdays on the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 1/17/24) which directed to apply an optifoam dressing (protective dressing) to the left elbow every 3 days for protection, a provider order (start date of 11/13/24) which directed to cleanse a skin tear to the left forearm with normal saline and apply a dry clean dressing daily, and a provider order (start date of 11/25/24) which directed to cleanse an abrasion to the left thigh with normal saline and apply a Kerralite Cool (hydrogel) dressing every 3 days for 14 days. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/1/24, 10/15/24, 10/29/24, 11/12/24, and 11/19/24. There was no body audit performed for Resident #58 for 21 days from 11/5/24 to 11/26/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:02 PM and identified Resident #58 had a skin tear to the left forearm which measured 2.5 centimeters (cm) by 2 cm and an area to the left thigh which appeared to be resolved. The Weekly Body Audit failed to identify documentation of the skin appearance of the left elbow correlating to the active treatment order in place. 13. Resident #65 was admitted to the facility in December of 2023 and had diagnoses that included muscle weakness, venous insufficiency, and osteoarthritis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #58 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 8), had dementia, was at risk for developing pressure injuries and had skin treatments, and was independent with bed mobility and transfers. The Resident Care Plan (RCP) dated 9/16/24 identified Resident #65 was at risk for pressure injuries related to impaired mobility and incontinence. Interventions included to remind Resident #65 to change position in his/her chair and to complete a weekly body audit on shower day. (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 Order Summary report dated 11/26/24 included a provider order (start date of 10/18/24) which directed to complete a weekly body audit on Thursdays on the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified weekly body audits were not completed on 10/17/24, 10/31/24, 11/7/24, and 11/21/24. There was no body audit performed for Resident #65 for 21 days from 10/24/24 to 11/14/24. Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 4:56 PM and identified Resident #65 had discoloration/scar tissue to an area on the buttocks previously identified with no additional skin issues or abnormalities. 14. Resident #69 was admitted to the facility in November of 2024 with diagnoses that included lung cancer with metastasis to the brain, muscle weakness, and a rotator cuff tear of the right shoulder. The annual Minimum Data Set assessment dated [DATE] identified Resident #69 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 8), had dementia, had a neurological surgery, was at risk for developing pressure injuries, had surgical wound care and skin treatments, and required supervision or touching assistance with bed mobility and partial/moderate assistance with transfers. The Resident Care Plan (RCP) dated 11/20/24 identified Resident #69 was at risk for pressure injuries related to dementia, impaired mobility, and incontinence. Interventions included to monitor for pain on/near bony prominences and pressure points and complete a weekly body audit on shower day. The RCP further identified Resident #69 was at risk for infection related to a surgical incision following a craniotomy. Interventions included to document drainage, appearance of site, signs and symptoms of infection, and how the treatment was tolerated. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/1/24) which directed to monitor the incision to the left parietal scalp for signs and symptoms of infection every shift and report abnormal findings to the provider, and a provider order (start date of 11/20/24) which directed to wash the skin tear to the right lower extremity with normal saline then apply a dry clean dressing every 3 days. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/22/24) which directed to complete a weekly body audit on Wednesday on the 7 AM to 3 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified a weekly body audit was not completed on 11/22/24. There was no body audit performed for Resident #69 for 11 days (11/15/24 to 11/26/24). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:20 PM and identified Resident #69 had an abrasion to the right lateral calf and failed to identify documentation of a surgical incision/healed incision to the parietal scalp correlating to the active treatment order in place. 15. Resident #326 was admitted to the facility in November of 2024 with diagnoses that included epilepsy, diabetes, and congestive heart failure (CHF). The Nursing Admission assessment dated [DATE] identified Resident #326 was admitted to the facility from the hospital following hospitalization for seizures and CHF. Resident #326 was alert and oriented to person, place, time, situation and was cognitively intact and had moisture associated skin damage (MASD) to the coccyx which measured 3 centimeters (cm) by 3 cm and required treatment with a barrier cream and placement of an air mattress. Resident #326 required assistance with bed mobility and transfers. The Resident Care Plan (RCP) dated 11/19/24 identified Resident #326 was at risk for pressure injuries related to impaired circulation, impaired mobility, and incontinence. Interventions included protective skin barrier with incontinent care and completion of a weekly body audit on shower day. Review of the Order Summary report dated 11/26/24 included a provider order (start date of 11/19/24) which directed to complete a weekly body audit on Mondays on the 3 PM to 11 PM shift with instructions to complete the weekly body audit form, inspect for altered skin integrity, changes in moles or abnormalities of skin, and to report findings to the provider. Weekly Body Audit reports dated 11/26/24 reviewed for October 2024 and November 2024 identified a weekly body audit was not completed on 11/25/24. There was no body audit performed for 7 days (11/19/24 to 11/26/24). Subsequent to surveyor inquiry, a Weekly Body Audit was completed on 11/26/24 at 5:24 PM and identified Resident #326 had no documented skin issues or abnormalities. The Weekly Body Audit failed to identify MASD or resolution of an area of MASD to the coccyx correlating to the documentation on the Nursing Admission assessment on 11/19/24. Review of the Body Audit policy directed, in part, nurses would perform a complete body audit weekly and/or more often as indicated per physician's orders, the nurse would document any abnormal findings and notify the physician. 51101

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestelm Health and Rehabilitation Center	534 Town St Moodus, CT 06469

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on clinical record review, review of facility policy, and interviews for 1 of 3 sampled residents (Resident #58) reviewed for accidents, the facility failed to ensure that side rails were used for positioning and bed mobility resulting in a fall. The findings include: Resident #58's diagnoses included hemiplegia (paralysis) affecting the left side, dementia, anxiety and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3) and was dependent for toileting hygiene, personal hygiene, bed mobility and transfers. The Resident Care Plan (RCP) dated 10/11/24 identified Resident #58 required assistance with ADL's due to left hemiplegia, mobility deficit and self-care deficit. Interventions included using 2 quarter siderails to assist with positioning and bed mobility, assistance with personal hygiene and maintaining proper body alignment and positioning. A facility fall investigation document dated 10/28/24 by RN #7 identified a witnessed fall incident on 10/28/24 at 1:23 PM. The form identified that NA #1 and NA #2 were providing care to Resident #58 while in bed and that when Resident #58 was being turned to the side, he/she slid off the bed. NA #1 and NA #2 both identified that the side rail was down when Resident #58 was being turned. Resident #58 was only oriented to person at the time of the fall. Post Fall assessment note dated 10/28/24 at 1:27 PM by RN #7 identified that she found Resident #58 laying on the side of the bed on his/her back and no injuries were noted. A Nurse's note dated 10/28/24 at 1:45 PM by LPN #2, identified that he was called to the room by NA #1 and observed Resident #58 with his/her back on the floor and his/her legs on the bed. The note identified that Resident #58 was only wearing a T-shirt at the time of the fall, the bed side rails were in the lowered position and noted NA #1 stated Resident #58 rolled out of bed while receiving incontinence care. The note identified that LPN #2 notified RN #7 who responded to the incident and assessed Resident #58. Interview with NA #1 on 11/22/24 at 10:30 AM, identified that she and NA #2 were providing incontinence care to Resident #58 when he/she fell out of bed. NA #1 further identified that NA #2 alerted her that she was going to roll Resident #58 over to the left side. NA #1 indicated that when Resident #58 was rolled over to the left side, she was unable to support Resident #58's weight and Resident #58 slid to the floor landing on his/her shoulders first followed by his/her entire upper body. NA #1 indicated that the bed was about 3 feet high, and the side rail was down at the time of the fall. NA #1 identified that she forgot to raise the side rail which could have helped prevent Resident #58 from falling out of bed. NA #1 indicated that Resident #58 appeared shocked when he/she realized he/she was on the floor and asked why he/she was on the floor and why he/she was naked. Furthermore, NA #2 identified that Resident #58 complained of pain, which she reported to RN #7. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2, on 11/22/24 at 11:35 AM, identified that she and NA #1 were providing incontinence care to Resident #58 when Resident #58 fell out of bed. NA #2 identified that she informed NA #1 that she was going to roll Resident #58 over, but when she rolled Resident #58 over, NA #1 was unable to support Resident #58 ' s weight and Resident #58 landed on the floor. NA #2 indicated that the side rail, which could have helped to prevent Resident #58 from falling out of bed, was down at the time of the fall. NA #2 further indicated that NA #1 stated that she forgot to raise the side rail before Resident #58 was rolled over. NA #2 identified that when she saw Resident #58 rolling over, she tried to catch him/her from across the bed, but it happened so fast that Resident #58 ended up on the floor. NA #2 indicated that Resident #58 appeared shocked when he/she realized he/she was on the floor and asked why he/she was on the floor. NA #2 identified that Resident #58 complained of pain, which she reported to RN #7. Interview and clinical record review with RN #7 on 11/25/24 at 12:30 PM, identified that she responded to the fall and completed a fall assessment when Resident #58 fell out of bed. RN #7 identified that she found Resident #58's torso on the floor and his/her legs were still in bed. RN #7 identified that she observed and palpated Resident #58's body, checked range of motion and noted slight blanchable redness on Resident #58's buttocks. Interview with the DNS on 11/26/24 at 10:30 AM, identified that NA #1 and NA #2 should have followed Resident #58's plan of care to use 2 quarter siderails for positioning and bed mobility while providing incontinence care. The DNS was unable to explain why NA #1 and NA #2 did not use side rails while positioning Resident #58 in bed leading to a fall out of bed. The DNS identified that education related to following the plan of care was provided to NA #1 and NA #2 after the fall incident on 10/28/24. Review of facility policy titled, Fall Management Program: Policy and Procedure, identified, in part, that the fall management program is designed to provide individualized person-centered care and manage resident falls and potential for falls with resident focused interventions.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 1. Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 residents (Resident #22 and Resident #34) reviewed for nutrition, the facility failed to obtain a reweight as directed by provider order and failed to notify a provider of a weight change and failed to obtain daily weights as directed by a provder order. The findings include: Resident #22 was admitted to the facility in October of 2024 and had diagnoses that included periprosthetic fracture around other internal prosthetic joint, constipation, heart failure and acute prosthetic anemia. A Nutrition evaluation dated 10/16/24 at 11:57 AM identified a regular puree consistency diet with thin liquids and identified no swallowing difficulties. The evaluation identified Resident #22 had dentures but did not wear them, had 2 remaining teeth on the bottom, and had a left hip surgical site. A provider order dated 10/16/24 directed to obtain weekly weights for 4 weeks then obtain monthly weights. Instructions directed to compare current weight to previous weight and if there was a discrepancy of 5 pounds (lbs) a re-weight must be obtained for verification. The Weights and Vital Signs summary identified a weight entry on 10/16/24 at 11:57 AM of 122.4 lbs which was obtained using a mechanical lift (lifting device to obtain weight measurement). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 was moderately cognitively impaired (brief interview for mental status (BIMS) score of 12) and required set up assistance for eating, supervision or touching assistance for personal hygiene, substantial maximum assistance to dependent for bed mobility, transfer, ambulation and toileting. The MDS further identified a weight of 122 lbs, no swallowing difficulties, no weight loss and a mechanically altered diet. The Resident Care Plan dated 10/29/24 identified potential for alteration in nutrition related to a mechanically altered diet, history of low body weight and limited oral intake. Interventions included to assess likes and dislikes and offer choices, pureed diet texture with thin liquids, offer health shakes in the evening, encourage 50% of meal intake, Registered Dietician assessment as indicated and refer to speech therapy as needed. Additionally, report significant weight changes and weights as ordered. A physician's order dated 11/19/24 at 3:00 PM directed to obtain a weekly weight. The Weights and Vital Signs summary identified a weight entry on 11/19/24 at 10:58 PM of 97 lbs which represented a 20.8% weight loss. A physician's order dated 11/20/24 at 6:20 AM directed to obtain a reweight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dietitian note on 11/20/24 indicated a weight review was done, a reweight was pending, and weight loss was discussed with the weight committee and the charge nurse. The note further indicated Resident #22 accepted health shakes (per the medication administration record (MAR) and nursing report), that there had been no significant change in oral intake and recommended offering chocolate ice cream. Review of the Medication Administration Record for November of 2024 identified there was no weight entry on 11/20/24. Interview and record review with the Director of Nursing (DNS) on 11/26/24 at 10:20 AM, verified the order for a reweight. The DNS confirmed that the reweight was not obtained as ordered and he did not know why the reweight was not obtained. The DNS identified that the Nursing Assistants (NA) are responsible for obtaining weights on the 11:00 PM to 7:00 AM shift and then the 7:00 AM to 3:00 PM shift NA's or nurses document the weights in the electronic medical record (EMR). Additionally, the DNS reviewed the clinical record and identified the provider was not notified of the documented weight loss. Observations on 11/26/24 at 12:01 PM, identified Resident #22's lunch tray was set up on the overbed table in front of him/her with pureed meat, potatoes and vegetables, soup and ice cream. Resident #22 indicated he/she only wanted the drinks on the tray and did not want to eat. Subsequent to surveyor inquiry, the facility added a weight entry of 113 lbs (7.68% weight loss) on 11/26/24 at 12:16 PM. Interview with the DNS on 11/26/24 at 2:30 PM indicated the 11/19/24 weight entry of 97 lbs was an error. Review of the Weight Trending policy and procedure directed, in part, residents with 5% or more weight change in 30 days, 7.5% in 90 days or 10% change in 180 days will be identified. If a 5 pound weight loss/gain is noted from prior weight the NA will reweigh to verify, and inform the charge nurse of the weight change. The charge nurse will document the weight change and inform the physician, family and the weight committee. The weight committee will review the weight history, and medical information. Additionally, will implement a high calorie nourishment snack of choice. The Dietician and DNS will record in the progress notes recommendations and interventions as indicated through the meeting and policy. 2. Resident #34's diagnoses included congestive heart failure (CHF), hypertension, acute posthemorrhagic anemia and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and required set-up assistance with eating, maximum assistance with personal hygiene and was dependent for toileting hygiene and transfers. A physician's order dated 10/31/24 directed to administer Torsemide (diuretic) tablet 20 milligrams (mg) by mouth one time a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/31/24 (discontinuation date of 11/9/24) directed to obtain daily weights and report a weight gain of 2 pounds in 24 hours or 5 pounds in one week, to the provider. A physician's order dated 11/9/24 at 11:00 PM directed to obtain daily weights and report a weight gain of 2 pounds in 24 hours or 5 pounds in one week to the provider. The Resident Care Plan (RCP) dated 11/9/24 identified Resident #34 was at risk for alteration in cardiac status related to congestive heart failure (CHF), Atrial fibrillation (an irregular and rapid heartrate resulting in poor blood flow), hypertension, coronary artery disease, hyperlipidemia (high fat particles/lipids in blood), valve disease, and severe aortic stenosis. Interventions included obtaining and reporting weights as ordered, therapeutic diet as ordered, monitoring intake and output per facility policy, lab work as ordered, elevating legs above heart while in bed or recliner, monitoring vital signs as ordered and elevating head of bed for ease in breathing. Review of the Weights and Vitals Summary identified no daily weights were recorded from 10/31/24 to 11/2/24 (3 days), and from 11/9/24 through 11/20/24 (11 days). Review of Resident #34's clinical record from 10/31/24 through 11/25/24 identified no documentation for weight refusals within the progress notes or RCP. Interview and record review with RN #7 on 11/25/24 at 12:30 PM identified Resident #34's daily weight order as current and in effect. RN #7 further identified that Resident #34 was not weighed daily as directed by the provider and indicated that both nurses and NA's could obtain weights but it is the nurses' responsibility to ensure that weights are obtained and communicate weight changes to the physician. RN #7 could not explain why Resident #34 was not weighed as directed by the physician but identified that Resident #34 should have been weighed daily due to CHF. Interview and clinical record review with the DNS on 11/26/24 at 10:30 AM identified Resident #34's daily weight order as current and in effect. The DNS identified that both NA's and licensed nurses are responsible for weighing residents, but licensed nurses are responsible for ensuring that weights are obtained and updating the provider of weight changes. The DNS was unable to explain why Resident #34 was not weighed as directed by the physician but identified that he/she needed to have been weighed daily per the physician's orders due to CHF. Review of facility policy, Weight Trending Policy and Procedures, identified in part, the intent of weight monitoring as maintaining the highest practical well-being of the residents/patients by monitoring weight loss/gain.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for the only sampled resident (Resident #1) reviewed for accidents and hazards, the facility failed to administer medications to the right resident. The findings include: Resident #1's diagnoses included anxiety, bilateral sensorineural hearing loss, and generalized body weakness. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required set-up assistance with eating and substantial/maximum assistance with personal hygiene, toileting hygiene, bed mobility and transfers. The Resident Care Plan in effect on 10/1/24 identified Resident #1 had history of gastro intestinal bleed (GIB) and a duodenal gastrointestinal bleeding ulcer with hemorrhagic anemia. Interventions included avoiding all Non-Steroidal Anti-inflammatory Drugs (NSAIDS), labs as ordered, medicating with a proton pump inhibitor (PPI) as ordered, and observing for signs of GIB and/or anemia. A Reportable Event form dated 10/11/24 identified that Resident #1 received Amlodipine 5mg (lowers blood pressure), Aspirin 81mg (NSAID), Depakote 250mg (anticonvulsant), Cymbalta 120mg (antidepressant), Gabapentin 800mg (anticonvulsant), Lacosamide 100mg (anticonvulsant), Keppra 500mg, (anticonvulsant), Metoprolol 25mg (lowers blood pressure), Movantik 25mg (treats opioid induced constipation), Docusate (stool softener), Simethicone (gas relief), Vitamin D (supplement), and Vitamin B12 (supplement) in error, by LPN #1. The report identified that an in-service regarding the 5 rights to medication administration was conducted with licensed nurses to mitigate future incidences. The Reportable Event form failed to identify Resident #1 ' s scheduled medications that were held, subsequent to the medication error, to include: Linzess 145 mcg (treats irritable bowel syndrome and chronic constipation), Loratadine 10 mg (allergy medication), MiraLAX 17gm, (treats constipation) Senna plus 8.6-50 mg 2 tablets (treats constipation), Detrol (treats overactive bladder), Gabapentin 100mg (anticonvulsant), Tramadol HCl 100mg, (pain relief medication), Chewable Tums 500 mg and Acetaminophen. A late entry Nursing progress note by the DNS on 10/16/24, dated 10/11/24 at 12:03 PM, identified LPN #1 (an agency nurse) administered medications to the wrong resident (Resident #1) during the morning medication pass. The progress note further identified that Advanced Practice Registered Nurse (APRN) #1 was notified and recommended to hold Resident #1 ' s scheduled morning medications, to monitor vital signs, and to monitor for sedation or change in mental status every 2 hours for 24 hours. The note further identified Resident #1 and his/her family were notified and LPN #1 was educated on the 5 rights of medication administration prior to restarting the medication pass. The note indicated that Resident #1 ' s mental status was at baseline and vital signs were monitored throughout the shift. Review of the Medication Administration Record for October of 2024 identified that Resident #1 had an allergy to Aspirin and NSAIDS. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DNS on 11/20/24 at 10:00 AM identified that on the morning of 10/11/24, LPN #1 administered Resident #14 ' s medications to Resident #1 in error. The DNS indicated that Resident #1 was evaluated by APRN #1 after the medication error and monitoring protocol was initiated to include monitoring of vital signs and neuro-checks every 2 hours for 24 hours. The DNS was unable to provide documentation that neuro-checks were completed as directed by APRN #1 and further identified that neuro-checks should have been completed. The DNS indicated that LPN #1 received education prior to continuing with the medication administration pass but was unable to provide documentation that education was provided. The DNS identified he did not obtain a written statement from LPN #1 regarding the medication error and did not complete a Medication Error Occurrence Record according to the facility policy. The DNS identified that agency nurses do not receive orientation to the facility. Interview and record review with MD #1 on 11/20/24 at 1:30 PM, identified that the 10/11/24 medication error incident was a significant medication error due to the medications administered to Resident #1. MD #1 further identified that Resident #1 needed to be monitored closely and neuro-checks should have been monitored as directed by the APRN. MD #1 identified that the facility failed to provide him with a Medical Error Occurrence Record according to facility policy. Interview with APRN #1 on 11/20/24 at 3:30 PM identified he was aware of the 10/11/24 medication error. APRN #1 identified he immediately went to assess Resident #1 after he was notified of the medication error because the combination of medications administered could have caused altered mental status, low blood pressure and sedation. APRN #1 identified that he initiated a monitoring protocol directing Resident #1 to be monitored every 2 hours for 24 hours. APRN #1 indicated that the medication error that occurred was a textbook definition of a significant medication error but not a clinically significant medication error because Resident #1 remained clinically stable. APRN #1 identified that he was not aware that neuro-checks were not monitored as directed but identified that neuro-checks should have been monitored every 2 hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 11/25/24 at 1:47 PM identified that she was assigned to administer morning medications to Resident #1 on 10/11/24. LPN #1 identified that she went into the wrong room and administered Resident #14 ' s medications to Resident # 1 in error. LPN #1 identified that Resident #1 was not wearing a name identification bracelet. LPN #1 further identified that she called Resident #1 by the wrong name, Resident #1 did not respond to the name, but she assumed that she had the correct resident and administered the medications. LPN #1 identified that after administering medications to Resident #1, she realized that she administered medications to the wrong resident secondary to Resident #1 not having an ordered medical device which she would have needed to monitor. LPN #1 reported the medication error when she realized she administered medications to the wrong resident. LPN #1 identified that APRN #1 assessed Resident #1 and verbally instructed her to monitor Resident #1 every 2 hours for respiratory distress, lethargy, change in vital signs and to notify him of any change in vital signs. LPN #1 identified that Resident #1's systolic blood pressure dropped by 15 to 20 mmHg within the first two hours, which she reported to the DNS and APRN #1. Additionally, LPN #1 reported that she did not receive any form of medication administration re-education prior to continuing with her medication pass. LPN #1 indicated that she asked the DNS if she should write a statement and a progress note in the clinical record, regarding the medication error, but the DNS declined and stated he would complete the medication error statement, and a progress note for the incident. LPN #1 identified that she failed to follow the 5 rights of medication administration while administering medications to Resident #1 because she did not use any resident identifier to confirm she was administering medications to the right resident. LPN #1 identified that she should have verified the picture on electronic medical record or confirmed resident identity with another staff member when she realized Resident #1 had no name identification bracelet. Interview with the DNS on 11/25/24 at 2:55 PM, identified he could not explain why he did not allow LPN #1 to provide a written statement, or a progress note in the clinical record related to the medication error incident. Interview on 11/25/24 at 3:10 PM with the Administrator indicated that the failure to obtain a statement from LPN #1 regarding the medication error on 10/11/24 was a learning experience indicating a statement should have been obtained. Subsequent to surveyor inquiry of provider documentation related to the 10/11/24 medication error, on 11/26/24 at 12:09 PM, APRN #1 entered an APRN progress note which included documentation of the 10/11/24 medication error. The APRN progress note was entered into the medical record 47 days late. Review of facility policy, Medication Errors Occurrence Reporting, identified in part, if a medical and or medication error is detected, the individual detecting it will complete the Medication Variance Event . The completed Medical Error Occurrence Record will be reviewed the next business day and signed by the risk manager, Administrator and the Director of Nursing. The completed Medical Error Occurrence Record will be reviewed by the medical Director. All errors will be reviewed and evaluated with the goal of identification of risk and or gap analysis to determine correction, systematic changes when indicated, in-service and education and appropriate follow up with monitoring.