STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of three (3) residents (Residents #1, 2 and 3) reviewed for skin impairments, the facility failed to review and revise the Resident Care Plans (RCP) to include additional interventions to prevent further deterioration following the identification of new skin impairments. The findings include: 1. Resident #1's diagnoses included cellulitis (bacterial skin infection), rheumatoid arthritis (chronic inflammatory disorder affecting small joints in the hands and feet) and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 11), required setup assistance for eating and bed mobility and supervision assistance with transfers. A nurse's note dated 3/16/25 at 7:51 AM by RN #5 identified Resident #1 had an irregularly shaped open area to the right lateral (outer) foot, the area was painful, and warm to touch. The note identified Resident #1 needed podiatry (foot) services and/or a wound care follow-up and that an order was obtained to cleanse the area and apply a scant (tiny) amount of Santyl (an ointment that's used to remove damaged tissue from skin ulcers and severely burned areas) followed by a dry dressing and gauze wrap to protect the area daily and as needed. Review of the facility census identified Resident #1 was admitted to the hospital from [DATE] through 3/26/25. Review of the hospital documentation dated 3/19/25 identified Resident #1 was noted with diffuse (spread over a wide area) rheumatoid arthritis nodules (firm lumps under the skin that form close to joints), an open foot ulcer and lower extremity cellulitis. The documentation identified the skin impairments as a right upper calf rash, an ulcer to the right medial (closer to the midline) first toe and an ulcer to the right posterior (backside) calf. The Nursing admission assessment dated [DATE] identified Resident #1 was readmitted to the facility with right lower leg cellulitis and a right medial (closer to the midline) foot vascular wound (an open sore that develops due to problems with blood circulation and can be slow to heal). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A wound physician note dated 4/2/25 at 4:13 PM identified Resident #1 was evaluated for right lower leg and right foot wounds. The note reported the wounds were full thickness (extending through all layers of the skin and can affect deeper tissues like muscle, bones or tendons) and that only the largest of the two (2) wounds were measured identifying the size as 20 centimeters (cm) by 16 cm by 1.5 cm with 25 to 49 percent (%) granulation tissue (newly formed connective tissue that develops at the wound site in the process of healing), 50 to 74 % slough (a collection of dead tissue and debris that's a pale yellow or brown color and can hinder the healing process) and a moderate amount of serosanguinous drainage (a thin and watery fluid that's pink in color due to small amounts of red blood cells). The Resident Care Plan (RCP) dated 4/22/25 (36-days after the skin impairements were identified and 4-days after the resident passed away at the facility) identified Resident #1 was at risk for skin breakdown due to decreased mobility and incontinence and other risk factors included poor nutrition, pronounced bony prominences (bones close to the surface), poor circulation and altered sensation. The RCP identified that on 3/26/25 Resident #1 was identified with cellulitis of the lower extremities. Interventions included inspecting skin when providing care for signs and symptoms of skin breakdown and consulting with the wound care nurse as ordered/needed. Interview with LPN #1 on 5/21/25 at 12:45 PM identified Resident #1 had rheumatoid arthritis nodules to both lower extremities since admission and they should have been documented in the RCP. 2. Resident #2's diagnoses included subarachnoid hemorrhage (a type of stroke where bleeding occurs in the space between the brain and the tissue covering the brain) and epilepsy (repeated seizures due to abnormal electrical signals produced by damaged brain cells). The RCP dated 3/11/24 identified Resident #2 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included inspecting the skin when providing care for signs and symptoms of breakdown, offloading heels while in bed and consulting with the wound care nurse as ordered/needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. The facility wound tracker identified Resident #2 acquired a right lateral foot pressure ulcer on 12/30/24 and a right lateral ankle pressure ulcer on 2/13/25. The facility wound tracker identified that as of 5/14/25 the right lateral foot pressure ulcer and the right lateral ankle pressure ulcer were still open, requiring wound care treatments. A nurse's note dated 5/14/25 at 7:15 PM identified the right lateral ankle and right lateral foot pressure ulcers remained unhealed and that the RCP was updated with new interventions as appropriate. Review of the clinical record failed to identify revisions or additional interventions were added to the RCP since 3/11/24 (one year, two months ago). (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	3. Resident #3's diagnoses included dementia without behavioral disturbances, type 2 diabetes mellitus, peripheral vascular disease (a circulatory condition when narrowed blood vessels reduce the blood flow to the limbs) and neuropathy (weakness, numbness and pain from nerve damage most often in the hands and feet). The Resident Care Plan (RCP) dated 6/18/24 identified Resident #3 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included inspecting the skin when providing care for signs and symptoms of breakdown, offloading heels while in bed and consulting with the wound care nurse as ordered/needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 7), was independent with bed mobility and dependent on staff for personal hygiene and transfers. A nurse's note dated 4/26/25 at 1:52 PM identified Resident #3's family member notified nursing of redness between the right great toe and right second toe. The note identified the area was assessed, cleansed, dried and lambs wool was applied to the area followed by gauze, Resident #3 denied pain and the Advanced Practice Registered Nurse (APRN) was notified. The facility wound tracker identified Resident #3 acquired a right second toe diabetic wound on 4/30/25. A nurse's note dated 5/14/25 at 7:39 PM identified the right second toe wound remained unhealed and that the RCP was updated with new interventions as appropriate. Review of the clinical record failed to identify any revisions or additional interventions to the RCP since 6/18/24 (eleven months ago). A nurse's note dated 5/20/25 at 1:13 PM identified, in part, that Resident #3 was receiving doxycycline (antibiotic) for a right second toe infection with no adverse (unwanted) effects. Interview with RN #2 (Infection Control nurse) on 5/21/25 at 1:35 PM identified that upon the discovery of a new skin impairment, the charge nurse is responsible for initiating/revising the RCP. She identified that if any additional interventions need to be added or if she evaluates the resident with the wound physician and new recommendations or interventions are initiated, she would be responsible for revising the RCP. RN #2 reported that the skin RCP's for Residents #1, 2 and 3 should have been revised following the discovery of skin impairments but was unable to explain why interventions had not been added timely to prevent further deterioration of the skin. Interview with RN #1 on 5/21/25 at 2:01 PM identified that RCP's should be an interdisciplinary effort but reported that for any resident change in condition, including a new skin impairment, the charge nurse or whoever assessed the area should initiate/revise the RCP immediately and then RN #2 would be responsible for ensuring the revision was made and further revising the RCP with any updated interventions and changes until the area is healed. RN #1 identified that she was unaware the RCP's of Residents #1, 2 and 3 had not been revised timely and that the RCP should be revised immediately but not to exceed 72-hours. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with RN #4 on 5/21/25 at 2:32 PM identified that following a new skin ulcer or skin irregularity, the charge nurse or RN #2 should have updated the RCP immediately to include a new intervention to prevent worsening of the area. She identified that she was unsure why the RCP hadn't been revised for Residents #1, 2 and 3 but reported she would revise the RCP for areas she identified as missing and for Resident #1, she updated the 3/26/25 occurrence when she closed out the MDS following his/her death in the facility. Review of the Wound and Skin Care Protocol policy (undated) directed, in part, that weekly body audits will be completed on bath/shower day by a licensed nurse and all skin areas will have weekly documentation until healed. The interdisciplinary plan of care will address problems, goals and interventions directed towards the prevention and/or treatment of impaired skin integrity/pressure ulcer, consistent with resident/family goals. The care plan including the admission/readmission care plan will address preventative and/or treatment of impaired skin integrity/pressure ulcer. Review of the Care Planning policy dated 10/30/20 directed, in part, that the care plan is developed by the Interdisciplinary Team (IDT) in collaboration with the resident and/or family/responsible party and the resident's physician. The IDT may include, but is not limited to, the Resident Care Coordinator, Charge Nurse, NA, Dietary Manager or Dietician, Social Worker, Rehab Therapist and Activities Director. The care plan will include: a statement of the problem/focus; reasonable and measurable goals; interventions to achieve these goals and the discipline(s) responsible for carrying out the interventions. The care plan is reviewed and updated at least quarterly and as necessary to reflect changes in the residents' status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for three (3) of three (3) residents (Residents #1, 2 and 3) reviewed for skin impairments, the facility failed to complete weekly skin assessments per physician's order. The findings include: 1. Resident #1's diagnoses included cellulitis (bacterial skin infection), rheumatoid arthritis (chronic inflammatory disorder affecting small joints in the hands and feet) and chronic pain syndrome. A physician's order dated 1/23/25 directed that a body audit was to be completed weekly on the shower day. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 11), required setup assistance for eating and bed mobility and supervision assistance with transfers. Review of the Weekly Body Audit dated 2/20/25 identified that a body audit was completed, and no new areas were identified. Review of the clinical record from 2/21/25 through 3/15/25 failed to identify any further Weekly Body Audits for Resident #1. A nurse's note dated 3/16/25 at 7:51 AM by RN #5 identified Resident #1 had an irregularly shaped open area to the right lateral (outer) foot, the area was painful, and warm to touch. The note identified Resident #1 needed podiatry (foot) services and/or a wound care follow-up and that an order was obtained to cleanse the area and apply a scant (tiny) amount of Santyl (an ointment that's used to remove damaged tissue from skin ulcers and severely burned areas) followed by a dry dressing and gauze wrap to protect the area daily and as needed. Review of the facility census identified that Resident #1 was admitted to the hospital from [DATE] through 3/26/25. Review of the hospital documentation dated 3/19/25 identified Resident #1 was noted with diffuse (spread over a wide area) rheumatoid arthritis nodules (firm lumps under the skin that form close to joints), an open foot ulcer and lower extremity cellulitis. It reported Resident #1 had a [NAME] Blood Cell (WBC) count of 15. 7 (signaling infection) and Resident #1 was continued on antibiotics and admitted for further evaluation. The documentation identified the skin impairments as a right upper calf rash, an ulcer to the right medial (closer to the midline) first toe and an ulcer to the right posterior (backside) calf. The Nursing admission assessment dated [DATE] identified Resident #1 was readmitted to the facility with right lower leg cellulitis and a right medial (closer to the midline) foot vascular wound (an open sore that develops due to problems with blood circulation and can be slow to heal). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A wound physician note dated 4/2/25 at 4:13 PM identified Resident #1 was evaluated for right lower leg and right foot wounds. The note reported the wounds were full thickness (extending through all layers of the skin and can affect deeper tissues like muscle, bones or tendons) and that only the largest of the two (2) wounds were measured identifying the size as 20 centimeters (cm) by 16 cm by 1.5 cm with 25 to 49 percent (%) granulation tissue (newly formed connective tissue that develops at the wound site in the process of healing), 50 to 74 % slough (a collection of dead tissue and debris that's a pale yellow or brown color and can hinder the healing process) and a moderate amount of serosanguinous drainage (a thin and watery fluid that's pink in color due to small amounts of red blood cells). The Resident Care Plan (RCP) dated 4/22/25 (36-days after the skin impairments were identified and 4-days after the resident passed away at the facility) identified Resident #1 was at risk for skin breakdown due to decreased mobility and incontinence and other risk factors included poor nutrition, pronounced bony prominences (bones close to the surface), poor circulation and altered sensation. The RCP identified that on 3/26/25 Resident #1 was identified with cellulitis of the lower extremities. Interventions included inspecting skin when providing care for signs and symptoms of skin breakdown and consulting with the wound care nurse as ordered/needed. 2. Resident #2's diagnoses included subarachnoid hemorrhage (a type of stroke where bleeding occurs in the space between the brain and the tissue covering the brain) and epilepsy (repeated seizures due to abnormal electrical signals produced by damaged brain cells). The RCP dated 3/11/24 identified Resident #2 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included inspecting the skin when providing care for signs and symptoms of breakdown, offloading heels while in bed and consulting with the wound care nurse as ordered/needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. A physician's order dated 1/27/24 directed a body audit be completed on admission and weekly by a licensed nurse on shower day and that it was to be documented on the body audit form. The facility wound tracker identified Resident #2 acquired a right lateral foot pressure ulcer on 12/30/24 and a right lateral ankle pressure ulcer on 2/13/25. Review of the Weekly Body Audit dated 2/2/25 identified that a body audit was completed, and no new areas were identified. Review of the clinical record from 2/3/25 through 5/21/25 failed to identify any further Weekly Body Audits for Resident #2. Review of nurse's notes from 2/6/25 through 5/21/25 failed to identify any documentation on the resident's wounds the week of 3/9/25, the week of 4/13/25, the week of 4/20/25, the week of 4/27/25 or the week of 5/4/25. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A nurse's note dated 5/14/25 at 7:15 PM identified the right lateral ankle and right lateral foot pressure ulcers remained unhealed and that the RCP was updated with new interventions as appropriate. The facility wound tracker identified that as of 5/14/25 the right lateral foot pressure ulcer and the right lateral ankle pressure ulcer were still open, requiring wound care treatments. 3. Resident #3's diagnoses included dementia without behavioral disturbances, type 2 diabetes mellitus, peripheral vascular disease (a circulatory condition when narrowed blood vessels reduce the blood flow to the limbs) and neuropathy (weakness, numbness and pain from nerve damage most often in the hands and feet). The Resident Care Plan (RCP) dated 12/17/24 identified Resident #3 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included inspecting the skin when providing care for signs and symptoms of breakdown, offloading heels while in bed and consulting with the wound care nurse as ordered/needed. A physician's order dated 12/31/24 directed a body audit be completed on admission and weekly by a licensed nurse on shower day and that it was to be documented on the body audit form. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 7), was independent with bed mobility and dependent on staff for personal hygiene and transfers. Review of the clinical record from 3/1/25 through 4/14/25 failed to identify any completed Weekly Body Audits. A physician's order dated 4/15/25 directed that a body audit was to be completed weekly by a licensed nurse on shower day. Review of the clinical record from 4/15/25 through 4/25/25 failed to identify any completed Weekly Body Audits. A nurse's note dated 4/26/25 at 1:52 PM identified Resident #3's family member notified nursing of redness between the right great toe and right second toe. The note identified the area was assessed, cleansed, dried and lambs wool was applied to the area followed by gauze, Resident #3 denied pain and the Advanced Practice Registered Nurse (APRN) was notified. The facility wound tracker identified Resident #3 acquired a right second toe diabetic wound on 4/30/25. Review of nurse's notes from 4/27/25 through 5/14/25 failed to identify weekly skin notes until 5/14/25. A nurse's note dated 5/20/25 at 1:13 PM identified, in part, that Resident #3 was receiving doxycycline (antibiotic) for a right second toe infection with no adverse (unwanted) effects. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Mystic	28 Broadway Mystic, CT 06355

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with RN #1 (Regional) on 5/21/25 at 2:01 PM identified that all residents are to have a skin/body audit weekly and that nursing should follow physician's orders. She was unsure why weekly skin audits were not done consistently for Residents #1, 2 and 3 but indicated they should have been. She reported that around mid-April 2025, the company adopted a new skin process where licensed nurses only chart by exception and if a new skin area is found, nurses should document the area in the clinical record, notify the provider and transcribe any new orders. RN #1 was unsure why the physician's orders for Residents #2 and #3 still directed to document the skin assessment on the body audit form but identified that prior to mid-April, licensed nurses should have been documenting on the Body Audit Form for each resident weekly. Although attempted, an interview with RN #5 was not obtained. Review of the Wound and Skin Care Protocol policy (undated) directed, in part, that weekly body audits will be completed on bath/shower day by a licensed nurse and all skin areas will have weekly documentation until healed. The interdisciplinary plan of care will address problems, goals and interventions directed towards the prevention and/or treatment of impaired skin integrity/pressure ulcer, consistent with resident/family goals. The care plan including the admission/readmission care plan will address preventative and/or treatment of impaired skin integrity/pressure ulcer. Although requested, a policy on following physician's orders was not obtained.?

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for medication storage, the facility failed to ensure a narcotic medication was removed from the medication cart timely following the resident's death within the facility. The findings include: Resident #1's diagnoses included cellulitis (bacterial skin infection), rheumatoid arthritis (chronic inflammatory disorder affecting small joints in the hands and feet) and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 11), required setup assistance for eating and bed mobility and supervision assistance with transfers. The Resident Care Plan (RCP) dated [DATE] identified that Resident #1 had a terminal illness and end of life and continued decline is expected. Interventions included pain management and administering medications as ordered. A physician's order dated [DATE] directed to administer Dilaudid (narcotic pain medication) oral liquid, four (4) milliliters (mL) by mouth every three (3) hours as needed for severe pain. The physician's order was noted to have an end date of [DATE]. A nurse's note dated [DATE] at 3:29 AM identified, in part, that Resident #1 was observed to have no breathing and no pulse and was pronounced dead at 3:04 AM. Review of the pharmacy Controlled Substance Disposition Record for the Dilaudid with prescription number R52895700 identified the medication was received by the facility on [DATE] and last administered to Resident #1 on [DATE]. It identified that the Dilaudid was removed from the medication cart and 'Returned to the Office' on [DATE] (20-days after Resident #1's death). Interview with LPN #2 on [DATE] at 9:42 AM identified that within a few days of Resident #1's death, she requested the previous DNS take possession of Resident #1's Dilaudid and indicated there were a lot of narcotics to count in the medication cart. She identified the DNS stated no and that he didn't have time for that, and refused to sign-off on the removal of the Dilaudid. Interview with the previous DNS on [DATE] at 12:59 PM identified he was employed at the facility for two months up until [DATE]. He reported he did not take possession of any narcotics from nursing staff and there were not many narcotics in the medication carts because it was a small facility. He identified he was not concerned with diversion or misappropriation of the narcotics and stated that removing the narcotics from the medication carts were not his top priority, as a lot was going on within the facility. He was unable to explain medication cart audits, how often they were to be done and if he had completed them while employed at the facility. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with RN #2 (the ADNS) on [DATE] at 1:49 PM identified that narcotics were not being removed from the medication carts timely following residents being discharged and expiring. She identified that when she was reemployed by the facility in May of 2025, she removed a bunch of narcotics from the medication carts and indicated they should have been removed as soon as possible or within a few days after a resident is no longer in the facility. She reported that Resident #1's Dilaudid was not removed from the medication cart timely. Interview with RN #1 (Regional) on [DATE] at 2:15 PM identified that when a resident is discharged or expires, the charge nurse should notify the DNS and request the DNS co-sign for the removal of the narcotic on the pharmacy disposition sheet. Once it is removed from the medication cart, the DNS is to put the narcotic in the designated double locked cabinet and destruction of narcotics is to be completed monthly. RN #1 identified that the narcotics should be removed from the medication cart within a day or two after a resident is no longer in the facility. RN #1 identified she co-signed the removal of Resident #1's liquid Dilaudid on [DATE] with RN #2, which was not a timely removal. Review of the Disposal/Destruction of Expired or Discontinued Medications policy dated [DATE] directed, in part, that once an order to discontinue a medication is received, facility staff should remove the medication from the resident's medication supply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on observations, review of the clinical record, review of facility policy/procedures and interviews for nine (9) of nine (9) residents (Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11) reviewed for Enhanced Barrier Precautions (EBP), the facility failed to ensure trash cans were positioned inside the residents rooms and near the exit for discarding Personal Protective Equipment (PPE) after removal and failed to ensure periodic monitoring of resident rooms with EBP supplies and staff adherence to EBP. The findings include: Review of the facility Multidrug Resistant Organisms (MDRO) and Precautions Log dated 5/14/25 identified that Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11 were on precautions, requiring PPE. Observations and interview with RN #2 (Infection Control nurse) on 5/21/25 at 1:35 PM failed to identify that trash receptacles were placed in the doorways of Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11's room. The closest trash receptacles in each room were located behind closed doors of the bathrooms. RN #2 identified she was responsible for ensuring each room had the proper precaution supplies, spot checking rooms intermittently to ensure proper precaution signage, PPE was available and in place, a trash receptacle was located inside each doorway and that staff were donning and doffing PPE appropriately when entering and exiting identified rooms. She identified she had not done the spot checks. RN #2 reported that the MDRO and Precautions Log was up-to-date and that Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11 required precautions. Additionally, she identified that the facility did not have enough trash receptacles available for all the residents currently on precautions and reported that she was going to the store to purchase more. Interview with NA #4 on 5/21/25 at 1:42 PM identified that since a trash receptacle was not available to discard PPE upon exiting residents' rooms, she either removed the PPE and placed it in the bathroom trash or in the community trash in the hallway. She identified there was a shortage of trash receptacles within the facility. Interview with RN #1 (Regional nurse) on 5/21/25 at 2:01 PM identified that for infection control, trash receptacles should be located inside the doorway of each resident room on precautions for easy disposal of contaminated PPE. She reported she was unaware that trash receptacles were not located inside the doorway of Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11's room. Observation on 5/22/25 at 10:58 AM identified covered trash receptacles were located inside the doorway of Residents #2, 4, 5, 6, 7, 8, 9, 10 and 11's room. Review of Center for Disease Control (CDC) guidance for the Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24 identified that when implementing Contact Precautions or Enhanced Barrier Precautions, a trash can is to be positioned inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. Additionally, it identified that the facility is to incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. Although received, the Enhanced Barrier Precautions policy dated 5/5/24 did not speak to trash receptacle location or periodic monitoring to the adherence of EBP.