STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075312	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wadsworth Glen Health Care and Rehabilitation Cent	30 Boston Rd Middletown, CT 06457

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, facility documentation, and facility policy the facility failed to ensure that the dietician reviewed and approved menus and failed to ensure portion sizes were included on posted menus. The findings include:Observation on 8/4/2025 at 11:50 AM of the facility's posted menu in the kitchen area identified breakfast entrees included cream of wheat, a donut, and scrambled egg; lunch entrees included baked chicken with rice, baked ham with seasoned zucchini and onions, boiled potatoes with parsley, a dinner roll, and peaches and cream; dinner entrees included vegetable and cheese quiche with chef's vegetable, oven browned potatoes, and dinner roll , BBQ pork on a bun with coleslaw, and sherbet. The menu failed to include serving sizes for any of the posted meals.Observation on 8/4/2025 at 12:18 PM of the facility's second floor dining room posted menu failed to include serving sizes for any of the listed meals.Interview on 8/6/2025 at 11:15 AM with Regional Dietician #2 identified menus came from an agency and are reviewed by all the on-site dieticians. Further, she identified that she had not signed the menus before emailing them to the facility. Regional Dietician #2 indicated that it was the expectation of the Dietary Director to include portion sizes on the posted menus, she had spoken with him on several occasions previously regarding the absence of portion sizes and had shown him how to print the menus to include the portion sizes.Observation on 8/6/2025 at 12:10 PM of the facility's third floor dining room posted menu failed to include serving sizes for any of the listed meals.Interview on 8/11/2025 with the Dietary Director identified that the kitchen menus were not signed by the on-site dietician because there may be changes to the menu during the week. Further, he stated that he prints the menus for posting as they are sent to him by dietary and indicated that portion sizes were not included on the menu he received from dietary. Interview on 8/11/2025 at 10:33 AM with Dietician #3 identified she has not received any emails from Regional Dietician #2 with a facility menu. Further, she identified that she does not sign the menus after they are reviewed or print menus for the facility to post.Review of the Food First - Nutrition Policy identified, in part, that menus are posted in designated areas. The facility policy failed to identify that portion sizes should be included on posted menus.Review of the Food and Dining Service Policy identified, in part, that therapeutic diets are to be planned by a qualified registered dietician, and that necessary substitutions are made by the dietician and/or food service manager and documented on the appropriate form. The policy failed to include the facility's dietician should review the menus and maintain a signed and reviewed copy of the menu.

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

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and a temperature test, for sampled residents (Resident #1, Resident #2, Resident #38, Resident #45, Resident #66, Resident #70 and Resident #76) reviewed for dietary services, the facility failed to ensure that food was palatable and failed to serve food at a safe and appetizing temperature. The findings included:1. Resident #1's diagnoses included fracture of the left patella, fracture of the left femur, and Type 2 diabetes mellitus.Interview with Resident #1 on 8/5/2025 at 10:48 AM identified he/she found the quality of the food to be terrible and that the food was served cold. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, was independent with eating, and required a mechanically altered diet.The Resident Care Plan (RCP) in effect on 8/4/2025 identified Resident #1 had a potential for impaired nutrition status due to unintentional weight loss, poor dentition, and a modified consistency diet. Interventions included providing supplements with meals, assisting with meals as needed, and assess and monitor the presence of factors interfering with nutrition status.A physician order in effect on 8/4/2025 identified Resident #1 was to receive a regular diet of mechanical soft ground texture, and thin (regular) liquid consistency.2. Resident 2's diagnoses included chronic kidney disease, chronic systolic and diastolic heart failure, and gastro-esophageal reflux disease.Interview with Resident #2 on 8/4/2025 at 2:57 PM identified he/she was concerned that the food was always cold.The quarterly MDS assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severe cognitive impairment, was independent with eating, and had no nutritional concerns.The Resident Care Plan in effect on 8/4/2025 identified Resident #2 was at risk for malnutrition. Interventions included providing supplements with meals, assisting with meals as needed, and assess and monitor the presence of factors interfering with nutrition status.A physician order in effect on 8/4/2025 identified Resident #2 was to receive a regular diet of regular consistency texture, and a thin (regular) liquid consistency.3. Resident 38's diagnoses included chronic systolic and diastolic heart failure, mixed lipidemia, and gastro-esophageal reflux disease.Interview with Resident #38 on 8/4/2025 at 2:57 PM identified many times he/she did not receive the substitute meal he/she requested, and that the food was always cold.The quarterly MDS assessment dated [DATE] identified Resident #38 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, required set-up with eating, and required a therapeutic diet.The Resident Care Plan in effect on 8/4/2025 identified Resident #38 was at risk for impaired nutrition status. Interventions included providing diet as ordered, obtain and update preferences as needed, and provide snacks as desired and in compliance with diet order.A physician order in effect on 8/4/2025 identified Resident #38 was to receive a low fat/low sodium diet of regular consistency texture, and thin (regular) liquid consistency.4. Resident 45's diagnoses included osteoarthritis, hyperparathyroidism, and gastro-esophageal reflux disease.Interview with Resident #45 on 8/04/2025 at 10:30 AM identified that the food was always cold, and that the food did not taste good.The quarterly MDS assessment dated [DATE] identified Resident #45 had a Brief Interview of Mental Status (BIMS) score of 3 indicating severe cognitive impairment, was independent with eating, and required a therapeutic diet.The Resident Care Plan in effect on 8/4/2025 identified Resident #45 was at risk for malnutrition. Interventions included providing supplements with meals, provide snacks as desired and in compliance with diet order, and assess and monitor the presence of factors interfering with nutrition status.A physician order in effect on 8/4/2025 identified Resident #45 was to receive a low sodium diet of regular consistency texture, and thin (regular) liquid consistency.5. Resident #66's diagnoses included Type 2 diabetes, Stage 3 chronic kidney disease, and hyperlipidemia.Interview with Resident #66 on 8/4/2025 at 12:30 AM identified the food was delivered cold at all meals.The quarterly MDS assessment dated [DATE] identified Resident #66 had a Brief Interview of Mental Status (BIMS) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 9 indicating moderate cognitive impairment, was independent with eating, and required a mechanically altered diet and a therapeutic diet.The Resident Care Plan in effect on 8/4/2025 identified Resident #66 had a potential for impaired nutrition status due to the need for a therapeutic diet and need for a texture modified diet. Interventions included assist with meals as needed, monitor weight as needed, and assess and monitor the presence of factors interfering with nutrition status.A physician order in effect on 8/4/2025 identified Resident #66 was to receive a controlled carbohydrate diet of regular consistency texture, and nectar thick liquid consistency.6. Resident #70's diagnoses included Type 2 diabetes, chronic diastolic heart failure, and hyperlipidemia.Interview with Resident #70 on 8/4/2025 at 11:45 AM identified the food did not taste good and there was not a variety of options for meals to choose from.The quarterly MDS assessment dated [DATE] identified Resident #70 had a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment, required set-up assistance with eating, required a therapeutic diet, and had a documented unintended significant weight loss.The Resident Care Plan in effect on 8/4/2025 identified Resident #70 was at risk for malnutrition due to the need for a therapeutic diet and history of weight variances. Interventions included obtain and update food preferences as needed, monitor weight as needed, and assess and monitor the presence of factors interfering with nutrition status.A physician order in effect on 8/4/2025 identified Resident #70 was to receive a controlled carbohydrate diet of regular consistency texture, and thin (regular) liquid consistency. 7. Resident #76's diagnoses included Type 2 diabetes, hypertension, and hyperlipidemia.Interview with Resident #76 on 8/4/2025 at 12:41 PM identified that many times the food was cold and did not taste good.The annual MDS assessment dated [DATE] identified Resident #76 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required set-up assistance with eating, and required a therapeutic diet.The Resident Care Plan in effect on 8/4/2025 identified Resident #76 had a potential nutritional problem related to obesity. Interventions included providing supplements as ordered, providing and serving his/her diet as ordered, and weigh at the same time of day weekly per physician orders.A physician order in effect on 8/4/2025 identified Resident #76 was to receive a controlled carbohydrate no added salt diet of regular consistency texture, and thin (regular) liquid consistency.On 8/6/2025 at 12:12 PM observation, interview and temperature check of the steam table was conducted with Kitchen Worker #1. The Director of Dietary was invited and declined to participate in the temperature check of the steam table, and instead he provided Kitchen Worker #1 his thermometer to use during the temperature check. Observation identified the lunch steam table contained breaded fish, chicken, mixed carrots and peas, mashed potatoes, and baked potatoes, and the steam table was plugged into a wall receptacle. The fish was noted to have a temperature of 122.0 degrees Fahrenheit (F), the chicken was 150.0 F. the mashed potatoes were 156.0 F, the carrots and peas were 160.0 F per the Dietary Director's thermometer. Kitchen Worker #1 stated that he would expect the food temperatures to be maintained between 150.0 and 160.0 F for both safety and for palatability of food. He was unable to identify why the low temperature of the fish was not maintained in the appropriate range of 150.0 to 160.0 *F. Kitchen Worker #1 indicated that the steam table may not have been working appropriately. On 8/6/2025 a test/temperature tray was conducted with the Dietary Director identified the lunch tray consisting of chicken, mixed carrots and peas, and gravy over mashed potatoes left the third floor steam table at 12:31 PM. The first tray on the third floor was delivered to residents starting at 12:32 PM. The last tray was delivered at 12:50 PM and, at that time, a temperature reading of the test tray was conducted with the Dietary Manager identifying the following: The chicken was 125.8 *F per the surveyor calibrated thermometer and 105 *F per the Dietary Manager's thermometer. The mixed carrots and peas temperature was 122.0 *F per the surveyor calibrated thermometer and 105.0 *F per the Dietary Manager's thermometer. The mashed potatoes and gravy temperature was 132.1 *F per the surveyor calibrated thermometer and 119.0 *F per the Dietary Manager's thermometer.Interview and observation with the Dietary Director on 8/6/2025 at 1:07 PM identified a safe temperature for all delivered food was 160 *F and a palatable (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature for the chicken, peas and carrots, and mashed potatoes should be 140 *F. Further, he stated there was no excuse that the temperature of the fish at the steam table was only 122.0 *F and it should have been higher. The Dietary Director identified he was aware of low food temperature issues prior to the temperature tray and stated he had previously notified the facility's Administrator about the low temperatures. He indicated no changes had been made to food service delivery since he reported the food service issues to the Administrator, and he was unable to identify why food was being served below safe and palatable temperatures.Subsequent to the identification of low food temperatures during the temperature tray inspection a taste tray sampling was conducted with the Dietary Director on 8/6/2025 at 1:19 PM by 3 surveyors. The test tray consisted of pureed chicken and gravy, mixed carrots and peas, and mashed potatoes and gravy. The chicken and the vegetables were seasoned well, and the mashed potatoes were bland and lacking flavor. The chicken and mashed potatoes were not palatable due to the unacceptable temperature.Interview with the Administrator on 8/7/2025 at 10:05 AM identified that she was aware of complaints of cold food and had directed food service to move the steam table into the hallway to serve residents. Further she identified that her directive had not been followed because there was no accessible outlet in the hallway in which to plus in the steam table resulting in cold food. The Administrator stated she was working with corporate offices to budget for and purchase additional steam tables.Review of the facility's Dietary Department Guidelines/Policy identified, in part, that hot cooked foods will be held at temperatures above 140 *F, and steam tables will keep food at proper temperature and will be maintained in safe and sanitary 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility documentation, facility policy, and interviews the facility failed to ensure safe thawing of frozen foods, failed to ensure refrigerated foods were stored under sanitary conditions, failed to ensure open food items were dated to include opened/expired/use by dates, failed to ensure food was served/prepared under sanitary conditions, and failed to ensure proper handwashing was performed during food service. The findings include:1. Tour of the kitchen with the Director of Dietary on 8/4/2025 at 9:50AM identified the following:a. The kitchen cleaning log and temperature logs for 8/4/2025 were incomplete and missing signatures. The cleaning log contained no signatures for 8/4/2025 and the temperature log was missing temperatures and signatures for the walk-in freezer.b. Reach-in cooler #1 had food debris on the inside bottom of the coolerc. Fan in the dishwashing area over the clean dishes was plugged in but not running and thickly coated with dust and dirt.d. The wall behind where the clean dishes were stored had a brown substance that had dripped down the wall and dried.Interview with the Director of Dietary identified that dishes that are washed in the dishwasher do not always come out clean and he stated the brown substance was from leftover debris in the cleaned dishes.e. Dried food and debris was located around the kitchen's air compressor.f. Plastic lids, debris, and small plastic items were located under the bottom shelf of the air compressor on the floor. The floor had multiple dried brown spots from a liquid both under it and in front of it.g. The air handling unit for the kitchen's air compressor was caked with dust like substance, potentially impeding proper air flow.Interview with the Director of Dietary identified he was not responsible for the cleanliness of the air handling unit because an outside vendor was contracted for cleaning and servicing the unit. Further, he identified he had not contacted the vendor as that was the responsibility of the Maintenance Department at the facility, and they were already aware.h. The counter next to the coffee pot was found to have dried debris and a dead insect on it.i. The windowsill behind the coffeepot was visibly soiled, had cobwebs in the corner of the window, had dead bugs in and around the cobwebs, and had clean serving utensils directly set on top of the soiled windowsill.j. Crumbs of food and food splatter were located on the inside of the microwave.k. An opened and undated 7/8 full 16 oz container of turmeric was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.l. An opened and undated 2/5 full 14 oz container of ginger was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.m. An opened and undated 7/8 full 16 oz container of basil was stored under the stove on a shelf in unsanitary condition on a tray with debris both on and under the tray.n. An opened and undated 7/8 full 16 oz container of cinnamon was stored under the stove on a shelf in unsanitary condition on a tray with debris both on and under the tray.o. An opened and undated 5/8 full 16 oz container of pumpkin pie spice was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.p. An opened and undated 7/8 full 16 oz container of basil was stored under the stove on a shelf in an unsanitary condition on a tray with debris both on and under the tray.q. An opened and undated 2/5 full 16 oz container of pickling spice was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.r. An opened and undated 5/8 full 14 oz container of red pepper flakes was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.s. An opened and undated 7/8 full 16 oz container of paprika was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.t. An unidentified bag of food meal was stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.u. 3 unopened paper boxes of [NAME] Sazon were stored under the stove on a shelf in unsanitary conditions on a tray with debris both on and under the tray.v. An opened and undated 16 oz bottle of imitation lemon juice was stored under the stove on a shelf in unsanitary conditions on a tray (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with debris both on and under the tray.w. A sheet of crumpled white paper was identified under the stove on a shelf with spices on a tray with debris both on and under the tray.An interview with the Director of Dietary identified that he did not use that particular stove so storing items under the cabinet under was permissible. He further identified the stove was in working order, but his staff did not use the stove, as they used a second stove to the left. The Director of Dietary stated he did not clean the cabinet as the spices were on trays, and he replaced the plastic trays with new ones when they became dirty. The Dietary Director was unable to identify the date that the trays were last taken out to be cleaned.x. The second six burner stove was found to be dirty. Dried food particles were in the burner areas and the splashguards around the stove were heavily coated with grease and grime.y. The counter next to the second six burner stove contained 10 covered bowls of soup, 1 metal container covered with plastic wrap of pureed peas, 1 metal container covered with plastic wrap of rice pilaf, 1 metal container covered with plastic wrap of gravy, 1 metal container covered with plastic wrap of pureed chicken, 1 metal container covered with plastic wrap of ground chicken, and 1 metal container covered with plastic wrap of ground ham.Interview with the Director of Dietary identified the food had been sitting on the counter since approximately 9:30 AM, when his Food Service Manager left the building, and had been removed from the walk in refrigerator before that time as part of preparation for lunch service. Further he identified the temperature danger zone for these food items was 40-41 *F.A temperature check, using the Director of Dietary's kitchen thermometer, performed on some of the items found: gravy was 69.8 *F, pureed chicken was at 78* F, ground chicken was at 80 *F, and ground ham was at 58 *F. Observation of the Dietary Director identified he was not as observed to clean the thermometer between temperature tests of the food items and indicated the risk of not cleaning his thermometer between putting it in different food items was cross contamination. He failed to identify why he didn't clean his thermometer between food items and stated the food was still safe to use as he would be bringing the temperature up to at least 150*F before serving it to residents.z. Two 32 oz opened containers of basil pesto were in the reach in refrigerator. The containers were not dated with an open date.Interview on 8/4/2025 at 10:00 AM with the Director of Dietary services identified the kitchen cleaning was his responsibility. The Director of Dietary failed to identify how he knew cleaning was being performed if staff did not initial the cleaning logs. Further, he failed to produce copies of the cleaning logs for the last 4 weeks upon request and stated the Kitchen Manager was responsible for filing them, but he did not know where they were kept.Although the Director of Dietary services was unable to locate copies of the cleaning logs requested, the Administrator was able to provide cleaning logs on 8/6/2025 from 6/29/2025 through 8/2/2025 which identified staff initials attesting that kitchen cleaning tasks had been performed daily.Interview on 8/6/2025 at 10:43 AM with the Kitchen Manager identified that she had signed all the initials on the weekly cleaning schedules yesterday (8/5/2025) for the previous two months. She further identified that she and the Dietary Director were responsible for ensuring staff sign the logs after cleaning, the logs had not been completed and initialed by staff, and she had signed the staff's initials on the log because she didn't want blank spots on the logs to be presented to the State Agency.Interview with the Administrator on 8/7/2025 at 10:05 AM identified the Director of Dietary was responsible for the cleanliness of the kitchen. She stated she was aware the kitchen was not clean, had spoken with the Director of Dietary in March and showed him what to clean, directed him to perform a thorough cleaning, but the kitchen had not been properly maintained by the Director of Dietary since the cleaning. Further, she stated she was not aware that the cleaning logs given to her on 8/6/2025 by the Kitchen Manager had been filled out and signed by the Kitchen Manager on 8/5/2025 because the logs had not been entirely filled out. 2. Observation of delivery of food to the kitchen from the food supplier was made on 8/5/2025 at 8:23 AM.An observation of the kitchen on 8/5/2025 at 10:05 AM identified the following:a. Two dirty pedestal fans were in the kitchen hallway. Both fans were visibly dusty, one fan was blowing onto clean dishes, the second fan was blowing into the main kitchen area where food was being preparedb. The three-bay sink next to the kitchen hood (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had frozen hamburgers in a dish of water to be thawed. There was no cold water running from the faucet into the dish of waterc. One multi-container box of single serve vanilla milkshakes, labelled refrigerate, was sitting on the kitchen prep counterd. One 6-pack box of frozen unshelled eggs in bags were sitting on the kitchen prep counterA second observation and interview on 8/5/2025 at 12:58 PM with the Director of Dietary services identified the following:a. One 6-pack box of frozen unshelled eggs in bags was sitting on the kitchen prep counter. The eggs inside the bags were not frozen solid and had a slushy consistency.b. One multi-box of single-serve vanilla milkshakes, labelled refrigerate, was sitting on the kitchen prep counter. The contents of the single-serve milkshake containers were not solid and could easily be squeezed.c. Two 32 oz opened containers of basil pesto were in the reach in refrigerator. The containers were not dated with an open date.The Director of Dietary identified the eggs and milkshakes were delivered earlier in the day and stated he was getting ready to put them in the fridge to thaw. He stated he believed that the boxes containing the perishable food items were still frozen, despite the delivery had occurred at 8:23 AM (4 and one half hours prior to the second observation). Further, he indicated he had forgotten to dispose of the opened and undated basil pesto containers identified on 8/4/2025, he was responsible for ensuring undated food items were disposed of, and subsequent to surveyor inquiry the items were discarded.3. Dietary serving observations identified the following:a. Observation and interview on 8/4/2-25 at 12:48 PM of the second floor dining room identified Nurse Aide (NA) #5 had long painted nails, was touching her hair repeatedly, was not performing hand sanitization after touching her hair and before serving resident's their food. Her nails made contact with multiple residents' plated food while she was serving. NA #5 stated she didn't use hand sanitizer before serving the Residents because she forgot but she should have hand sanitized, per the facility's policy.b. Observation on 8/4/2025 at 12:56 PM identified the Director of Dietary and his staff transporting uncovered plates of food to serve to the third floor residents in the dining room. The facility's Food First Nutrition policy identified, in part, that all dining rooms will have a hand washing area and/or hand sanitizer available. Staff members will wash their hands prior to serving/distributing food.The facility's Controlling Time and Temperature During Preparation policy identified, in part, that the facility will follow State or local Health Department requirements, use clean and sanitized equipment while preparing food, prepare foods as close to the serving times as the menu will allow, limit the time for preparation of any batches of food so that ingredients are not at room temperature for more than 30 minutes before cooking, serving, or being returned to the refrigerator, immediately return ingredients to the refrigerator if the anticipated preparation completed time is expected to exceed 30 minutes, and if potentially hazardous foods are not cooked or served immediately after preparation, quickly chill.

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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** Based on clinical record review, interviews and facility policy for 2 of 2 sampled residents, (Resident #98 and Resident #99) reviewed for advance directives, the facility failed to ensure the advance directives consent and physician's order were in place. The findings included:1. Resident #98's diagnoses included muscular dystrophy, polyarthritis, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition and was dependent on staff for dressing, personal hygiene, and transfers. The Resident Care Plan dated [DATE] identified Resident #98 had an established advanced directive and wished to receive cardiopulmonary resuscitation (CPR). Interventions included a review of advance directives with the resident and/or the healthcare decision maker quarterly, and to support the resident's decision for CPR. The physician's orders failed to direct an advance directive code status. A review of Resident #98's clinical record identified the Advanced Directives Declaration Health Care Wishes and Advanced Directives Declaration Code Status located in the front of the Resident #98's paper chart failed to include the resident's wishes for a code status, failed to include the resident/responsible party signature, and failed to include a physician's signature. Interview and clinical record review with Licensed Practical Nurse (LPN) #2 on [DATE] at 12:43 PM identified the facility policy for advanced directives was to review code status choices upon admission/re-admission and obtain a signature either from the resident or responsible party within 24 hours. Additionally, she identified that in the event of an emergency the nurse would check the physician orders in the electronic health record or the advance directives code status form in the chart. A review of Resident #98's electronic health record, and a review of the advanced directives code status form with LPN #2 failed to identify a code status choice. Although there was a code status form from [DATE] that was signed in the chart, LPN #2 identified there should have been an updated form since Resident #98 went to the hospital multiple times since [DATE]. Interview and clinical record review with the Director of Nursing (DNS) on [DATE] at 12:59 PM identified the facility policy on advance directives was for the admitting nurse to obtain a signature and physician's order for a code status the same day, or at least within 24 hours. A review of the clinical record with the DNS failed to identify a code status, and she could not identify why Resident #98's code status had not been reviewed upon readmission from the hospital. Subsequent to surveyor inquiry, the DNS made social services aware of the missing advanced directives and forms were sent to the responsible party for review and signature. 2. Resident #99's diagnoses included acute cystitis, mild cognitive impairment and depression. The Nursing admission assessment dated [DATE] identified Resident #99 was mildly cognitively impaired and required assistance of 1 staff for activities of daily living. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated [DATE] did not address Resident #99's code status/advance directives. Physician's orders dated [DATE] did not direct Resident #99's choice for a code status/advance directive. LPN #1's nurse's note dated [DATE] at 3:47 PM identified Resident #99 and his/her responsible party had not decided on an advance directive status and had not signed the consent form. A review of nursing, social services, and practitioner (physician and APRN #1) documentation from [DATE] through [DATE] failed to identify that the facility had reapproached the issue of Resident #99's code since LPN #1's note dated [DATE] (6 days prior). Further, there was no resident/responsible person education documented to explain code status/advance directive information. Observations from [DATE] through [DATE] identified that Resident #99's responsible party was at the facility every morning visiting until after lunch. An interview with the DNS on [DATE] at 9:45 AM identified that advance directives should be addressed on admission and if no decision was made, to reapproach the resident/responsible party to make a decision. The DNS stated it was the responsibility of nursing to ensure advanced directives were signed. The DNS stated she was not familiar with the facility's policy as she was new to the facility and had only been in her role for a few weeks nor was she aware that Resident #99's code status/advance directives had not been readdressed. Subsequent to surveyor inquiry Resident #99's consent was signed, and a physician's order was obtained. An interview with LPN #1 on [DATE] at 12:00 PM identified that advance directives were to be addressed on admission and if, at that time, a resident was undecided, then it would have to be readdressed, but was unsure if this had occurred. LPN #1 indicated she had not provided any written educational material regarding code status to Resident #99 and/or the responsible party and that it would be a good idea to have something to provide on admission. LPN #1 stated she was unsure if Resident #99's code status/advanced directive had been readdressed by any staff until the advance directive was signed per the DNS directive on [DATE]. A review of Advance Directive Regarding CPR and DNR Policy dated 3/2019 directed, in part, prior to or at the time of admission, if possible, the facility will review and hand out Cardiac/Respiratory Arrest Explanation Sheet to the competent resident or responsible party. After review, the appropriate party will check off the appropriate box on the CPR/DNR Consent Form. Based on the CPR/DNR Consent Form, the nurse is responsible for obtaining a physician's order for the resident's code status.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 2 sampled residents (Resident #38) reviewed for personal property, the facility failed to follow their grievance policy to ensure the grievance was resolved. The findings include:Resident #38's diagnoses included congestive heart failure, mild cognitive impairment, and intellectual disabilities. Review of a concern form dated 3/19/2025 identified bleach issues with clothing. The Department Head Resolution area identified when resident's clothing gets soiled, the laundry has to wash the item in soil program which required washing with the addition of bleach. After the clothes get washed, the clothes would get discolored, or bleach stained. This was signed on 3/20/2025 by the Laundry Department Head but failed to be signed by the Resident Council President, the Administrator, or the Director of Recreation, and did not indicate the issue had been resolved. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #38 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and required supervision for lower body dressing, and transfer and was independent with eating, upper body dressing and bed mobility. The Resident Care Plan in effect from 3/20/2025 through 8/4/2025 failed to address clothing concerns. An interview with Resident #38 on 8/4/2025 at 2:09 PM identified when he/she complained about the condition of a state college insignia sweatshirt, originally blue, returned from the laundry now purple, he/she was told nothing could be done. Resident #38 stated that this was communicated to the head of laundry. Observation and interview with Resident #38 on 8/7/2025 at 10:55 AM identified the purple state college insignia sweatshirt as well as another clothing item, a pair of sweatpants, that had been black and was now gray. An interview with the Director of Housekeeping/Laundry on 8/7/2025 at 11:45 AM identified that if a piece of resident's clothing was damaged during laundering, she would make administration aware and replace the item of clothing. The Director of Housekeeping/Laundry indicated she was aware of Resident #8's bleached state college insignia sweatshirt and black sweatpants. She stated that soiled linen was placed in a plastic bag and could not be separated if it was visibly soiled with fecal matter. The Director of Housekeeping/Laundry indicated that she did not fill out a grievance form for the damaged clothing items and could not replace all of the items all of the time when they were coming into the laundry area soiled with fecal matter. An interview with the Administrator on 8/7/2025 at 12:59 PM identified the process for damaged clothing is to fill out a grievance form and this would be sent to the Social Work Department for review and then sent to her and the facility would replace the damaged clothing. A re-interview with the Administrator on 8/11/2025 at 10:06 AM identified that she spoke to Resident #38 and would re-educate the resident about how to bag the personal laundry to avoid bleaching and would be replacing the damaged clothing items. Additionally, she spoke with Social Services and the Director of Housekeeping/Laundry related to following the grievance policy. The Administrator could not state why a grievance was not filed for Resident #38's bleached clothing items. Review of the Grievance policy directed, in part, the grievance officer will be responsible for overseeing the grievance process including reviewing and tracking grievances to conclusion, conducting any necessary investigations. Upon receipt of a grievance, the staff person receiving the grievance shall immediately notify the grievance officer. The Director of Social Service has been appointed as the grievance officer. Review of the infection control policy and procedure laundry/handling linen directed, in part, all laundry in the facility will be treated as contaminated and handled using standard precautions. Contaminated laundry includes both the residents' linen and clothing and reusable protective equipment, The facility will wash all laundry with the appropriate mix of temperature and chemical as established by the chemical supply contractor.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 2 sampled residents (Resident #14 and Resident #26) reviewed for abuse, the facility failed to ensure freedom from physical abuse. The findings include:The Accident and Incident Report dated 6/13/25 identified that on 6/13/25 at 1:10 PM Resident #26 hit another resident (Resident #14) while sitting next to each other on the second-floor hallway. 1. Resident #14's diagnoses included Alzheimer's disease, dementia, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was severely cognitively impaired, independent with eating, and required substantial/maximal assistance for transfers. The Resident Care Plan dated 4/2/25 identified Resident #14 was at risk for impaired communication due to dementia, Alzheimer's, and anxiety. Interventions included using simple, direct language or gestures as needed, observe for understanding, and give time to respond and repeat as necessary. A nurse's progress note dated 6/13/25 at 4:08 PM identified Resident #14 was struck by another resident on his/her cheek and grabbed by his/her wrists. There were no signs of distress or complaints of pain. Following the incident, Resident #14 displayed his/her usual behavior. 2. Resident #26's diagnoses included major depressive disorder, essential hypertension, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #26 was moderately cognitively impaired and required setup help with transfers. The Resident Care Plan dated 5/26/25 identified Resident #26 was using psychotropic medications related to depression. Interventions included monitoring for side effects and monitoring for target behaviors. A psychiatric evaluation and consultation assessment dated [DATE] at 1:20 PM (following the incident) identified that Resident #26 was considered a danger to self or others and sent to the Emergency Department for further evaluation. A nurse's progress note dated 6/13/25 at 3:15 PM identified that Resident #26 was conversing with another resident, then hit the other resident with a backhanded punch to his/her left cheek and grabbed both of his/her wrists. Staff intervened and Resident #26 was immediately removed from the vicinity and was placed on 1:1 monitoring until transferred to the Emergency Department for evaluation. The summary of findings report submitted to the state agency dated 6/16/25 at 12:00 AM identified that on 6/13/25 at 1:10 PM, there was a resident-to-resident altercation. Resident #26 and Resident #14 were sitting in the hallway having a conversation. Resident #26 became agitated and struck Resident #14 with a backhand to the left cheek and then Resident #26 grabbed both of Resident #14's wrists and held them. Staff members who witnessed the altercation immediately separated the residents and Resident #26 was placed on continuous (1 to 1) observation. An investigation was initiated; the MD, local Police Department and POA/responsible party of both residents were notified. Both residents were assessed by psychiatry services immediately. Resident #26 was considered a danger to self or others and sent to the Emergency Department for further evaluation. Resident #14 did not have any recollection of the incident. Interview with Licensed Practical Nurse (LPN) #3 on 8/7/25 at 10:51 AM identified on 6/13/25 she was standing at the medication cart to the side of the nurse's station. LPN #3 heard residents yelling and immediately responded. Although she did not witness Resident #26 strike Resident #14, she did witness Resident #26 holding both of Resident #14's wrists and with the help of another staff member, separated the residents. LPN #3 indicated that Resident #26 stated that they were arguing over who is better at life. Resident #14 did not remember the incident happening. Interview with the Psychiatry Advanced Practice Registered Nurse (APRN) #2 on 8/11/25 at 10:25 AM identified that on 6/13/25 she was standing at the nurse's station on the second floor and heard yelling. APRN #2 stated when she turned around to intervene, she witnessed Resident #26 back hand Resident #14 on the left cheek and then grabbed both of his/her wrists. APRN #2 and LPN #3 immediately separated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents and Resident #26 was placed on a continuous (1 to 1) observation. APRN #2 indicated that while evaluating Resident #26 after the incident, Resident #26 indicated that he/she would do it again. APRN #2 identified Resident #26 as being a danger to self and others and placed an order for transfer to emergency room for further evaluation. APRN #2 identified that Resident #14 had no recollection of the incident. Additionally, APRN #2 identified that Resident #26 did not have a history of hitting. Review of the Abuse, Neglect, and Exploitation policy, dated 2/2023, identified the facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.

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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** Based on review of the clinical record, facility policy and interviews for 2 of 5 sampled residents (Resident #1 and Resident #18) reviewed for nutrition, the facility failed to ensure daily weights were obtained per the physician's orders and for 1 of 2 sampled residents (Resident #90) reviewed for medication administration the facility failed to ensure a medication was available at the time of administration. The findings include: 1. Resident #1's diagnoses included chronic diastolic congestive heart failure, coronary artery disease, and atrial fibrillation. A physician's order dated 7/9/2025 directed to administer bumetanide (diuretic) 2 milligrams (mg) daily, obtain a daily weight and give an extra 2 mg of bumetanide for weight gain of greater than 2 pounds (lbs.) in a day or 5 lbs. in a week. The admission 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14, required moderate assistance from staff for activities of daily living, and required a mechanical lift for transfers out of bed. A physician's order dated 8/1/2025 directed to decrease bumetanide to 1 mg once a day. The Resident Care Plan dated 8/5/2025 identified a history of congestive heart failure (CHF) and to monitor weights, administer diuretics as ordered, monitor for early signs of CHF such as fatigue and weight gain and monitor for swelling to his/her feet, legs and ankles. A review of the clinical record lacked documentation that weights had been obtained daily from 7/9/2025 through 8/6/2025. Out of 28 opportunities, Resident #1 had not been weighed 24 times. Interview with APRN #1 on 8/6/2025 at 11:00 AM identified that she was not aware daily weights had not been obtained. APRN #1 indicated that bumetanide parameters for administration were in place based on Resident #1's daily weight. APRN #1 stated that Resident #1 was on daily weights due to his/her significant cardiac history and recent hospitalizations. Further she identified that it was the nurse's responsibility to ensure that weights were obtained and documented as directed. APRN #1 indicated that she would be discontinuing the bumetanide parameters for Resident #1, but he/she would remain on daily weights. APRN #1 stated that Resident #1 had recently lost weight, but it was not related to his/her CHF, instead due to a general health decline and lack of appetite. APRN #1 identified that Resident #1 was being followed by the dietitian and receiving health shakes. Interview with LPN #1, the resident's nurse, on 8/7/2025 at 12:30 PM identified that she was not aware that Resident #1 had been placed on daily weights with bumetanide parameters in place. Although requested, a policy on congestive heart failure and daily weights was not provided. 2. Resident #18's diagnoses included dementia, gastroesophageal reflux disease (GERD), and depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 had a Brief (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview of Mental Status (BIMS) score of 1 indicating severely impaired cognition, and was independent for eating, transfers, and bed mobility. The Resident Care Plan dated 7/24/2025 identified Resident #18 had a potential for impaired nutrition/malnutrition related to dementia, dysphagia, cachexia (weakness and wasting of the body), sub-optimal meal intake, and weight loss. Interventions included monitoring meal intake and weights as needed. The physician's order dated 7/11/2025 directed for weekly weight monitoring on Mondays during the day shift. Review of Resident #18's weight monitoring documentation identified 1 weight of 117.4 lbs. that was obtained on 7/20/2025 since the physician implemented the order dated 7/11/2025. (weights were missing for 8/14, 8/21, and 8/28/25). Interview with Nurse Aide (NA) #2 on 8/6/25 at 10:05 AM identified it was the facility policy for the NA's to obtain a resident weight upon admission or monthly, and any other weights required needed to be communicated by the nurse. Interview and clinical record review with Licensed Practical Nurse (LPN) #1 on 8/6/25 at 10:13 AM identified it was the facility policy for the nurse to review the physician's order in the electronic health record, then highlight the residents who needed a weight taken on the daily NA vital sign and weight sheet for the NAs to obtain. The charge nurse would then enter the resident weight into the electronic health record. A review of Resident #18's clinical record with LPN #1 identified a physician order to obtain a weekly weight had been placed on 7/11/25. The only weight documented as obtained since then was 7/30/25 (3 missed opportunities to weigh). LPN #1 identified Resident #18 was scheduled to receive a shower on Mondays during the 3:00 PM to 11:00 PM shift and weight monitoring was supposed to coincide with the weekly shower schedule. LPN #1 indicated that the facility had not obtained Resident #18's weight, most likely, due to the order indicating the weight should have been taken 7:00 AM to 3:00 PM shift instead of the 3:00 PM to 11:00 PM shift, when the residents shower had been scheduled. Interview and record review with Registered Nurse Supervisor (RN) #1 on 8/11/25 at 11:00 AM identified that it was the facility policy for the NA to weigh the resident, then have the nurse confirm that it was accurate. If there was a discrepancy, the supervisor would be alerted to obtain a reweight. A review of Resident #18's clinical record with RN #1 identified he/she should have been weighed weekly as of 7/11/25 but was only weighed on 7/30/25. She identified that the weights would not be documented anywhere else and was unable to identify why the physician's order was not followed. Review of the Weights Policy dated 8/15 directed in part that weekly weights will be obtained per physician's order. 3. Resident #90's diagnoses included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had a BIMS score of 12 indicating moderate cognitive impairment and required the assistance of 1 staff for activities of daily living. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 6/1/2025 directed to administer Trelegy Ellipta inhaler 200-62.5-25 MCG (micrograms) 1 puff once a day for COPD. The Resident Care Plan dated 6/3/2025 identified COPD with interventions to administer inhalers and nebulizer treatments as ordered, elevate the head of the bed, follow up with pulmonary as needed, and monitor for signs and symptoms of an exacerbation of COPD. Observation of Resident #90's medication administration with LPN #2 on 8/5/2025 at 9:26 AM and interview with Resident #90 identified that the Trelegy inhaler was unavailable for administration. Resident #90 stated that he/she had not received the inhaler for a couple of days and that it needed to be reordered. LPN #2 contacted the supervisor, the pharmacy, and APRN #1 to update them that the Trelegy inhaler was unavailable for administration. A physician order was obtained to administer the Trelegy inhaler when received at the facility from the pharmacy. A review of Resident #90's Medication Administration Record (MAR) identified LPN #2 had administered Resident 90's Trelegy inhaler on 8/5/2025 at 5:20 PM. Although Resident #90 indicated that the Trelegy inhaler had not been administered for the past few days, a review of the MAR identified that LPN #6 had signed the medication as being given on 8/1/2025, 8/2/2025, 8/3/2025, and 8/4/2025. Several attempts to contact LPN #6 were made by the DNS and surveyor but were unsuccessful. Interview with Pharmacist #1, the pharmacy manager, on 8/5/2025 at 1:10 PM identified that Resident #90's Trelegy inhaler had been ordered on 1/5/25, 1/30/2025, 3/9/2025 and last ordered on 4/3/2025. Pharmacist #1 stated each Trelegy inhaler provided 30 doses, and that based on the dates of delivery there would not have been enough medication to last for the time period indicated unless the medication had been obtained by another source. An interview with the DNS on 8/6/2025 at 9:15 AM identified that if a medication was unavailable, then it should not have been signed as given. The facility process for unavailable medications directed the nurse to indicate on the MAR that the medication was not available, contact the pharmacy, notify the supervisor, and notify the APRN for further instructions. The DNS indicated that if a medication was not administered and orders were not obtained from the practitioner then it would be considered to be a medication error. The DNS stated she had not received any medication error report for Resident #90 and was not made aware that his/her inhaler was unavailable until 8/5 when it was brought to her attention by the surveyor. A review of the policy Medications Unavailable directed, in part, in the event that medication is unavailable for any reason, the facility shall act promptly to notify the appropriate practitioner for orders to be followed and the pharmacy to obtain the medications in accordance with the updated order. Upon identifying that a medication is unavailable, the facility shall investigate all instances to assess whether appropriate actions were taken to ensure continuity of care.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and interviews for 2 of 3 sampled residents (Resident #1 and Resident #24) reviewed for communication/sensory deficits, the facility failed to ensure services related to vision were provided and for Resident #24, the facility failed to revise the Resident Care Plan when a change in visual needs occurred. The findings include: 1. Resident #1's was admitted on [DATE] with diagnoses that included type 2 diabetes, anxiety disorder, and depression. An interview with Resident #1 on 8/5/25 at 10:51 AM identified that he/she was having trouble seeing due to broken eyeglasses. Resident #1 indicated that the lens was loose and the hinge on his/her glasses was broken so the temple of the glasses came off. Resident #1 stated it was difficult to see, and he/she was not even able to watch television on the wall across from his/her bed, adding that he/she had informed a Nurse Aid (NA) but did not recall which one. Review of the Nursing admission Assessments dated 6/26/25 and 7/9/25 identified Resident #1 was near sighted and had adequate vision with glasses. A physician's order dated 7/9/25 directed to administer Lutein (vitamin for the eyes) 20mg (milligrams) once a day. A readmission 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition, required moderate assistance from staff for activities of daily living and required a mechanical lift for transfers out of bed. The Resident Care Plan dated 7/26/25 failed to identify Resident #1 needed glasses. A review of APRN #1's progress note dated 7/28/25 identified Resident #1 had poor vision secondary to broken glasses. An interview with the unit secretary on 8/6/25 at 9:45 AM identified that she was responsible for having residents sign consents for ancillary services on admission regardless of payor type. She identified that Resident #1 not signing his/her consent since admission (41 days) must have been an oversight on her part. Additionally, the unit secretary indicated that she was not aware that Resident #1's eyeglasses needed repair. Subsequent to surveyor inquiry, Resident #1 signed consent for optometry services, and his/her eyeglasses were sent out for repair. Although requested, an Optometry Service Policy was not provided. 2. Resident #24's diagnoses included dementia, diabetes, and bipolar disorder. A review of the eye care group consultation note dated 9/11/2024 identified moderate nuclear cataracts in both eyes, cataract surgery recommended: ophthalmology consult, follow up in 4-5 months. Referral for ophthalmology consult cataract surgery evaluation, please refer to eye physician (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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for evaluation. A review of eye care group consultation note dated 1/16/2025 identified moderate nuclear cataracts in both eyes, cataract surgery recommended: ophthalmology consult, follow up in 4-5 months. Referral for ophthalmology consult cataract surgery evaluation, Resident #24 wishes to have a cataract evaluation, please refer to outside ophthalmologist for evaluation. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #24 had a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment and required assistance with eating and bed mobility substantial maximum to total assistance for transfers and was totally dependent on staff for dressing. The Resident Care Plan dated 8/5/2025 identified Resident #24 had glasses and could see small print. Interventions included assisting with cleaning glasses as needed, and vision consults as ordered. A review of nurse's notes dated 1/3/2025 through 8/11/2025 failed to identify an ophthalmology consultation for cataract surgery was scheduled. A physician's order in effect for July directed an ophthalmology consult, cataract surgery was recommended. An interview with Resident #24 on 8/4/2025 at 11:00 AM identified he/she needed cataract surgery, and the facility would not arrange transportation. Resident #24 indicated he/she had seen the facility eye physician and was told that cataract surgery was necessary. Resident #24 was unaware as to why the facility had not scheduled a consultation appointment. Interview with the unit secretary on 8/7/2025 at 12:30 PM identified she had not received any documentation indicating an ophthalmology consultation was requested for Resident #24. In an Interview and clinical record review with Registered Nurse Supervisor (RN) #1 on 8/7/2025 at 12:45 PM she was unable to identify that the recommendations for ophthalmology referral for cataract evaluation had been addressed. RN #1 indicated that Resident #24 currently was not enrolled in any insurance plan and had no active insurance. Further, RN #1 verified with the APRN that she was not aware of the need for an ophthalmology consultation. RN #1 was unable to identify why the Ophthalmology consultation was not completed. RN #1 placed a call to the Finance Department and identified Resident #24's insurance was inactive since October 2024 and that a state appointed conservator was working with the facility to apply for insurance for Resident #24. Interview with the Administrator on 8/7/2025 at 12:55 PM identified that she was unaware Resident #24 needed an ophthalmology evaluation for cataract surgery or that there was a problem with Resident #24's insurance. Further, the Administrator indicated that the nursing supervisor should have informed the unit secretary of the need for the evaluation, but due to Resident #24's inactive insurance, the appointment could not have been scheduled. Review of the consultant services policy directed, in part, a note should be recorded on the consultation form by any health care consultant who sees the resident at the request of the physician or family. The consultant should document findings and recommendations on this form. The charge nurse will then notify the attending physician of the findings, and he/she can then order the specific treatments as outlined by the consultant. A consultant's report or some form of documentation pertaining to the results will be retained in the clinical record.

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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 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** Based on observations, interviews and record reviews for 1 of 2 residents, (Resident #98) reviewed for positioning, the facility failed to ensure a splint for contractures was applied per the physician's order. The findings included:Resident #98's diagnoses included muscular dystrophy, polyarthritis, and chronic pain syndrome.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition and was dependent on staff for dressing, personal hygiene, and transfers.The Resident Care Plan dated 6/30/25 identified Resident #98 had an ADL deficit related to generalized weakness, muscular dystrophy and poor dentition. Interventions included left hand splint applied with morning care and off with evening care. Check the skin for redness and bruising.The physician's order dated 8/1/25 directed left hand liter grip splint to be applied daily with AM care and taken off with PM care, every day.The Resident Care Card (NA care directive) dated 8/1/25 indicated that a left hand splint was to be placed on before lunch and taken off after dinner.Observations on 8/4/25 at 11:30 AM, 8/5/25 at 10:22 AM and 8/7/25 at 10:02 AM identified Resident #98 in bed without the benefit of the left-hand splint.Interview and observation with Resident #98 on 8/6/25 at 12:28 PM identified he/she was in bed without the benefit of the left hand splint, stating he/she wears it when the staff applies it because it makes his/her hand feel better. Additionally, Resident #98 stated he/she does not refuse to wear the splint, and that staff don't apply the splint consistently. Interview and observation with Nurse Aid (NA) #1 on 8/6/25 at 12:37 PM identified the facility policy for NA was to follow the directive of the Resident Care Card to apply the hand splint. Even though NA #1 identified the splint was in the room (on a chair under pillows and blankets), and the care card instructed splint application, she stated the splint was on hold and had not been applied since surgery due to Resident #98's arm swelling.Interview and clinical record review with the Director of Rehabilitation on 8/6/25 at 2:25 PM identified the facility policy on hand splints was that Occupational Therapy performed the evaluation, education was provided to staff on the unit, and from there a physician's order was written directing the nursing staff in the application and removal of the splint. Additionally, the splinting company came out annually in June to perform fit checks and identify any necessary replacements that were required for residents utilizing splints. Review of Resident #98's clinical record with the Director of Rehabilitation identified he/she had an order for a left hand splint to be on placed on in the AM and off in the PM due to the diagnosis of muscular dystrophy. The most recent evaluation had been completed upon a readmission dated 8/1/25 and an initial evaluation had been completed on the resident's admission to the facility dated 5/20/23. The Director of Rehabilitation identified that the splint was not on hold, and failure to utilize the splint could cause a loss in range of motion, decreased skin integrity, and increase in contractures that could lead to increased impairments.Subsequent to surveyor inquiry the Director of Rehabilitation retrained staff on the application and removal of Resident #98's left hand splint. An observation on 8/11/25 at 11:02 AM identified Resident #98 in bed with the left hand splint in place.Review of the Splints/Orthotics/Prosthetics Policy dated 4/15 directed in part that residents will receive splints/orthotics/prosthetic devices as deemed appropriate by the physician and rehabilitation services. Additionally, the nursing staff will apply/remove the designated splint/orthotic/prosthetic device during wearing times.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 2 of 5 sampled residents (Resident #8 and Resident #50) reviewed for nutrition, for Resident #8 the facility failed to implement recommendations for a nutritional supplement for a resident with a significant weight loss, failed to obtain weights per physician orders, and failed to update the Resident Care Plan after a significant weight loss, and for Resident #50 the facility failed to assess and implement nutritional interventions for a resident with a pressure ulcer. The findings include:1. Resident #8's diagnoses included hemiplegia and hemiparesis on the right side, hypertension, and hyperlipidemia.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severely impaired cognition, was independent for eating and required supervision walking 50 feet with a walker and had no significant weight loss.A. The Resident Care Plan (RCP) in effect from 2/8/2025 identified Resident #8 was at risk for malnutrition due to multiple chronic conditions, the need for adaptive equipment, and polypharmacy. Interventions included assessing and monitor for the presence of factors interfering with nutrition status as needed, document the percentage of solids and fluids consumed, and monitor weights as needed.A quarterly Nutritional Evaluation dated 2/17/2025 identified Resident #8 had experienced reduced appetite, was on monthly weights, and noted he/she had experienced a non-significant weight loss. The dietician recommended to initiate 120 milliliters (ml) of Mighty Shake (calorie and protein supplement) twice a day and record the percentage completed.A quarterly Nutritional Evaluation signed 3/24/2025 identified Resident #8 had a supplement ordered for 120 ml of Mighty Shake twice a day, was consuming 50-75% of most meals, was on monthly weights, and that the results of the evaluation had been communicated, to nursing. The Nutritional Evaluation failed to address if the Mighty Shake recommendation dated 2/17/2025 had or not been implemented for Resident #8.A significant change Nutritional Evaluation dated 6/30/2025 identified Resident #8 had a weight loss of 8 lbs. (greater than a 5% weight loss), was eating 25-50% of his/her meals, had a decreased appetite, and indicated that Mighty Shakes had been ordered as well as the resident was being weighed weekly. The Nutritional Evaluation failed to address if the recommendations for Mighty Shake (dated 2/17/2025) or weekly weights had been implemented.Although the Nutritional Evaluations dated 2/17/2025, 3/24/2025, and 6/30/2025 indicated monthly, then weekly weights to be taken, a review of the clinical record identified weights had been recorded on the following dates: 1/21/2025, 4/10/2025, 5/2/2025, 5/4/2025, 5/7/2025, 5/8/2025, 5/9/2025, 5/10/2025, 6/3/2025, 6/4/2025, 6/5/2025, 6/6/2025, and 6/6/2025 with no weights being recorded for the months of February, March, July or August 2025 and no record of weights being taken weekly.Review of physician, Advanced Practice Registered Nurse (APRN) orders and notes and nursing notes from 2/17/2025 through 6/29/2025 failed to identify the dietician recommendation for Mighty Shake administration twice daily or that weekly weighing had been addressed and failed to identify that Resident #8 had experienced significant weight loss. Additionally, a review of Resident #8's Intake/Output record and Amount Eaten Flowsheets for 2025 failed to identify any documentation indicating the Mighty Shake had been given since the dietician's recommendation dated 2/17/2025.Interview and record review on 8/6/2025 at 11:15 AM with Regional Dietician #2 identified that the on-site dietician was notified by facility staff, during report, of any residents who experienced a significant weight loss. Further, she identified it was the expectation of dieticians to monitor resident weights at least monthly and follow-up on weight loss if not noted to be a beneficial weight loss. Regional Dietician #2 indicated the dietician documented in their nutrition note dated 3/24/2025 Resident #8's weights would be monitored, as well as weight trends and patterns of weight loss, however, the documentation failed to show weight monitoring or any notes for Resident #8 for the months of April 2025 or May 2025. Additionally, the facility dietician had failed to indicate Resident #8 had been seen again until 6/30/2025. Regional Dietician #2 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated it was the expectation that the facility dietician would have followed up on the weights at some point during April 2025 and May 2025 but had failed to do so.B. A physician order dated 4/1/2025 directed to obtain monthly weights every shift on the first during the first 10 days of the month.Record review of Resident #8's weights identified the following weight entries: On 4/10/2025 a weight of 127.0 pounds (lbs.) was recorded, on 5/10/2025 a weight of 119.8 lbs. was recorded for a 7.2 lb. weight loss (5.7% in one month), and on 6/6/2025 a weight of 119.0 lbs. was recorded. The facility documentation failed to indicate a monthly weight was taken in July 2025 per the physician order.Interview and clinical record review on 8/7/2025 at 1:40 PM with Licensed Practical Nurse (LPN) #1 identified that Resident #8 was being weighed monthly and unless his/her favorite Nurse Aide (NA) was the NA asking to obtain the weight, he/she often refused. Review of the clinical record failed to indicate that Resident #8 had refused being weighed in July or August 2025. LPN #1 further identified that the facility practice required all residents to be weighed within the first 10 days of the month. LPN #1 stated that reviewing Resident #8 for weight loss was not her responsibility and that the dietician was the responsible staff member. Interview and record review on 8/7/2025 at 2:16 PM with Registered Nurse (RN) #3 identified that no weights had been taken for Resident #8 in July 2025 or as yet in August 2025. RN #3 indicated it was the expectation for NAs and LPNs to obtain resident weights according to the physician order and to notify her if any attempt to obtain a weight was refused. She indicated that her staff had not notified her that Resident #8 had refused being weighed. RN #3 stated she would instruct her staff to obtain a weight on the resident now and she would re-educate her staff that if a resident refused to be weighed, she was to be informed. Subsequent to surveyor inquiry, on 8/7/2025 a weight of 124.0 lbs. (a 5 lb. weight gain since June 2025) was recorded for Resident #8.Interview on 8/11/2025 at 10:18 AM with APRN #3 identified that nurses would notify her of any significant resident weight loss verbally, but she could not recall ever being notified of a weight loss for Resident #8. Further, she identified if a dietary recommendation for a supplement needed to be ordered, the dietician would text or call her. Upon reviewing her telephone log, APRN #3 indicated that she had not received any texts or calls from the dietician regarding weight loss, weekly weights, or a recommendation for a supplement for Resident #8.Interview and record review with the Regional DNS on 8/11/2025 at 11:07 AM identified that the current order for Resident #8 was to obtain a weight monthly. Given Resident #8's weight loss of 5.7% in a month, the facility should have implemented their weekly weight policy. The Regional DNS identified that Resident #8 had experienced a 1 month significant weight loss (7.2 lb. loss from 4/10/2025 to 5/10/2025, 5.7% in one month). The Regional DNS indicated the facility had not followed the policy or physician order to obtain a monthly weight for Resident #8 and had not implemented the weight loss policy for a significant weight loss which directed weekly weights be taken for 4 weeks following an unanticipated weight loss of greater than 5% in 1 month. Further she identified nursing should have notified the physician, dietician, and resident's family of the 7.2 lb. weight loss but had failed to do so.Review of the Weight Policy identified, in part, that residents with an unanticipated, unplanned weight loss of greater than 5% in one month are to be weighed weekly for 4 weeks. If a significant weight loss/gain is identified (> 5% in 30 days, or > 10% in 6 months), the interdisciplinary team, dietician, physician, and family are notified. All residents with a significant weight loss are reviewed by the interdisciplinary team and the resident/responsible party and interventions implemented as appropriate and are monitored weekly.C. Although a review of the Resident Care Plan (RCP) in effect from February 2025 through 8/7/2025 identified Resident #8 was at risk for malnutrition; the RCP failed to reflect that Resident #8 had a significant weight loss, failed to reflect the intervention for Mighty Shake administration per the dietician, and failed to indicate the facility policy to weigh a resident weekly when a significant weight loss had occurred. Interview and record review with the Regional DNS on 8/11/2025 at 11:07 AM identified that Resident #8's RCP failed to be updated with Resident #8's change in condition.Review of the Comprehensive Care Plans Policy identified, in part, that care plans are oriented toward preventing avoidable decline in clinical and functional levels, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintaining a specific level of functioning and reflect resident preferences and the right to refuse certain services or treatment. Additionally, the care is evaluated and revised as needed, but at least quarterly. 2. Resident #50's diagnoses included idiopathic peripheral autonomic neuropathy (damage to nerves that control involuntary bodily functions), atherosclerosis of bilateral lower extremities, and chronic pain.A hospital Wound Care Consult note (during Resident #50's hospitalization from 5/3/2025 to 5/5/2025) dated 5/4/2025 identified a need to optimize nutrition per a hospital Registered Dietician recommendation due to left and right heel, pink, blanchable areas. readmission physician's order dated 5/5/2025 failed to direct supplementation for wound prevention.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #50 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was independent with eating, putting on/taking off footwear, bed mobility, transfers, and walking 150 feet using a walker. Resident #50 was noted to be at risk for pressure ulcer development.A nursing note dated 5/23/2025 identified that Resident #50 had self-reported a Stage 3 pressure ulcer, measuring 5.0 cm x 6.0 cm x 0.1 cm on his/her right foot that was caused by his/her shoe insert. (Resident #50 independently inserted shoe inserts designed for different footwear.) Further, the note indicated the APRN, charge nurse, and conservator were notified, and he/she was scheduled for an evaluation with the wound nurse (APRN #4) at the next visit. The Resident Care Plan (RCP) was updated on 5/23/2025 with interventions for the facility acquired pressure ulcer.Review of physician and Advanced Practice Registered Nurse (APRN) orders from 5/5/2025 through 5/23/2025 (date of pressure ulcer development) failed to identify orders for supplementation for wound prevention and from 5/23/2025 8/11/2025 failed to identify orders for Resident #50 to receive a supplement to assist with wound healing. Review of the APRN #4's wound notes dated 5/29/2025, 6/2/2025, 6/9/2025, 6/16/2025, 6/30/2025, 7/7/2025, 7/16/2025, 7/23/2025, 7/28/2025, and 8/4/2025 (10 visits) identified Resident #50 had a right heel Stage 3 pressure ulcer and had received wound care. Additionally, during each of the 10 evaluations the APRN had directed a Registered Dietician consultation for supplementation to aid wound healing.Dietician #3's re-admission Nutritional Evaluation dated 6/26/2025 (34 days after Resident #50's facility acquired pressure ulcer developed and 52 days since readmission from the hospital) failed to identify Resident #50 had a nutritional evaluation for pressure ulcer prevention or had been evaluated for a supplement before or after the development of his/her stage 3 pressure ulcer, or that Dietician #3 was made aware of a pressure ulcer.Interview on 8/11/2025 at 10:33 AM with Dietician #3 identified she was responsible to follow-up with all residents on a monthly basis and as needed. She indicated she had never been notified that Resident #50 required an assessment to provide a supplement upon his/her readmission 5/5/2025. Additionally, when Dietician #3 reviewed her facility communication, she indicated staff had never notified her of the development of Resident #50's pressure ulcer or that APRN #4 requested a consultation for supplementation. Dietician #3 indicated that her evaluation dated 6/26/2025 was for a routine, quarterly evaluation.Interview and record review on 8/11/2025 at 11:07 AM with the Regional Director of Nursing Services (DNS) identified that wound care nurse, APRN #4, was responsible for notifying the dietician for consultation or supplement requests. During a review of the clinical record, she failed to identify documentation indicating an evaluation by the dietician, and if Resident #50 had a supplement implemented when first requested, it would have aided in his/her wound healing. Interview with facility APRN #5 on 8/11/2025 at 2:35 PM identified that she had verbally ordered Resident #50 to be seen by the dietician for a nutritional evaluation and supplement to aid in wound healing and had documented the request in her notes. She stated that she personally did not place any electronic orders for supplements and that APRN #4 (the wound APRN) was responsible for ordering and entering supplement orders. Further, APRN #5 identified that a facility staff nurse accompanied APRN #4 during wound rounds and any requests for supplements made by APRN #4 were reported to the facility nurse. Attempts to reach APRN #4 (the wound APRN) were unsuccessful.The Prevention and Management of Pressure Injuries Policy identified, in part, that residents with pressure injuries and those at risk for skin breakdown are identified, assessed and provided with appropriate treatment to encourage healing and/or maintenance of skin integrity.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policy, and interviews for 3 of 3 sampled residents (Resident #1, Resident #2, and Resident #49) reviewed for respiratory care, the facility failed to ensure that nebulizer tubing and masks were labeled, dated, and appropriately stored. The findings include:1. Resident #1's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF).A physician's order dated 7/9/25 directed to administer Albuterol Sulfate inhalation treatment 1 vial every 3 hours as needed for wheezing and shortness of breath.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14 indicating no cognitive impairment and required moderate assistance from staff for activities of daily living and required a mechanical lift for transfers out of bed.The Resident Care Plan (RCP) dated 8/5/25 identified a history of COPD with interventions to administer oxygen and nebulizer treatments as needed, head of bed to be elevated, follow up with pulmonology, and monitor for signs of exacerbation.Observations on 8/5/25 at 11:02 AM, 8/6/25 at 8:30 AM, and 8/7/25 at 12:55 PM identified an undated and unlabeled nebulizer tubing. Additionally, the tubing was noted to be stored inappropriately, without a cover, and open to the environment.2. Resident #2's diagnoses included Congestive Heart Failure (CHF) and coronary artery disease (CAD).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 9 indicating moderately impaired cognition and required maximum assistance with activities of daily living. Physician's orders dated 6/28/25 directed to administer Albuterol inhalation 0.5-2.5 3 milligrams (mg)/3 milliliters (ml) administer 3 ml every 6 hours as needed for shortness of breath and wheezing.The Resident Care Plan dated 7/1/25 failed to identify Resident #2's respiratory status and did not identify the use of nebulizer treatments.Observations on 8/4/25 at 3:14 PM, 8/5/25 at 11:15 AM, and 8/6/25 at 1:00 PM identified undated and unlabeled nebulizer tubing. Additionally, the tubing was noted to be stored inappropriately, without a cover, and open to the environment.3. Resident #49 diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and atrial fibrillation.Physician's orders dated 6/23/25 directed to administer Albuterol Inhalation solution 0.5 milligram (mg)/1 milliliter (ml) give 3 ml inhalation every 4 hours as needed.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #49 had a BIMS score of 15 indicating intact cognition and required minimal assistance with activities of daily living.The Resident Care Plan dated 7/8/25 identified a history of COPD with interventions to administer oxygen and nebulizer treatments as needed, head of bed to be elevated, follow up with pulmonology, and monitor for signs of exacerbation.Observations on 8/5/25 at 11:00 AM and 1:30 PM and on 8/6/25 at 6:30 AM identified undated and unlabeled nebulizer tubing. Additionally, the tubing was noted to be stored inappropriately, without a cover, and open to the environment.Interview with the central supply staff on 8/6/25 at 10:10 AM identified that she was responsible for ordering nebulizer and oxygen tubing and bags for storage. She indicated she conducted an inventory of respiratory supplies at least weekly to ensure there was an adequate supply on all the units. Additionally, there was an inventory of master supplies kept in the main central supply room. She indicated that there was plenty of nebulizer tubing and bags available to use in the storage rooms.An interview with LPN #1 on 8/7/25 at 12:00 PM identified that it was the facility policy to date and label all nebulizer tubing and store nebulizer masks in a bag. LPN #1 indicated that the licensed staff on the 11:00 PM to 7:00 AM shift were responsible to ensure the tubing had been changed. LPN #1 stated many times that the masks were not in bags and indicated that she was not sure why the items were unlabeled, undated, and not stored appropriately, in a bag.An interview with the DNS on 8/6/25 at 12:30 PM indicated that she was not sure what the facility policy was for changing tubing as she was new to the facility, but the standard was to change the tubing weekly, and ensure the tubing was labeled, dated, and stored appropriately, not open to the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment.Although requested, a policy for nebulizer treatments/tubing was not provided.A policy on Oxygen Administration was provided that directed, in part, oxygen tubing should be changed weekly and when visibly soiled.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, and interview for 2 of 2 sampled residents (Resident #1) reviewed for dental services, the facility failed to ensure a consent to treat was signed in a timely manner in order to provide dental services to a resident with known dental issues. The findings include:Resident #1 was admitted on [DATE] with diagnoses that included protein calorie malnutrition, type 2 diabetes, and Gastroesophageal Reflux Disease (GERD).Review of Resident #1's nursing admission Oral Health assessment dated [DATE] and subsequent Oral Health assessment dated [DATE] identified Resident #1 had more than 4 missing and decaying teeth. A physician order dated 6/26/25 direct to provide a diet that was small bite size solids with thin liquids and while sitting upright 90 degrees.A Physician's order dated 7/9/2025 directed to give a mechanical soft, ground texture diet. (the resident diet was downgraded)The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition, was able to eat independently, perform oral hygiene independently after set up, had obvious or likely cavity or broken natural teeth and had mouth or facial pain, discomfort or difficulty with chewing. The Resident Care Plan in effect during June, and July 2025 failed to identify that Resident #1 had any dental issues.A review of APRN #1's progress note dated 8/1/2025 identified Resident #1 had a significant amount of weight loss since admission and poor intake was multifactorial including a recent readmission to the hospital.Interview and observation with Resident #1 on 8/5/2025 at 10:51 AM identified that he/she was scheduled for extractions of teeth and to be fitted for dentures prior to admission. Resident #1 indicated that he/she had many missing and broken teeth that were causing difficulty with eating. Observation of Resident #1's mouth when speaking showed several broken teeth on the top and bottom. Resident #1 indicated that he/she had informed staff he/she required a follow up dental visit, could not recall who he/she had told, and that no facility staff had offered any information related to dental services.A review of speech therapy notes dated 8/5/2025 identified that speech therapy was being discontinued as Resident #1 was not being appropriate for a diet upgrade due to requiring follow up dental work. Resident #1 was noted to have 8 remaining teeth that were broken and/or decaying.An Interview with the unit secretary on 8/6/2025 at 9:45AM identified that she was responsible for having residents sign consents for ancillary services on admission. She indicated that it is the normal process for her to offer the services on admission to all residents regardless of payment source. She indicated it was an oversight on her part, that Resident #1 was not offered to sign a consent for dental services on admission. She also indicated that she was not aware of Resident #1 needed to be seen by a dentist.Subsequent to surveyor inquiry, Resident #1 signed consent for dental services and would be added to the dental list for an upcoming visit once a date was scheduled.Review of the Consultant Services policy directed, in part, once the consultant is identified by the physician and after the family has been notified and given permission for the consultation, the staff will call the consultant to notify them of the request and document the response in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075312	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wadsworth Glen Health Care and Rehabilitation Cent	30 Boston Rd Middletown, CT 06457

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 2 of 2 Residents (Resident #70) reviewed for dental services, the facility failed to ensure an outside dental provider appointment was scheduled and failed to update the Resident Care Plan for dental issues. The findings include: Resident #70's diagnoses included diabetes, bipolar disorder, and lesions of oral mucosa.A dental note dated 1/2/2025 identified crowns and bridges throughout mouth, and that a follow up visit was scheduled for 6/20/2025. The note did not identify a missing crown or lesion on Resident #70's tongue.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, was independent when eating, and required set-up assistance for oral hygiene, and failed to indicate dental issues.A nurse's note dated 4/23/2025 at 11:04 PM identified Resident #70 informed LPN #5 that his/her third tooth on the top right side was very loose. Resident #70 indicated that his/her teeth were implanted, and he/she would like to be seen by a dentist. The note indicated that LPN #5 placed Resident #70's request in the appointment book and the supervisor was made aware.The Advanced Practice Registered Nurse (APRN) #6's note dated 5/19/2025 identified Resident #70 requested an evaluation for a dark spot on the lateral aspect of the right side of his/her tongue. Resident #70 reported the spot had not changed since first noticing it approximately 1 month ago.A Physician order dated 5/19/2025 directed Resident #70 to be seen by a dentist as soon as possible to evaluate a painless dark spot-on right side of his/her tongue.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #70 had a Brief Interview for Mental Status (BIMS) score of 14 indicating no cognitive impairment, required set-up assistance for eating and oral hygiene, and failed to indicate dental issues.APRN #1's note dated 6/16/2025 directed a follow up dental evaluation for Resident #70's tongue lesion.The Resident Care Plan dated 7/25/2025 identified a dark area on the tongue that was not painful and a history of cancer, chooses not to be seen by an in-house dentist at times. Currently, Resident #70 had been seen by the in-house dental services. Interventions included observing the dark area daily, ask Resident #70 if the area was painful or if they were having any difficulty chewing, and providing a dental consultation as soon as possible. The care plan failed to identify the missing crown or loose tooth.Interview and observation on 8/4/2025 at 11:45AM with Resident #70 identified that his/her front tooth crown had fallen off in April. Resident #70 indicated he/she needed to go to an outside dentist to have the crown repaired because the facility dentist could not repair a crown in house.An interview and clinical record review with the unit secretary on 8/7/2025 at 12:30 PM indicated she was responsible to schedule dental the consultation. The unit secretary was unable to locate a referral to an outside state dental provider.An interview on 8/7/2025 at 12:56 PM with the Administrator indicated she was unaware that Resident # 70 needed a state dental appointment with an outside dental provider. Subsequent to surveyor inquiry, the Administrator provided documents dated 8/8/2025 at 7:28 AM that had been sent to a state outside dental provider requesting an appointment as soon as possible. Review of the Consultant Services policy directed, in part, once the consultant is identified by the physician and after the family has been notified and given permission for the consultation, the staff will call the consultant to notify them of the request and document the response in the medical record. If the consultant will not come to the facility, the Physician will either identify a consultant who does make facility visits, or the social worker, nurse and family will arrange for consultation outside the facility. A note should be recorded on the consultation form by any health care consultant who sees the resident at the request of the Physician or family. The consultant should document findings and recommendations on this form.