STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075309	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwich Woods Rehabilitation	1165 King Street Greenwich, CT 06831

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 documentation, review of facility policy/procedures and interviews for two of two sampled residents (Residents #9 and #336) reviewed for choices, the facility failed to ensure the resident's choices were accommodated when the resident requested to go to bed, and staff did not assist the resident for four hours and failed to ensure menu choices were provided at mealtime. The findings include: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty walking, abnormal posture, pain, and peripheral neuropathy. The quarterly MDS assessment dated [DATE] identified Resident #9 had intact cognition, required partial to moderate assistance with personal hygiene, required total dependent with transfers (chair to bed/bed to chair), bed mobility, toileting, dressing, and utilized a wheelchair for mobility. The care plan dated 1/27/25 identified Resident #9 had an ADL (activities of daily living) function compromise and required substantial and maximal assist with transfers. Interventions directed extensive assist of 2 with bed transfers, extensive assist of 1 with dressing, personal hygiene, bed mobility, and toileting. The physician orders dated 3/1/25 - 3/12/25 directed to transfer with extensive assist of 2. The nurse's note dated 3/1/25 - 3/12/25 failed to reflect documentation for 3/4/25 on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. Review of the nurse aide's late loss ADL report dated 3/1/20 - 3/12/25 failed to reflect documentation for 3/4/25 on the 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. Review of the nurse aide's point of care ADL category report dated 3/1/25 - 3/12/25 failed to reflect documentation for 3/4/25 on the 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. Review of the concern/complaint form dated 3/5/25 identified Resident #9's representative had concerns regarding Resident #9 being put to bed late and no one answering his/her call light. The investigation identified NA #7 was coached because she did not put Resident #9 to bed in a timely manner. NA #7 was in-service on putting residents to bed and answering call lights in a timely manner. A discussion with the 3:00 PM - 11:00 PM shift nursing staff regarding putting residents to bed in a timely manner. The resident representative was satisfied with the resolution. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An e-mail statement by the resident representative dated 3/5/25 at 2:26 PM identified Resident #9 told him/her that he/she had the worst night. Apparently, nobody put Resident #9 to bed until midnight and fully clothed. The night nurse had finally answered Resident #9 call light and explained that there was nobody to help him/her for another half an hour. Resident #9 indicated he/she did not get much sleep. Resident #9 indicated he/she hates going to bed at night because he/she never knows who's going to be assigned to him/her and what type of care they will provide. The resident representative indicated it all goes back to the shortage of staffing and resident not getting care. The resident representative indicated it is a travesty. During the Resident Council meeting on 3/10/25 at 12:30 PM Resident #9 identified the night (3/4/25) the president gave his speech he/she was put back to bed at midnight. Interview with the DNS on 3/10/25 at 1:15 PM identified was aware of the issue. The DNS indicated she was notified via an e-mail on 3/5/25 at 2:26 PM from the resident representative. The DNS indicated a concern/complaint form was initiated and an investigation was conducted. The DNS indicated the investigation concluded that the nurse aide that was assigned to Resident #9 failed to provide care to the resident on 3/4/25 on the 3:00 PM - 11:00 PM shift. The DNS identified NA #7 indicated she was not aware that Resident #9 was on her assignment, and she did not provide care to the resident. Interview with Resident #9 on 3/10/25 at 1:40 PM identified the night (3/4/25 on the 3:00 PM - 11:00 PM shift) the president gave his speech was the night the nurse aide did not put him/her to bed. Resident #9 indicated he/she rang the call light, and no one answered. Resident #9 indicated he/she was put to bed at midnight, and he/she was very upset. Resident #9 indicated he/she notified his/her representative of the issue. Resident #9 indicated he/she likes to go to bed after supper around 7:00 PM and no later than 8:00 PM. (Resident #9 was put to bed 4 hours later). Interview with the DNS on 3/18/25 at 9:10 AM identified the expectation of the facility is that all nurse aides read their assignment thoroughly and provide resident care in a timely manner. The DNS indicated NA #7 should have put Resident #9 to bed in a timely manner. The DNS indicated all nursing staff on the 3:00 PM - 11:00 PM shift were in-service. Interview with NA #7 on 3/19/25 at 1:25 PM identified she has been employed by the facility since 9/2024. NA #7 indicated she works on the 3:00 PM - 11:00 PM shift and she is a float. NA #7 indicated she does not remember if Resident #9 was on her assignment. NA #7 indicated if she did not put Resident #9 to bed it was a mistake. NA #7 indicated she did not provide any care to Resident #9. Although attempted, an interview with NA #1, NA #8, NA #10, LPN #6, and RN #10 was not obtained. Review of the facility Activities of Daily Living (ADL) policy identified residents will receive services to optimize their level of independence with activities of daily living and the assistance they need to complete activities of daily living. The resident will receive assistance daily with hygiene, dressing, bathing, feeding, transfer, ambulation, and elimination as necessary. Resident are encouraged to make choices regarding their care including the timing of care and choice of clothing and activities. Review of the facility Resident's [NAME] of Rights identified you have the right to be treated equally with other residents in receiving care and services, and regarding transfer and discharge, regardless of the source of payment for your care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #336's diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, atrial fibrillation, and heart failure. The Nursing Admission assessment/observation dated 3/7/25 identified Resident #336 was alert and oriented to person, place and time, had no impairment to upper and lower extremities and utilized a walker for mobility. The care plan dated 3/7/25 identified Resident #336 had potential for ADL function compromise with interventions that included resident was independent with meal set-up. The physician's order dated 3/7/25 directed regular diet with thin liquids. Observation on 3/10/25 at 12:56 PM identified Resident #336 was seated in his/her wheelchair with the overbed table positioned in front of him/her. On top of the overbed table was the lunch tray which contained a plate with a sandwich made with lettuce and bacon on tossed bread, a cup of hot water, a small carton of milk, small container with yellow-orange colored fruit, unopened tea bag, sugar packets, glass with yellow liquid, utensils, and napkins. On the resident's meal ticket, it indicated coffee, milk, no cheese, no onion, ginger ale zero, and BLT (bacon, lettuce and tomato) with mayo. Resident #336 indicated that he/she was unable to eat the sandwich provided as it did not have the tomato nor the mayo which he/she had specifically requested. Resident #336 continued to identify that his/her meal trays have been wrong since being admitted to the facility and has made them aware. She further noted that they conveyed they were going to ensure he/she would receive what she had ordered moving forward. Interview with the Director of Dietary Services and the Dietician on 3/10/25 at 1:07 PM identified that there were no tomatoes on the sandwich as they did not receive any tomatoes on Friday's delivery. The Dietician identified she had spoken to the resident in the morning to discuss the menu as there was no chef salad and he/she then selected a BLT sandwich and coffee as he/she reported not wanting to have tea. She identified that this was communicated on the meal ticket and to the kitchen. The Director of the Dietary services identified that it was the kitchen staff who were responsible for placing the coffee, tea and beverages on the trays and to ensure that resident have the items they select on their meal tray. Interview with [NAME] #1 on 3/14/25 at 9:25 AM identified she had prepared the sandwich for the resident on that day and there were no tomatoes and that she had placed the mayo on the sandwich but moving forward the mayo will be placed on the side. Interview with the Director of Dietary Services on 3/18/25 at 9:15 AM identified he was not aware that there were no tomatoes and if he did, he would have gone to the store or informed the residents they had no tomatoes. He further identified that the BLT was an alternative menu and was not on the regular menu for the day. He identified that everyone on the tray line is responsible for checking and ensuring that the items selected by the residents are on their tray prior to leaving the kitchen. The Director of Dietary Services identified he did not see the mayo on the sandwich but moving forward that the mayonnaise will be placed on the side for the resident to add. He also identified that residents should get the menu items they select on their meal ticket and staff will be in-service as such. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Menus policy identified that menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Review of the Dietary Notice policy identified when resident food/fluid preferences are identified by the staff, a dietary notice should be completed allowing communication to the kitchen of the resident's choice. 47900

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility documentation, review of facility policy/procedure, and interviews for one of two sampled residents (Resident #335) reviewed for advanced directives, the facility failed to ensure consents were obtained regarding the resident's wishes regarding advance directives and decisions related to cardiopulmonary code status from the resident/responsible party. The findings include: Resident #335 was admitted to the facility in March/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia and cellulitis of the left lower limb. The admission MDS assessment dated [DATE] identified Resident #335 was moderately impaired cognition, required maximal assistance with dressing, toileting hygiene and bed mobility. The physician's order dated [DATE] directed full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive). The care plan dated [DATE] identified Resident #335 had chosen to be a full code with interventions that included the resident or responsible party will notify social service if choses to change code status. Review of Resident #335's physical chart and the electronic clinical record system both failed to identify a signed Acknowledgement of Receipt Advance Directive/Medical Treatment Decisions form signed by the resident/resident representative indicating the code status of Full Code was completed. Interview with the Charge Nurse (RN #5) on [DATE] at 11:20 AM identified that if Resident #335 had a life-threatening emergency where it would be necessary to provide CPR or withhold CPR, she would look in the physical chart under the advance directive tab as this is the most accurate place than the physician's order to determine the resident's code status. RN #5 reviewed the physical chart and noted Resident #335 did not have a completed Acknowledgement of Receipt Advance Directive/Medical Treatment Decisions form signed by the resident/resident representative. RN #5 identified the Acknowledgement of Receipt Advance Directive/Medical Treatment Decisions form should be completed on admission and based on what the resident/resident representative selected the physician's order would then be written. Subsequent to surveyor's inquiry, an Acknowledgement of Receipt Advance Directive/Medical Treatment Decisions form for Resident #335 was completed and signed by the resident on [DATE] indicating a code status of do not resuscitate (DNR) and do not intubate. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Supervisor (RN #8) who was the admitting nurse on [DATE] at 9:32 AM identified the advance directive form was not completed at the time of admission. RN #8 identified that Resident #335 was capable of completing the advance directive paperwork but when she went to the resident to sign the form, he/she was asleep. She added that she then utilized the code status written on the hospital discharge paperwork to determine what the code status was until the resident/responsible party signed the form. RN #8 identified the hospital discharge code status is often used when the resident is unable to complete the form, and the facility is unable to reach the responsible party. RN #8 identified on that evening she had received a total of three admissions and had passed on in report that Resident #335 advance directive form was not completed and for the next shift to follow-up. Review of the Advance Directives policy and procedures identified Advance Directive are discussed with the resident and/or primary decision maker by a licensed nurse at the time of admission. The policy further identified that the resident and/or primary decision maker will be asked to sign the appropriate form according to his/her wishes which will be maintained in the clinical record and the physician will then sign the Advance Directive form.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility documentation, review of facility policy/procedure and interviews for one of two sampled residents (Resident #62) reviewed for Pre-Admission Screening and Record Review (PASRR), the facility failed to ensure that a Level 2 determination was completed when the 30-day approval stay expired. The findings include: Resident #62 was admitted to the facility in January/2025 and had diagnoses that included anxiety disorder, type 2 diabetes mellitus, and squamous cell carcinoma The admission MDS assessment dated [DATE] identified Resident #62 was cognitively intact, independent with personal hygiene, and was dependent on care with toileting hygiene, lower body dressing, and transfers. Review of the PASRR screen level 1 dated [DATE] identified Resident #62 was approved for 30 days. The Psychiatric APRN note dated [DATE] identified Resident #62 has a history of bipolar disorder. Interview with the Social Worker (SW) on [DATE] at 12:20 PM identified she is responsible for submitting the request for PASRR screens to the PASRR agency. She further identified Resident #62 was approved for a 30 day stay which ended on [DATE] but she had not requested for a PASRR screen Level 2 (rescreen) because the approved time expired on [DATE]. The SW identified that she submitted the request for the screen on [DATE], after the request was made by the surveyor for the information. She added that the resident stayed beyond the 30 days (discharged [DATE]) and had a diagnosis of bipolar so a level 2 PASRR request should have been submitted prior to the expiration date. She identified she was the only Social Worker in the building and had expressed to both the DNS and Administrator that she was behind and needed some assistance. Interview with the DNS and the Administrator on [DATE] at 1:18 PM identified the social worker was responsible for submitting request for PASRR. They both identified, they were only aware that she was behind with MDS assessment and needed assistance, which they provided. However, they were unaware that she needed any other assistance or was behind in any other areas of her work. Review of the Pre-admission Screening and Resident Review (PASRR) policy and procedure identifies a level of Care are also required to determine the medical necessity for individuals continued stay at a Skilled Nursing facility. In addition, if a resident is admitted with a short-term level 1 or level of care add them to facility PASRR/Ascend Smart sheet tracker and ensure to place a due date for 10 days prior to expiration date. The policy and procedure further identified that a level of care request for continued approval must be submitted no later than 10 days prior to current approval expiration, and up to 15 days prior to current level of care approval expiration.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of clinical records, review of facility policy/procedures and interviews for two of three sampled residents (Resident #33 and Resident #336) observed with medications at the bedside, the facility failed to ensure that medications were administered according to acceptable standards of practice and the facility failed to ensure that medication was not left at the resident's bedside for a resident who is without an order or assessment for self-administration. The findings include: 1. Resident #33's diagnoses included chronic diastolic congestive heart failure, hypoxemia, and acute cough. The quarterly MDS assessment dated [DATE] identified Resident #33 had severe cognitive impairment, required moderate assistance with toileting hygiene, and supervision or touch assistance with dressing and personal hygiene. The assessment further identified the resident uses a walker with supervision for ambulation. The care plan dated 3/13/25 identified Resident #33 had a memory/recall problem related to low BIMS (brief Interview for Mental Status) score with interventions that included ensure resident's areas are free of hazards and encourage assistive devices available and in good condition. The physician's order dated 2/13/25 directed medications may not be self-administered. The physician's order dated 3/6/25 directed Guaifenesin liquid 100 milligram/5mililiter (mg/ml) to give 10 ml by mouth four times daily at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. Observation on 3/10/25 at 10:53 AM identified Resident #33 was out bed and seated in the wheelchair with the overbed table positioned directly in front of the resident, and on top of the overbed table was a medicine cup containing approximately 15ml of a reddish liquid and other personal items in which resident indicated the nurse left the medicine cup for him/her to take. Observation on 3/10/25 at 11:12 AM with the Charge Nurse (RN #5) identified Resident #33 was out bed and seated in the wheelchair with the overbed table positioned directly in front of the resident, and on top of the overbed table was a medicine cup containing 15ml of a reddish liquid and other personal items. RN #5 identified the liquid in the medication cup as the resident's cough medicine. RN #5 then removed the medicine cup and brought it to the medication cart to discard. Interview with RN #5 on 3/10/25 at 11:12 AM identified she brought the resident's medication in the room when the resident had to use the bathroom and was to return to check if the resident had taken the medication, but she did not return. RN #5 identified Resident #33 did not have a medication self-administration order and she should not have left the medication for the resident to take without being present. RN #5 signed off in the Medication Administration Record indicating that she had administered the medication to Resident #33 but should have only signed when the resident had taken the medication. She added that she then changed the MAR subsequent to the surveyor's inquiry. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Supervisor (RN #3) on 3/12/25 at 11:37 AM identified the nurse should stay with the resident when administering medication for safety and to ensure they took the medication. Interview with the DNS on 3/14/25 at 12:50 PM identified the nurse should watch the resident take the medication and staff was provided education. Review of the General Guidelines for Medication Administration policy identified the resident is always observed after administration to ensure that the dose was completely ingested. The policy further identifies that residents are permitted to self-administer medications when specifically authorized by the attending physician and in accordance with the procedures for self-administration of medication. 2. Resident #336's diagnoses included chronic obstructive pulmonary disease (COPD) with acute exacerbation, atrial fibrillation, and heart failure. The Nursing Admission assessment/observation dated 3/7/25 identified Resident #336 was alert and oriented to person, place and time, had no impairment to upper and lower extremities and utilized a walker for mobility. The care plan dated 3/11/25 identified Resident #336 had altered respiratory status related to pneumonia complicated by COPD with interventions that included to administer mediation/antibiotic as ordered and to observe alterations in respiratory status and report abnormalities to MD. The physician's order dated 3/7/25 directed Albuterol Sulfate HFA aerosol inhaler 90 microgram (mcg)/actuation to inhale 2 puffs into lungs every four hours as needed (PRN) for COPD. The physician's order dated 3/7/25 directed medications may not be self-administered. Observation on 3/10/25 at 10:13 AM identified Resident #336 was out bed and seated in the wheelchair with the overbed table positioned directly in front of the resident, and on top of the overbed table was an opened medication box containing albuterol sulfate HFA aerosol inhaler 90 microgram (mcg)/actuation, television remote, water pitcher, and other personal items. Resident #336 identified the nurse left the medication. Review of the Medication Administration Record from 3/7/25 to 3/11/25 failed to identify that the medication was administered. Observation on 3/10/25 at 11:51 AM with the Charge Nurse (RN #6) identified Resident #336 was out bed and seated in the wheelchair with the overbed table positioned directly in front of the resident, and on top of the overbed table was an opened medication box containing albuterol sulfate HFA aerosol inhaler 90 microgram (mcg)/actuation, water pitcher, and other personal items as resident identified that he/she had taken the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #6 on 3/10/25 at 11:52 AM identified the resident did have a PRN physician's order for the medication but the medication should not have been left in the resident's room. She also identified that the medication was dispensed from the facility's pharmacy. RN #6 further identified that Resident #336 did not have an order for medication self-administration, and she had not administered this medication to the resident. Interview with the Nursing Supervisor (RN #3) on 3/12/24 at 11:37 AM identified that if a resident wanted to administer their medication a self-administration assessment would need to be completed, and the medication would be stored in the medication cart. Review of the General Guidelines for Medication Administration policy identified the resident is always observed after administration to ensure that the dose was completely ingested. The policy further identifies that residents are permitted to self-administer medications when specifically authorized by the attending physician and in accordance with the procedures for self-administration of medication. Review of the Medication, Self-Administration and Discharge Program policy identified that an individual may self-administer medications only after the interdisciplinary team has determined that this practice is safe.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observation, review of clinical records, review of facility documentation, review of facility policy, and interviews for one of five sampled residents (Resident #62) reviewed for unnecessary medication the facility failed to ensure that physician's orders were implemented and completed as prescribed by the physician and one of seven residents (Resident #335) reviewed for accidents the facility failed to ensure that medications were administered as prescribed by the physician. The findings include: 1. Resident #62's diagnoses included anxiety disorder, type 2 diabetes mellitus, and squamous cell carcinoma. The admission MDS assessment dated [DATE] identified Resident #62 was cognitively intact, independent with personal hygiene, and was dependent on care with toileting hygiene, lower body dressing, and transfers. The assessment further identified the resident utilized antipsychotic (used for managing mental health disorders) medication which the assessment noted to be of the high-risk drug classes. Review of physician orders from January/2025 through March 12, 2025, directed to administer Risperidone 1 milligrams (mg) two tablets by mouth twice daily at 9:00 AM and 9:00 PM (used to treat bipolar disorder). Review of the Medication Administration Records (MAR) from January/2025 through March/2025 identified anti-psychotic drug use and to observe closely for significant side effects: sedation, drowsiness, dry mouth, extra pyramidal reactions, postural hypotension, loss of appetite, edema and urinary retention. The physician order dated 2/2/25 directed orthostatic blood pressure (BP) monitoring once weekly on Monday on the day shift for four weeks, lying and standing or lying and sitting, if unable to stand, and to notify the provider for systolic change greater than 20 millimeters of mercury (mm Hg) and/or diastolic change greater than 10 mm Hg and to document BP readings in progress note. The Pharmacy Medication Regimen Review by the Consultant Pharmacist dated 1/20/25 identified a recommendation to consider adding an order for orthostatic blood pressure (BP) monitoring once weekly for four weeks, lying and standing or lying and sitting if unable to stand and notify MD for systolic change greater than 20 millimeters of mercury (mm Hg) and/or diastolic change greater than 10 mm Hg, which APRN #1 signed and agreed on 2/2/25. Review of the MAR from February/2025 through March 12, 2025, identified nurses initial on the date the orthostatic BP was ordered to be completed, which indicated that the order was completed. However, a review of Resident #62's clinical records failed to identify the orthostatic blood pressure that was taken as ordered by the APRN #1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the Nursing Supervisor (RN #3) on 3/18/25 at 12:15 PM failed to identify the orthostatic BP readings after reviewing resident #62's nursing progress notes, vitals and MAR. RN #3 identified when the order was transcribed, the task option should have been trigger for the nurse to document the reading. She further identified the order did indicate to document the BP readings in the progress note, therefore the charge nurse should have documented the readings in his/her note as the physician's order had indicated. Interview with the Charge Nurse (RN #5) who worked on some of the Mondays when the Orthostatic BP was to be completed on 3/18/25 at 1:50 PM identified when she signs the MAR it indicates that the order was completed, or the medication was administered, or she would write a note if it was not completed. RN #5 was asked where she would document the orthostatic BP and her response was there was no place on the MAR to document the readings and if the order was inputted correctly, they would have been written there. She was then asked if orthostatic BP was taken, and she did not respond. She further identified she could not recall if she had written them in her nurse's note or in the vital section of the electronic record and kept indicating that the order was inputted incorrectly. Interview with APRN #1 on 3/18/25 at 1:20 PM identified that normally she puts in her orders into the electronic health record system and added that she did enter the orders for Resident #62 on 2/2/25. The APRN #1 identified she does not know how to place the drop down for the nurses to input the BP, hence why she added to the order that the BP reading be placed in the progress note. She added that orthostatic blood pressure monitoring was ordered as the resident was on an antipsychotic medication which could cause orthostatic changes to resident's BP. Further, she indicated that there wasn't a need to follow-up whether the orthostatic blood pressure was completed because if there was a concern with the reading the facility would have notified her as stated in the order. Interview with the DNS on 3/18/25 at 2:10 PM identified that 11-7AM shift nurse completes a 24-order check to ensure orders are inputted correctly. The DNS further identified if the charge nurse was responsible for reviewing and completing a physician's order as directed and if he/she signs it means that the order was completed so the BP should have been documented as directed. Review of the Doctor's Order policy identified that the facility would meet all current standards of nursing practice in accepting, transcribing and executing doctor's orders to ensure compliance with current standards of nursing practice a ensure the resident's needs are met. 2. Resident #335's diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypoxia and cellulitis of the left lower limb. The admission MDS assessment dated [DATE] identified Resident #335 was moderately impaired cognition, required maximal assistance with dressing, toileting hygiene and bed mobility. The care plan dated 3/10/25 identified Resident #335 had COPD related to recent acute respiratory failure and it may be hard for the resident to breathe at times with interventions that included offer to provide resident with nebulizer treatments, and if increased coughing, respiratory rate, decreased oxygen levels, trouble breathing, increased mucus production could indicate an exacerbation of the resident COPD. The physician's order dated 3/5/25 directed Trelegy Ellipta (Fluticasone-umeclidin-vilanter) 200-62-5-25 micrograms (mcg) to inhale one puff once daily at 9:00 AM (used to treat COPD). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic Medication Administration Record (MAR) identified the following: On 3/6/25 and 3/7/25 the medication was not administered with a note that indicated the resident was a new admission and awaiting pharmacy delivery. On 3/8/25, 3/9/25, 3/10/25, and 3/11/25 the medication was administered On 3/12/25 and 3/13/25 the medication was not administered with a note that indicated drug/item unavailable. Review of Resident #335 clinical records failed to identify the provider was updated regarding Trelegy medication was unavailable until 3/13/25. Interview and observation of the Medication Cart on unit with the day shift Nursing Supervisor (RN #3) and the Charge Nurse (LPN #12) on 3/12/25 at 11:30 AM failed to identify the Trelegy medication within the cart. LPN #12 identified that the medication was not there as she was unable to administer the medication in the morning. LPN #12 added she looked in the medication storage room and was unable to locate the medication. RN #3 indicated that she had spoken to the pharmacy regarding the medication to clarify the duplicate order and that the pharmacy would deliver the medication. Interview with the Pharmacist #1 on 3/14/25 at 9:28 AM identified Trelegy was not dispensed to the facility due to a duplicate warning which was clarified on 3/7/25 and due to a billing issue. However, she added that the pharmacy sent an email to the facility (usually to the DON and ADON) on 3/7/25, 3/9/25, 3/10/25, 3/11/25, and 3/12/25 for authorization to bill the facility for the medication, which the pharmacy received no response from the facility. Pharmacist #1 identified if the resident was not receiving the medication he/she could have an exacerbation of symptoms, and it would not be immediate as the medication was a long-acting inhaler. Interview with the DNS on 3/14/25 at 12:50 PM identified she had received the notification from the pharmacy regarding Resident #335 inhaler. She added that the email sent by the pharmacy was also sent to the nursing supervisor's, however, she usually prints the email and gives it to the nursing supervisor to follow-up. The DNS was unable to locate the copy of the pharmacy notification she had provided to the nursing supervisor after searching through a folder in her office where she kept her records. Interview with RN #3 on 3/14/25 at 12:19 PM identified she was unable to recall receiving any information from the pharmacy from the DNS as if she did, she would have followed up as she was looking for the medication. RN #3 added that she had called the pharmacy on 3/12/25 and discovered that the medication was not sent as it was not covered by the resident's insurance, and this would need approval from the DNS. She further added that the resident's family was notified, and they picked up the medication from the local pharmacy and brought it to the facility. RN #3 was asked if the provider was notified throughout the time-period the resident was not getting the medication, which she responded that the charge nurse was responsible for notifying the provider if the medication was unavailable. She further indicated that she then notified the provider on 3/13/25 regarding the resident not receiving the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Charge Nurse (RN #6) on 3/17/25 at 10:20 AM identified she did not notify the provider as she thought the medication would have been delivered by the pharmacy to administer the medication. However, she added that the provider should have been notified as the medication was not available to administer. Interview with the Nursing Supervisor (RN #7) on 3/17/25 at 11:05 AM identified she had worked on 3/9/25 and had signed the MAR, indicating Trelegy was administered. She further identified she was unable to recall if the medication was there and had not notified the provider regarding the resident not receiving the inhaler but should have if the medication was unavailable. Review of the General Guidelines for Medication Administration policy identified if 3 consecutive doses of vital medication are withheld or not available, the physician is notified and nursing documents the notification and physician's response. The policy further identifies the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.

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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** 42117 Based on review of the clinical record, review of facility policy, and interviews for two of four sampled residents (Resident #36 and #286) reviewed for pressure ulcer/injury, the facility failed to ensure weekly skin audits were completed per the physician's order. The findings include: 1. Resident #36's diagnoses included dementia, and pressure ulcers on the right and left buttock. The quarterly MDS assessment dated [DATE] identified Resident #36 had severely impaired cognition, was always incontinent of bowel and bladder and required total assistance with eating, bed mobility, toileting, dressing, and personal hygiene. Additionally, Resident #36 had one stage 4 pressure ulcer. The care plan dated 12/10/24 identified Resident #36 had a coccyx pressure ulcer. Interventions included pressure reducing mattress and cushions and provide incontinent care with barrier cream as needed. Physician's orders dated 12/19/24 directed to perform weekly body audits on shower days Tuesday 3:00 PM to 11:00 PM shift and document under skin observation section in the EMR. Review of the weekly body audits dated 12/17/24 to 3/4/25 did not reflect the body audits were completed on 12/31/24, 1/14, 2/4, 2/11, 2/18, and 2/25/25. There were 6 missing out of 12 weeks. Interview with the DNS on 3/19/25 at 11:58 AM indicated that the charge nurses are responsible for performing the weekly body audits on the resident's shower day and document in the EMR. The DNS indicated that Resident #36 was to have a weekly body audit completed and documented on Tuesdays 3:00 PM to 11:00 PM shift. Interview and clinical record review with the DNS on 3/19/25 at 12:20 PM was unable to provide documentation to reflect that the weekly body audits had been completed during that time frame. Review of the facility Body Audits identified residents will have a body audit performed weekly to ensure that skin is intact and without impairment. Body audits are scheduled to coincide with shower days. Body audits are completed by the licensed nurse assigned to that unit. Body audits are signed as done on the body audit form. Any area of skin that is not intact or is impaired will be followed up per the facility protocol. 2. Resident #286 was admitted to the facility on [DATE] with diagnoses that included zoster without complications, hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side, benign hyperplasia with lower urinary tract symptoms, and atopic dermatitis. A physician's order dated 12/2/24 directed to complete a body audit weekly, on Tuesday; 7:00 AM-3:00 PM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS dated [DATE] identified Resident #286 had moderately impaired cognition, was dependent for personal and toilet hygiene, required substantial/maximal assistance rolling left to right and lying to sitting on the side of the bed, had an indwelling catheter, was frequently incontinent of bowel, and had no pressure ulcers/injuries. The APRN note dated 12/23/34 at 8:00 AM identified Resident #286 was seen for pain management status post shingles treatment and pain management was reviewed. The patient was admitted to the facility for short term rehabilitation following a recent hospitalization for fever and abdominal shingles. The review of systems identified a left buttock blister with treatment recommendations directing to cleanse the wound, apply Calcium Alginate, secure dry/clean dressing, and change daily and as needed. The care plan dated 12/30/25 identified Resident #286 had fragile skin. Interventions included handling skin with extra care, inspecting skin tears, and providing dressing and skin tear treatments as ordered. Review of the December 2024 through February 2025 weekly body audits documentation failed to identify weekly body audits were completed during the week of: 12/31/24, 1/4/25, 2/4/25, and 2/11/25. Review of the nurse's notes on 12/31/24, 1/4/25, 2/4/25, and 2/11/25 failed to identify that a body audit was completed or that Resident #286 had refused a shower or body audit. Interview and clinical record review with the RN Supervisor (RN #3) on 3/19/25 at 12:13 PM identified Resident #286 does not ambulate and is incontinent of bowel, which places him/her at risk for skin issues and has current skin conditions with treatments in place. RN #3 indicated that she was not aware that Resident #286's weekly body audits were not completed on 12/31/24, 1/4/25, 2/4/25, and 2/11/25, and she was not notified of any refusals. RN #3 identified that weekly body audits are to be completed by the charge nurse on the resident's first shower day, and she would expect to be notified if the skin audit was not completed, for any reason. Interview and clinical record review with the DNS on 3/19/25 at 12:02 PM identified that she was not aware that Resident #286 did not have documented body audits completed on 12/31/24, 1/4/25, 2/4/25, and 2/11/25. The DNS indicated that she would expect weekly skin audits to be completed on the resident's shower day, by the floor nurse, per the facility policy. Interview and clinical record review with the charge nurse (RN#5) on 3/19/25 at 12:41 PM identified that she could not recall if she was the nurse assigned to Resident #286 on 12/31/24, 1/4/25, 2/4/25, or 2/11/25, but the expectation is that body audits are completed weekly on the resident's shower day and documentation would be completed on the body audit form. RN #5 indicated that she could not recall if Resident #286 had refused any body audits, but if he/she had refused a shower or bed bath she would have documented the refusal in the chart, notified the RN Supervisor, educated the resident, and reapproached at a later time. Although attempted, an interview with the wound nurse was not obtained. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Body Audit policy directs that residents will have a body audit performed weekly to ensure the skin is intact and without impairment. Body audits are scheduled to coincide with shower days by the licensed nurse assigned to that unit and body audits are signed as done on the Body/Oral Check form. 47457 r

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on clinical record review, observations, review of facility policy/procedures and interviews for one sampled resident (Resident #24) reviewed for pressure ulcer/injury, the facility failed to ensure the bilateral hand rolls/rolled wash cloths were in place as ordered. The findings include: Resident #24's diagnoses included multiple sclerosis, deformity of the wrist, deformity of the hand and right sided weakness. The quarterly MDS assessment dated [DATE] identified Resident #24 was severely cognitively impaired, was dependent with bed mobility, transfers, bathing and personal hygiene. The care plan dated 2/1/25 identified Resident #24 was at risk for skin breakdown/redness related to bilateral hand deformities (contractures), with interventions that included the application of bilateral hand rolls or rolled wash cloths at all times. The nursing assistant (NA) care card identified left and right-hand rolls (can utilize wash cloths) to be worn at all times. Physician's orders for March 2024 directed that bilateral hand rolls and or rolled wash cloths be placed in the resident's hands, to be worn at all times. Remove for skin checks and hygiene, and check every shift, per facility policy. Observation on 3/10/25 at 10:43 AM identified Resident #24's air mattress was set at 200, and the resident had no hand rolls or rolled washcloths in place. Observation on 3/12/25 at 11:28 AM identified, Resident #24 did not have hand rolls nor rolled washcloths in place. Bilateral heel lift boots were on. Left foot observed with thick scaley like areas covering the top and side of the left foot and slightly on the lower ankle area of the left foot. Scaley skin appeared brown to dark brown in color. Observation on 3/14/25 at 9:54 AM of Resident #24 identified, there were no hand rolls or wash cloths placed for the resident as ordered by the physician. Interview on 3/14/25 at 9:58 AM with LPN #4, indicated, NA #3, had just been getting supplies ready to provide care for Resident #24, that's why the heel lift boots were off and possibly why the hand rolls were not in place. The hand rolls/splints should be worn at all times, except when providing skin care or changing them when they are soiled. The heel lift boots would be put on after care is provided as ordered by the physician. Interview on 3/14/25 at 10:03 AM with RN #3 (7-3 supervisor), indicated the supervisor was not sure why the hand rolls or splints for the resident's hands were not in place. RN #3 was unable to find or locate any hand rolls or splints for the resident in the resident's room, closet or dressers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, a soft pillowcase was placed by RN #3 to Resident #24's left hand. RN #3 was unable to place a rolled washcloth or rolled soft pillowcase to Resident #24's right hand, due to right hand and finger deformity and stiffness. RN #3 explained, due to the contracture, it could cause pain to the resident. RN #3 spoke to one of the Occupational Therapists, OT #1 to update him/her regarding the inability to place a rolled wash cloth to the right hand. Occupational therapy to evaluate due to inability to place the hand roll to the right hand. Interview on 3/14/25 at 10:08 AM with NA #3, indicated there were hand rolls in each hand, that were removed by NA #3 as they were soiled. NA #3 along with RN #3 attempted to place a rolled washcloth and or soft rolled pillowcase in the right hand and were unsuccessful at placing it, due to right hand contractures. NA #3 then indicated bilateral clean hand rolls would have been placed once care was provided/completed. Interview on 3/14/25 at 11:55 AM with OT #1, indicated OT had been working with Resident #24 and is very familiar with the resident. OT #1 also indicated the resident had been followed by all 3 OT's ongoing, due to bilateral hand contractures and wheelchair positioning needs. Initially, splints were utilized then carrots (carrot shaped splints) due to the ongoing bilateral hand contractures. Resident #24 occasionally resists the placement of the washcloths subsequently; the staff may have found it difficult to place the washcloths at times. This has been an ongoing issue with the staff, education has been provided to staff on how to place the washcloths. Wash cloths are utilized now, as the splints and carrots are no longer appropriate due to the worsening of the hand contractures. OT #1 placed wash cloths to both hands prior to the interview. OT #1 also indicated that he/she informed the resident prior to placing the washcloths and had no issues placing the washcloths today. Review of the Splint/Orthotics/Prosthetics policy identified the nursing staff will apply/remove the designated splint/orthotic/prosthetic device during the scheduled wear times. Also, the nursing staff should notify the rehabilitation department of any ill-fitting and or misplaced splint/device. Including, if the resident refused to wear any device, to notify the rehab department, physician and responsible party.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, review of facility documentation, review of facility policy, and interviews, the facility failed to ensure the second-floor windows contained mechanisms to prevent them from fully opening, presenting a safety hazard to residents residing on the unit (dementia unit). The findings include: Observation on 3/10/25 at 10:05 AM identified in room [ROOM NUMBER](a resident room), the window was fully opened, and did not contain a screen. The degree to which the window was opened presented a safety hazard to residents who were able to access the window. Interview with NA #2 on 3/10/25 at 10:10 AM indicated that she was providing care to a resident in that room with NA#1 and NA #1 opened the window because it was very hot in the room. Interview with NA #1 on 3/10/25 at 10:15 AM identified she had opened the window in room [ROOM NUMBER] because while providing care to the resident she had gotten hot. NA #1 indicated that she was aware that windows are only supposed to open a little but that for at least a month the window could be opened fully. NA #1 indicated that she opens the windows because it is hot on the second floor, and she needs the cool air. She further identified that some residents ask for their windows to be opened and indicated that she had not put it in the maintenance book for repair nor had she informed anyone. Interview with the Director of Maintenance (DOM) on 3/10/25 at 10:27 AM indicated that it was maintenance's responsibility to make sure the windows have a safety device on them to prevent the windows from opening more than 6 inches. The DOM indicated that he does not make rounds to check that the windows have the safety device he relies on the nursing staff to report it in the maintenance book. The DOM measured the open window in room [ROOM NUMBER] and it measured 17 inches high by 33 inches wide and the windowsill from the floor to the base of the window was 30.5 inches. The DOM indicated that he was not aware that this window did not have the safety device, and no one had put it in the maintenance book. The DOM indicated that the window never should be able to open that much especially on the second floor. The DOM indicated that he would have it fixed right away. The DOM indicated that most windows do not have screens, and he does not think they need them. Tour with the Director of Maintenance on 3/10/25 at 10:50 AM on the secured dementia unit on the second floor identified 8 (room [ROOM NUMBER], 253, 257, 258, 259, 260, 263, and 269) out of 17 rooms had windows that did not have the safety device to prevent the windows from fully opening. The DOM measurements of the open windows were from 17 to 22 inches high by 33 inches wide. Below the windows on the outside of the buildings contained grass or a concrete walkway. The DOM indicated that the windows had air conditioners in them that had been removed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator, DOM, DNS, and the [NAME] President of Clinical Services on 3/10/25 indicated that the second floor contained 23 residents. The Administrator identified the windows were not to open more than a maximum of 6 inches and the maintenance director was responsible for periodically checking the windows to make sure there was a safety device on them. The Administrator indicated that there was no documentation of the periodical checks. The VP of Clinical Services indicated that maintenance will immediately go around and repair the 8 windows that were identified on the second floor and then audit all the rest of the windows in the facility on first and second floor. The VP of Clinical Services indicated that nursing will immediately start education with staff regarding the windows must have a safety device to prevent windows from opening more than 6 inches and if a safety device was missing to remove the residents from the room for safety and call maintenance immediately to repair it. The VP of Clinical Services indicated that if maintenance was not in the facility residents would be removed and someone would stay in that room until maintenance came in and repaired the window. The VP of Clinical Services indicated that since the beginning of October when the air conditioners were removed there have not been any residents that have attempted to exit the windows that she was aware of. The VP of Clinical Services identified that she was aware that all residents on the second floor were at risk of an accident or incident occurring. Interview with LPN #1 on 3/10/25 at 12:10 PM indicated there were 23 residents on the secured unit and there were 7 residents that ambulate independently on the secure dementia unit and there were 3 residents that ambulate independently with supervision but do get up unassisted at times. Interview with the Director of Maintenance on 3/10/25 at 1:30 PM identified when the air conditioners were removed by his maintenance guys in the first 2 weeks of October, they did not install the safety devices to the windows. The DOM indicated that he should have informed them to do that and then checked the windows after removal to make sure there was a safety device installed but he was his fault he did not do that. Interview with the Administrator on 3/10/25 at 1:40 PM identified that all windows in resident areas cannot open more than a maximum of 6 inches. The Administrator indicated that he was not aware of the issue regarding the windows being able to open fully on the second floor. The Administrator identified there was not a system in place for routine checking and monitoring of the windows for the safety devices in the facility unless it was reported by nursing to maintenance. Interview with VP of Clinical Services on 3/10/25 at 1:50 PM identified that the 8 windows that were identified as not secured was repaired and the education has started. Review of the Window Opening Policy identified windows within the residents' accessible areas shall not be allowed to open more than 6 inches at any time. This limitation is in place to ensure safety, prevent unauthorized access, and maintain proper building conditions. When air conditioning units are removal from windows, appropriate stopping devices (window stoppers or locks) must be installed security and prevent the window from being inadvertently opened beyond the safe limit. Prior to the winter season, it is required that when air conditioning units are removed, the stopper or screw used to secure the window should be replaced if it has been removed during the unit's installation or removal. The stopper or screw must be inspected for wear or damage, and if needed, replaced to ensure propre window security. A training and awareness program will be provided to educate all relevant personnel on the importance of this procedure and the proper installation of the stopper or screw to maintain window security during colder months. This will be monitored and checked monthly and as needed by maintenance.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, clinical record reviews, facility policy review, and interviews for one sampled residents (Resident #51) for enteral feeding, the facility failed to ensure enteral feeding were properly labeled with date and time and discarded when appropriate in accordance to the facility policy. The findings include: Resident #51's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant hand, dysphagia, and gastrostomy. The significant change MDS assessment dated [DATE] identified Resident #51 with intact cognition, required extensive assistance with eating and had an enteral feeding tube. The physician's orders dated 2/13/25 directed to administer Jevity 1.5 calories via enteral feeding at 30 centimeters (cc) per hours in which the enteral feeding will be stop every day at 6:00 AM and resume at 10:00 AM every day. The care plan dated 2/20/25 identified Resident #51 had an enteral feeding tube to supplement food intake. Care plan interventions directed to check the placement of the enteral feeding, kept the head of bed at least 45 degree to prevent aspirations, and to provide the enteral feeding and fluid per physician orders. Observation on 3/17/25 at 9:00 AM identified Resident #51 lying in bed, with Jevity 1.5 calories with approximately 700 milliliters (ml) left in the plastic container hung in the pole with no label and tubing was hung in the pole with no cap (means tubing was exposed and not covered with cap) and not connected to the resident. Observation on 3/17/25 at 11:15 AM identified Resident #51 was sitting in the wheel chair, with Jevity 1.5 calories (same bottle) was connected to Resident #51 and the Jevity 1.5 calories bottle had a date label on 3/16/25 and with time at 8:00 PM. Interview with LPN #4 on 3/17/25 at 11:30 AM identified that she stopped and disconnected Resident #51's enteral feeding at 6:00 AM and re-started the enteral feeding at 10:00 AM per physician's order. She identified that the enteral feeding must be labeled with date, time, rate and the tubing should be re-capped when not in use to ensure the safe administration of the enteral feeding. She identified that she noted that the enteral feeding was not labeled this morning. She further identified that she labeled the enteral feeding bottle dated for 3/16/25 at 8:00 PM because she knew that it was changed the previous shift. She further identified that she should discarded the undated enteral feeding bottle and replaced with the new one when she noticed that it was not labeled. Subsequent to surveyor inquiry, LPN #4 discarded the old container of Jevity and replace with a new container. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 3/17/25 at 11:45 AM identified that the facility policy for enteral feeding was to properly label the enteral feeding with date, time, and rate for each administration. She further identified that the enteral feeding can be re-connected to the resident as long as enteral tubing was capped when not in use; otherwise, the enteral feeding should be replace when the enteral feeding was not properly label and/or when the enteral feeding cap was missing. The Enteral Feeding policy identified to check the physician's order for formula, rate, and water flushes. The policy also identified to label the formula and administration set with date, time, resident's name and discard the supplies and equipment when appropriate.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, review of facility policy, and interviews for one of three sampled residents (Resident #68) reviewed for pain management, the facility failed to ensure pain medication was administered in accordance with the physician's order. The findings include: Resident #68 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of unspecified lumbar vertebra, malignant neoplasm of pancreas, and Myelodysplastic syndrome. The nurse's note dated [DATE] at 7:20 PM identified that Resident #68 was readmitted to the facility at 2:00 PM. Resident was alert and oriented to person, place, and time. The care plan dated [DATE] identified Resident #68 required an opioid medication to help with pain management. Interventions included providing opioid medication to manage pain and evaluate its efficacy. A physician's order dated [DATE] directed to administer Tramadol 50mg, 1 tablet by mouth, every 12 hours as needed (PRN) for pain, for 10 days. Interview with Resident #68 on [DATE] at 8:29 AM identified that he/she had an order for Tramadol to take as needed for pain, and that he/she requests it every night usually around 9:00 PM or just before going to bed. Resident #68 indicated that he/she had requested Tramadol before bed on [DATE], and a male staff member told him/her that the nurse would return with the medication, but nobody returned. Resident #68 further indicated that he/she had difficulty falling asleep and was finally given Tylenol around 3:30 AM, because he/she was done requesting the Tramadol. Resident #68 identified that he/she had ,d+[DATE] pain in the head, mouth, and ribs, which was not relieved by the Tylenol. Resident #68 indicated that the nurse did not assess his/her pain. Resident #68 further indicated that around 6:00 AM somebody communicated to him/her that the Tramadol order needed to be renewed and that was why the medication had not been available. Interview and clinical record review with RN #5 on [DATE] at 9:01 AM identified that during morning report LPN #3 identified that on [DATE], Resident #68 had requested Tramadol, but the PRN order had been completed and the order needed to be renewed, and he administered Tylenol for pain. RN #5 indicated that LPN #3 told her that he added a request to renew the Tramadol order to the APRN notification book, at the desk, and asked RN #5 to follow up on the order. Review of the clinical record identified that the Tramadol 50mg, 1 tablet by mouth, every 12 hours as needed (PRN) for pain, for 10 days order was active and had an end date of [DATE]. RN #5 identified that since the Tramadol order remained active, she would assess Resident #68's pain and offer him/her Tylenol or Tramadol, if needed. Subsequent to surveyor inquiry Tramadol 50mg was administered on [DATE] at 9:50 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on [DATE] at 9:16 AM identified that Resident #68 has chronic pain that he/she had asked for Tramadol by name but could not recall the exact time of the request because he was working on both units. LPN #3 indicated that while he did not assess his/her pain using a pain rating scale, he/she appeared to be a ,d+[DATE] based on non-verbal indicators, so he had repositioned Resident #68 and gave him/her water. LPN #3 further indicated that he saw that the PRN order for Tramadol had expired and could not be given without a provider's order. LPN #3 identified that he returned to Resident #68's room, but he/she had fallen asleep, and when he returned to check on Resident #68, he/she had identified that he/she was in more pain. LPN #3 indicated that he informed Resident #68 that the PRN Tramadol order had expired and needed to be renewed, and he administered Tylenol for pain. LPN #3 identified that he did not contact a medical provider overnight to renew the order, but he notified the RN supervisor, wrote a notification of the expired Tramadol in the APRN book, and reported off to the on-coming nurse to ensure the order got renewed. Interview with the Nursing Supervisor (RN #2) on [DATE] at 9:48 AM identified that LPN #3 notified her that Resident 68's Tramadol order had expired, and that LPN #3 had medicated Resident #68 with Tylenol. RN #2 indicated that LPN #3 had put the renewal request in the APRN book, which she felt was appropriate because usually Tylenol is offered first for pain, and she was not notified that Resident #68 had unrelieved pain after the Tylenol. Interview with APRN #1 on [DATE] at 10:43 AM identified that Resident #68 has chronic pain, and she would have expected a pain assessment to have been completed when Resident #68 requested the Tramadol, and if he/she reported ,d+[DATE] pain, she would have expected the on-call physician to have been notified to reinstate the Tramadol order, if it had expired. Interview and clinical record review with the DNS on [DATE] at 12:26 PM failed to identify that the Tramadol order had expired. The DNS indicated that, had the Tramadol been expired, she would have expected Resident #68's pain to be assessed and if he/she reported ,d+[DATE] pain the doctor should have been contacted to renew the order so the Tramadol could have been given that night. The facility's Pain Management policy directs general treatment principles to include: ask about pain regularly, believe the resident's and family's reports of pain and what relieves it, choose appropriate pain control options, deliver interventions in a timely, logical, and coordinated fashion, and empower patients and their families.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of facility documentation, facility policy, and interviews, the facility failed to complete license nurses and nurse aides education and competencies related to intravenous therapy (IV) therapy and the facility failed to ensure licensed nurses had intravenous therapy (IV) certificate. The findings included: 1. Review of the State Agency documentation identified the facility has a licensed bed capacity of 217 and an IV therapy program. Review of the census daily report dated 3/10/25 identified the facility census was 83 residents in the facility. A request was made on 3/17/25 for documentation of the annual licensed nurses and nurse aides IV competencies for 2023. The facility failed to provide any documentation regarding the completion of 2023 annual competencies. Review of the nursing IV competencies provided for 2024 identified only 15 of 29 licensed nurses received competency training in intravenous therapy (IV), and 17 of 43 nurse aides received competency training in intravenous therapy (IV). Although requested, RN #1 (Infection Preventionist) and LPN #9 failed to provide documentation that IV therapy education/training/in-service and competencies was provided to the license nurse and nurse aides in 2023 and 2024. Interview with RN #1 on 3/17/25 at 11:34 AM identified she has been employed by the facility since 3/2024 as the Infection Preventionist (IP), staff development, and the wound nurse. RN #1 indicated she could not locate IV competencies completed in 2023. RN #1 indicated she was unable to find any more documentation related to IV competencies for 2024. RN #1 indicated she was responsible for the education, in-service and competencies of the IV therapy to the nursing staff for the year 2024. Interview with the DNS on 3/18/25 at 8:00 AM identified she was not aware that all the licensed nurses and nurse aides did not have yearly education, in-service, and competencies of IV therapy for the year 2024. The DNS indicated it was the responsibility of RN #1 to provide the nursing staff with education, in-service and competency of IV therapy. Although requested, a facility policy was not provided. Review of the facility assessment dated [DATE] identified staff competencies that are necessary to provide the level and types of care needed for the resident population. Establishing a peripheral venous route, central line dressing changes, and intermittent infusion via peripherally inserted catheter. Annual competencies/training, and in-service. Clinical departments are encouraged to utilize continuing education. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the licensed nurses IV certificate log failed to reflect documentation (IV certificate) for 11 of 29 licensed nurses had IV certificates. Review of the State Agency documentation identified the facility has a licensed bed capacity of 217 and an IV therapy program. Review of the census daily report dated 3/10/25 identified the facility census was 83 residents in the facility. A request was made on 3/17/25 for documentation of IV certificate for licensed nurses. The facility failed to provide 11 of 29 IV certificates. Interview and facility documentation review with RN #1 on 3/17/25 at 11:34 AM identified she was not aware of the issue. RN #1 indicated she was not aware that 11 of 29 licensed nurses do not have an IV certificate. RN #1 indicated she will contact the pharmacy IV department and schedule an IV education and certificate class. Interview with the DNS on 3/18/25 at 8:10 AM identified she was not aware of the issue and that RN #1 was responsible to oversee the staff development position and review the licensed nurse's IV certificates. The DNS indicated the facility will address the issue. Although requested, a facility policy was not provided. Review of the facility assessment dated [DATE] identified staff competencies that are necessary to provide the level and types of care needed for the resident population. Establishing a peripheral venous route, central line dressing changes, and intermittent infusion via peripherally inserted catheter. Annual competencies/training, and in-service. Clinical departments are encouraged to utilize continuing education.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37293 Based on observations, review of facility documentation, review of facility policy, and interviews for four of four medication carts, the facility failed to ensure shift to shift controlled drug counts were consistently completed. The findings include: Based on observations, review of facility documentation, facility policy, and interviews for 4 of 4 medication carts, the facility failed to ensure shift to shift controlled drug counts were consistently completed. The findings include: Observations on 3/18/25 between 1:44 PM - 2:00 PM of the medication carts with LPN #9 (IP from another facility) identified the February 2025 and March 2025 narcotic drug change of shift audit sheet (the narcotic count that the on-coming and off-going nurses complete to ensure the narcotic medications are counted) were missing signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift on the following units: The [NAME] 1 unit was missing 21 signatures for the month of February 2025, and 9 signatures for the month of March 1, 2025 - March 18, 2025. The Aspen unit was missing 10 signatures for the month of March 1, 2025 - March 18, 2025. The [NAME] 2 unit was missing 21 signatures for the month of February 2025, and 11 signatures for the month of March 1, 2025 - March 18, 2025. The Redwood unit was missing 6 signatures for the month of March 1, 2025 - March 18, 2025. Interview with LPN #2 on 3/18/25 at 1:50 PM identified she is an agency nurse. LPN #2 indicated would you like for me to sign the narcotic drug change of shift audit sheet now. Interview with RN #3 on 3/18/25 at 1:53 PM identified all nurses are responsible to sign the narcotic drug change of shift audit sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. Interview with LPN #4 on 3/18/25 at 1:55 PM identified it was the responsibility of all the nurses to sign the narcotic count sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. Interview with LPN #1 on 3/18/25 at 2:00 PM identified all nurses are responsible to sign the narcotic count sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 3/19/25 at 8:30 AM identified she was aware of the issue, and she has been educating the licenses nurses regarding signing the narcotic count sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. The DNS indicated the expectation of the facility is that the on-coming and out-going nurse count the controlled substances during each shift change and sign the narcotic count sheet after completing the count. The DNS indicated that the facility would continue to educate the licensed nurses. Review of the pharmacy storage of controlled substance form identified the medications classified by the Drug Enforcement Administration (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical records, review of facility policy, and interviews for two of three sampled residents (Resident #15 and #68) reviewed for pain management, the facility failed to ensure accurate administration documentation of pain medication. The findings include: 1. Resident #15 was admitted to the facility on [DATE] with diagnoses that included lower back pain, pain in the left upper arm, and dementia. The care plan dated 2/7/25 identified Resident #15 had activities of daily living (ADL) function compromised related to dementia, weakness, and advanced age. Interventions included referring to Resident #15's 24-hour positioning plan and to encourage him/her to do as much as possible before offering assistance. The quarterly MDS dated [DATE] identified Resident #15 had moderately impaired cognition, had pain with occasional frequency with a numeric rating scale of 3/10, and was not on a scheduled pain medication regimen. A physician's order dated 1/20/25 directed to administer Acetaminophen 325mg, administer 2 tablets by mouth, every 6 hours, as needed (PRN) for pain/fever. A physician's order dated 3/4/25 directed to administer Acetaminophen 325mg, administer 2 tablets by mouth, twice daily at 9:00 AM and 5:00 PM. The 24-Hour Shift Report dated 3/1/25 identified that Resident #15 was given PRN APAP (Acetaminophen) with positive effects, on the 7:00 AM-3:00 PM shift. The 24-Hour Shift Report dated 3/13/25 identified that Resident #15 was given Tylenol (Acetaminophen) at 12:30 AM, crushed with applesauce and tolerated well. The 24-Hour Shift Report dated 3/17/25 identified that Resident #15 was given PRN Tylenol 650mg. The March 2025 Medication Administration Record (MAR) failed to identify documentation that PRN Acetaminophen was administered on 3/1/25, 3/13/25, and 3/17/25. Interview and clinical record review with LPN #8 on 3/17/25 at 11:20 AM identified that the nurse aide had notified her that Resident #15 had requested Tylenol for arm pain, but she was unable to administer Tylenol because he/she had just received her scheduled Tylenol dose, and that, during morning report, LPN #10 had told her that she had given Resident #15 a PRN dose not too long ago around 5:00 AM or 6:00 AM. Review of the MAR failed to identify that the PRN dose was administered. LPN #8 indicated that she would expect medication administration times to be documented in the MAR to ensure resident safety and appropriate administration times. LPN #8 further indicated that she would follow up with Resident #15 to assess his/her pain. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #10 on 3/18/25 at 9:29 AM identified that she had worked at the facility on 3/17/25 from 11:00 PM-7:00 AM, and that she had medicated Resident #15 with Tylenol around 6:00 AM and thought that she had signed the medication as given in the MAR. LPN #10 indicated that she was aware that the expectation was to sign a medication as given right away but she must have forgotten. LPN #10 further indicated that she usually always signs out PRN medications on the MAR and also documents on the 24-hour report. Interview and clinical record review with the DNS on 3/19/25 at 11:37 AM failed to identify documentation in Resident #15's MAR that corresponded with the documentation on the 24-Hour Report that Acetaminophen was given on 3/1, 3/13, and 3/17/25. The DNS indicated that she would expect that any order completed, and medication given to a resident would be signed off in the MAR and only documenting in the 24-hour report was not the expectation; documentation needed to be completed in the resident's clinical record. The facility's General Guidelines for Medication Administration policy directs the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications. When PRN medications are administered, the following documentation is provided: date and time of the administration, dose, complaints or symptoms for which the medication was given, results achieved from giving the dose, and the time the results were noted. 2. Resident #68 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of unspecified lumbar vertebra, malignant neoplasm of pancreas, and Myelodysplastic syndrome. The nurse's note dated 3/6/25 at 7:20 PM identified that Resident #68 was readmitted to the facility at 2:00 PM. Resident was alert and oriented to person, place, and time. A physician's order dated 3/6/25 directed to administer Tramadol 50mg, 1 tablet by mouth, every 12 hours as needed (PRN) for pain, for 10 days. The care plan dated 3/7/25 identified Resident #68 required an opioid medication to help with pain management. Interventions included providing opioid medication to manage pain and evaluate its efficacy. Interview with Resident #68 on 3/12/25 at 8:29 AM identified that he/she has an order for Tramadol to take as needed for pain, and that he/she requests it every night around 9:00 PM or just before going to bed. Resident #68 indicated that he/she was told that Tramadol was unavailable last night because the order needed to be renewed and that he/she had been in pain throughout the night. The Control Substance Disposition Record (accountability record) identified that one Tramadol 50mg tablet was dispensed on the following dates in March of 2025: 3/6 at 9:00 PM, 3/7 at 9:00 PM, 3/8 at 9:00 PM, 3/9 at 9:00 PM, 3/10 at 9:00 PM, 3/12 at 9:15 AM and 9:45 PM, 3/13 10:00 PM, 3/14 at 9:00 PM, 3/15 at 9:00 PM, 3/16 at 9:30 PM, and 3/17 at 11:15 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwich Woods Rehabilitation	1165 King Street Greenwich, CT 06831

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2025 Medication Administration Record (MAR) failed to identify that Tramadol was administered to Resident #68 on 3/6, 3/7, 3/10, 3/15, and 3/17/25. The Progress Notes dated 3/6/25 through 3/17/25 failed to identify documentation that Tramadol was administered to Resident #68 on 3/6, 3/7, 3/10, 3/15, and 3/17/25. Interview and clinical record review with RN #5 on 3/19/25 at 11:14 AM identified that it was her initials on Resident #68's Control Substance Disposition Record for the removal of Tramadol on 3/6, 3/7, and 3/17/25 but failed to document that the medication was administered on the MAR. RN #5 indicated that she was aware of the importance to document on both the disposition record and MAR, and she also tries to write a progress note identifying the reason the medication was given. RN #5 further indicated that sometimes she works double shifts or works on multiple units, and may get pulled away to assist another resident before she has the time to circle back and sign the medication off in the MAR. Interview and clinical record review on 3/17/25 at 12:26 PM with the DNS failed to identify that the Tramadol that was signed off on the Control Substance Disposition Record on 3/6, 3/7, 3/10, 3/15, and 3/17/25 was also signed off as administered in Resident #68's MAR. The DNS identified that it was her expectation that when a controlled substance is removed and signed off on the Control Substance Disposition Record it must also be signed off, as administered, in the resident's MAR. The DNS indicated that the nurse administering the medication would be responsible for both signoffs, and re-education would be provided to licensed nursing staff. The facility's Controlled Substances policy directs the provider pharmacy shall identify medications as controlled medications either as a part of the label, or by sending a controlled medication countdown sheet with the medication, or both. Accurate inventory of all controlled medications is maintained at all times. When a controlled substance is administered, the licensed nursing personnel administering the medication immediately enters the following information on the accountability record and the MAR: date and time of administration (MAR and Accountability Record), amount administered (Accountability Record), remaining quantity (Accountability Record), signature of the nursing personnel administering the dose (Accountability Record), and the initials of the nurse administering the dose, completed after the medication has been administered (MAR).

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation, and interviews, the facility failed to follow the manufacturers' recommendations for replacing the Nephros water filters which were in place since [DATE], following a presumptive positive case of Legionella in a resident at the facility, and the facility failed to ensure that a positive Legionella water sample was reported to the State Agency in a timely manner. These failures resulted in the finding of Immediate Jeopardy. The findings include: The daily census report dated [DATE] identified a resident census of 83. The facility's total capacity is 217. The facility's layout consists of two floors with resident units on both floors. There are three nursing units on the first floor and four nursing units on the second floor with three of the units closed (no residents residing on the units) and one resident unit (Redwood) with twenty-three residents residing on the unit. On [DATE] at 9:00 AM the Administrator was asked to provide documentation of all Legionella water sample testing from [DATE] to February 2025 along with all documentation related to the facility's water management maintenance records such as flushes. Review of the water management plan and facility documentation identified the facility contracted with two outside water management companies. The first water contractor (WC #1) is responsible for recommendations, collecting water samples, and providing the water sample test results. The second water contractor (WC #2) is responsible for the chlorination system (a water treatment method that uses chlorine to disinfect water by killing harmful bacteria, viruses, and other pathogens). Review of facility documentation and Department of Public Health documentation identified that in July of 2024, the facility transferred a resident to the hospital who subsequently tested positive for Legionella which was considered a presumptive healthcare associated case because the resident had resided in the facility during the incubation period. Subsequently, the facility received recommendations from Epidemiologist #1 (Department of Public Health), as a result, the following recommendations were implemented: The facility placed Nephros water filters on all faucets and shower heads in July of 2024, held weekly water management meetings, started biweekly water sampling testing and started flushing the potable water sources 2 to 3 times per week. The water management plan identified that when Legionella species is found in the water, the following interpretive testing guidance should be considered: When the positive Legionella test sites detect less than (<) 1 CFU/ml, the facility will maintain their environmental assessment and Legionella monitoring. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	When the positive Legionella test sites detect greater than (>) or equal to 1 CFU/ml, the facility will review the water sample collection, handling, and testing for potential areas. The facility will confirm the water system (chlorination) is currently operating. Review the record of its water management plan. Review the water characteristics and any incoming water changes. Immediately institute a short-term control measure in accordance with the direction of the qualified professional (contracted water management providers) and notify the local health department, and the state Department of Public Health (DPH). The guidance further identified that the water system should be re-tested no sooner than 48 hours and no later than 7 days after a disinfection to determine the efficacy of the treatment. If the re-tested water indicates a greater than or equal to 1, the facility will repeat the short-term measures, and additional measures should be reviewed. When the positive legionella test sites detect greater than or equal to 10 CFU/ml, the facility will immediately institute a short-term control measure in accordance with the direction of a qualified professional and will immediately notify the local health department and the state Department of Health (DPH). Additionally, the water system should not be used for potable water until the facility is cleared by the local health department and DPH. The water management documentation identified laboratory water testing results in various sites throughout the facility (resident occupied areas and none resident occupied areas) for Legionella species that noted the following: Five test samples (5 different locations of potable water sources) in [DATE] resulted in positive results ranging from 1.2 to 31.9 Colony Forming Units per milliliters (CFU/ml). Five test samples in [DATE] resulted in positive results ranging from 1.2 to 6.9 CFU/ml. Six test samples in [DATE] resulted in positive results ranging from 1.4 to 10.6 CFU/ml. Eight testing sites in [DATE] resulted in no positive results. Three test samples in [DATE] resulted in positive results ranging from 5.9 to 7.2 CFU/ml. Four test samples in [DATE] resulted in positive results ranging from 1.3 to 14.5 CFU/ml. Five test samples in February 2025 resulted in positive results ranging from 4.2 to 13.6 CFU/ml. The March testing results were pending and unavailable during the course of the survey. The facility's water management plan identified that when a positive Legionella water sample is identified, the following short-term control measures would be taken: 1. The use of potable water will be restricted and bottled water will be utilized. 2. The faucet aerators removed (a device to prevent unnecessary water splashes that could result in the spread of the bacteria), soaked in a bleach solution for 30 minutes and left off until otherwise directed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	3. The removal and replacement of shower heads and lines throughout the facility that are in use and assess the need for point of use filters that are in accordance with the Environmental Protection Agency (EPA). 4. Flush each affected area faucet immediately for 5 to 10 minutes (hot and cold tap water). 5. Notify the Medical Director and state Department of Health (DPH). 6. Perform clinical surveillance on residents for any respiratory signs and symptoms. 7. Consider the need to notify the residents, families, and staff. Review of facility documentation failed to reflect documentation that the state Department of Public Health was notified of the positive water sample test results when the tests indicated the Legionella species was greater than 1CFU/ml. The Legionella committee's documented agenda identified the committee consists of the Administrator, DNS, Maintenance Director, Infection Preventionist, Staff Development, and any other facility staff deemed appropriate. The documentation identified that each section of the water management plan would be reviewed with an open discussion on areas that may need improvement or other concerns. Tasks are assigned to members to oversee based on the recommendation of the mitigation plan. The agenda further noted that there was a recommendation that the water committee members meet annually to review the plan and document meeting minutes. It also identified that Legionella results are reviewed with the water contractor and in the event of a positive result, confirmed case, or outbreak, the water contractor would be contacted immediately for guidance to protect resident safety. Review of the Legionella committee members meeting minutes identified the committee met on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. One of purposes of the water management committee meetings was to discuss the water sample positive results and continue to follow state guidelines and water contractor recommendations, but the minutes failed to identify in detail how the positive Legionella testing results were addressed. Observation on [DATE] at 10:48 AM on the Redwood unit identified rooms 256, 261, 268, 272, 273 and the Soiled utility room lacked Nephros water filters on the faucets. Tour with the Maintenance Director on [DATE] at 11:25 AM on the Redwood unit identified 5 of the 17 resident bathroom faucets without the Nephros water filters. Two of the 5 resident rooms were occupied (rooms [ROOM NUMBERS]). Interview with the Maintenance Director on [DATE] at 11:30 AM identified he was unaware that the identified rooms did not have water filters in place. The Maintenance Director indicated the Nephros water filters were installed last year in [DATE] when the facility had the Legionella issue and the manufacturer's expiration dates on the installed Nephros water filters are [DATE]. The Maintenance Director indicated he would immediately install the Nephros water filters to the rooms that do not have them in place. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Interview with the Administrator on [DATE] at 12:55 PM identified he was unaware of the missing filters. The Administrator indicated the Nephros water filters only get replaced when the water filter falls off the faucet or breaks. Interview with WC #1 on [DATE] at 12:58 PM identified he last provided the facility with recommendations on [DATE]. WC #1 indicated the facility does not have an additional contract for further recommendations. WC #1 indicated the facility installed 90-day water filters in ,d+[DATE] and noted the facility should be flushing the systems. WC #1 indicated he did not convey to the facility that the water filters should be replaced every 90 days. He further identified the facility should change the water filters based on the water test results and indicated that he only collects the water samples for testing bi-weekly and then e-mails the Administrator the testing results. Interview with the Administrator on [DATE] at 1:20 PM identified the facility installed a chlorination system in [DATE] and identified that the water filters installed on all faucets in the building have not been changed and identified that it was never conveyed to him that the filters needed to be changed after 90 days of use. Interview with the Maintenance Director on [DATE] at 1:50 PM identified he flushes the water system 2 to 3 times a week. The Maintenance Director indicated that when the filters are broken in the resident bathroom sinks the nurse aides notify the maintenance department, and the maintenance staff replaces the water filters. The Maintenance Director indicated he did not keep a record of the rooms where the water filters have been replaced but moving forward he will keep a record of the rooms. Interview on [DATE] at 6:28 PM with the Northeast Regional Manager of the water filter company that supplied the Nephros filters identified the water filters are certified by the FDA to be used in place for 90 days and when the 90 days are exceeded the efficacy of the filters decrease. The Northeast Regional Manager further indicated that the filters are the first line of defense in removing Legionella from the potable water supply. Interview with the Maintenance Director on [DATE] at 7:14 AM identified he flushes the system 2 - 3 times a week and randomly selects resident rooms that are occupied, but he flushes every room on the [NAME] and Oakwood units (closed nursing units). The Maintenance Director identified he has not flushed or changed the water filters in the areas that have tested positive for Legionella species. The Maintenance Director indicated that on [DATE], the Administrator directed him to change the water filters in all the areas where the testing results have exceeded 1cfu/ml. The Maintenance Director indicated WC #2 will be coming to raise the chlorine in the chlorination system. Interview with RN #1 (Infection Preventionist) on [DATE] at 9:28 AM identified that she started working at the facility in [DATE]. RN #1 indicated she was aware of the Legionella issue at the facility since [DATE] and indicated she does not review the water sample test results. RN #1 identified the Administrator notifies her of the positive results. RN #1 indicated she does not maintain a line list specific for Legionella monitoring; she indicated she monitors residents for cold symptoms. RN #1 further noted she was not monitoring the residents in the rooms with positive water sample results. Additionally, RN #1 indicated that when a resident has pneumonia and there is a known etiology, and a history of respiratory diagnosis the facility does not test for Legionella. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Interview with MD #1 (Medical Director) on [DATE] at 12:54 PM identified he was unaware of the water test results identifying positive Legionella species. MD #1 indicated that if he was aware of the positive test results, he would have ordered the Legionella antigen test for residents with respiratory symptoms. Facility documentation identified that Nephros filters were installed on all faucets and shower heads in [DATE], and they have not been replaced. According to Manufacturer's recommendations the filters should have been replaced in [DATE] and [DATE]. The facility failed to follow the manufacturers' recommendations for replacing the Nephros water filters which were in place since [DATE], following a presumptive positive case of Legionella, and placed all residents at risk for Legionnaire disease. Which resulted in the finding of Immediately Jeopardy. The Immediate Jeopardy template was provided to the DNS on [DATE] at 3:05 PM. The facility provided an Immediate Jeopardy removal plan that was accepted on [DATE] at 5:44 PM. The plan included the following measures: replace the water filters on all shower heads and previous resident care areas that tested positive. 35 water filters based on number of shower and positive areas, were shipped overnight and replaced by 10:00 AM on [DATE]. WC #2 adjusted chlorine levels per WC #1's guidance on [DATE]. The previous level was 1.0mg, the updated level is 2.2mg. Additions to the plan of correction requested by DPH on [DATE] identified that 115 additional water filters were ordered and should be delivered and installed on [DATE]. All water filters in the kitchen were replaced on [DATE]. The provision of bottled water for drinking and oral care until the water filters are replaced/changed. Staff education to be provided on the use of bottled water for drinking and providing oral care. The plan further identified the facility will continue to perform bi-weekly water sampling testing to be conducted by WC #1. Hand sanitizer was provided for hand hygiene and disposable wipes have been provided for use in resident rooms. The sinks have been marked for non-use until water filters are replaced. The plan further identified residents and families will be notified of the concern with the water and residents will continue to be monitored, and physician orders will be obtained to conduct further testing if indicated. Review of the Immediate Jeopardy removal plan with the DNS on [DATE] at 9:20 AM identified water filters were due to be delivered on [DATE], but she received an email from United Parcel Services (UPS) on [DATE] indicating delivery was delayed due to the weather conditions and delivered on [DATE]. The DNS indicated the water filters were delivered and the Maintenance Director was in the process of changing out all the existing expired filters. She further noted that over the weekend all resident rooms that did not have a new water filter, the faucets were bagged with signs posted identifying not to use. Wipes and hand sanitizers were placed in every room. Signs were placed to not use the water on the front door and on the units. Every resident was educated regarding the wipes and hand sanitizer in the affected rooms. The staff were able to use the shower room, staff bathroom, and the soiled utility room sinks for hand washing. Additionally, water bottles were delivered to all units. The survey team validated the implementation of the removal plan through observations, staff and resident interviews, and facility verification that all water filters in the facility had been replaced including in the kitchen. The Immediate Jeopardy was removed on [DATE] at 10:30 AM (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	The water management plan policy identified that the facility complies with all federal requirements for the purpose of reducing the risk of growth and the spread of Legionella and other opportunistic pathogens in the water system.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on clinical record reviews, review of facility documentation, review of facility policy, and interviews for 5 of 5 sampled residents (Resident #14, 16, 24, 56, and 73) reviewed for immunizations, the facility failed to offer and provide influenza vaccine as required and for 4 of 5 residents (Resident #12, 26, 37, and 61) reviewed for immunizations, the facility failed to offer and provide pneumococcal vaccine as required. The findings include: Interview and review of facility immunization documentation with RN #1 (Infection Preventionist) on 3/17/2023 at 12:37 PM identified the following: a) Resident #14 was admitted to the facility on [DATE] with diagnosis that included diabetes mellitus, hypertension, and hypothyroidism. The quarterly MDS assessment dated [DATE] identified Resident #14 had severe cognitive impairment. The assessment further identified that Resident #14 influenza vaccination was not up to date. Review of Resident #14 clinical record on 3/17/25 at 12:37 PM failed to identified that the influenza vaccine was offered and/or administered to the resident. b) Resident #16 was admitted to the facility on [DATE] with diagnosis that included vascular dementia, psychotic disturbance, and mood disturbance. The quarterly MDS assessment dated [DATE] identified Resident #16 had severe cognitive impairment. The assessment further identified that Resident #16 influenza vaccination was not up to date. Review of Resident #16 clinical record on 3/17/25 at 12:37 PM failed to identified that the influenza vaccine was offered and/or administered to the resident. c) Resident #24 was admitted to the facility on [DATE] with diagnosis that included multiple sclerosis, hypertension, and hydrocephalus. The quarterly MDS assessment dated [DATE] identified Resident #24 had severe cognitive impairment. The assessment further identified that Resident #24 influenza vaccination was not up to date. Review of Resident #24 clinical record on 3/17/25 at 12:37 PM failed to identified that the influenza vaccine was offered and/or administered to the resident. d) Resident #56 was admitted to the facility on [DATE] with diagnosis that included schizophrenia, and pulmonary fibrosis. The quarterly MDS assessment dated [DATE] identified Resident #56 had moderate cognitive impairment. The assessment further identified that Resident #56 influenza vaccination was not up to date. Review of Resident #56 clinical record on 3/17/25 at 12:37 PM failed to identified that the influenza vaccine was offered and/or administered to the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Resident #73 was admitted to the facility on [DATE] with diagnosis that included dementia with psychotic disturbance, and psychotic disorder with delusions. The quarterly MDS assessment dated [DATE] identified Resident #73 had intact cognition. The assessment further identified that Resident #73 influenza vaccination was not up to date. Review of Resident #73 clinical record on 3/17/25 at 12:37 PM failed to identified that the influenza vaccine was offered and/or administered to the resident. f) Resident #12 was admitted to the facility on [DATE] with diagnosis that included atherosclerotic heart disease, and hyperlipidemia. The annual MDS assessment dated [DATE] identified Resident #12 had moderate cognitive impairment. The assessment further identified that Resident #12 pneumococcal vaccination was not up to date. Review of Resident #12 clinical record on 3/17/25 at 12:37 PM failed to identified that the pneumococcal vaccine was offered and/or administered to the resident. g) Resident #26 was admitted to the facility on [DATE] with diagnosis that included hemiplegia and hemiparesis, and cerebrovascular disease affecting the right dominant side. The annual MDS assessment dated [DATE] identified Resident #26 had intact cognition. The assessment further identified that Resident #26 pneumococcal vaccination was not up to date. Review of Resident #26 clinical record on 3/17/25 at 12:37 PM failed to identified that the pneumococcal vaccine was offered and/or administered to the resident. h) Resident #37 was admitted to the facility on [DATE] with diagnosis that included cerebral palsy, and hydronephrosis. The quarterly MDS assessment dated [DATE] identified Resident #37 had severe cognitive impairment. The assessment further identified that Resident #37 pneumococcal vaccination was not up to date. i) Resident #61 was admitted to the facility on [DATE] with diagnosis that included subarachnoid hemorrhage, and diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #61 had severe cognitive impairment. The assessment further identified that Resident #61 pneumococcal vaccination was not up to date. Review of Resident #61 clinical record on 3/17/25 at 12:37 PM failed to identified that the pneumococcal vaccine was offered and/or administered to the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #1 on 3/17/25 at 1:00 PM identified that she did not receive some of the influenza vaccine consent forms from the resident representatives, so the facility was unable to administer the influenza vaccine. RN #1 was unable to verify if the facility had followed up with the resident representatives. RN #1 indicated the facility had obtained some consents for the influenza and pneumococcal vaccination on 3/13/25. RN #1 indicated she was unable to find any previous pneumococcal vaccination records from 2023 and 2024. RN #1 indicated she did not administer any pneumococcal vaccine in 2024 and 2025. Interview with RN #1 on 3/19/25 at 9:50 AM identified influenza and pneumococcal vaccine were offered on 3/14/25 but the pharmacy did not deliver the vaccines. RN #1 indicated she will reach out to the pharmacy regarding the delay of the influenza and pneumococcal vaccines. Interview with RN #1 on 3/19/25 at 11:10 AM identified that the pharmacy received the vaccines but some where the profile for payment purpose and insurance coverage was not communicated. RN #1 indicated the communication from the pharmacy to the facility to explain why there was a delay and/or a reason why there was not a delivery done. RN #1 indicated that she asked the pharmacy to escalate to quality insurance and she was told that it would take approximately 48 hours for a response. Interview with the DNS on 3/19/25 at 11:30 AM identified she was not aware of the issue. The DNS indicated RN #1 is responsible to oversee that all resident in the facility receives their influenza and pneumococcal vaccines in a timely manner. Review of the facility immunization of residents policy identified all eligible residents will be offered the influenza and pneumococcal vaccines unless medically contraindicated. The resident or the resident's legal representative will be provided a copy of the current vaccine information statement prior to administration. The resident or resident's legal representative has the right to refuse the vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075309	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenwich Woods Rehabilitation	1165 King Street Greenwich, CT 06831

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on clinical record reviews, facility documentation, facility policy, and interviews for 5 of 5 residents (Resident #2, 12, 19, 59, and 61) reviewed for immunizations, the facility failed to offer and provide Covid-19 immunizations as required. The findings include: Interview and review of facility immunization documentation with RN #1 (Infection Preventionist) on 3/17/2023 at 12:37 PM identified the following: 1) Resident #2 was admitted to the facility on [DATE] with diagnosis that included fracture of shaft of left femur, difficulty walking, and muscle weakness. The admission MDS assessment dated [DATE] identified Resident #2 had intact cognition. The assessment further identified that Resident #2 Covid-19 Booster vaccination was not up to date. Review of Resident #2 clinical record on 3/17/25 at 12:37 PM failed to identified that the Covid-19 Booster vaccine was offered and/or administered to the resident. Review of the Covid-19 immunization record identified Resident #2 had a consent for the vaccine. 2) Resident #12 was admitted to the facility on [DATE] with diagnosis that included atherosclerotic heart disease, and hydrocephalus. The annual MDS assessment dated [DATE] identified Resident #12 had intact cognition. The assessment further identified that Resident #12 Covid-19 Booster vaccination was not up to date. Review of Resident #12's immunization record identified the Covid-19 vaccine additional dose/booster was last administered on 12/18/23. Review of the clinical record on 3/17/25 at 12:37 PM failed to identified that the Covid-19 Booster vaccine was offered and/or administered to the resident. 3) Resident #19 was admitted to the facility on [DATE] with diagnosis that included schizoaffective disorder, and hypothyroidism. The quarterly MDS assessment dated [DATE] identified Resident #19 had intact cognition. The assessment further identified that Resident #19 Covid-19 Booster vaccination was not up to date. Review of Resident #19's immunization record identified the Covid-19 vaccine additional dose/booster was last administered on 12/18/23. Review of the clinical record on 3/17/25 at 12:37 PM failed to identified that the Covid-19 Booster vaccine was offered and/or administered to the resident. 4) Resident #59 was admitted to the facility on [DATE] with diagnosis that included malignant neoplasm of right female breast, and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #59 had severe cognitive impairment. The assessment further identified that Resident #59 Covid-19 Booster vaccination was not up to date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's immunization record identified the Covid-19 vaccine additional dose/booster was last administered on 12/19/23. Review of the clinical record on 3/17/25 at 12:37 PM failed to identified that the Covid-19 Booster vaccine was offered and/or administered to the resident. 5) Resident #61 was admitted to the facility on [DATE] with diagnosis that included subarachnoid hemorrhage, and diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #61 had severe cognitive impairment. The assessment further identified that Resident #61 Covid-19 Booster vaccination was not up to date. Review of Resident #69's immunization record identified the Covid-19 vaccine additional dose/booster was last administered on 12/19/23. Review of the clinical record on 3/17/25 at 12:37 PM failed to identified that the Covid-19 Booster vaccine was offered and/or administered to the resident. Review of the Covid-19 vaccine documentation form identified Resident #2, 12, 19, 59, and 61 had a sign consent dated 3/13/25 by the residents and/or the resident representative. Interview with RN #1 on 3/17/25 at 1:00 PM identified that she did not receive some of the Covid-19 vaccine consent forms from the resident representatives, so the facility was unable to administer the Covid-19 booster vaccine. RN #1 was unable to verify if the facility had followed up with the resident representatives. RN #1 indicated the facility had obtained some consents for the Covid-19 vaccination on 3/13/25. RN #1 indicated she did not administer any Covid-19 Booster vaccine in 2024 and 2025. Interview with RN #1 on 3/19/25 at 9:50 AM identified Covid-19 vaccine were offered on 3/14/25 but the pharmacy did not deliver the vaccines. RN #1 indicated she will reach out to the pharmacy regarding the delay of the influenza, pneumococcal, and Covid-19 Booster vaccines. Interview with RN #1 on 3/19/25 at 11:10 AM identified that the pharmacy received the vaccines but some where the profile for payment purpose and insurance coverage was not communicated. RN #1 indicated the communication from the pharmacy to the facility to explain why there was a delay and/or why there was no delivery was not done. RN #1 indicated that she asked the pharmacy to escalate to quality insurance and she was told that it would take approximately 48 hours for a response. Interview with the DNS on 3/19/25 at 11:30 AM identified she was not aware of the issue. The DNS indicated RN #1 is responsible to oversee that all resident in the facility receives their Covid-19 Booster vaccines in a timely manner. Review of the facility resident Covid-19 vaccine documentation form identified the vaccine will be offered to all eligible residents as recommended by the Center for Disease Control (CDC), and the resident or legal guardian is provided with education regarding the pros and cons of the vaccine. The resident or resident's legal representative has the right to refuse the vaccine.