STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075325	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Wade Home, the Incorporated	118 Clinton Ave New Haven, CT 06513

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 residents (Resident #46) reviewed for urinary catheters, the facility failed to maintain dignity for a resident with a urinary catheter drainage bag. The findings include: Resident #46 was admitted to the facility in October of 2023 with diagnoses that included osteoarthritis of bilateral knees, neuromuscular dysfunction of bladder, generalized muscle weakness and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 12), and was dependent on toileting hygiene, personal hygiene, bed mobility and transfers. The MDS identified that Resident #46 had an indwelling catheter, and was always incontinent of bowel. The Resident Care Plan dated 1/1/24 identified Resident #46 had an indwelling catheter due to obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed either structurally or functionally) and neurogenic bladder (lack of bladder control due to medical issues). Interventions included enhanced barrier precautions, foley catheter care every shift, foley bag/leg bag to be changed weekly and foley to be changed monthly. Observations on 2/19/25 at 10:45 AM and on 2/20/25 at 9:30 AM and 11:04 AM identified Resident #46 lying in bed without the benefit of a privacy cover over the drainage bag. Urine was visible in the drainage bag from the hallway. A privacy cover was observed positioned above the drainage bag. Interview and observation with NA #8 on 2/20/25 at 11:55AM identified a privacy cover connected to a drainage bag but the privacy cover was positioned above the drainage bag and not covering the drainage bag. NA #8 identified that a privacy cover should cover the drainage bag and should not be positioned above the drainage bag. NA #8 could not explain why the privacy cover was positioned above the drainage bag. Subsequent to surveyor inquiry, Resident #46's privacy cover was pulled down to cover the drainage bag. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER: Mary Wade Home, the Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 Clinton Ave New Haven, CT 06513	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Unit Manager (LPN #6) on 2/20/25 at 12:10 PM, identified that privacy covers are used for dignity purposes and indicated that they should cover the drainage bag and should not be left pulled up or positioned above the drainage bag. LPN #6 was unable to explain why staff pulled the privacy cover above the drainage bag leaving urine visible from the hallway. Interview with the DNS on 2/20/25 at 1:55 PM identified that privacy covers should cover the drainage bag to conceal urine from public view. The DNS further identified that privacy covers provide dignity for residents with urinary catheters. Although requested, a policy for urinary catheter drainage bags or privacy covers was not provided.

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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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). 50179 Based on observations, review of the clinical records, facility documentation, facility policy and interviews for 2 of 2 nursing units, the facility failed to ensure residents who did not meet clinical criteria to reside on a locked unit were provided with a method of opening doors independently. The findings include: Observations on 2/11/2025, 2/13/2025, 2/18/2025, 2/19/2025, 2/20/2025, 2/21/2025, 2/24/2025 and 2/25/2025 identified both nursing units: first floor (unit K1) and second floor (unit K2), had secured doors for entering and exiting the units to both stairwells and the elevator. A number code entered into a keypad was required to open the doors. Intermittent observation on all survey days identified only facility staff inputting the code for visitors and residents to enter and exit the units. Additionally, signage on the doors instructed to call a phone number if staff were not available to open the doors and to avoid knocking on the window/door to obtain staff members attention for opening the doors. Review of the Elopement Risk report dated 2/20/2025, for unit K1 identified 32 residents (Resident #12, Resident #15, Resident #17, Resident #21, Resident #24, Resident #26 , Resident #37, Resident #38, Resident #42, Resident #49, Resident #52, Resident #56, Resident #57, Resident #61, Resident #62, Resident #65, Resident #66, Resident # 67, Resident #73, Resident #81, Resident #84 , Resident #192 , Resident #193, Resident #194, Resident #195, Resident #196, Resident #197, Resident #198, Resident #199, Resident #200, Resident #201, and Resident #202) who were not at risk for elopement, Review of the Elopement Risk report dated 2/20/2025, for unit K2, which was equipped with a Wander Guard system (safety system that utilizes bracelets and door sensors to alert caregivers when a resident approaches the monitored area) identified 31 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #18, Resident #20, Resident #23, Resident #27, Resident #28, Resident #30, Resident #36, Resident #40, Resident #45, Resident #46, Resident #50, Resident #51, Resident #53, Resident #54, Resident #58, Resident #59, Resident #64, Resident #68, Resident #70, Resident #75, Resident #76, Resident #78, Resident #82, Resident #86, and Resident #203) who were not at risk for elopement. Although requested, the facility was unable to identify or provide a risk assessment for any residents residing on the secured/locked units or criteria for requiring a secured/locked unit. Interview on 2/19/2025 at 9:35 AM with LPN #1 identified that the unit doors were locked and residents needed to be accompanied by a staff member to different units or the lobby. LPN #1 indicated no residents were allowed off the unit without a staff member, independent/cognitively intact residents included. Interview with the Chief Operations Officer (COO) on 2/19/25 at 3:35 PM identified that both units were locked, unit K2 was equipped with a Wander Guard system and an Elopement Risk assessment was performed for all residents upon admission to the facility. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 2/20/2025, at 3:35 PM with the Maintenance Director identified that the State Agency's Building Fire Safety Inspection on 2/6/2025 recommended the facility install delayed egress hardware because the existing keypad system prohibited anyone from leaving the units. Observation on 2/20/2025, at 3:55 PM, on the elevator from the first floor to the second floor, identified Resident #23 exited the elevator to the second floor and was unable to enter the unit because he/she did not have the code to the keypad. Resident #23 began to panic and stated to the surveyor let me in, please let me in. The surveyor entered the code and entered unit K2 with Resident #23. Observation of the unit identified that no staff were present near the door to the elevator and the closest staff identified were approximately 15 to 20 feet away, near the nurse's station, on the opposite side of the elevator. Interview on 2/20/2025, at 3:55 PM with NA #3 identified that Resident #23 was a resident on unit K2. NA #3 identified that a staff member should have accompanied Resident #23 from the first floor to the second floor and that Resident #23 should have knocked on the door to enter the unit if he/she was alone when he/she exited the elevator to obtain attention from a staff member to open the locked door. Interview on 2/25/25 at 9:41 AM with the DNS identified that independent residents residing on unit K1 were provided the keypad code to freely enter and exit the unit while independent residents residing on unit K2 (unit equipped with a Wander Guard system) were not provided with the keypad code. The DNS was unable to explain how the facility would ensure residents provided with the keypad code would know to secure the door behind them when entering or exiting the unit or how they would know what residents were not permitted to leave the units. The DNS further identified that the facility had no strategy to secure only the residents who were identified as elopement risks and identified all residents, whether or not an elopement risk, were scattered throughout both units indicating the need to secure both units in entirety. Although requested, a facility policy for secured/locked units was not provided. Although requested, a facility policy for assessment/criteria for placement on a secured/locked unit was not provided. A review of the Elopement and Wandering Resident policy identified, in part, that the facility ensures that residents that exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered care plan addressing the unique factors contributing to wandering or elopement risk. The policy further identified that the facility is equipped with door locks and alarms to help avoid elopement. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring effectiveness and modifying interventions when necessary.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #20) reviewed for abuse, the facility failed to keep Resident #20 free from physical restraint. The findings include: Resident #20 was admitted to the facility in June of 2022, with diagnoses that included Alzheimer ' s disease, dementia with other behavioral disturbance and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE], identified Resident #20 was cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), was dependent for bed mobility, transfer and toileting, was non-ambulatory, and was independent with eating. A Resident Care Plan dated 10/12/2024 (start date of 7/12/23) identified increased combative behaviors and anxiety with medications and an intervention to start Trazadone 30 minutes prior to morning and evening care twice daily. The Accident and Incident report dated 10/31/2024, identified NA #10 alleged that LPN #9 hit Resident #20. A statement dated 10/31/2024 by NA #10 indicated that when she walked into Resident #20 ' s room to deliver a meal tray, she overheard LPN #9 speaking to Resident #20 in an aggressive tone, while attempting to administer medications. The statement identified NA #10 then saw LPN #9 hit Resident #20 on the arm. The statement indicated NA #10 delivered and set up the meal tray and encouraged Resident #20 to take his/her medication, then left the room. The statement identified LPN #9 returned to her medication cart and LPN #9 told staff nearby that Resident #20 scratched her. A statement dated 10/31/2024 by LPN #9 identified she was administering medications in applesauce to Resident #20 with a spoon and Resident #20 accepted the first bite then resisted taking another bite. The statement indicated Resident #20 scratched LPN #9 ' s arm and held onto LPN #9 ' s arm tightly. The statement indicated LPN #9 placed her hands on top of Resident #20 ' s hands and held Resident #20 ' s hands against his/her stomach. The statement identified that at that time, NA #10 entered the room with the meal tray. The statement indicated LPN #9 attempted to administer the rest of the medication to Resident #20, but Resident #20 refused. The statement identified that NA #10 approached LPN #9 about the incident and that LPN #9 called the Assistant Director of Nursing Services (ADNS) and that the Director of Nursing Services (DNS) initiated an investigation. A Progress note by Physician ' s Assistant (PA) #1 dated 11/1/2024 at 9:22 AM identified she was requested to assess Resident #20 for agitation and combativeness. The note identified that Resident #20 was reported to have had an episode involving nursing and was increasingly noncompliant with taking medications and becoming more agitated when reapproached by nursing to administer medications. The note further identified that Resident #20 was calm at the time seen and given the frequency of refusals, would attempt switching to liquid medications and/or discontinuing non-essential medications. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 2/20/2025 at 10:30 AM with the DNS identified the facility conducted an investigation for the 10/31/24 allegation of abuse and the outcome of the investigation was unsubstantiated because NA #10 gave conflicting statements. The DNS was unable to produce documentation of the conflicting statements. The DNS identified that during the investigation no other residents on the unit were interviewed. She identified that statements were obtained from the alleged abuser, the alleged witness, the nursing supervisor and one other NA but failed to obtain statements from the remaining 4 staff members who were working on the unit. Interview on 2/21/2025, at 4:18 PM with NA #10 identified that on 10/31/2024 at approximately 5:00 PM, she entered Resident #20 ' s room to deliver a meal tray and witnessed LPN #9 standing on the door side of Resident #20 ' s bed, facing Resident #20 while Resident #20 was lying in bed, and she observed LPN #9 holding Resident #20 ' s hands down and LPN #9 hit Resident #20 ' s arm. Interview on 2/25/2025 at 12:37 PM with LPN #9 identified that on 10/31/2024 at around 5:00 PM she was trying to administer medications to Resident #20 and that Resident #20 grabbed her (LPN #9 ' s) hand. LPN #9 indicated that she did not call for help when Resident #20 became agitated/combative and did not attempt to step away from Resident #20 when he/she became agitated/combative. LPN # 9 indicated that the incident happened fast and grabbing Resident #20 ' s hands was a reaction. LPN #9 indicated that, at times, it was difficult to administer medications to Resident #20 and Resident #20 needed to be reapproached but had not attempted reapproaching Resident #20 during this incident. LPN #9 identified that she had not received training to restrain residents. Review of the Abuse, Neglect Exploitation and Misappropriation of Residents Property policy directed, in part, to provide protection for the health, welfare and rights of each resident by implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. The facility has developed and implemented these written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property and establishes policies and procedures to investigate any such allegations and includes training for new and existing staff on activities that constitute abuse, neglect, exploitation and misappropriation of resident property, reporting procedures and dementia management and resident abuse prevention. Additionally, it establishes coordination with the facility QAPI program.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #20) reviewed for abuse, facility failed to conduct a complete and thorough investigation for an allegation of abuse. The findings include: Resident #20 was admitted to the facility in June of 2022, with diagnoses that included Alzheimer ' s disease, dementia with other behavioral disturbance and anxiety disorder. The quarterly Minimum Data Set assessment dated [DATE], identified Resident #20 was cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), was dependent for bed mobility, transfer and toileting, was non-ambulatory, and was independent with eating. A Resident Care Plan dated 10/12/2024 (start date of 7/12/23) identified increased combative behaviors and anxiety with medications and an intervention to start Trazadone 30 minutes prior to morning and evening care twice daily. The Accident and Incident report dated 10/31/2024, identified NA #10 alleged that LPN #9 hit Resident #20. A statement dated 10/31/2024 by NA #10 indicated that when she walked into Resident #20 ' s room to deliver a meal tray, she overheard LPN #9 speaking to Resident #20 in an aggressive tone, while attempting to administer medications. The statement identified NA #10 then saw LPN #9 hit Resident #20 on the arm. The statement indicated NA #10 delivered and set up the meal tray and encouraged Resident #20 to take his/her medication, then left the room. The statement identified LPN #9 returned to her medication cart and LPN #9 told staff nearby that Resident #20 scratched her. A statement dated 10/31/2024 by LPN #9 identified she was administering medications in applesauce to Resident #20 with a spoon and Resident #20 accepted the first bite then resisted taking another bite. The statement indicated Resident #20 scratched LPN #9 ' s arm and held onto LPN #9 ' s arm tightly. The statement indicated LPN #9 placed her hands on top of Resident #20 ' s hands and held Resident #20 ' s hands against his/her stomach. The statement identified that at that time, NA #10 entered the room with the meal tray. The statement indicated LPN #9 attempted to administer the rest of the medication to Resident #20, but Resident #20 refused. The statement identified that NA #10 approached LPN #9 about the incident and that LPN #9 called the Assistant Director of Nursing Services (ADNS) and that the Director of Nursing Services (DNS) initiated an investigation. A Progress note by Physician ' s Assistant (PA) #1 dated 11/1/2024 at 9:22 AM identified she was requested to assess Resident #20 for agitation and combativeness. The note identified that Resident #20 was reported to have had an episode involving nursing and was increasingly noncompliant with taking medications and becoming more agitated when reapproached by nursing to administer medications. The note further identified that Resident #20 was calm at the time seen and given the frequency of refusals, would attempt switching to liquid medications and/or discontinuing non-essential medications. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 2/20/2025 at 10:30 AM with the DNS identified the facility conducted an investigation for the 10/31/24 allegation of abuse and the outcome of the investigation was unsubstantiated because NA #10 gave conflicting statements. The DNS was unable to produce documentation of the conflicting statements. The DNS identified that during the investigation no other residents on the unit were interviewed. She identified that statements were obtained from the alleged abuser, the alleged witness, the nursing supervisor and one other NA but failed to obtain statements from the remaining 4 staff members who were working on the unit. Interview on 2/21/2025, at 4:18 PM with NA #10 identified that on 10/31/2024 at approximately 5:00 PM, she entered Resident #20 ' s room to deliver a meal tray and witnessed LPN #9 standing on the door side of Resident #20 ' s bed, facing Resident #20 while Resident #20 was laying in bed, and she observed LPN #9 holding Resident #20 ' s hands down and LPN #9 hit Resident #20 ' s arm. Interview on 2/25/2025 at 12:37 PM with LPN #9 identified that on 10/31/2024 at around 5:00 PM she was trying to administer medications to Resident #20 and that Resident #20 grabbed her (LPN #9 ' s) hand. LPN #9 indicated that she did not call for help when Resident #20 became agitated/combative and did not attempt to step away from Resident #20 when he/she became agitated/combative. LPN # 9 indicated that the incident happened fast and grabbing Resident #20 ' s hands was a reaction. LPN #9 indicated that, at times, it was difficult to administer medications to Resident #20 and Resident #20 needed to be reapproached but had not attempted reapproaching Resident #20 during this incident. LPN #9 identified that she had not received training to restrain residents. Review of the Abuse, Neglect Exploitation and Misappropriation of Residents Property policy directed, in part, investigation of alleged abuse, neglect and exploitation in accord with Federal and State mandates an immediate investigation is initiated when suspicion of abuse, neglect, or exploitation occur. Written procedures for investigation include identifying the staff member responsible for the investigation, exercising caution in handling evidence that could be used in a criminal investigation, investigating different types of alleged violations, Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others that may have knowledge of the allegations, focusing the investigation on determining if abuse, neglect or exploitation and/or mistreatment has occurred, the extent, the cause and providing complete and thorough documentation of the investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the clinical record and facility policy for 1 of 3 residents (Resident #80) reviewed for elopement the facility failed to develop a comprehensive Resident Care Plan (RCP) for a resident at risk for elopement. The findings include: Resident #80 was admitted to the facility in May of 2024 and had diagnoses that included dementia, hypertension and depression. The Elopement Risk assessment dated [DATE] identified Resident #80 was at risk for elopement and precautions must be initiated. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #80 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), had fluctuating behaviors of inattention, fluctuating behaviors of disorganized thinking, was independent with eating, transfers and ambulating at least 150 feet without an assistive device. The RCP dated 9/18/2024 identified Resident #80 was alert and oriented to self with confusion and forgetfulness and walked around the unit. Interventions included to provide a daily routine that resembled Resident #80's prior lifestyle and provide a safe environment. The RCP identified Resident #80 was at risk for altered cognition related to dementia and would become confused as to where his/her room was, would enter other rooms and would lay down in empty beds thinking they were his/her bed. Interventions included to monitor cognitive changes and reorient as needed. The RCP failed to identify Resident #80 was at risk for elopement. A Provider progress note by PA #1 on 12/4/2024 at 1:15 PM identified Resident #80 was alert and disoriented, his/her mental status was at baseline, he/she ambulated around the unit, was generally quiet, enjoyed sitting at the nurses station and had poor safety awareness which was expected to progress. Review of the Elopements and Wandering Residents policy identified residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered care plan. The policy defines wandering as random or repetitive locomotion that may be goal-oriented or non-goal directed or aimless. The policy identified the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Review of the Comprehensive Care Plans policy directed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs including all services identified in the resident's comprehensive assessment. The process will include an assessment of the resident's strengths and needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observations, review of the clinical record, facility policy and interviews for 2 of 4 residents (Resident #21 and Resident #57) reviewed for oxygen therapy the facility failed to revise the Resident Care Plan (RCP) for residents on oxygen therapy per facility policy. The findings include: 1. Resident #21 was admitted to the facility in August of 2024 and had diagnoses that included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was severely cognitively impaired, required substantial/maximal assistance for eating and bed mobility, and dependent for transfers. The Resident Care Plan (RCP) dated 1/8/2025 identified Resident #21 was at risk for altered cardiopulmonary status. Interventions included assessing lung sounds per provider orders and consult with respiratory therapist as needed. The RCP failed to identify interventions for administration of continuous/intermittent oxygen with flow rate and type of oxygen delivery system, changing and labeling of the nasal cannula oxygen tubing, and monitoring for complications related to oxygen use. Review of the admission nursing assessment dated [DATE] identified Resident #21 required oxygen at 2 liters per minute (LPM) via nasal cannula. The Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was severely cognitively impaired, received continuous oxygen therapy, and was dependent for oral hygiene, bed mobility, and transfers. A provider order dated 1/30/2025 directed to change oxygen tubing weekly on Sundays during the 11 PM to 7 AM shift and included instructions which directed to place tubing in a labeled bag and not leave tubing exposed. A provider order dated 2/18/2025 directed to administer oxygen at 2 LPM via nasal cannula as needed for comfort. Interview with Registered Nurse (RN) #5 on 2/19/2025 at 12:10 PM identified her (RN #5) and Licensed Practical Nurse (LPN) #4 updated the RCPs. RN #5 identified she completed RCPs for short term care residents and new admissions. RN #5 indicated she did not update RCPs for short term residents because they did not often remain in the facility for greater than a couple weeks. RN #5 identified she was not aware Resident #21 had an order for oxygen for comfort and that Resident #21 was transitioned to long term care. RN #5 further identified that LPN #4 completed the RCPs for long term care residents. Interview with LPN #4 on 2/19/2025 at 12:20 PM identified that she updated the RCPs for the long-term care residents. LPN #4 identified she added information to the focus section of the RCP as she received it, but the interventions were updated quarterly or if residents had a significant change. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mary Wade Home, the Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Clinton Ave New Haven, CT 06513	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #57 was admitted to the facility in January of 2022 and had diagnoses that included pneumonia, dysphagia, and chronic kidney disease. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers. Observation on 2/11/2025 at 12:45 PM AM identified an unlabeled oxygen nasal cannula connected to a portable oxygen tank belonging to Resident #57. The Resident Care Plan (RCP) dated 2/17/2025 identified Resident #57 was at risk for altered cardiopulmonary status. Interventions included assessing lung sounds per provider orders and consult with respiratory therapist as needed. The RCP failed to identify interventions for administration of continuous/intermittent oxygen with flow rate and type of oxygen delivery system, changing and of the nasal cannula oxygen tubing, and monitoring for complications related to oxygen use. Observation on 2/19/2025 at 7:40 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator, set at 3 LPM, belonging to Resident #57. Interview with LPN #4 on 2/19/2025 at 12:20 PM identified that she updated the RCPs for the long-term care residents. LPN #4 identified she added information to the focus section of the RCP as she received it, but the interventions were updated quarterly or if residents had a significant change. Review of the Oxygen Administration Policy directed that the resident's care plan shall identify interventions for oxygen therapy based upon resident assessments and provider orders and include but not be limited to: the type of oxygen delivery system; when to administer oxygen (continuous or intermittent) and/or when to discontinue oxygen; equipment setting for the ordered flow rate (LPM); monitoring of oxygen saturation levels (blood oxygen level) or vitals signs per provider order; and monitoring for the complications associated with oxygen use (vertigo, nausea, convulsions, slowed respiratory rate, medical device related pressure injury). The policy further directed to change oxygen tubing weekly and as needed if soiled or contaminated. Review of the Comprehensive Care Plans policy identified the comprehensive care plan includes measurable objectives and timeframes to meet the resident's needs and alternative interventions are documented as needed.

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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** 51183 Based on observations, review of the clinical record, facility policy and interviews for 1 of 4 residents (Resident #62) reviewed for dining the facility failed to provide supervision for a resident who required supervised feeding. The findings include: Resident #62 was admitted to the facility in November of 2020 and had diagnoses that included dementia, respiratory failure with hypoxia, and dysphagia. A Physician ' s Order dated 7/25/2024 directed an assist of 2 staff members for activities of daily living and assist of 1 staff member for supervision for feeding. A Physician Order dated 12/12/2024 directed for a dysphagia evaluation with treatment 3 times a week for 4 weeks. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #62 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), was on a mechanically altered diet, started speech therapy on 12/12/2024, required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers. The MDS failed to accurately code Resident #62's eating functional ability per provider orders. A Physician Order dated 12/31/2024 directed to provide a carbohydrate controlled, no added salt, mildly thick diet which included instructions for a lidded sippy cup, extra sauce/gravy on the side, may have cheerios with thickened milk (let sit to get soft),thickened coffee and super oatmeal daily with breakfast. The Dysphagia Therapy note by Speech Therapist (ST) #1 dated 1/7/2025 at 2:46 PM identified Resident #62 was seen in the morning for dysphagia therapy, that nursing staff informed ST #1 that a chest X-RAY was performed for Resident #62 on 1/6/2025 which revealed aspiration pneumonia. ST #1 subsequently placed Resident #62 on aspiration precautions which included supervision with meals. The note further identified that nursing staff were informed of the new recommendations. A Physician's Order dated 1/7/2025 directed aspiration precautions: Supervision during meals, encourage Resident #62 to be out of bed for all meals, and if eating in bed, position Resident #62 upright with HOB at 90 degrees. The Resident Care Plan (RCP) dated 1/8/2025 identified Resident #62 was at risk for inadequate nutrition and required feeding assistance with meals but would refuse. Interventions included 1 to 1 feeding and that Resident #62 should be out of bed for all meals, but if in bed, the head of the bed (HOB) must be positioned at 90 degrees. The Resident Care Card (RCC) dated 1/15/2025 identified Resident #62 was on a limited concentrated sweets, no added salt, soft and bite sized diet, aspiration precautions, swallowing precautions, needed to sit upright with the HOB at 90 degrees during meals, and required 1 to 1 feeding assistance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dysphagia Therapy note by ST #2 dated 1/28/2025 at 5:51 PM identified Resident #62 was seen for dysphagia therapy and during the session Resident #62 verbalized that he/she had vomited earlier during the lunch meal because the meal was too dry and the food just wouldn't go down. The note further identified Resident #62 had emesis at the end of therapy treatment which was reported to the nurse. A Nutrition Assessment progress note by the Dietician dated 2/4/2025 at 10:58 AM identified Resident #62 had a history of dysphagia, was on a mechanically altered diet and was seen by ST #1. The note identified Resident #62 was observed at meals and ate well and identified a goal to have no symptoms of aspiration. Observation in the dining room on 2/11/2025 at 12:32 PM identified Resident #62 eating his/her meal without assistance or supervision from staff. No staff members were in the dining room while Resident #62 ate lunch. A Dysphagia Therapy note by ST #3 dated 2/20/2025 at 6:22 PM identified Resident #62 was seen for dysphagia therapy, and upon entry into the dining room, Resident #62 was observed red faced and coughing and reported, It just wouldn't go down for a second. The note further identified no additional swallowing difficulties observed with food and fluid intake during the therapy session and that safe swallowing strategies were reviewed with Resident #62. Observation on 2/25/2025 at 8:38 AM identified Resident #62 sitting upright (90 degrees) in bed, eating behind a privacy curtain, with no staff member in the room. Observation of the plate identified part of a muffin and some scrambled eggs were consumed. Resident #62 was observed drinking juice from a handled lidded sippy cup. Interview with RN #3 on 2/25/2025 at 8:40 AM identified there was a provider order for Resident #62 to have supervised feeding assistance, Resident #62 was not on the list of residents requiring feeding assistance, Resident #62 should have been on the list of residents requiring feeding assistance, and Resident #62 should not have been eating alone in his/her room without staff member supervision. Subsequent to surveyor inquiry, Resident #62 was added to the supervised feeding assistance list and RN #3 instructed a staff member to supervise Resident #62 with breakfast. Interview with NA #1 on 2/25/2025 at 9:05 AM identified she used the RCCs to determine the care residents needed. NA #1 identified that Resident #62 was not on the list of residents who required feeding assistance and she did not realize the RCC instructed to feed Resident #62 because she had not looked at it. Further identified by NA #1 was that if no one was in the dining room while Resident #62 was eating lunch, she would sit with Resident #62 until his/her meal was finished. Interview with ST #1 on 2/25/2025 at 11:08 AM identified Resident #62 was receiving speech therapy because he/she had a history of aspiration pneumonia and requested a diet upgrade to liberalize his/her diet. ST #1 identified Resident #62 had aspiration pneumonia again while on therapy services and he/she was subsequently placed on aspiration precautions. ST #1 indicated Resident #62 should have a staff member present while eating to help him/her during coughing episodes and to cue him/her to slow down and use proper swallowing techniques. ST #1 further identified it was beneficial for Resident #62 to have an extra set of eyes on him/her during meals to help prevent future episodes of aspiration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Aspiration Precautions Protocol policy identified, in part, that for residents on aspiration precautions to follow these steps: encourage resident to maintain the HOB at 90 degrees if tolerated, offer small sips and bites at a feeding rate suitable for residents, and if a resident has trouble, notify the nurse immediately for: inability to chew food within diet consistency, increased coughing during feeding/after bites or sips, choking, and with pocketing of food (food getting trapped in cheek or mouth without swallowing).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 residents (Resident #46) reviewed for pressure ulcers, the facility failed to follow the plan of care for a resident with a pressure ulcer. The findings include: Resident #46 was admitted to the facility in October of 2023 with diagnoses that included abnormal weight gain, osteoarthritis of bilateral knees, neuromuscular dysfunction of bladder, generalized muscle weakness and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 12), and was dependent on toileting hygiene, personal hygiene, bed mobility and transfers. The MDS identified that Resident #46 had an indwelling catheter, was always incontinent of bowel, was at risk of developing pressure ulcers and had a pressure reducing device for bed. The Resident Care Plan (RCP) dated 12/18/24 identified Resident #46 was a potential for skin breakdown. Interventions included an air mattress to the bed and to turn and reposition every 2 hours. A Physician ' s order dated 1/1/25 directed an air mattress with instructions to check functioning every shift. Review of the Weekly Ulcer Skin Assessment Flow Sheet dated 1/8/25 by the Infection Preventionist Nurse (LPN #3) identified a new stage II facility acquired pressure ulcer to the left buttock measuring 1.5 centimeters (cm) by 1.1 cm by 0 cm and was described as having a wound bed containing 55% red granulation tissue, 37% yellow and 8% black (discolored) tissue, was tender to touch with scant serosanguinous drainage noted. The flow sheet identified topical treatment with Medi-honey followed by a piece of calcium alginate (absorptive topical treatment) and border gauze dressing. The Resident Care Card dated 2/1/25 failed to direct turning and repositioning every 2 hours. Although the RCC contained a section to check off turning and repositioning, this intervention was not selected. Review of Weekly Ulcer Skin Assessment Flow Sheet dated 2/10/25 by LPN #3 identified a stage II pressure ulcer to the right and left buttock with treatments in progress. The wound on the left buttock measured 1.7 cm by 1.5 cm by 0 cm and the wound on the right buttock measured 0.6 cm by 0.5 cm by 0 cm. 1. Observation and interview with Resident #46 on 2/11/25 at 1:07 PM identified he/she was lying in bed with the head of the bed elevated. Resident #46 indicated he/she did not have the ability to re-position him/herself in bed and relied on staff for bed to chair transfers. Resident #46 identified that she had sores in his/her buttocks with ongoing treatments. An air mattress was observed in place but appeared mildly deflated. The indicator light on the power switch did not display any light. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation with Resident #46 on 2/11/25 at 2:54 PM identified Resident #46 lying in bed with head of bed elevated. The air mattress was observed in place but still appeared mildly deflated and the indicator light on the power switch did not display any light. Resident #46 indicated that he/she could not feel the air mattress fluctuate as it always did, and the bed felt uncomfortable. Interview and observation with LPN #1 on 2/11/25 at 2:56 PM identified that she disconnected the air mattress plug from the wall outlet when she performed incontinent care for Resident #46 before lunch. LPN #1 indicated she forgot to plug the air mattress back in and did not check for functioning before leaving Resident #46's bedside. LPN #1 identified that she should have checked the air mattress for functioning before leaving Resident #46's bedside. LPN #1 further identified that Resident #46 had a stage II pressure ulcer to the bilateral buttocks and was receiving daily wound treatments. Subsequent to surveyor inquiry, the air mattress was plugged into the wall outlet and placement and functioning was confirmed by LPN #1 prior to leaving the bedside. Interview with the DNS on 2/25/25 at 1:58 PM, identified that LPN #1 should have checked air mattress function and placement after performing incontinence care. 2. Observation and interview with Resident #46 on 2/20/25 at 10:00 AM, identified that he/she was lying on his/her back with head of bed slightly elevated. Resident #46 identified that he/she had been incontient of stool for approximately 1 hour and was waiting for staff to assist him/her with incontinence care. Resident #46 identified that, at times, it takes up to 4 hours for staff to assist him/her with incontinence care and indicated that waiting for staff to assist with washing him/her up caused him/her distress. Resident #46 identified that he/she turned on the call bell to request help at 10:30 AM and 1 of the NA's went into his/her room, switched the call bell off and informed him/her that his/her assigned NA was with a different resident and would assist him/her when finished. Observation on 2/20/25 at 11:20 AM identified Resident #46 had still not received incontinence care and Resident #46 again turned on the call bell. LPN #1 responded at 11:25AM, switched off the call bell, and informed Resident #46 that his/her assigned NA would be available shortly to assist him/her with incontinence care. Observation on 2/20/25 at 11:55 AM identified NA #8 arrived at Resident #46's bedside to assist Resident #46 with incontinence care. Observation of Resident #46 ' s skin identified a Stage II pressure ulcer to the right buttock and a stage II pressure ulcer to the left buttock. Resident #46 was observed lying on his/her back before the incontinence care was provided and was returned to his/her back after the incontinence care. Interview with NA #8 on 2/20/25 at 12:05 PM identified that Resident # 46 was not repositioned in bed after the incontinence care because he/she is not bed bound. NA #8 identified that turning and repositioning only occurs for residents who are bed bound. NA #8 indicated that Resident #46 is sometimes transferred to a recliner at the bedside, therefore he/she is not considered bed bound. NA #8 further identified that the RCC did not direct Resident #46 to be turned and repositioned every 2 hours. Interview with LPN #1 on 2/20/25 at 12:08 PM identified that she was the nurse assigned to care for Resident #46 and that Resident #46 repositioned him/herself in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the Unit Manager (LPN #6) on 2/20/25 at 12:10 PM identified an RCP intervention to turn and reposition Resident #46 every 2 hours effective 9/24/24. LPN #6 indicated that the intervention of turning and repositioning every 2 hours should have been added the RCC and a Physician's order for turning and repositioning should have been obtained. LPN #6 indicated that since the RCC was not updated and there was no Physicians order, staff had not been turning and repositioning Resident #46 in bed, but only transferred him/her out of bed to the recliner. LPN #6 identified that Resident #46 was dependent for turning and repositioning in bed and currently had a stage II pressure ulcer to the right buttock and to the left buttock and needed to be turned and repositioned every 2 hours while in bed. Interview with the Rehabilitation Director on 2/24/25 at 11:35 AM identified that Resident #46 was dependent on staff for bed mobility and transfers and did not have the ability to turn or reposition him/herself in bed. Interview with the DNS on 2/25/25 at 1:58 PM identified Resident #46 had mobility issues and needed staff assistance with bed mobility and transfers. The DNS indicated that the RCC should have included interventions to turn and reposition Resident #46 every 2 hours as a pressure ulcer prevention strategy. Interview with PA #1 on 2/25/25 at 2:30 PM identified that Resident #46 did not have the ability to turn or reposition him/herself in bed. PA #1 identified that there were no contraindications to turning or repositioning Resident #46 in bed. PA #1 further identified that NAs were responsible for turning and repositioning residents in bed and indicated that they should have been turning and repositioning Resident #46. PA #1 indicated that if a resident is left in the same position and not moved, they would develop pressure ulcers, wounds or breakdown in skin. Review of facility policy titled, Turning and Repositioning Policy, identified that all residents at risk or with existing pressure injuries, will be turned and repositioned unless it is contraindicated due to a medical condition. In this case small shifts in repositioning will be employed. Turning and repositioning is a primary responsibility of nursing assistants. However, all nursing staff are expected to assist with turning and repositioning. A routine turn schedule includes using both side-lying and back positions, alternating from the right, back, and left side. A resident's condition will warrant whether specialized turn schedule is warranted. The frequency of turning and repositioning will be documented in the resident's plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 51183 Based on clinical record review, facility policy, and interviews for 2 of 3 residents (Resident #14 and Resident #80) reviewed for elopement, the facility failed to provide adequate supervision to prevent elopement. The findings include: 1. Resident #14 was admitted to the facility in September of 2024 with diagnoses that included alcohol and opiate use disorder, cognitive impairment, major depressive disorder and diabetes. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), was independent with eating, required partial/moderate assistance with transfers and ambulated with a walker. An Elopement risk assessment performed on 11/4/24 identified Resident #14 as at risk for elopement. A Physician ' s order dated 12/23/25 by Physician Assistant (PA#1), directed to apply a wander guard (a wearable monitoring device to ensure resident safety and prevention of exiting the facility) to left ankle and check function and placement every shift. The Resident Care Plan (RCP) dated 12/24/24 Identified Resident #14 as at risk for elopement. Interventions included applying a wander guard for safety or 15 minutes checks for wander guard refusal, involving Resident #14 in recreation/diversional activities, maintaining safety and offering rest breaks, redirecting out of other residents rooms or staff areas, encouraging rest periods, providing emotional support, speaking in a calm and gentle tone and visitation by the social worker as needed. A Nursing progress note by RN #1 on 1/8/25 at 1:21 PM identified Resident #14 went to a medical appointment accompanied by NA #7. The note identified that upon return from the appointment with NA #7, Resident #14 refused to re-enter the facility. The note further identified that Resident #14 stepped out of the transport vehicle and began walking away from facility, refused redirection and was aggressive. Additionally, the note identified that NA #7 left Resident #14 unattended, outside on the sidewalk, and went inside the facility to request assistance. The note identified that the Director of Nursing (DNS), the Assistant Director of Nursing (ADNS) and NA #7 went outside to assist Resident #14 who was identified across the street at the stop sign of a 4-way intersection. The note further identified that Resident #14 continued walking to a liquor store despite being re-directed back to the facility and the DNS and ADNS remained with the Resident until he/she returned to the facility. A Nursing progress note by the ADNS on 1/9/25 at 12:31 PM, identified Resident #14 was accompanied by person #2 (a volunteer escort from an outside agency) to a medical appointment. Upon arrival back to the facility, Resident #14 was unresponsive in the transport van and subsequently transferred to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's Evaluation/Conservatorship (PC-370) form dated 1/17/25 by MD #2 identified Resident #14 with alcohol dependance and associated cognitive impairments, major depression and multiple medical conditions. MD #2 further identified Resident #14 had poor insight and judgement, minimized risk and harm caused by his/her drinking, was vulnerable to abuse and became confused easily when ill. Interview with NA #7 on 2/19/25 at 2:22 PM identified that she escorted Resident #14 to a medical appointment on 1/8/25 in a medical transportation van. NA #7 indicated that Resident #14 was calm and cooperative throughout the trip but once they arrived back to the facility, Resident #14 told her he/she wanted to buy alcohol from a liquor store. NA #7 indicated that she tried to redirect Resident #14 but he/she became agitated and pushed her out his/her way. NA #7 identified that she ran back to the building and notified the DNS and the ADNS who responded to the incident and Resident #14 was located across the street at a stop sign of a 4-way intersection, approximately 150 feet from the facility's entrance. NA #7 indicated that they tried to redirect Resident #14, but he continued walking towards a liquor store. NA #7 identified that she was directed by the DNS to go back to the facility and notify the provider that Resident #14 eloped. NA #7 identified that she was not aware that Resident #14 was an elopement risk, and no education was provided to her prior to the appointment. She indicated that she worked on a different nursing unit and was pulled off her assignment to accompany Resident #14, who she had never previously cared for. She indicated she did not know how to respond to the incident and could not identify if she could have used her cell phone to alert the facility rather than leaving Resident #14 unattended outside the facility. Interview with the Unit Manager (LPN #6) on 2/19/25 at 3:56 PM identified that volunteer escorts do not receive resident healthcare information or education prior to escorting residents on medical appointments as that would be a Health Insurance Portability and Accountability Act (HIPAA) violation. LPN #6 further identified that Person #2 was not notified that Resident #14 was at risk of elopement. LPN #6 was unable to identify why NA #7 was not notified of Resident#14's elopement risk prior to the medical appointment on 1/8/25. Interview with the DNS on 2/20/25 at 2:00 PM identified that NA #7 accompanied Resident #14 to his/her medical appointment for safety due to his/her elopement risk. The DNS further identified that NA #7 should have been notified by the unit nurse that Resident #14 was an elopement risk and education should have been provided to NA #7 prior to accompanying Resident #14 to the medical appointment. Observation with the DNS on 2/20/25 at 2:15 PM, identified a one-way street in front of the facility's entrance, with cars parked on both sides of the street, causing low visibility, and a stop sign at a busy 4-way intersection, approximately 150 feet from the facility's entrance, on the opposite side of the street, was the location where Resident #14 was discovered during the elopement incident on 1/8/25. Interview with RN #1 on 2/20/25 at 3:36 PM identified that verbal education was provided to NA #7 after the elopement incident, but no education was provided to other facility staff. Interview with the DNS on 2/21/25 at 10:35 AM identified that the facility does not perform elopement drills for locating missing residents. Interview with Person #2 on 1/24/25 at 10:55 AM identified that no information, including Resident #14's elopement risk, was communicated to him by the facility, prior to accompanying Resident #14 to a medical appointment on 1/9/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mary Wade Home, the Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Clinton Ave New Haven, CT 06513	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #80 was admitted to the facility in May of 2024 and had diagnoses that included dementia, hypertension and depression. The Elopement Risk assessment dated [DATE] identified Resident #80 was at risk for elopement and precautions must be initiated. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #80 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), had fluctuating behaviors of inattention, fluctuating behaviors of disorganized thinking, was independent with eating, transfers and ambulating at least 150 feet without an assistive device. The Resident Care Plan (RCP) dated 9/18/2024 identified Resident #80 was alert and oriented to self with confusion and forgetfulness and walked around the unit. Interventions included to provide a daily routine that resembled Resident #80's prior lifestyle and provide a safe environment. The RCP further identified Resident #80 was at risk for altered cognition related to dementia and would get confused as to where his/her room was and enter other rooms and lay down in empty beds thinking they were his/hers. Interventions included to monitor cognitive changes and reorient as needed. The RCP failed to identify Resident #80 as an elopement risk. The Resident Care Card (RCC) dated 9/27/24 identified Resident #80 was oriented to self, confused at times, forgetful, independent with transfers, and independent with ambulation. Further identified was an entry dated 10/6/2024 which directed staff to take Resident #80 to a common area when awake. The RCC failed to identify Resident #80 was an elopement risk. A Provider progress note by PA #1 on 12/4/2024 at 1:15 PM identified Resident #80 was alert and disoriented, his/her mental status was at baseline and Resident #80 ambulated around the unit, was generally quiet and enjoyed sitting at the nurses station. Further identified was Resident #80 had poor safety awareness which was expected to progress. A Nursing progress note by Registered Nurse (RN) #2 on 12/8/2024 at 9:20 PM identified Resident #80 had dinner at 5:00 PM, had snacks at 6:00 PM, and was escorted to the unit at 6:40 PM by Security Guard #1. The note identified that the front desk cameras were reviewed and identified Resident #80 had exited the facility from a stair well door and walked toward the front door and re-entered the facility by the front door. The progress note further identified Resident #80's possible exit was by a wet floor sign inside the door, and that the Director of Nursing Services (DNS) and Resident #80's family member were notified of the incident. The RCP dated 12/11/2024 identified Resident #80 was at risk for elopement related to Resident #80 walking off the unit through the stair well door that was propped open and went down the stairs and out the door and walked back in through the front door. Interventions included to complete an elopement assessment per policy and as needed, redirect Resident #80 as needed, and provide an escort for off unit activities. A Psychiatric progress note dated 12/31/2024 at 1:50 PM identified Resident #80 received services in the context of behavioral assessment and medication management related to dementia, and Resident #80 was almost always confused. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 2/24/2025 at 11:00 AM identified she had been notified by Licensed Practical Nurse (LPN) #8 on 12/8/24, that Resident #80 was brought back to the unit by Security Guard #1 at 6:40 PM after Resident #80 walked in the front door of the facility. RN #2 indicated that no staff members were aware Resident #80 was missing prior to Security Guard #1 bringing Resident #80 back to the unit and she did not know the last time Resident #80 was seen after Resident #80 received a snack at 6:00 PM. RN #2 identified she filled out an Accident and Incident (A&I) report which included statements from herself and Security Guard #1 and that she notified the DNS and Resident #80's family member of the incident. She indicated she recently destroyed the copy of the A&I report she filled out because she thought it was no longer needed. RN #2 further identified Resident #80 walked around the unit alone and she did not know if Resident #80's picture was in the elopement book at the nurses station. Interview with LPN #8 on 2/24/2025 at 12:32 PM identified Security Guard #1 brought Resident #80 back to the unit after Resident #80 walked in the front door. LPN #8 identified that none of the staff on the unit knew how Resident #80 exited the unit and did not know how long Resident #80 was off the unit. LPN #8 identified she was not aware of the elopement book on the unit, that exit seeking was passed on in report, and she had not received in report that Resident #80 was exit seeking. LPN #8 further identified she did not complete an elopement assessment for Resident #80 after the elopement, and she did not recall receiving education on elopement except during orientation to the facility. Interview with the DNS on 2/24/2025 at 1:35 PM identified she had been notified by RN #2 that Resident #80 had gone outside through the stairwell door next to the Chapel, walked left out the door, and then walked to the front door and re-entered the facility where he/she was discovered by Security Guard #1 and brought back to the unit. The DNS identified she had not reported the 12/8/2024 incident of Resident #80 exiting the building unattended by staff because she was new to her position and did not know the criteria for defining an elopement. The DNS identified she did not perform further investigation of the incident beyond the investigation conducted by RN #2 on 12/8/2024. The DNS did not know how long Resident #80 was off the unit and had not reviewed the A&I report filled out by RN #2 after the incident. The DNS identified the criteria for a resident being entered into the elopement book was a resident having the ability to ambulate in addition to exit seeking behaviors. The DNS was unable to identify why Resident #80 was not in the elopement book. Interview with LPN #6 on 2/24/2025 at 3:00 PM identified the unit managers are responsible for updating the elopement books and was unable to identify why the elopement book had not been updated to include Resident #80's picture. Interview with Security Guard #1 on 2/25/2025 at 12:54 PM identified he was at his post at the front desk on the ground floor on 12/8/2025 when Resident #80 walked into the building through the front door wearing a long sleeved shirt and pants. Security Guard #1 identified he asked Resident #80 if he could help him/her but did not receive a response, and after asking multiple questions without a response, Resident #80 finally responded yes to living at the facility. Security Guard #1 identified he immediately brought Resident #80 to the first floor unit and indicated the staff were surprised to see Resident #80 with him. Security Guard #1 further identified he reviewed the camera at the front desk and saw Resident #80 exit the building through the stairwell door and turn left and walk straight to the front door and re-enter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Incidents and Accidents policy dated 12/23/2024 identified it is the policy to use the CT Accident and Injury form to report, investigate, and review accidents or incidents that occur, and elopement is listed in the policy as an incident requiring a report be written. Review of the Elopements and Wandering Residents policy identified residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered care plan addressing the unique factors contributing to wandering or elopement risk. The policy defined elopement as when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The policy identified the facility is equipped with door locks and alarms to help avoid elopements, a photo of each resident deemed to be at risk for elopement will be placed at the front desk and each nurse's station, and adequate supervision would be provided to help prevent accidents or elopements.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50249 Based on facility documentation, facility policy and interviews for 4 of 6 employee files, the facility failed to ensure the required annual performance evaluations were completed. The findings include: 1. NA #3's date of hire was 10/19/21. No performance evaluation was identified in the employee's personnel file. Although requested, the facility could not provide annual evaluations for NA #3. 2. NA #4's date of hire was 6/6/18. No performance evaluation was identified in the employee's personnel file. Although requested, the facility could not provide annual evaluations for NA #4. 3. NA #5's date of hire was 10/20/21. No performance evaluation was identified in the employee's personnel file. Although requested, the facility could not provide annual evaluations for NA #5. 4. NA #6's date of hire was 3/1/95. No performance evaluation was identified in the employee's personnel file. Although requested, the facility could not provide annual evaluations for NA #6. Interview and review of facility documentation with the Director of Nurses (DNS) on 2/13/25 at 1:19 PM identified that performance evaluations would be in the employee's personnel file and that she was not aware that the evaluations had not been completed. The DNS indicated that the prior DNS would have been responsible for completing the performance evaluations and that she (the current DNS) had only been the DNS since December of 2024. The DNS identified that it is facility policy that performance evaluations be completed annually and that she would work on getting them completed. Review of the facility policy, Performance Evaluations, dated 7/2012, directed that employees will receive an evaluation after completing 90 days of consecutive service and then be placed on an annual schedule. The policy further directed that evaluations will be prepared by Supervisors, submitted to the Administrator for review and the evaluation would be maintained in the employee's personnel file.

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	075325	A. Building B. Wing	02/25/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51102 Based on observations, interviews, and facility policy for 2 of 2 medication rooms reviewed for medication storage and lebeling, the facility failed to date 3 of 3 multi dose Tuberculin PPD vials upon opening. The findings included: During a review of the facility medication storage rooms on 2/13/25 at 10:17 AM, the following was identified: a. On the K1 unit a vial of Tuberculin PPD was stored in the refrigerator. The vial was noted to have been opened, was half full, without the benefit of being dated. b. On the K1 unit a vial of Tuberculin PPD was stored in the refrigerator. The vial was noted to have been opened, and was slightly more than half full, without the benefit of being dated. c. On the K2 unit a vial of Tuberculin PPD was stored in the refrigerator. The vial was noted to have been opened, was half full, without the benefit of being dated. Observation and interview of the K1 medication room with Registered Nurse (RN) #1 on 2/13/25 at 10:07 AM identified it is facility policy that the nurse who opens a multi-use vial dates it upon opening. Observation and interview of the K2 medication room with Licensed Practical Nurse (LPN) #1 on 2/13/25 at 10:51 AM identified it is facility policy for multi-use vials to be dated when opened. Interview with Pharmacist #1 on 2/13/25 at 2:15 PM identified multi use vials are good for 28-30 days, and should be dated upon opening. If a multi-use vial of tuberculin PPD is not dated, but used after 30 days of opening the efficacy of the medication and the accuracy of the Mantoux test (a diagnostic procedure that uses tuberculin PPD to detect latent tuberculosis infection) can be impacted. Review of the Multi-Dose Vials Policy dated 12/23/24 directed, in part, that multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured. The beyond use date rule will begin on the first day the multi-use vial is opened or punctured and the medication label will also include the initials of the nurse who opened the vial. The unit manager will perform random checks of opened multi dose vials for appropriate dating.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Surveyor: Green, [NAME] Based on facility policy and interviews for 8 residents (Resident #7, Resident #13, Resident #24, Resident #39, Resident #62, Resident #72, Resident #73, and Resident #76) reviewed for Resident Council, the facility failed to provide a selective menu for residents to make selections for meals. 1. Interview with Resident #72 on 2/11/2025 at 11:25 AM identified he/she did not receive a selective menu and would like to be able to choose what he/she is served at mealtime. Resident #72 indicated food was often overcooked and meats tough. Interview with Resident #76 on 2/11/2025 at 2:00 PM identified Resident #76 did not know what he/she would be served at mealtimes until the tray arrived. Resident #76 indicated he/she was not provided a selective menu and indicated he/she would like a menu to choose from because he/she was served the same foods repeatedly. During the Resident Council meeting on 2/13/2025 at 1:30 PM Resident #7, Resident #13, Resident #24, Resident #39, Resident #62, and Resident #73 identified they did not fill out selective menus, staff did not review menus with them, and they did not know what they were being served until they received their meal. The residents identified that if they sent their meal back to the kitchen because they did not like what they were served, an alternative meal would take up to 30 minutes to be delivered. The residents further identified they wanted selective menus to make their own menu selections and identified that the same request had been made at previous Resident Council meetings. During the Resident Council meeting on 2/13/2025 at 1:30 PM Resident #13 identified he/she had not had a staff member review a menu with him/her in over 2 years. Interview with the Interim Dietary Manager on 2/25/2025 at 10:20 AM identified that there were not enough staff in the dietary department to help residents fill out selective menus. Review of the Selective Menus policy identified residents may be offered the option of selecting his/her menus. Selective menus are available to those residents who choose to make their own menu selections. The dietary staff will label menus with the resident's name, room number, and diet and deliver the menus to the residents, menus are returned to the dietary department once they are filled in. 51183

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50179 Based on the tour of the Dietary Department, observations, staff interview, facility documentation and facility policy, the facility failed to ensure the Dietary Department served food at temperatures outside of the danger zone and failed to maintain dishwasher hot water temperatures at or above 160 degrees Fahrenheit. The findings included: 1. Observation of the tray line on 2/18/2025 at 12:49 PM identified a test tray was placed on the last meal delivery cart which was brought to the first floor. The meal delivery cart lacked doors and resembled a commercial sheet pan rack. The meal plates were covered with hard plastic covers and did not contain warming pellets. The test tray was the last tray served on the first floor. On 2/18/2025 at 1:00 PM the surveyor and [NAME] #1 obtained temperatures of the test tray food which identified the vegetable temperatures as follows: Surveyor temperature: 121.5 degrees Fahrenheit, [NAME] # 1 temperature:122.5 degrees Fahrenheit Interview on 2/18/2025 at 1:00 PM with [NAME] #1 identified that the meal delivery carts did not contain covers or doors and that a pellet system (heating system to keep plates warm to maintain food temperatures) was not used for food that is transported from the kitchen to resident rooms and dining rooms. Interview on 2/19/2025, at 9:47 AM with the Interim Dietary Director identified the meal delivery carts had always been uncovered and that a pellet system had never been used. Observation on 2/19/2025 at 12:21 PM identified a test tray was placed on the last meal delivery cart which was brought to the first floor. On 2/19/2025 at 12:25 PM the surveyor and [NAME] #1 obtained temperatures of the test tray food which identified the vegetable temperatures as follows: Surveyor temperature: 129.9 degrees Fahrenheit, [NAME] # 1 temperature:130.1 degrees Fahrenheit Interview on 2/19/2025 at 12:25 PM with [NAME] #1 identified that the food temperatures were low. Review of the policy Food Safety Handling identified danger zone food temperature are between 41 degrees Fahrenheit and 135 degrees Fahrenheit and allow for rapid growth of pathogenic microorganisms that can cause food borne illnesses. Holding hot food temperature to minimize the growth of microorganisms after food has been cooked to its proper temperature should be held at or above 135 degrees Fahrenheit until it is served. Appropriate food transport equipment is to be used to maintain safe temperatures for food while transporting the food in the facility to help minimize the risk of foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 2/24/2025 at 10:59 AM identified the dishwasher hot water temperatures were 149 to 150 degrees Fahrenheit and should have been 160 degrees Fahrenheit according to the label on the dishwasher temperature gauge. Interview on 2/24/2025 at 11:02 AM with the Dietary Manager identified that after several cycles of washing, the wash temperature did not rise above 150 degrees Fahrenheit which is below the standard of 160 degrees Fahrenheit. The Dietary Manager indicated he would notify the Maintenance Director and Ecolab (dishwasher servicer) of the low water temperatures. Subsequent to surveyor inquiry, the dishes were rewashed and sanitized in the 3 bay sink. Observation on 2/24/2025 at 1:20 PM identified that a Ecolab servicer was evaluating the dishwasher and identified a damaged terminal which he was replacing. The dishwasher temperatures were at 170 degrees Fahrenheit after the terminal was replaced. Review of food safety best practices from Ecolab identified, in part, a malfunctioning or improperly maintained machine that fails to clean tableware adequately can increase the risk of cross-contamination the next time it comes into contact with food or beverages. To help ensure that your machine functions as it should to effectively clean dishes and destroy harmful microorganisms, perform these steps: Inspect racks for damage and replace them when necessary. For conveyer-style machines: check the gauges and compare their readings with the minimum temperatures, chemical concentrations and pressure measurements listed on the data plate: High-temperature, or heat-sanitizing, machines will show a minimum rinse temperature of 180 F and minimum wash temperatures of 150 F, 155 F or 160 F, depending on machine type and make and model.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51183

Based on observations, review of the clinical record, facility policy and interviews for 4 of 4 residents (Resident #13, Resident #21, Resident #35, and Resident #57) reviewed for oxygen therapy, the facility failed to label, date and store oxygen tubing per facility policy. The findings include:

1. Resident #13 was admitted to the facility in July of 2022 and had diagnoses that included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, and congestive heart failure.

The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), received oxygen therapy, was independent with eating, and required partial/moderate assistance with bed mobility and transfers.

The Resident Care Plan (RCP) dated 2/5/2025 identified Resident #13 was at risk for altered cardiopulmonary status. Interventions included changing oxygen tubing weekly and monitor oxygen concentrator every shift.

Observation on 2/13/2025 at 9:17 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator belonging to Resident #13.

Observation on 2/19/2025 at 7:59 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator belonging to Resident #13.

Interview with Licensed Practical Nurse (LPN) #2 on 2/19/2025 at 12:25 PM identified it was the responsibility of the 11 PM to 7 AM shift nursing staff to label and date oxygen tubing weekly.

Interview with Registered Nurse (RN) #4 on 2/19/2025 at 2:35 PM identified that she changed, labeled and dated all oxygen tubing on Sundays during the 11 PM to 7 AM shift. RN #4 further identified that if any resident's tubing was not labeled and dated she must have missed labeling that tubing.

Review of the Physician Order Report dated 2/1/2025 through 2/20/2025 identified a provider order (order start date 2/19/2024) which directed to change oxygen tubing weekly on Sundays during the 11 PM to 7 AM shift.

Review of the Treatment Administration History report for February of 2025 identified RN #4 documented the order for the oxygen tubing change as administered on 2/9/2025 and 2/16/2025.

2. Resident #21 was admitted to the facility in August of 2024 and had diagnoses that included Alzheimer's disease, chronic obstructive pulmonary disease (COPD), and diabetes.

The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was severely cognitively impaired, required substantial/maximal assistance for eating and bed mobility, and dependent for transfers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan (RCP) dated 1/8/2025 identified Resident #21 was at risk for altered cardiopulmonary status. Interventions included assessing lung sounds per provider orders and consult with respiratory therapist as needed. The RCP failed to identify changing and labeling of the nasal cannula oxygen tubing per facility policy. A provider order dated 1/30/2025 directed to change oxygen tubing weekly on Sundays during the 11 PM to 7 AM shift and included instructions which directed to place the tubing in a labeled bag and to not leave the tubing exposed. A provider order dated 2/1/2025 directed to administer oxygen continuously at 2 LPM via nasal cannula. Observation on 2/11/2025 at 11:12 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator belonging to Resident #21. A provider order dated 2/18/2025 directed to administer oxygen at 2 LPM via nasal cannula as needed for comfort. Observation on 2/19/2025 at 7:32 AM identified Resident #21's oxygen concentrator was turned off with a labeled oxygen nasal cannula oxygen disconnected from the oxygen concentrator and lying uncovered on a chair on top of a blanket. Observation on 2/19/2025 at 12:25 PM identified Resident #21's oxygen concentrator was off with two separate labeled oxygen nasal cannulas laying on top of the oxygen concentrator with one hanging approximately 2 inches from the top of a trash can. Interview with Licensed Practical Nurse (LPN) #2 on 2/19/2025 at 12:25 PM identified it was the responsibility of the 11 PM to 7 AM shift to label and date oxygen tubing weekly. LPN #2 identified the two unbagged oxygen nasal cannulas on top of the oxygen concentrator should not have been exposed and she removed the tubes and discarded them. Interview with Registered Nurse (RN) #4 on 2/19/2025 at 2:35 PM identified that she changed, labeled and dated all oxygen tubing on Sundays during the 11 PM to 7 AM shift. RN #4 further identified that if any resident's tubing was not labeled and dated she must have missed labeling that tubing. Review of the Medication Administration Record for February of 2025 identified RN #4 documented the order for the oxygen tubing change as administered on 2/9/2025 and 2/16/2025. 3. Resident #35 was admitted to the facility in October of 2023 and had diagnoses that included congestive heart failure (CHF), chronic kidney disease, and obstructive sleep apnea. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #35 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 10), received oxygen therapy, and was independent with eating, bed mobility, and transfers. The Resident Care Plan (RCP) dated 2/13/2025 identified Resident #35 was at risk for altered cardiopulmonary status. Interventions included assessing lung sounds per provider orders and change oxygen tubing weekly as scheduled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Mary Wade Home, the Incorporated		STREET ADDRESS, CITY, STATE, ZIP CODE: 118 Clinton Ave New Haven, CT 06513	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 2/13/2025 at 9:21 AM identified an oxygen nasal cannula connected to an oxygen concentrator, belonging to Resident #21, labeled with a date of 2/3/2025. Observation on 2/20/2025 at 10:30 AM identified an oxygen nasal cannula connected to an oxygen concentrator, belonging to Resident #21, labeled with a date of 2/3/2025. Interview with Licensed Practical Nurses (LPN) #5 on 2/24/2025 at 12:55 PM identified she changed oxygen tubing on Sundays during the 11 PM to 7 AM shift and did not know why Resident #35 ' s oxygen tubing was not labeled and dated. Review of the Physician Order Report dated 2/1/2025 through 2/25/2025 identified a provider order (order start date 3/22/2024) which directed to administer oxygen continuously via nasal cannula at 2 liters per minute (LPM). Review of the Physician Order Report dated 2/1/2025 through 2/25/2025 identified a provider order (order start date 3/22/2024) which directed to change oxygen tubing every weekly on Sundays during the 11 PM to 7 AM shift. Review of the Treatment Administration History report for February of 2025 identified LPN #5 documented the order for the oxygen tubing change as administered on 2/2/2025 and 2/16/2025. 4. Resident #57 was admitted to the facility in January of 2022 and had diagnoses that included pneumonia, dysphagia, and chronic kidney disease. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers. Observation on 2/11/2025 at 12:45 PM AM identified an unlabeled oxygen nasal cannula connected to a portable oxygen tank belonging to Resident #57. Observation on 2/13/2025 at 10:41 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator belonging to Resident #57. The Resident Care Plan (RCP) dated 2/17/2025 identified Resident #57 was at risk for altered cardiopulmonary status. Interventions included assessing lung sounds per provider orders and consult with respiratory therapist as needed. The RCP failed to identify changing and labeling of the nasal cannula oxygen tubing per facility policy. Observation on 2/19/2025 at 7:40 AM identified an unlabeled oxygen nasal cannula connected to an oxygen concentrator belonging to Resident #57. Interview with Licensed Practical Nurse (LPN) #2 on 2/19/2025 at 12:25 PM identified it was the responsibility of the 11 PM to 7 AM shift to label and date oxygen tubing each week. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician Order Report dated 2/1/2025 through 2/20/2025 identified a provider order (order start date 2/9/2025) which directed to change oxygen tubing weekly on Sundays during the 11 PM to 7 AM shift and included instructions which directed to place tubing in a labeled bag and not leave tubing exposed. Review of the Treatment Administration History report for February of 2025 identified RN #4 documented the order for the oxygen tubing change as administered on 2/9/2025 and 2/16/2025. Interview with Registered Nurse (RN) #4 on 2/19/2025 at 2:35 PM identified that she changed, labeled and dated all oxygen tubing on Sundays during the 11 PM to 7 AM shift. RN #4 further identified that if any resident's tubing was not labeled and dated she must have missed labeling that tubing. Review of the Oxygen Administration Policy directed that oxygen is administered under orders of the provider, the resident's care plan shall identify the interventions for oxygen therapy, to change oxygen tubing/nasal cannula weekly and as needed if soiled or contaminated, and keep oxygen delivery devices (tubing) in a plastic bag when not in use.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, review of facility policy, and interviews, the facility failed to store personal care items in a clean and sanitary manner. The findings include: 1. Resident #55 was admitted to the facility in March of 2023 with diagnoses that included diabetes, anxiety and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required partial/moderate assistance for personal hygiene but was independent for bed mobility and transfers. Observation on 2/11/25 at 11:37 AM, identified water pitchers on the floor next to Resident # 55's bed. Additionally, a urinal 3/4 full of urine was observed next to the meal tray on the overbed table. Observation on 2/13/25 at 10:30 AM, identified water pitchers on the floor next to Resident # 55's bed. Observation on 2/20/25 at 2:43 PM, identified water pitchers on the floor next to Resident # 55's bed. Additionally, a urinal 1/4 full of urine was on the overbed table. Interview with Resident #55 on 2/20/25 at 2:43 PM, identified that he did not have any other place to keep the water pitches other than on the floor. Review of Resident #55's clinical record failed to identify care refusal or infection prevention education provided to Resident #55 regarding placing water pitchers on the floor and urinal storage on the overbed table. Observation on 2/25/25 at 10:30 AM identified water pitchers on the floor next to Resident #55's bed. Interview and observation with the Infection Preventionist Nurse (LPN#3) on 2/25/25 at 1:50 PM identified Resident #55 had received verbal education regarding not placing water pitchers on the floor but indicated that he/she preferred having them on the floor next to his/her bed. LPN #3 identified that she did not document the education provided to Resident #55 in the clinical record or update the care plan to note Resident #55's preference. Subsequent to surveyors' inquiry on 2/25/24, Resident #55's Care Plan was updated effective 2/25/25 identifying Resident #55 with knowledge deficit and with preference of putting water pitchers and urinal on the floor next to bed with interventions directing staff to educate Resident #55 regarding infection control practices. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Observation on 2/11/25 at 11:32 AM identified unlabeled personal care items on top of the toilet tank, shared by Resident #6 and Resident #64, In addition, under garments were observed in an unlabeled basin on the floor underneath the toilet tank. Observation on 2/13/25 at 11:46 AM identified unlabeled personal care items on top of the toilet tank, shared by Resident #6 and Resident #64. Observation on 2/20/25 at 2:43 PM identified unlabeled personal care items on top of the toilet tank, shared by Resident #6 and Resident #64. Interview and observation with LPN #3 on 2/25/25 at 1:50 PM identified the personal care items in the bathrooms shared by Resident #6 and Resident #64 should be labeled with resident identifiers and should be kept at the resident's bedside and not in the bathroom. Although requested facility's policy on storage of personal care items was not provided. The Resident [NAME] of Rights, Safe Environment section, identified, in part, that residents have a right to safe, clean, comfortable and homelike environment that allows them to use personal belongings to the extent possible and receive and care services safety.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 50249 Based on review of facility documentation, facility policy and interviews for 2 of 2 employee files, the facility failed to ensure that the required employee training/in-services were completed. The findings include: 1. LPN #2's date of hire was 2/22/23. Review of facility documentation for LPN #2 identified that she worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for LPN #2 failed to identify that in-service training had been provided (Dementia, Communication and Behavioral Health) and included in the files from 2023 until present. Although requested, the facility could not provide documentation that current required trainings had been completed for LPN #2. 2. RN #2's date of hire was 7/6/16. Review of facility documentation for RN #2 identified that she worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for RN #2 failed to identify that in-service training had been provided (Dementia, Communication and Behavioral Health) and included in the files from 2023 until present. Although requested, the facility could not provide documentation that current required trainings had been completed for RN #2. Interview and review of facility documentation with the Staff Development RN (RN #1) on 2/13/25 at 3:48 PM identified that she was unable to provide current documentation for the required annual in-service training for LPN #2 and RN #2 because the prior Staff Development nurse did not keep good records. RN #1 indicated that it would have been the responsibility of the prior staff development nurse to ensure the required in-service trainings were completed, documented, and placed in the employee file. Although RN #1 provided in-service documents for LPN #2 and RN #2 from 2023, she indicated that she could not locate the current required in-service documentation for LPN #2 and RN #2 for 2024 or 2025. RN #1 indicated that it is facility policy to have staff complete the required in-service trainings upon hire and annually, but she had only worked at the facility since December of 2024. Interview and review of facility documentation with the Director of Nurses (DNS) on 2/13/25 at 3:52 PM identified that she was unable to locate the current required annual in-service training documentation for LPN #2 and RN #2 and that it would have been the responsibility of the prior Staff Development nurse to ensure the required trainings were completed, documented, and placed in the employee file. The DNS indicated that the facility did not have a staff person trained to conduct Dementia training and that the only staff person trained to conduct Dementia training worked in another building. The DNS identified it is facility policy that staff complete the required in-service trainings upon hire and annually and that she and RN #1 would work on them. Review of the facility policy, Training, dated 2/2010, directed that the facility maintains an effective training program for all employees and the required annual in-service training of employees would be offered at the discretion of the Administrator and/or Department Head.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 50249 Based on review of facility documentation, facility policy and interviews for 5 of 5 employee files, the facility failed to ensure that the required Communication training/in-service was completed. The findings include: 1. LPN #2's date of hire was 2/22/23. Review of the facility documentation for LPN #2 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for LPN #2 failed to identify that the required Communication in-service training had been provided and included in the files from 2023 until present. Although requested, the facility could not provide documentation that a current required Communication training had been completed for LPN #2. 2. RN #2's date of hire was 7/6/16. Review of the facility documentation for RN #2 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for RN #2 failed to identify that the required Communication in-service training had been provided and included in the files from 2023 until present. Although requested, the facility could not provide documentation that a current required Communication training had been completed for RN #2. 3. NA #1's date of hire was 12/11/24. Review of the facility documentation for NA #1 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #1 failed to identify that required Communication training/in-service had been provided and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required Communication training had been completed for NA #1. 4. NA #2's date of hire was 12/23/24. Review of the facility documentation for NA #2 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #2 failed to identify that the required Communication training/in-service had been provided and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required Communication training had been completed for NA #2. 5. NA #3's date of hire was 10/19/21. Review of the facility documentation for NA #3 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #3 failed to identify that the required Communication in-service training had been provided and included in the files from 2023 until present. Although requested, the facility could not provide documentation that a current required Communication training had been completed for NA #3. (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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview and review of facility documentation with the Staff Development RN (RN #1) on 2/13/25 at 3:48 PM identified that she was unable to provide current documentation for the required Communication in-service training for LPN #2, RN #2, NA #1, NA #2, and NA #3 because the prior staff development nurse did not keep good records. RN #1 indicated that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service training was completed, documented, and placed in the employee file. Although RN #1 provided in-service documents for LPN #2, RN #2 and NA #3 from 2023 she indicated that she could not locate the current required in-service documentation for LPN #2, RN #2, NA #1, NA #2 or NA #3 for 2024 or 2025. RN #1 indicated that it is facility policy to have staff complete the required Communication in-service training upon hire and annually, but she had only worked at the facility since December of 2024. Interview and review of facility documentation with the Director of Nurses (DNS) on 2/13/25 at 3:52 PM identified that she was unable to locate the required Communication in-service training documentation for LPN #2, RN #2, NA #1, NA #2 and NA #3 and that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service trainings were completed, documented, and placed in the employee file. The DNS identified it is facility policy that staff complete the required Communication in-service training upon hire and annually and that she and RN #1 would work on getting it completed. Review of the facility policy, Training, dated 2/2010, directed that the facility maintains an effective training program for all employees and the required annual in-service training of employees would be offered at the discretion of the Administrator and/or Department Head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 50249 Based on review of facility documentation, facility policy and interviews for 3 of 5 employee files, the facility failed to ensure that the required Resident's Rights training/in-service was completed. The findings include: 1. NA #1's date of hire was 12/11/24. Review of the facility documentation for NA #1 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #1 failed to identify the required Resident's Rights training/in-service had been provided and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required Resident's Rights training had been completed for NA #1. 2. NA #2's date of hire was 12/23/24. Review of the facility documentation for NA #2 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #2 failed to identify the required Resident's Rights training/in-service had been provided and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required Resident's Rights training had been completed for NA #2. 3. NA #3's date of hire was 10/19/21. Review of the facility documentation for NA #3 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #3 failed to identify the required Resident's Rights annual in-service training had been provided and included in the files from 2023 until present. Although requested, the facility could not provide documentation that an annually required Resident's Rights training had been completed for NA #3. An interview and review of facility documentation with the Staff Development RN (RN #1) on 2/13/25 at 3:48 PM identified that she was unable to provide current documentation for the required Resident's Rights in-service training for NA #1, NA #2 and NA #3 because the prior Staff Development nurse did not keep good records. RN #1 indicated that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service training was completed, documented, and placed in the employee file. Although RN #1 provided in-service documents for NA #3 from 2023 she indicated that she could not locate the current required in-service documentation for NA #1, NA #2 or NA #3 for 2024 or 2025. RN #1 indicated that it is facility policy to have staff complete the required Resident's Rights in-service training upon hire and annually, but she had only worked at the facility since December of 2024. (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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation with the Director of Nurses (DNS) on 2/13/25 at 3:52 PM identified that she was unable to locate the required Resident's Rights in-service training documentation for NA #1, NA #2 and NA #3 and that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service trainings were completed, documented, and placed in the employee file. The DNS indicated it is facility policy that staff complete the required Resident's Rights in-service training upon hire and annually and that she and RN #1 would work on getting it completed. Review of the facility policy, Training, dated 2/2010, directed that the facility maintains an effective training program for all employees and the required annual in-service training of employees would be offered at the discretion of the Administrator and/or Department Head.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50249 Based on review of facility documentation, facility policy and interviews for 3 of 3 employee files, the facility failed to ensure that the required employee training/in-services were completed. The findings include: 1. NA #1's date of hire was 12/11/24. Review of the facility documentation for NA #1 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #1 failed to identify that in-service training had been provided (Resident Rights, Dementia, Communication and Behavioral Health) and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required trainings had been completed for NA #1. 2. NA #2's date of hire was 12/23/24. Review of the facility documentation for NA #2 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #2 failed to identify that in-service training had been provided (Resident Rights, Dementia, Communication and Behavioral Health) and included in the files from the date of hire until present. Although requested, the facility could not provide documentation that the required trainings had been completed for NA #2. 3. NA #3's date of hire was 10/19/21. Review of the facility documentation for NA #3 identified that she had worked in the facility between 1/28/25 and 2/13/25. Review of the employee file for NA #3 failed to identify that annual in-service training had been provided (Resident Rights, Dementia, Infection Control, Communication and Behavioral Health) and included in the files from 2023 until present. Although requested, the facility could not provide documentation that the required annual trainings had been completed for NA #3. Interview and review of facility documentation with the Staff Development Registered Nurse (RN #1) on 2/13/25 at 3:48 PM identified that she was unable to provide current documentation for the required in-service training for NA #1, NA #2 and NA #3 because the prior Staff Development nurse did not keep good records. RN #1 indicated that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service trainings were completed, documented, and placed in the employee file. Although RN #1 provided in-service documents for NA #3 from 2023 she indicated that she could not locate the current required in-service documentation for NA #1, NA #2 or NA #3 for 2024 or 2025. RN #1 indicated that it is facility policy to have staff complete the required in-service trainings upon hire and annually, but she had only worked at the facility since December of 2024. (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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of facility documentation with the Director of Nurses (DNS) on 2/13/25 at 3:52 PM identified that she was unable to locate the required in-service training documentation for NA #1, NA #2 and NA #3 and that it would have been the responsibility of the prior Staff Development nurse to ensure the required in-service trainings were completed, documented, and placed in the employee file. The DNS indicated that the facility did not have a staff person trained to conduct Dementia training and that the only staff person trained to conduct Dementia training worked in another building. The DNS identified it is facility policy that staff complete the required in-service trainings upon hire and annually and that she and RN #1 would start working on them. Review of the facility policy, Training, dated 2/2010, directed that the facility maintains an effective training program for all employees and the required annual in-service training of employees would be offered at the discretion of the Administrator and/or Department Head.