STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075310	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave Plainfield, CT 06374

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 51102 Based on interviews and record reviews for 2 of 2 residents, (Resident #40 and Resident #46) reviewed for advance directives, for Resident #40, the facility failed to transcribe advance directives according to the signed resident's wishes and for Resident #46, the facility failed to ensure the advance directive consent had been signed and available in the medical record. The findings include: 1. Resident #40's diagnoses included chronic obstructive pulmonary disease, type 2 diabetes mellitus and hypertension. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #40 was severely cognitively impaired, and was independent for eating, toileting, and transfers. The Resident Care Plan dated [DATE] identified Resident #40 had a status of DNR and a Registered Nurse (RN) may pronounce death. Interventions included not to resuscitate. The physician's orders dated [DATE] directed that Resident #40's advance directive was for a full code indicating cardiopulmonary resuscitation (CPR) was to be performed. The Do Not Resuscitate (DNR) consent form dated [DATE], signed by Resident #40, indicated not to resuscitate Resident #40. Interview with Registered Nurse (RN) #7 on [DATE] at 6:30 AM identified facility policy for signed advance directives was to ensure the document was in the chart as well as in the electronic health record (EHR). RN #7 was unable to locate Resident #40's signed advance directives form in the EHR or paper chart and could not identify who was responsible to ensure the document was available. Furthermore, RN #7 stated that in the event of an emergency which would require advance directive information, (resuscitation status), she would follow the physician's order in the EHR whick directed that Resident #40 was to receive CPR. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the Director of Nursing (DNS) on [DATE] at 6:43 AM identified the facility policy stated the advance directive form be signed by the resident or responsible party, the physician's order match the signed advance directive, and the information be accurately reflected in the EHR. During a review of the clinical record with the DNS the signed advance directive dated [DATE] reflected a DNR status while the EHR physician order dated [DATE] directed a full code (CPR). The DNS indicated that in the event of an emergency the nurse would follow physician's orders directing Resident #40 receive CPR. Subsequent to survey inquiry, the DNS indicated she would investigate the inconsistency. Re-interview with the DNS on [DATE] at 8:21 AM, identified the nurse who had entered the readmission orders on [DATE] had mistakenly transcribed that Resident #40 was a full code from the hospital discharge paperwork, however, the DNR signed in 2015 should have been honored. The DNS indicated it was the facility policy to fill out a new advanced directive consent form upon admission or readmission. Further, the DNS indicated that Resident #40's responsible party identified Resident #40 should have never been listed as a full code, he/she had always been a DNR, and the responsible party was on the way in to sign a new DNR consent to ensure Resident #40 remained a DNR. 2. Resident #46 was admitted to the facility in [DATE] with diagnoses that included vascular dementia with unspecified psychotic disturbances and other behavioral disturbances, anxiety disorder, and unspecified mental disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was severely cognitively impaired, was able to eat independently after set up for meals, and required assistance of 1 for transfers. The Resident Care Plan dated [DATE] identified Resident #46 was a Do Not Resuscitate (DNR) and Registered Nurse Pronouncement of Death (RNP). Interventions included that the resident or appointed family member would sign the appropriate paperwork and would be filed in the chart. Additional interventions included to obtain a copy of a living will, conservator appointment, advance directives, healthcare agent appointment, and/or power of attorney. The physician's order currently in effect and originally dated [DATE] directed Do Not Resuscitate (DNR) and Registered Nurse Pronouncement of Death (RNP). A review of the clinical record on [DATE] at 12:30 PM with RN #1 identified a signed Advanced Directive consent form was unable to be located in Resident 46's chart. Review of a new physician's order dated [DATE] identified Do Not Hospitalize (DNH), Do Not Intubate (DNI) and Do Not Transfer (DNT). Re-interview with RN #1 on [DATE] at 11:45 AM indicated that the nurses would check physician's orders in the electronic record for code status for cardiopulmonary resuscitation (CPR) or for DNR, then double check for verification by looking at the Advance Directive consent form in the clinical chart which was still unable to be located. (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 DNS on [DATE] at 11:50 AM identified that Resident #46's Healthcare Agent had come into the facility on the evening of [DATE] and signed a new advance directive indicating that Resident #46's status was to be a DNR, DNI, DNT, and DNH. The DNS indicated she was not sure if there had been a signed advance directive prior to surveyor inquiry. A review of the Advance Directive policy dated [DATE] directed, in part, that on admission the facility would provide the resident or responsible party with information to make advance directive decisions, the nurse would complete the form and ensure that the Advance directive was placed in the medical record, and that the facility would honor the advance directive wishes of residents, which included not performing CPR on residents who had a valid DNR. 51756

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41018 Based on observation, interviews, and review of facility policy for 1 of 3 units for 1 resident (Resident #6), the facility failed to ensure furniture was in good repair to provide a home-like environment. The findings include: Observation on 11/5/24 at 11:45 AM identified the facility-supplied furniture (footboard and two dressers) belonging to Resident #6 had been damaged: the footbed attached to the bed had significant marring to the bottom left corner leaving a large area of the footboard missing with the boards inside material exposed/jagged and a strip of plastic edging material hanging off. Two dressers in the front of the room were also damaged along the front and sides near the bottom areas and were missing pieces of the veneer exposing the material underneath. There was yellow reflective tape on the damaged furniture pieces; however, the tape was not intact and was observed to be worn/peeling off. An interview with Resident #6 on 11/5/24 at 11:46 AM identified that he/she damaged the furniture when previously using an electric wheelchair due to being legally blind and running into the items. Additionally, Resident #6 identified that he/she didn't like the furniture being in disrepair, that it had been damaged for at least three months, and he/she had been waiting for someone to fix the furniture when they were not too busy. An interview with the Maintenance Director on 11/6/24 at 2:45 PM identified although he was aware of the condition of Resident #6's dressers, he was unaware Resident #6's footboard was in disrepair and he had just replaced the item 2 to 3 months ago. The Maintenance Director indicated that the Nursing Department was responsible for environmental rounds, but they had not written a request to replace Resident #6's footboard. Although the Maintenance Assistant performed monthly resident room checks for other items, he was not required to check for damaged furniture, but maybe that task should be added to his monthly checklist. An interview with the Administrator on 11/6/24 at 2:50 PM identified that Resident #6's footbed should not have remained damaged for 3 months and the facility has plenty of footboards in storage. Further, the footboard was made of particle board and was not likely to pose a safety risk; however, it should have been replaced sooner. An interview with the Maintenance Assistant on 11/08/24 at 11:30 AM identified that he performed monthly resident room checks but did not look for damaged furniture. The Maintenance Assistant indicated that he was aware Resident #6's furniture was damaged, the Maintenance Director knew about the issue, but the facility was unable to replace the footboard due to a lack of supplies. Although a verbal request was made to the Maintenance Director for a copy of the facility maintenance logs on the wing where Resident #6 resided, logs were not provided. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility policy for Environmental Rounds identified it was the responsibility of all department heads, managers, and nursing supervisors to monitor and be alert to issues related to the general environment of the facility which included all areas of the facility including resident rooms. Further review identified that interventions were to be instituted at the time problems were noted and notify the appropriate department head, manager, or supervisor of the corrective actions taken. The facility policy for Resident Room Furniture identified that facility staff are to report damaged or missing furniture to the Maintenance Department via the maintenance log and that maintenance staff reviewed the log and repairs or replaces damaged or missing items as soon as practical.

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of clinical records, facility documentation, facility policy and interviews for 6 residents, (Resident #3, Resident #51, Resident #588, Resident #52 and Resident #12) reviewed for grievances, the facility failed to investigate grievances. The findings include: 1. Resident #3 was admitted to the facility in October 2021 with diagnoses that included unspecified disorder of adult personality and behavior, anxiety disorder, and adjustment disorder with depressive mood. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was cognitively intact and required minimal assistance with activities of daily living (ADLs). Additionally, the MDS identified Resident #3 was able to move independently with the use of a motorized wheelchair or rolling walker, eat independently, and self-transfer. A grievance form dated 7/20/23 identified a concern by Resident #3 that he/she had a conversation with the DNS and felt the DNS was curt and dismissive. The grievance lacked documentation that an investigation was conducted. There was no statement from the DNS regarding the incident and no further statements from Resident #3. On 7/27/23, Social Worker (SW) #1 documented on the grievance form she followed up with Resident #3 and a witness would be present for any future conversations between the DNS and Resident #3. A review of SW #1 notes from 7/1/23 through 7/30/23 failed to reflect documentation related to Resident # 3's concerns regarding the DNS's approach and/or resolution. 2. Resident #51 was admitted to the facility in October 2023 with diagnoses that included major depressive disorder, recurrent without severe psychotic features, and anxiety disorder. The annual MDS assessment dated [DATE] identified Resident #51 was cognitively intact and required extensive assistance of 2 people for ADLS, was able to eat independently and utilized a mechanical lift for transfers. A grievance form dated 12/15/23 identified a concern by Resident #51 that he/she waited a long time when he/she rang the call bell. The grievance lacked documentation that an investigation was conducted. There was no documentation when the incident(s) may have occurred and how long Resident #51 had to wait for his/her call bell to be answered. There were no interviews or statements from the Resident #51 and/or nursing staff. On 12/18/23, SW #1 followed up with Resident #1 indicating a call bell audit was initiated. A review of SW #1 notes from 12/1/23 through 12/30/23 failed to reflect documentation related to Resident # 51's concerns regarding call bell response time and/or resolution. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	3. Resident #588 was admitted to the facility in March 2024 with diagnoses that included multiple sclerosis, muscle weakness, and adjustment disorder. The discharge MDS assessment dated [DATE] identified Resident #588 was cognitively intact and required the assistance of 2 with ADLS, was able to eat independently and required a mechanical lift for transfers. A grievance form dated 4/3/24 identified a concern by Resident #588 that he/she felt rushed to get ready by a Nurse Aide (NA). The grievance lacked an investigation (i.e. regarding date of occurrence, and what activity was being performed by NA when Resident #588 felt rushed). There was no interview and/or statement from Resident #588 or the NA. The resolution to the grievance was education to be provided to staff. A review of SW #1 notes from 4/1/24 through 4/30/24 failed to address Resident #588's concerns related to feeling rushed getting ready and/or a resolution. 4. Resident #52 was admitted to the facility in August 2024 with diagnoses that included adjustment disorder and anxiety. A Significant Change MDS assessment dated [DATE] indicated that Resident #52 was cognitively intact and required assistance of 1 with ADLs, was able to eat independently and required a mechanical lift for transfers. A grievance form dated 10/3/24 indicated that Resident #52 put his/her call bell on and felt like he/she waited a long time. The grievance lacked documentation that an investigation was conducted, there was no documentation when the incident may have occurred, how long Resident # 52 had to wait for his/her call bell to be answered and no interview or statements from Resident #52 and/or nursing staff. The grievance form further identified on 10/3/23 that SW #1 confirmed the call bell was functioning properly and initiated call bell audits. A review of SW #1 notes from 10/1/24 through 10/30/24 failed to reflect documentation of Resident #52's concerns related to call bell response time and/or resolution. 5. Resident #12 was admitted to the facility in July 2024 with diagnoses that included anxiety disorder and muscle weakness. A quarterly MDS assessment dated [DATE] identified Resident #12 was moderately cognitively impaired and required assistance of 1 with ADLs, was able to eat independently after meal set up and required assistance of 1 with transfers. A grievance form dated 10/15/24 was initiated by Person #4 on behalf of Resident #12 with SW #1 indicating that he/she had some questions regarding the approach of a NA. The grievance lacked an investigation regarding date of occurrence, and the NA's approach with Resident #12. There was no interview and/or statement from Resident #12, NA's and (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	nursing staff. The resolution to the grievance was customer service education to the NA. A review of SW #1 notes from 10/1/24 through 10/30/24 failed to reflect documentation related to Resident #12's concerns regarding the NA approach. An interview with SW #1 on 11/8/24 at 11:30 AM identified that there was no other documentation or investigation for the grievances for Resident #3, Resident #51, Resident #587, Resident #588, Resident #52 and Resident #12 and if there was, it would be attached to the Grievance form. SW #1 indicated that there needed to be more details, specifics and a timeline of what occurred. Furthermore, SW # 1 indicated that the grievances did not have a complete investigation. A review of the Grievance Policy and Procedure date 7/15/2017 directed, in part, upon receipt of Concern/Grievance forms, the Social Service Director/Designee reviewed the concern involving other departments as appropriate and then Concerns/Grievances were reviewed with the interdisciplinary team members at morning report. The assigned Department head investigated the concern and took action to correct the identified problem.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on staff interview, observations, review of the clinical record, and facility policy for 1 of 8 residents (Resident #13) reviewed for accidents, the facility failed to implement fall prevention interventions as per the Resident Care Plan (RCP). The findings include: Resident #13's diagnoses included dementia, lack of coordination, and abnormality of gait and mobility. The RCP dated 9/3/19 through 11/7/24 identified Resident #13 had a history of falls with no serious injury (fell on [DATE], 7/11/22, 11/2/22, 5/22/23, 10/25/23, 11/13/23, and 9/24/24). Interventions implemented to prevent future falls included the placement of a floor mat to the door side of the bed at nighttime, wearing proper footwear, placement of skid strips in front of the dresser and next to his/her bed on the door side of the bed. An Advanced Practice Registered Nurse (APRN) progress note dated 11/13/23 directed skid strips in front of the dresser. The significant change in status Minimum Data Set assessment dated [DATE] identified Resident #13 had moderately impaired cognition, was independent in achieving a sit to stand position from a bed or his/her wheelchair and required moderate assistance in walking 10 feet. Additionally, the MDS identified Resident #13 had no falls within the previous month. A Fall Risk assessment dated [DATE] identified Resident #13 was at a moderate risk for falls. Observation on 11/6/24 at 12:01 PM failed to identify skid strips were applied to the floor in front of the dresser as per APRN orders. Additionally, skid strips were present on the door side of the bed, but there were no floor mats next to the bed or located anywhere in the room. An interview with Nurse Aide (NA) #1 on 11/7/24 at 9:18 AM identified that fall prevention interventions for NA's to follow were listed on the electronic Kardex. Review of the Kardex with NA #1 identified that floor pads and skid strips were not included on the Kardex. NA #1 noted that Resident #13 was not a fall risk because he/she did not have anything listed on the Kardex identifying Resident #13's fall risk. NA #1 further indicated for residents with floor pads listed on the Kardex, the NAs would be responsible for placing the floor mats next to the bed at night and removing them in the morning. NA #1 noted for all residents who use a floor mat for fall prevention, the floor mats were stored behind the resident's bed or next to their closet and never removed from their room. An observation of Resident #13's room with NA #1 during the interview failed to locate floor mats for Resident #13 within his/her room and NA #1 stated she had never placed or removed floor mats from Resident #13's floor as she was not aware of the need for floor mats. Further, NA #1 also failed to identify the placement of skid strips in front of Resident #13's dresser. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #1 on 11/7/24 at 9:30 AM identified that the Nurse Supervisor was responsible for transcribing information from a RCP to the Kardex. During a review of Resident #13's RCP with LPN #1, it was noted Resident #13 should have floor mats, skid strips, and proper footwear as part of his/her fall mitigation interventions. An observation of Resident #13's room with LPN #1 during the interview failed to locate floor mats or the placement of skid strips in Resident #13's room per the RCP. Subsequent to surveyor inquiry, LPN #1 notified the Nursing Supervisor of the intervention of floor pads and skid strips for Resident #13. An observation of Resident #13's room on 11/7/24 at 9:35 AM with RN #1 identified that neither floor pads nor skid strips in front of the dresser were in the room. RN #1 failed to identify the reason neither the floor pads nor skid strips were being used for Resident #13. Post-surveyor inquiry, the Kardex Report dated 11/7/24 was updated for Resident #13 to include placement of skid strips in front of the dresser and next to his/her bed on the door side of the bed, and the placement of a floor mat to the door side of the bed at nighttime. Review of the facility's Falls Mitigation policy identified that nurses are responsible for updating the RCP after a resident fall with interventions to prevent future falls.

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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** 50249 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #30), reviewed for a change in condition, the facility failed to follow the physician order for blood sugars and blood pressures, and for 1 of 2 residents (Resident #34), reviewed for accidents and hazards, the facility failed to administer medications to the appropriate resident. The findings include: 1. Resident #30's diagnoses include type 2 diabetes, hypertension, and vascular dementia. The Resident Care Plan (RCP) dated 7/24/24 identified Resident #30 had hypertension with an intervention to monitor vital signs per physician (MD) order and notify the MD of abnormalities in the vital signs. Furthermore, the RCP identified Resident #30 had a history of abnormal glucose levels for which the intervention was to perform blood glucose checks and MD notification per provider orders. The Quarterly Minimum Data Set assessment dated [DATE] identified Resident #30 had severe cognitive impairment, required insulin injections for diabetes management, and required maximal assistance with chair/bed to chair transfers. a. An order from MD #1 dated 10/1/24 directed blood glucose levels were to be completed two times a week, on Monday and Thursday both in the morning (AM) and night (PM), and to notify the MD if levels were below 70 or above 350. A Weights and Vitals Summary identified on Thursday 10/10/24 at 4:50 PM, Resident #30's blood glucose level was 417 milligrams (mg)/deciliter (dl) (physician orders directed to notify MD if levels were above 350). Additionally, on Thursday 10/24/24 at 10:27 PM, Resident #30's blood glucose level was 402 mg/dl (physician orders directed to notify MD if levels were above 350) and on Monday 10/28/24 at 4:50 AM, Resident #30's blood glucose level was 69 mg/dl (physician orders directed to notify the MD if levels were below 70). An interview and record review on 11/7/24 at 12:11 PM with RN #1 failed to identify the MD or Advanced Practice Registered Nurse (APRN) was notified on 10/10/24, 10/24/24, or 10/28/24 regarding Resident #30's blood glucose levels being above 350 or below 70. RN #1 further indicated that nursing document when calls are made to providers within their progress notes. An interview on 11/7/24 at 1:25 PM with MD #1 identified that he could not recall if he was notified on 10/10/24, 10/24/24, or 10/28/24 of Resident #30's blood glucose results. MD #1 indicated if he were notified, he would have wanted to ask staff if Resident #30 had any symptoms related to an abnormal blood glucose and would have asked staff to monitor him/her for such symptoms. An interview with Registered Nurse (RN) #4 on 11/7/24 at 3:03 PM failed to identify that she notified the nursing supervisor or MD #1 of any abnormalities in Resident #30's blood glucose levels on 10/10/24 after her documentation of an abnormal blood glucose level of 417 mg/dl. She further indicated that a progress note should have been written and the nursing supervisor should have been notified of a blood glucose level to contact the MD per the 10/1/24 MD blood glucose orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A progress note from APRN #1 dated 10/10/24 identified Resident #30 was being evaluated for a change in condition for a weight gain of greater than 5% within a 30-day timeframe after a medication change. As an intervention, documented within the progress note, APRN #1 directed staff to monitor Resident #30's blood pressure daily. Review of physician orders from 10/10/24 through 11/8/24 failed to identify that a RN transcribed APRN #1's order for daily blood pressure monitoring into the electronic medical record (EMR). Resident #30's Weights and Vitals Summary from 10/10/24 through 11/2/24 identified no blood pressure readings were recorded on 10/10/24, 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, 10/16/24, 10/17/24, 10/18/24, 10/19/24, 10/20/24, 10/21/24, 10/22/24, 10/23/24, 10/24/24, 10/25/24, 10/27/24, 10/28/24, 10/29/24, 10/30/24, and 10/31/24 (missing 21 of 24 opportunities). An interview with APRN #1 on 11/8/24 at 11:26 AM identified that the RN supervisor for 10/10/24 was responsible for transcribing APRN #1's order for daily blood pressures into the EMR as she enters orders into the progress note then verbally provides the RN manager with the order to be entered. APRN #1 stated she was not physically present in the facility at 4:50 PM on 10/10/24 when the order was given, so the order was given to the RN supervisor over the telephone. An interview with RN #5 on 11/8/24 at 11:45 AM, (the nursing supervisor working on 10/10/24 at 4:50 PM), failed to identify that she transcribed the daily blood pressure order into the EMR. An interview and record review with the Director of Nursing Services (DNS) on 11/8/24 at 11:49 AM failed to identify that an order for daily blood pressures for Resident #30 was entered into the EMR. Subsequent to surveyor inquiry, the DNS transcribed the orders for daily blood pressures into the EMR. Review of the Policy identified that it is the responsibility of the RN Supervisor to transcribe orders from the Physician's order sheet or other referring documentation source to the EMR. 2. Resident #34's diagnoses included dementia, chronic kidney disease, atrial fibrillation and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 was severely cognitively impaired and required physical assistance of 1 person for bed mobility, toileting and transfers. The Resident Care Plan dated 9/13/24 identified an impaired cognitive function. Interventions included to administer medications as ordered and monitor and document for side effects and effectiveness. A nursing progress note dated 10/30/24 at 5:00 AM identified Resident #34 had received the wrong medications during morning medication pass. The progress note indicated that an Advanced Practice Registered Nurse (APRN) was notified and recommended to monitor Resident #34's vital signs and monitor for sedation or a change in mental status. (continued on next page)

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	075310	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave Plainfield, CT 06374

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's medication error report dated 10/30/24 identified that Resident #34 was administered Baclofen 10 mg, Hydralazine 25 mg, Gabapentin 300 mg and Levothyroxine 112 mcg in error on 10/30/24 at 5:00 AM by LPN # 2. The medication error report indicated that Resident #34 should have been administered Omeprazole 20 mg and Synthroid 88 mcg on 10/30/24 at 5:00 AM but was administered the wrong medications. The medication error report further identified that an on-call advanced practice registered nurse (APRN) was notified of the error along with Resident #34's responsible party. An APRN (APRN #1) progress note dated 10/30/24 at 2:35 PM identified Resident #34 was evaluated after a medication error where he/she received another resident's medications. The progress note indicated that after Resident #34 received the wrong medications he/she was very drowsy but was able to briefly open his/her eyes. Additionally, the progress note identified that due to Resident #34's fatigue and weakness he/she was to be monitored closely for any adverse effects due to the medication error. APRN #1 indicated in her progress note that she would follow-up with the nursing staff regarding correct medication administration as well as prevention of recurrence in the future. An APRN (APRN#1) progress note dated 11/1/24 at 12:00 PM identified Resident #34 was evaluated status post episode of lethargy and somnolence after being administered the wrong medications. The progress note indicated that Resident #34 was more awake and alert without any complaints. APRN#1 identified in her progress note that Resident #34 would continue to be monitored for any delayed adverse effects. Interview with APRN #1 on 11/7/24 at 10:40 AM identified she was aware of the medication error on 10/30/24 when Resident #34 received Baclofen 10 mg, Hydralazine 25 mg, Gabapentin 300 mg and Levothyroxine 112 mcg in error. APRN#1 indicated that she evaluated Resident #34 on 10/30/24 and was concerned about the resident's sedation because he/she was sleeping a lot that day. APRN #1 further identified that Resident #34 was closely monitored and was not found to be unstable. APRN #1 indicated that LPN #2 had not correctly identified Resident #34 before she administered him/her Resident #9's medications in error. Interview with DNS on 11/7/24 at 11:00 AM identified that on the morning of 10/30/24, LPN #2 administered Resident #9's medications to Resident #34 in error. The DNS indicated that after the medication error, LPN#2 received re-education at the facility and has not been back to work at the facility. The DNS identified that, although she was unable to indicate if the facility's investigation had concluded that Resident #34 identification band was in place the morning of 10/30/24, LPN #2 had other methods to identify Resident #34 before she administered the wrong medications. The DNS indicated other identification methods would have included review of the resident's photo in the administration record or the resident's name posted above the bed as well as other facility staff could have assisted LPN #2 with identification of Resident #34. Subsequent to surveyor inquiry on 11/7/24 at 2:00 PM the DNS identified that the nursing agency which employed LPN #2 had been contacted and informed her that LPN #2 was counseled by the nursing agency after the medication error occurred. The DNS further indicated that LPN #2 had been placed on the facility's do not return list. (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 LPN #2 on 11/7/24 at 3:00 PM identified that she was working at the facility on 10/30/24 and was responsible for administering morning medications to Resident #34. LPN #2 indicated that she dispensed Gabapentin, Baclofen, Hydralazine and Levothyroxine for Resident # 9 and then went into the wrong room and administered the medications to Resident #34 in error. LPN #2 identified that when she went to dispense Resident #34's medications and saw the resident's picture in the administration record, she realized she had already given the wrong medications to Resident #34. LPN #2 further indicated that she failed to identify Resident #34 before she administered medications to the resident on 10/30/24 and she should not have done that. Review of the facility policy, Medication Administration and Documentation, undated, directed that medication administration occurs in an accurate manner and residents are to be identified before medications are administered. 51182 Based on observations, interviews, and record review for 1 of 2 residents, (Resident #40), reviewed for respiratory care, the facility failed to obtain a physician's order to administer oxygen to a resident with Chronic Obstructive Pulmonary Disease (COPD). The findings include: Resident #40's diagnoses included chronic obstructive pulmonary disease, type 2 diabetes mellitus, and hypertension. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #40 was severely cognitively impaired, and independent for eating, toileting, and transfers. Additionally, Resident #40 had no shortness of breath but was receiving respiratory treatments. The Resident Care Plan dated 10/8/24 identified Resident #40 had COPD. Interventions included to give aerosol and bronchodilators as ordered and monitor for difficulty breathing on exertion. The care plan did not indicate oxygen use. Observations on 11/4/24 at 11:40 AM, 11/5/24 at 10:02 AM, and 11/7/24 at 9:25 AM identified Resident #40 was receiving oxygen at 1 liter per minute from a concentrator (not an emergency tank), via a nasal canula (tubing). Interview and record review with Registered Nurse (RN) #1 on 11/7/24 at 9:30 AM identified licensed nurses were responsible to check the physician's order for oxygen use to identify how much oxygen to administer and ensure any orders to titrate (increase or decrease) the oxygen flow rates were implemented. Although the facility policy indicated that oxygen could have been put in place as a nursing measure, review of the documentation with RN #1, failed to identify oxygen use in the physician's orders, nursing progress notes, or the care plan for the 3 days Resident #40 was observed to be receiving oxygen therapy. Interview with APRN #1 on 11/7/24 at 10:39 AM identified she was familiar with Resident #40, his/her diagnosis of COPD, and that parameters for oxygen saturations should have been maintained between 88% and 92%. APRN #1 indicated although she would assess Resident #40 for oxygen use, his/her saturations were in the 90's so oxygen use would be unlikely. Additionally, she stated she tried to avoid giving residents with COPD oxygen if it was unnecessary as oxygen use caused retention of carbon dioxide in the lungs and increased the bicarbonate in the body which impeded breathing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, Resident #40 was assessed by APRN #1, and an order was placed to administer oxygen at 1 liter per minute via nasal canula, every shift, as needed, to maintain oxygen saturations greater than 88% and to titrate oxygen by 0.5 liters per minute via nasal canula to maintain oxygen saturations greater than 88% every shift. The Oxygen Administration Policy and Procedure dated 4/15/23 identified that it was the policy of the facility to ensure residents requiring oxygen were administered oxygen per the physician's orders. In addition, when an emergency arouse, the nurse may administer oxygen at 2 liters per minute via nasal canula and obtain physician orders within 24 hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #34) reviewed for nutrition, the facility failed to appropriately supervise a resident during mealtime per the physician's order and during the initial facility tour, the facility failed to ensure water temperatures were maintained within acceptable parameters of 105 to 120 degrees Fahrenheit for 17 of 50 rooms. The findings include: 1. Resident #34's diagnoses included dementia, dysphagia, gastro-esophageal reflux disease and pneumonia with respiratory failure. A physician's order dated 8/8/24 directed supervision and out of bed with upright posture for meals. A Speech Therapy (ST) #1 progress note dated 8/8/24 at 3:03 PM identified that staff were reminded Resident #34 would benefit from eating his/her meals in the dining room and supervision for meals was required. The progress note further indicated that Resident #34's physician's orders for eating had been changed to supervision and to be out of bed with upright posture for meals. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 was severely cognitively impaired and required physical assistance of 1 person for bed mobility, toileting and transfers. The MDS further indicated signs and symptoms of a possible swallowing disorder as evidenced by loss of liquids/solids from the mouth when eating or drinking with nutritional approaches applied as mechanically altered/therapeutic diet. The Resident Care Plan dated 9/13/24 identified a nutritional problem related to dysphagia and a self-care performance deficit. Interventions included to monitor, document and report any signs and symptoms of dysphagia with supervision and to be out of bed with upright posture for meals. A nursing progress note dated 9/28/24 at 5:30 PM identified that Resident #34 had a foreign body airway obstruction during mealtime and was unable to communicate for a short period of time due to persistent coughing. The progress note further indicated that Resident #34's diet was downgraded and a speech therapy consult was ordered. A physician's order dated 9/28/24 directed to provide Resident #34 with a regular diet with dysphagia puree texture and regular liquid consistency. A physician's order dated 9/30/24 directed a speech therapy dysphagia evaluation and treatment for management of dysphagia. ST #1's progress note dated 9/30/24 at 2:30 PM identified Resident #34 was seen for a swallowing evaluation after an episode of coughing while eating spaghetti over the weekend which resulted in his/her diet being downgraded to puree. The progress note included that skilled speech therapy was indicated for delivery of education and training with staff caregivers related to diet recommendations and the use of safe swallowing strategies to minimize the risk of aspiration. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ST #1's progress noted dated 10/16/24 at 12:51 PM identified that Resident #34 was complaining of a hard time swallowing and was spitting up brown mucous prior to any oral intake. The progress note indicated that Resident #34 was eating moderate portions of breakfast without overt signs or symptoms of aspiration despite intermittent complaints of difficulty with swallowing. Advanced Practice Registered Nurse (APRN) #1's progress note dated 10/17/24 at 1:30 PM identified Resident #34 was seen for follow-up of possible cough with brown tinged sputum. The progress note indicated that Resident #34 was seen on 10/16/24 for brown sputum and the resident reported trouble swallowing with his/her diet downgraded due to dark brown tinged sputum observed that morning. APRN #1's progress note dated 10/30/24 at 2:45 PM identified Resident #34 continued to be followed by ST for dysphagia and should continue to be monitored for swallowing ability with diet adjustments made as needed. Observation 11/04/24 at 12:30 PM identified Resident #34 was in his/her room sitting in the bedside recliner and was independently eating a pureed meal of meat and vegetables. Resident #34 was unsupervised and alone in his/her room while eating lunch. Observation on 11/6/24 at 7:45 AM identified Resident #34 was in his/her room and was sitting up at the side of the bed when NA# 2 delivered his/her breakfast tray and left the room. Resident #34 was independently eating her pureed meal of cheese omelet and toast. Resident #34 was seated behind the privacy curtain and was unsupervised and alone in his/her room while eating breakfast. Interview with ST #1 on 11/7/24 10:20 AM identified he was familiar with Resident #34 and had frequently worked directly with him/her for a diagnosis of dysphagia. ST #1 indicated that Resident #34 was to be supervised by staff during all meals and staff were to monitor and assist if he/she had any swallowing difficulty during the meal. ST #1 further identified that the reason for Resident #34's meal supervision was to minimize his/her risk of aspiration or choking. Additionally, ST #1 identified when Resident #34 was dining in his/her room, staff should have been present in the room and supervised the resident while he/she was eating. ST #1 indicated that he would need to remind the nursing staff regarding Resident #34's required supervision during meals. Interview and record review with APRN #1 on 11/7/24 at 10:30AM identified that Resident #34 had a current order for supervision during meals. APRN #1 indicated that the order for supervision meant that staff was present and monitored Resident #34 while he/she ate and drank during his/her mealtimes. APRN #1 identified that if Resident #34 was dining in his/her room, the nursing staff should have been present in the room while Resident #34 was eating. Additionally, APRN #1 indicated that, due to a diagnosis of dysphagia, Resident #34 required supervision by the nursing staff in order to be monitored for aspiration or choking during meals. APRN #1 further identified that she would need to address the lack of supervision further with the nursing supervisor on that unit. Interview with NA #2 on 11/7/24 at 3:18PM identified that on the morning of 11/6/24 she had served Resident #34 his/her breakfast tray. NA #2 indicated that since Resident #34 was independent and just a set-up, Resident #34 ate breakfast unsupervised. Additionally, NA #2 identified she was not in the room with Resident #34 while he/she was eating, and only went back into the room to pick up the breakfast tray. NA #2 further indicated that although the NA care card directed that Resident #34 was to have supervision during meals, she was not aware the resident needed to be supervised because she had not referenced the NA care card before providing care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Supervison Resident Dignity During Mealtimes Policy and Procedure, dated 12/29/12, directed, in part, that residents requiring supervision while eating in their room may be observed by the nurse assigned to the unit. 2. Observations of water temperatures on 11/4/24 at 12:00 PM identified the following: A. room [ROOM NUMBER] the water temperature was 124 degrees. B. room [ROOM NUMBER] the water temperature was 125.6 degrees. C. room [ROOM NUMBER] the water temperature was 124.5 degrees. D. room [ROOM NUMBER] the water temperature was 125.8 degrees. E. room [ROOM NUMBER] the water temperature was 126.3 degrees. F. room [ROOM NUMBER] the water temperature was 126.7 degrees. G. room [ROOM NUMBER] the water temperature was 124.0 degrees. H. room [ROOM NUMBER] the water temperature was 121.1 degrees. I. room [ROOM NUMBER] the water temperature was 128.1 degrees. J. room [ROOM NUMBER] the water temperature was 123.8 degrees. K. room [ROOM NUMBER] the water temperature was 123 degrees. L. room [ROOM NUMBER] the water temperature was 128.5 degrees. M. room [ROOM NUMBER] the water temperature was 121.3 degrees. N. room [ROOM NUMBER] the water temperature was 122.5 degrees. O. room [ROOM NUMBER] the water temperature was 126.3 degrees. P. room [ROOM NUMBER] the water temperature was 126.0 degrees. Q. room [ROOM NUMBER] the water temperature was 130 degrees. An interview on 11/4/24 at 12:30 PM with the Maintenance Director identified that he thought the water temperature acceptable parameters were to be maintained between 105 degrees to 125 degrees. Additionally, he indicated that the mixing valve was set at 145 degrees. Review of the temperature logs from 2/29/24 to 10/30/24 identified that for 133 days out of 168 days the water temperatures were logged at 121 degrees or higher, with the highest temperature being 130 degrees on 9/3/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/4/24 at 12:35 PM with the Administrator identified that the water system could be bled and purged to force the water temperatures to be lowered and that the buildings high water temperatures could be fixed in minutes using this method. Subsequent to surveyor inquiry, the water temperatures were adjusted. Review of the facility Water Temperature Policy and Procedure identified water that water temperatures were to be maintained between 105 and 120 degrees Fahrenheit and were not to exceed 120 degrees Fahrenheit at all water sources to ensure individual safety for those with access. Additionally, staff were trained and aware that temperatures could rise or fall due to seasonal changes and circulation devices and that the Maintenance Director was responsible to review variances and adjust the mixing valve to proper temperatures as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of the clinical record, facility policy and interviews for the only sampled resident, (Resident #49), reviewed for hemolytic treatment, the facility failed to communicate a new allergy to the treatment center. The findings include: Resident #49's diagnosis included chronic kidney disease, end stage renal disease, diabetes, and was noted to be legally blind. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #49 was cognitively intact, required set up for eating, and partial/moderate assist for showering, dressing, and personal hygiene. Also, identified was that Resident #49 required a wheelchair and went for hemolytic treatments. A nursing progress note dated 8/19/24 identified that Resident #49 had a change in condition on 8/19/24 related to an allergic reaction from eating peanut butter. Resident #49 experienced numbness and tingling to his/her lips. The APRN was notified and directed to add peanut butter to the allergy list. The Resident Care Plan (RCP) dated 8/20/24 identified Resident #49 was receiving hemolytic treatments and had impaired visual function. Interventions included to send out for hemolytic treatments 3 times weekly and have staff tell Resident #49 where they were placing items to assist with visual impairment. Interview with Resident #49 on 11/7/24 at 10:50 AM identified that he/she was allergic to peanuts and on 11/6/24 he/she was sent for hemolytic treatment with peanut butter crackers which was provided by the facility. Resident #49 stated that the staff at the hemolytic treatment center got the facility provided food out of the backpack for him/her because of his/her visual impairment. Resident #49 indicated that when offered, she/he refused the peanut butter crackers because eating peanuts would have produced another allergic reaction (hives and shortness of breath.) An interview with RN #1 on 11/7/24 at 11:03 AM identified that Resident #49 was sent for treatments with a sandwich and with a protein snack, usually peanut butter crackers. Subsequent to surveyor's inquiry RN #1 returned to the surveyor on 11/7/24 at 2:00 PM and indicated she made an error when stating that Resident #49 was sent to treatments with peanut butter, and that Resident #49 was sent with cheese and crackers. Interview with the hemolytic center employee on 11/8/24 at 10:01 AM identified that Resident #49 has been sent with peanut butter crackers from the facility and that the treatment center was unaware of a peanut allergy as it was not identified on the W10 transfer record form. She further identified that it was not in the electronic medical record at the treatment center. Review of the hemolytic center book, W10 transfer form, which accompanied Resident #49 to every visit, was noted to be dated March 2024. The W-10 failed to indicate Resident #49's peanut allergy. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interview and review of the clinical record with the Director of Nursing (DNS) on 11/8/24 at 11:18 AM identified Resident #49's allergy was first noted on 8/19/24. The DNS identified that the W10 should have been updated to reflect the peanut allergy. The DNS was unable to find documentation that the hemolytic treatment center had been advised of Resident #49 's allergy to peanuts. The DNS indicated that the W10 that was in the treatment book was the form that accompanied Resident #49's appointments to the treatment center. Review of the facility policy and procedure for hemolytic treatment residents identified that a Licensed Nurse was to review the communication form for changes and update. Review of the hemolytic treatment contract identified that the facility shall ensure that all appropriate medical information accompany residents at the time of transfers to the center including any changes in a patient's condition.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51313 Based on observations, staff interviews, and review of facility policy, the facility failed to ensure foods were dated when opened and staff personal food/fluids were not stored in the facility walk-in refrigerator. The findings include: On 11/4/24 at 10:40 AM, a tour of the Dietary Department with the Food Service Director (FSD) identified the following: A. In the dry storage area, opened and undated: one box of oatmeal cookies, one box of Oreo cookies, and a 5-gallon bucket of chicken base. B. In the main freezer- opened and undated: one bag of fried steak and one bag of Salisbury steak, two uncooked pie shells, 5 cooked apple pies, and 6 boxes of frozen cookies. C. In the walk-in refrigerator: opened and undated one 5-gallon bucket of pickles and a staff's lunch bag was noted to be stored on a shelf with facility supplied resident food items. Interview with the FSD on 11/4/24 at 10:40 AM indicated that he or the chef were responsible for dating items when the packaging was opened. He was unable to explain why the identified items were opened and undated. The FSD was unable to explain the reason Dietary Aide #1 had stored her lunch bag with resident food, the facility policy prohibited staff storing items in the walk in refrigerator, and subsequent to surveyor inquiry, he stated he would have the lunch bag removed. Interview with Dietary Aide #1 on 11/7/24 at 10:50 AM identified she was working on 11/4/24 and had stored her lunch bag in the main walk-in refrigerator of the facility's kitchen. Dietary Aide #1 indicated that she normally did not bring a lunch bag, but she brought extra drinks to work and put everything in there on that day. Dietary Aide #1 further identified that she was aware that facility policy prohibited the storage of personal food in the main walk in refrigerator and should not have put her lunch bag there. Review of the facility food storage policy directed that dry storage foods would be dated as appropriate and cold foods would be labeled and dated.