STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075339	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lord Chamberlain Nursing & Rehabilitation Center	7003 Main Street Stratford, CT 06614

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 51183 Based on observations, review of the clinical record, facility policy, and interviews for 3 dining rooms (Resident #17, 43, 79, 80, 102, 105, 110, 154, 163) reviewed for dining, the facility failed to provide a dignified dining experience. The findings include: 1. Resident #17's diagnoses included dementia, anorexia, and adult failure to thrive. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #17 was severely cognitively impaired and was independent with eating, required setup or clean-up assistance with oral hygiene and partial/moderate assistance with chair/bed to chair transfers. The Resident Care Plan dated 8/23/24 identified Resident #17 was at risk for decreased nutrition related to dementia and failure to thrive. Interventions included monitor oral intake and set up and assist with meals as needed. Further identified was Resident #17 required assistance with activities of daily living (ADLs) related to failure to thrive. Interventions included to consider appropriate setting for feeding where Resident #17 has supportive assistance. 2. Resident #43's diagnoses included Alzheimer's disease, dysphagia, and left hand contracture. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #43 was severely cognitively impaired and was dependent with eating, oral hygiene and chair/bed to chair transfers. The Resident Care Plan dated 8/28/24 identified Resident #43 was at risk for aspiration related to dysphagia and having no teeth. Interventions included supervision of all meals to monitor for signs and symptoms of aspiration (cough, tearing eyes, respiratory distress). Further identified was Resident #43 required assistance with activities of daily living (ADLs) related to his/her left hand contracture. Interventions included to assist with eating as ordered. 3. Resident #79's diagnoses included dementia, anxiety, and hypertension. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #79 was severely cognitively impaired and was independent with eating, dependent for oral hygiene and independent with chair/bed to chair transfers. (continued on next page)

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

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	The Resident Care Plan dated 10/14/24 identified Resident #79 was at risk for decreased nutrition related to dementia. Interventions included to set up and assist with meals as needed. 4. Resident #80's diagnoses included vascular dementia, dysphagia, and anxiety. The admission Minimum Data Set assessment dated [DATE] identified Resident #80 was severely cognitively impaired and was independent with eating, required supervision or touching assistance for oral hygiene and partial/moderate assistance with chair/bed to chair transfers. The Resident Care Plan dated 10/14/24 identified Resident #80 was at risk for aspiration related to dysphagia. Interventions included supervision of all meals to monitor for signs and symptoms of aspiration (cough, tearing eyes, respiratory distress). 5. Resident #102's diagnoses included dysphagia, anxiety, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #102 was severely cognitively impaired and required setup and clean-up assistance with eating, was dependent for personal hygiene and required partial/moderate assistance with chair/bed to chair transfers. The Resident Care Plan dated 8/29/24 identified Resident #102 was at risk for aspiration related to dysphagia and dementia. Interventions included supervision of all meals to monitor for signs and symptoms of aspiration (cough, tearing eyes, respiratory distress) and check for pocketing of food with all oral intake. 6. Resident #105's diagnoses included dementia, diabetes, and Barrett's esophagus. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #105 was severely cognitively impaired and independent with eating, required substantial/maximal assistance with oral hygiene and chair/bed to chair transfers. The Resident Care Plan dated 8/13/24 identified Resident #105 was at risk for decreased nutrition related to diabetes and dementia. Interventions included monitor oral intake and set up and assist with meals as needed. 7. Resident #110's diagnoses included Alzheimer's dementia, diabetes, and osteoporosis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #110 was moderately cognitively impaired and independent with eating, required setup or clean-up assistance with oral hygiene and partial/moderate assistance with chair/bed to chair transfers. The Resident Care Plan dated 10/8/24 identified Resident #110 was at risk for decreased nutrition related to diabetes and dementia. Interventions included set up and assistance with meals as needed. 8. Resident #154's diagnoses included dementia, dysphagia, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #154 was severely cognitively impaired and required partial/moderate assistance with eating, oral hygiene and chair/bed to chair transfers. (continued on next page)

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	The Resident Care Plan dated 8/20/24 identified Resident #154 was at risk for weight loss related to dysphagia. Interventions included to monitor dietary intake as ordered. Further identified was Resident #154 was at risk for aspiration related to dysphagia. Interventions included to observe during mealtimes for any signs and symptoms of aspiration or difficulty swallowing. 9. Resident #163's diagnoses included dementia, diabetes, and insomnia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #163 was severely cognitively impaired and independent with eating, dependent for oral hygiene and required substantial/maximal assistance with chair/bed to chair transfers. The Resident Care Plan dated 9/24/24 identified Resident #163 required assistance with activities of daily living. Interventions included to encourage Resident #163 to feed him/herself and assist with set up as needed. Observation on 10/24/24 at 8:45 AM identified Resident # 17, 43, 79, 80, 102, 105, 110, 154, 163 eating their breakfast meal in the hallway lined up in a train like formation, 1 resident behind another, down one side of the hallway, with each resident seated with their overbed table and meal in front of them. Interview with RN #5 on 10/24/24 at 12:18 PM identified that Resident #17, 43, 79, 80, 102, 105, 110, 154, 163 ate their breakfast meal in the hallway instead of in the dining room due to the 4th floor unit having more residents requiring assistance with feeding than the other units, and in order to provide the necessary morning care efficiently the staffing levels for the 4th floor unit did not support dedication of a nurse aide to the dining room to supervise breakfast. Interview with NA #5 on 10/24/24 at 12:25 PM identified that the 4th floor unit used to have more nurse aides scheduled for the day shift and 1 nurse aide would be assigned to the dining room to assist with supervision of meals and feeding of residents, but that no longer was the case. Although requested, the facility was unable to provide documentation of when the day shift staffing for the 4th floor was dropped to 7 nurse aides which the 4th floor head nurse felt did not support staffing of the dining room for breakfast. Although requested, a policy on facility dining was not provided.

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 19953 Based on review of the Resident Trust Accounts, interviews and facility policy for 2 of 2 sampled residents (Resident #94 and Resident #100) reviewed for personal funds, the facility failed to ensure interest was provided to the resident account. The findings On 10/24/24 at 9:10 AM, review of the Resident Trust Accounts with the Business Office Manager identified the following: 1. Resident #94 was admitted to the facility in March 2023 and currently has a payor source of Medicaid. On 10/24/24 at 9:10 AM, review of the Resident Trust Accounts with the Business Office Manager identified on 12/13/23 Resident #94 had a balance of 100.00 dollars ($), although interest was posted to other Resident Trust Accounts within the facility on 1/2/24, the Resident Fund Statement identified Resident #94 did not receive interest. On 2/1/24, Resident #94 had a balance of $65.00, interest was posted to other Resident Trust Accounts within the facility on 2/1/24, but Resident #94 did not receive interest. On 3/1/24, Resident #94 had a balance of $65.00, interest was posted to other Resident Trust Accounts within the facility on 3/1/24, but Resident #94 did not receive interest. On 4/1/24, Resident #94 had a balance of $65.00, interest was posted to other Resident Trust Accounts within the facility on 4/1/24, but Resident #94 did not receive interest. On 5/1/24, Resident #94 had a balance of $165.00, interest was posted to other Resident Trust Accounts within the facility on 5/1/24, but Resident #94 did not receive interest. Resident #94 did receive interest of $0.01 on 7/1/24, 8/1/24 and 9/3/24 for a balance of $127.02 in the Resident Trust Account. On 10/1/24, Resident #94 had a balance of $89.04, interest was posted to other Resident Trust Accounts within the facility on 10/1/24, but Resident #94 did not receive interest. 2. Resident #100 was admitted to the facility in January 2024 and currently has a payor source of Medicaid pending. On 10/24/24 at 9:30 AM, review of the Resident Trust Accounts with the Business Office Manager identified on 3/30/24, 4/1/24, 5/1/24 and 6/1/24, Resident #100's balance in the Resident Trust Account was 100.00 dollars ($). Interest was posted to other Resident Trust Accounts within the facility on 4/1/24, 5/1/24, and 6/23/24, but Resident #100 did not receive interest. On 7/1/24 and 8/1/24 Resident #100's balance in the Resident Trust Account was $80.00, interest was posted to other Resident Trust Accounts within the facility on 7/1/24 and 8/1/24, but Resident #100 did not receive interest. (continued on next page)

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	On 9/3/24, Resident #100's balance in the Resident Trust Account was $60.00, interest was posted to other Resident Trust Accounts within the facility on 9/3/24, but Resident #100 did not receive interest. On 10/24/24 at 11:00 AM, interview with the Business Office Manager identified that she contacted the company that manages the Resident Trust Accounts and the procedure for posting interest was they distribute interest to the residents with the highest balances descending downward. The Facility Account Specialist submitted the policy for posting interest to Resident Trust Accounts and identified interest was allocated to each resident based on their daily accrual throughout the month. Additionally, the system allocated the earned interest of $0.01 or more based on the daily balance and will post interest to only those resident with the highest balances. Interview with the Facility Account Specialist customer service on 10/25/24 at 10:59 AM identified that the management system assigned to the Resident Trust Account was in contact with banking to identify the issue with posting of interest.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 51101 Based on facility documentation and interviews for Resident Trust Accounts, the facility failed to ensure a Surety Bond was in place prior to October 24, 2024. The findings include: On 10/25/24 at 9:10 AM, interview with the Business Office Manager identified the Resident Trust Account balance was over 94,759.89 dollars ($). A review of the Resident Trust Fund Surety bond on 10/25/24 at 9:10 AM with the Business Office Manager identified the Resident Trust Fund Surety bond was in effect on 10/24/24 for $100,000.00 but was unable to provide a Surety Bond that was in effect prior to 10/24/24. An interview with the Business Office Manager on 10/25/24 at 9:15 AM identified the facility did not have a copy of the previous Resident Trust Fund Surety bond and would reach out to their corporate office to obtain a copy. A phone interview with the underwriter assistant on 10/25/24 at 9:26 AM identified that the facility had a Resident Trust Fund Surety Bond with an effective date from 10/24/24 to 10/24/25. Additionally, the interview identified through a search of their data base there was no record of a previous Resident Trust Fund Surety Bond for the facility prior to 10/24/24.

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #42) reviewed for a change in condition, the facility failed to ensure the physician/APRN was notified of the unavailability of a medication resulting in hospitalization , and for 2 of 2 residents (Resident #33 and Resident #38) reviewed for edema, the facility failed to notify the physician of weight increase of 5 pounds (lbs.) in one week for a resident with diagnosis of Congestive Heart Failure (CHF). The findings included: 1. Resident #42's diagnoses included Chronic inflammatory demyelinating polyneuritis (disorder of the autonomic nervous system), and dysarthria and anarthria.(a condition that results in complete or partial loss of speech due to a severe motor speech impairment). A physician's order date 7/25/24 directed to administer immunoglobulin 10% every 4 weeks. An Inter-Agency Referral Report dated 7/25/24 indicated the resident was to receive immunoglobulin 10% every 4 weeks intravenously. The admission Minimum Data Set assessment dated [DATE] identified Resident #42 was cognitively intact and required maximum assistance for toileting, showering, and personal hygiene. The Resident Care Plan dated 10/15/24 identified Resident #42 as a paraplegic related to a spinal injury. Interventions included to medicate the resident as ordered. A nurse's note dated 10/5/24 at 7:50 PM identified Resident #42 requested to go to the hospital because she/he had not received her/his immunoglobulin in 3 months and felt she/he was having an immune response. Furthermore, the resident reported stiffness and pain in his/her hands, and a burning sensation in his/her chest. Resident #42 was sent to the emergency room (ER) for an evaluation. A nurse's noted dated 10/10/24 at 12:37 PM identified the resident returned from hospital at 10:20 AM and identified the resident received 3 immunoglobulin infusions: 1 per day for 3 days while in the hospital. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	An interview and record review on 10/24/24 at 10:30 AM with Unit Manager RN#4 identified the hospital discharge summary and/or the Inter-Agency Referral Report were reviewed for physician's orders and the Medical Director also reviews the documents and writes physician's orders based on the facility's recommendations. Review of the clinical record indicated an order was written on 7/25/24 for the administration of IV Immunoglobulin every 4 weeks, however the clinical record identified the medication was not administered until October 2024 when Resident #42 requested to go to the hospital. RN#4 indicated she was aware of the situation with the IV Immunoglobulin. The facility was unable to administer IV Immunoglobulin because the facility could not find an infusion center that would administer the medication. RN #4 called the resident's oncologist at the end of August 2024; however, they were unable to administer the IV Immunoglobulin due to insurance restrictions. RN #4 further stated that she did not document her efforts, nor did she recall notifying the Advanced Practice Registered Nurse (APRN)/MD that she was having difficulty finding a clinic to administer the IV Immunoglobulin medication. In an interview on 10/25/24 at 9:30 AM with APRN #1 s/he identified s/he was aware Resident #42 had an order for monthly infusions of immunoglobulin. APRN #1 indicated s/he was aware Resident # 42 went to theER on [DATE], but was unsure of the details in-between 7/25/24 and 10/5/24. APRN #1 also identified she asked nursing at the end of August 2024 the status of scheduling the infusion and was told they were working on getting it scheduled. The next time she was updated was on October 5, 2024, when the resident was sent out to an acute care facility. APRN #1 identified s/he would have sent the resident to the ED if s/he was aware that the staff was having difficulty scheduling the infusion. Review of the Policy for Medication Errors dated 8/23/2005 and currently active directs, in part, that an omission of a medication is an error. Further it defines that when a medication error has occurred the physician and the supervisor are notified immediately. According to Drug. Com Intravenous Immunoglobulin is used for treatment of primary immunodeficiency. 2. Resident #33's diagnoses included CHF, diabetes, and peripheral vascular disease. The Resident Care Plan dated 7/17/24 identified Resident #33 had potential for alterations in cardiac output related to CHF. Interventions included to monitor, document and report to the MD/APRN, as needed, any signs or symptoms of CHF (dependent edema of legs and feet, periorbital edema, weight gain unrelated to nutritional intake, and crackles or wheezes upon listening to the lungs) and weight monitoring per the facility policy. The admission Minimum Data Set assessment dated [DATE] identified Resident #33 was cognitively intact and required supervision or touching assistance with eating, was dependent with lower body dressing, and required partial/moderate assistance with rolling left and right. A physician's order dated 7/24/24 directed to obtain weights weekly every Friday before breakfast. Physician's order in effect from 8/1/24 through 8/13/24 directed to notify the Medical Doctor (MD)/Advanced Practice Registered Nurse (APRN) if there was a weight gain of 2 lbs. or more in 1 day or 5 lbs. or more in 1 week. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Resident #33 was admitted to the hospital from 8/13/24 through 8/26/24. Physician's orders dated 8/26/24 directed to obtain a daily weight before breakfast and notify the MD/APRN if there was a weight gain of 2 lbs. or more in 1 day or 5 lbs. or more in 1 week. Physician's orders dated 9/4/24 directed to discontinue the daily weight before breakfast and a new order directed to obtain a weight weekly on Friday. Review of weight documentation in Resident #33's clinical record for 7/16/24 through 10/18/24 identified 3 occurrences of weight gain of 5 lbs. or more in 1 week. Between 7/26/24 (231 lbs.) and 8/2/24 (241 lbs.) a gain of 10 lbs. was noted. Between 9/1/24 (225.4 lbs.) and 9/6/24 (236.6 lbs.) a gain of 11.2 lbs. Between 9/13/24 (230 lbs.) and 9/20/24 (235 lbs.) a gain of 5 lbs. Although a review of the Medication Administration Records for August 2024 and September 2024 identified the MD/APRN was notified of the weight gains, a review of nurses' progress notes between 8/2/24 and 9/20/24 failed to identify documentation of MD/APRN notification of a weight gain of 5 lbs. or more in 1 week. Interview with APRN #1 on 10/25/24 at 12:00 PM identified that she had not been notified by the nurses of a 5 lbs. or more weight gain for Resident #33 on 8/2/24, 9/6/24 and 9/20/24, and that if she had been notified she would have evaluated Resident #33's lungs, checked for edema, looked for a trend for weight gain, evaluated Resident #33's current medications, and she would have looked at documentation of Resident #33's ejection fraction (amount of blood pumped out with each heart beat) and if stable would have considered medication changes. 3. Resident #38's diagnoses included CHF, diabetes, and aphasia following a stroke. The annual Minimum Data Set assessment dated [DATE] identified Resident #38 was severely cognitively impaired and was dependent for eating, oral hygiene, and rolling left and right. The Resident Care Plan in effect from 5/1/24 through 5/31/24 identified Resident #38 had potential for alterations in cardiac status related to CHF. Interventions included to monitor, document and report to the MD/APRN as needed any signs or symptoms of CHF (dependent edema of legs and feet, periorbital edema, weight gain unrelated to nutritional intake, and crackles or wheezes upon listening to the lungs) and weight monitoring per policy. Physician's orders dated 5/1/24 directed to obtain weights weekly every Monday and notify the MD/APRN if there is a weight gain of 2 lbs. or more in 1 day or 5 lbs. or more in 1 week. Review of weight documentation in Resident #38's clinical record for 5/1/24 through 5/31/24 identified 2 occurrences of weight gain of 2 or more lbs. in 1 day or 5 lbs. or more in 1 week. Between 5/13/24 (215.0 lbs.) and 5/13/24 (218.0 lbs.) gain of 3 lbs. in the same day. Between 5/17/24 (217.6 lbs.) and 5/20/24 (228.5 lbs.) a gain of 10.8 lbs. in 3 days was noted. Although a review of the Medication Administration Record for May 2024 identified the MD/APRN was notified of the weight gains, a review of the nurses' progress notes between 5/13/24 through 5/27/24 failed to identify documentation of MD/APRN notification of a weight gain of 2 or more lbs. in 1 day or 5 lbs. or more in 1 week. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Interview with APRN #3 on 10/25/24 at 10:15 AM identified he could not recall being updated by nurses of a weight gain of 2 or more lbs. in 1 day or 5 lbs. or more in 1 week for Resident #38 and if he had been updated, he would have requested for the nurse to provide him with information about Resident #38's lung sounds and any presence of edema. He further stated that if the information the nurse provided revealed acute signs or symptoms of CHF, he would have provided orders to the nurse right away and he would have visited the resident the next day. If the information provided by the nurse revealed non-acute signs or symptoms of CHF there wouldn't have been a need for immediate orders, but Resident #38 would have received an APRN visit the next day. Review of APRN #3's progress notes from 5/13/24 to 5/27/24 failed to identify a visit for follow-up related to a notification of weight gain of 2 or more lbs. in 1 day or 5 lbs. or more in 1 week. Although attempted, interviews with nursing staff from 5/13/24 and 5/20/24 were unable to be obtained. Review of the CHF policy directed, in part, that residents with a diagnosis of congestive heart failure would be managed according to physician recommendations and weights would be taken as prescribed per physician orders. Review of the Weight Assessment and Intervention policy failed to identify directives for management of weight gain related to a resident disease process. _____ 51183

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on clinical record review, facility policy review and interviews for 1 of 1 sampled resident (Resident #71) reviewed for dignity, the facility failed to investigate an allegation of mistreatment. The finding include: Resident #71's diagnosis included depression, anxiety, and breast cancer. The Resident Care Plan (RCP) dated 7/13/24 identified Resident #71 had a history of suicidal thoughts or actions due to potential or actual mood and impaired coping. Interventions included to assess the resident for potential harm to self or others. The RCP also identified Resident #71 had psychotropic drug use related to anxiety, insomnia and bipolar disorder. Intervention included to monitor for a decline in mood, and behavior. The quarterly Minimum Data set (MDS) assessment dated [DATE] identified Resident #71 was cognitively intact, independent with eating, toileting, personal hygiene, and transfers, and required supervision with bathing. An interview with Resident #71 on 10/21/24 at 11:30 AM identified that some of the Nurse Aides (NA) can be disrespectful when s/he asks for things by saying get it yourself. Resident #71 stated she/he reported this to RN #1. Review of the grievance log failed to identify any grievances were filed for Resident #71 regarding above. An interview with RN #1 on 10/25/24 at 9:25 AM identified Resident #71 had spoken to RN #1 about the NAs at times speaking to him/her disrespectfully and RN #1 failed to complete an investigation. An interview with the Director of Nursing Services (DNS) on 10/25/24 at 9:45 AM identified that if a supervisor was aware of an incident, a formal investigation should be completed and that was in the facility policy regarding abuse and mistreatment. The DNS also stated she was unsure of the reason this incident was not investigated. Review of the facility policy directed a concern or complaint be brought to the attention of the charge nurse/nursing supervisor, the concern/complaint should be brought and/or documented (on a concern form) and submitted to the Director of Social Services. All concerns/complaints are investigated, and findings reviewed with the Administrator.

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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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility policy and staff interviews for 2 of 4 residents reviewed for hospitalization s (Residents #63 and 167), the facility failed to provide the responsible party notice of the facility bed hold of the bed hold at the time of a facility transfer. The findings include: 1. Resident #63's diagnoses included gastroenteritis, Type II diabetes mellitus and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #63 was moderately cognitively impaired and dependent (2 person assist) with activities of daily living (ADL) care, one person assists with eating. The Resident Care Plan dated 5/29/24 identified Resident #63 had an Activities of Daily Living (ADL) deficit and was at risk for constipation. Interventions directed to be upright for all meals and feed with every meal in small bites. A review of the admission clinical record identified Resident #63 was not self-responsible. A nurse's note dated 7/27/24 at 6:24 PM identified Resident #63 was transferred to the community hospital at the request of the responsible party after s/he was noted to be sleepy with poor intake for the preceding two days. Resident #63 was subsequently admitted and treated for colitis. A review of the clinical record failed to reflect the bed hold policy detailing reason for transfer and duration of the bed hold was provided to the responsible party at the time of transfer. An interview with the Admissions Director on 10/24/24 at 12:53 PM identified she was not responsible for providing the bed hold policy to the responsible party at the time of transfer. An interview with the Social Worker, SW #1 on 10/24/24 at 1:34 PM identified she was not responsible for providing the bed hold policy to the responsible party at the time of transfer. An interview with the DNS on 10/24/24 at 1:40 PM identified that although a copy of the bed hold policy was provided to residents and responsible parties on admission, she thought either Social Services or Admissions provided the bed hold policy detailing reason and duration of bed hold at the time of transfer. The DNS further identified she learned, subject to surveyor inquiry, the provision of bed hold policy at the time of admission was not being done. A review of the facility policy for Reservation of the Resident's Bed if the Resident is hospitalized (no date) directs that prior to transfers and therapeutic leaves, the resident/representative will be informed in writing of the bed hold/ return policy. Prior to the transfer, written information will be given to the resident /representative that explains the duration of the bed hold, the reserve bed payment policy as indicated by the state plan and the details of the transfer. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #167 's diagnoses included enterocolitis due to clostridium difficile, pseudomonas aeruginosa, extended spectrum beta lactamase resistance, acute and chronic respiratory failure, and Chronic Obstructive Pulmonary Disease (COPD). The Resident Care Plan dated 6/20/24 identified discharge plan was to return to community living. Interventions include to evaluate discharge planning needs taking into consideration plan of care, the resident's goals, cognitive skill level, functional level and need for assistive devices. Additionally, to plan with required community resources to support independence post discharge and refer to a home care agency. The admission Minimum Data Set assessment dated [DATE] identified Resident #167 was cognitively intact could eat without assistance and required set up assistance with hygiene, total assistance with toileting, and dressing, substantial maximum assistance with bed mobility and indicated the resident was unable to transfer out of bed due to medical conditions. Clinical record review failed to identify a bed hold policy was given to the resident at the time of transfer to the hospital Interview with Admission Director on 10/24/24 at 12:53 PM identified she does not provide the bed hold policy when a resident is transferred to the hospital. Interview with the Social Worker #identified that she does not complete the bed hold policy for transfers. Interview with DNS on 10/24/24 at 1:40 PM identified that either social services or admissions was overseeing this process. After surveyor inquiry it was determined that no one was completing the bed hold form or notifying the resident or representative of the right to hold the bed and return to the facility. Review of the notice regarding reservation of the resident's bed if the resident is hospitalized policy directed, in part, that prior to transfer, written information will be given to the resident and representative that explain the duration of the bed hold for Medicaid assisted residents, for residents with Medicare A, Managed care, commercial insurance coverage and private pay. 50179

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48950 Based on record review, facility policy review and interviews for 1 of 2 sampled residents (Resident #128) reviewed for anticoagulation, the facility failed to develop a comprehensive care plan for Resident #128 who was receiving an anticoagulant and for 1 of 2 residents (Resident #160) reviewed for urinary catheters, the facility failed to implement a care plan for a resident with a urinary catheter. The findings included: 1.Resident #128's diagnosis included dementia, hypertension, and respiratory failure. The physician's orders dated 5/6/24 directed to administer Lovenox (an anticoagulant medication) 40 (MG) milligrams, to be injected subcutaneously at bedtime for prophylaxis. The Medication Administration Record from 5/7/24 through 10/23/24 further identified Resident #128 was receiving the anticoagulant Lovenox 40 MB every day at bedtime. The quarterly Minimum Data Set assessment (MDS) assessment dated [DATE] identified Resident #128 was severely cognitively impaired and dependent for toileting, showering, dressing, personal hygiene, and transfers. Also, the MDS identified Resident #128 was receiving an anticoagulant. The Resident Care Plan failed to include comprehensive plan of care that included Resident #12 on an anticoagulant and failed to include interventions for bleeding precautions. An interview on 10/24/24 at 9:58 AM with Registered Nurse (RN #1) identified Resident #128 was on an anticoagulant and that the RCP failed to identify Resident #128 was on anticoagulant therapy and should have been monitored for bleeding precautions. Also identified by RN #1 was the resident's anticoagulant therapy was started on 5/6/24 and the policy was for the RCP to have included this. An interview on 10/24/24 at 10:39 AM with the DNS identified the RCP should have included that Resident #128 was on anticoagulant therapy (Lovenox) and should have included monitoring for bleeding precautions. The DNS also identified when the order for anticoagulant was started the care plan should have reflected interventionf for bleeding. A facility policy for anticoagulant therapy was requested but the DNS stated the facility did not have one specific for Lovenox. However surveyor was provided a policy for Coumadin which is also an anticoagulant. The facility policy for Coumadin Protocol identified that any resident receiving anticoagulant therapy was to have been monitored for signs and symptoms of bleeding. The facility policy for Care Planning identified that ongoing changes in the residents' status shall be updated by nursing and/or the Interdisciplinary Team. Also identified that the Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #160 's diagnoses included neuromuscular dysfunction of bladder and urinary retention. The quarterly Minimum Data Set assessment dated [DATE] identified Resident # 160 was moderately cognitively impaired and was dependent with toileting hygiene. The MDS also identified Resident #160 had an indwelling catheter. A physician's order dated 9/22/24 directed to insert a foley catheter for Resident #160 secondary to urinary retention. A nurse's note dated 9/22/24 at 2:25 PM identified Resident # 160 continued to have urinary retention, bladder scan was completed, and a foley catheter was placed. A physician's order dated 10/6/24 for Resident # 160 directed to add diagnosis of neurogenic bladder and keep the foley catheter in place. A physician's note dated 10/7/24 at 1:45 PM identified Resident #160 was seen by urology and a suggestion was made to keep the urinary catheter in place due to a neurogenic bladder. In an interview and clinical record review with the MDS Manager (RN #7) on 10/25/24 at 10:26 AM, the care plan failed to reflect documentation for a urinary catheter for Resident #160. RN #7 identified a care plan should be in place for a urinary catheter, and it was the responsibility of the Interdisciplinary Team to ensure that a care plan had been put in place to ensure appropriate monitoring. Review of the Care Planning - Interdisciplinary Team policy identified that the facility's care planning/ interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each reside. Additionally, the policy identified that ongoing changes in residents' status shall be updated by Nursing and/or the Interdisciplinary Team as needed. 51101 51102

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37721 Based on clinical record reviews, review of facility documentation, review of facility policy, and staff interviews for 1 of 3 sampled residents (Resident #27) reviewed for Advance Directives, the facility failed to revise the care plan when the resident changed his/her code status from a Full Code to Do Not Resuscitate (DNR) and for 2 of 8 residents reviewed for care planning (106, 113) the facility failed to revise the care plan timely. For Resident #232, the facility failed to revise the resident care plan following an unwitnessed fall, and for 1 of 8 residents (Resident #65), the facility failed to invite a resident to care plan meetings. The findings included: 1. Resident #27's diagnosis included Alzheimer's disease, hypertension, and heart failure. Review of the Advance Directive dated 6/8/23 identified Resident #27 was a Full Code and on 4/29/24 the code status was changed to Do Not Resuscitate (DNR). The physician's orders dated 4/29/24 identified that Resident #27 was a DNR. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #27 was cognitively intact and required extensive assist of 2 people for bed mobility, and transfers, totally dependent for toileting and supervision for eating. The Resident Care Plan on 10/20/24 failed to identify Resident #27's care plan was revised when Resident #27 code status was changed on 4/29/24 to DNR. An interview on 10/24/24 at 10:06 AM with RN #1 identified Resident #27's care plan was not reviewed until 10/21/24 and was not revised when the code status had changed on 4/29/24 from being a Full Code to DNR. She also identified per the facility Care Planning Policy that ongoing changes in residents' status shall be updated. RN #1 further identified everyone was responsible to update the Resident Care Plan including herself. An interview on 10/24/24 at 10:39 AM with the Director of Nursing Services (DNS) identified Resident #27's care plan was not updated timely and that it should have been updated when the new Advance Directives were put in place on 4/29/24. The DNS also identified all the nurses were responsible for updating the Resident Care Plan, it was an oversight and should have been done with any new orders and reviewed every quarter. The facility policy for Care Planning identified that ongoing changes in the residents' status shall be updated by nursing and/or the Interdisciplinary Team. Additionally noted, Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. 2. Resident #113 's diagnoses included acquired absence of the right toe, non-pressure chronic ulcer of the left foot, diabetes mellitus, peripheral vascular disease, end stage renal disease, dependence on end stage renal disease with specialized treatment, and polyneuropathy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 2/15/24 identified wounds necessitate the use of a wound vac due to excessive exudates and need for optimal wound healing. Interventions include pressure reduction support surface on bed, change dressing every 48 hours and as needed for impaired dressing seal integrity, wound vac therapy per physician order, wound measurements every week and to notify the physician of no progress or deterioration. The quarterly Minimum Data Set assessment dated [DATE] identified Resident # 113 was cognitively intact and was independent with eating and required partial moderate assistance with bed mobility and required total assistance with hygiene, dressing, transfers, and toileting. The resident had unstageable (covered by dead tissue) pressure wounds as well as surgical wounds. Additionally noted specialized treatment Monday, Wednesday and Fridays. A physician's order dated 9/24/24 directed to change dressing to both feet right foot old surgical site and left foot heel every other day with betadine-soaked gauze cover with an abdominal pad and Keflex every morning shift Tuesday, Thursday and Saturday on hold. A physician's order dated 10/16/24 directed for dressing change to be done at the wound care center, right foot wound culture proteus mirabilis. Start cephalexin (antibiotic) 500 milligrams twice a day for 7 days. Follow up in 1 week on 10/23/24. A physician's order on 10/23/24 directed to discontinue cephalexin and change to ciprofloxacin (antibiotic) 500 milligrams every 12 hours for 7 days and start floras tor 250 milligrams orally for 10 days. Bilateral heel lift boots to be worn in and out of bed unless with therapy. Observation on 10/22/24 at 11:21 AM identified dressing on both feet with heel lift boots intact to both feet. Interview with RN #1 on 10/23/24 at 11:00 AM identified the resident previously had a wound vac but no longer has it. An interview and clinical record review with RN #6 on 10/24/24 at 10:31 AM identified every nursing staff can update the care plan. The care plans are updated after morning meeting as things occur, quarterly and with changes of condition. RN # 6 identified Resident # 113 was not her resident. An interview and record review with RN # 7 on 10/24/24 at 11:00 AM identified care plans are updated every 3 months with each MDS assessment. The nurse managers, supervisors and nurses can update care plans. RN # 7 identified that she would expect Resident # 113's care plans would have been updated in May 2024. RN # 7 identified the current care plan indicates the wound vac on the care plan. Additionally, identified the physician's order dated 3/2 24 discontinued the wound vac order. RN #7 identified that she would expect the care plan to be updated when the order was noted. RN # 7 did not know why the care plan was not updated. Review of the policy care planning interdisciplinary team directed, in part, ongoing changes in resident status shall be updated by nursing and/or interdisciplinary team (IDT) as needed. 3. Resident #106's diagnosis included dementia, Parkinson's disease, and falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 7/25/24 identified a problem with falls. Interventions included to redirect the resident to use call light and keep resident in an area of close monitoring (dining room) for activities, and hallway for socialization with other residents. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #106 was severely cognitively impaired and was dependent for toilet hygiene, bathing, personal hygiene and dressing. The MDS also identified Resident #106 required set up for eating and had a history of falls. A nursing note dated 9/26/24 at 11:35 AM identified Resident #106 had an unwitnessed fall on 9/26/24 and received a 1.5-centimeter laceration to the back of his/her head. Resident #106 was sent to the emergency room to be evaluated. A Reportable Event form dated at 9/26/24 identified Resident #106 was trying to self-toilet and fell backwards when trying to open the bathroom door. Disposition and actions taken was Resident #106's laceration to the back of the head was cleansed, attempted to stop the bleeding and checked the resident's range of motions to extremities. A nursing note dated 9/26/24 at 10:34 PM identified Resident #106 returned from the emergency room and had 2 staples placed to the back of head laceration. Review of the Resident Care Plan on 10/22/24 at 9:41 AM failed to identify the RCP was reviewed and revised to include the fall with injury from 9/26/24 and failed to include additional interventions to prevent further falls. After surveyor inquiry with the DNS on 10/22/24, the RCP was updated and back dated for 9/26/24 to include the fall from 9/26/24 and interventions updated which directed staff to keep Resident #106 in the hallway and in activities so she/he can be watched and she/he will state need for toileting. Also, Resident #106 can sit in the recliner chair if family is present. The facility policy for Care Planning identified that ongoing changes in the residents' status shall be updated by nursing and/or the Interdisciplinary Team. Also identified the Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident. 4. Resident #232's diagnoses included dementia with psychotic disturbance. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #232 was severely cognitively impaired, required hands on one-person moderate assist with bed mobility, transfers, toileting, and self-propelled using a wheelchair. The Resident Care Plan dated 3/6/24 identified Resident #232 was at risk for falls, had a history of falls, and a deficit in activities of daily living (ADL). Interventions directed to provide verbal reminders of individual limitation, provide assist of one with a rolling walker for transfers and ambulation as ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility Reportable Event dated 4/25/24 at 8:50 AM identified Resident #232 experienced an unwitnessed fall. The Investigation identified Resident #232 was last checked for incontinence care at 8:00 AM where s/he was in bed. Resident #232 was subsequently found on the floor in h/her room. Resident #232 reported s/he was self-ambulating and lost balance. Resident #232 reported hitting h/her head, had complaints of rib pain, headache and blurred vision. The right hip was observed to be externally rotated. Resident #232 was subsequently transferred to the emergency room for further evaluation and returned the same day with no new orders. The care plan failed to reflect that the fall was reviewed and or any additional interventions to reduced risk of further falls. An interview with the Director of Nursing Services on 10/23/24 at 1:49 PM identified she should have updated the care plan following the fall on 4/25/24. A review of the facility policy for Care Planning (no date) directed that the care plan is based on the resident's comprehensive assessment and developed by the interdisciplinary team. Ongoing changes in residents' status shall be updated by Nursing/Interdisciplinary team as needed. 5. Resident #65's diagnoses included fusion of the spine, difficulty walking, and adjustment disorder. The quarterly MDS assessment dated [DATE] identified Resident #65 was cognitively intact and participated in the quarterly assessment process. A review of the paper clinical record identified an interdisciplinary care conference attendance record dated 5/16/24. The record had four staff signatures and did not contain a resident signature or indication that the resident had attended or had declined an invitation. Additionally, all other sections of the interdisciplinary care conference attendance record were blank. A social services quarterly note dated 5/17/2024 indicated a resident care conference was held and plans for discharge to the community. The social services note did not indicate if the resident had attended the care conference or if the resident had been invited to attend. On 10/21/2024 at 3:11 PM, during screening, Resident #65 indicated s/he did not know what a care conference was but would be interested in attending if one was held. Resident #65 did indicate s/he is able to see the social worker whenever s/he needs something. On 10/23/2024 at 1:30 PM, an interview with Social Worker (SW) #2 indicated the MDS Coordinator schedules and runs the care conference meetings and writes the care conference notes. Social Worker #2 indicated that the last care conference meeting would have been around the time of the resident's last quarterly note, but she could not recall if the resident attended the conference. Social Worker #2 also identified the social worker, recreation, the head nurse, and the MDS Coordinator usually attend the care conferences. On 10/23/2024 at 1:31 PM, an interview with RN #1 indicated she could not recall when the last care conference meeting was and whether the Resident # 65 attended. RN #1 did indicate that if she could not attend the care conference meeting, she would give her update to the MDS Coordinator and sign the attendance sheet afterward. Additionally, RN # 1 indicated the MDS Coordinator would go see the residents to update them and see if they have any questions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/23/2024 at 2:30 PM, an interview with the MDS Coordinator (RN#10) indicated Resident #65 are invited to the care plan meetings, and if the resident declines, she updates them afterward. RN #10 indicated residents are invited by a letter that is sent out by the unit secretary. RN #10 also indicated that she checks with the residents on the day of the care conference meeting to see if they will be attending. RN #10 further indicated when a resident has declined to attend the care conference meeting, she would write it on the care conference attendance record and the paper care conference record is the only documentation of the care conference, since it is not documented on the electronic health record. A record review with RN #10 during the interview identified the last documented quarterly care conference meeting was on 5/16/2024. RN #10 was unable to identify if a care conference was held in August 2024, the time the next quarterly care conference would have been due to be held. On 10/24/2024 at 9:14 AM an interview with Unit Secretary #1 indicated Resident #65 does not get a letter because the resident does not have an address other than the facility address. Unit Secretary #1 indicated that she does not hand deliver the letters because she was unsure if the letters could be delivered by hand or had to be stamped. Unit Secretary #1 indicated she was not aware of how else the resident would be informed of the care conference date. On 10/24/2024 at 12:00 PM, an interview with the MDS Supervisor (RN # 7) indicated that there should have been a care conference meeting in August 2024, but the MDS supervisor could not identify a reason for the absence of a care conference meeting. Additionally, RN #7 indicated that Resident #65 was on the schedule for a care conference on 11/7/2024. Interdisciplinary care conference attendance records from 1/1/2023 to 10/24/2024 were requested from the facility, however, only the care conference attendance record for 5/16/2024 was received. On 10/25/2024 at 10:00 AM an interview with the DNS indicated the facility looked for the missing care conference attendance records but were unable to locate them. The facility policy for care planning notes every effort should be made to schedule a care plan meeting at the best time of the day for resident and family. The facility policy did not address how a resident is encouraged to participate in the development of the care plan or how they are invited to the care conference. 48880 48950 50179

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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** 51102 Based on observation, staff interview, and facility policy for 1 of 4 residents, (Resident #44) reviewed for pressure ulcers, the facility failed to ensure pressure ulcer treatments were performed in accordance with infection control standards. The findings include: Resident #44's diagnoses included congestive heart failure, anxiety disorder, and unspecified atrial fibrillation (an irregular and fast heartbeat). The quarterly Minimum Admission Set assessment dated [DATE] identified Resident #44 was severely cognitively impaired and was dependent for eating, toileting and transfers. Additionally, the MDS identified Resident #44 was at risk for developing pressure ulcers and had two Stage 3 pressure ulcers. The Resident Care Plan dated 10/11/24 identified Resident #44 was at risk for skin issues due to fragile skin, and decreased activity and mobility. Interventions included to follow facility policies/protocols for the prevention/treatment of skin breakdown and obtain wound measurements and documentation of findings per policy and as needed. The physician's orders dated 10/25/24 directed a daily treatment for 30 days to the right hip wound was to cleanse with Normal Saline, 1/4 strength Dakins solution (an antiseptic used to prevent infections), followed by packing with 1/4 strength Dakins solution soaked gauze and cover with an Allevyn dressing (foam dressing). Additional physician orders directed a daily treatment for 30 days to the coccyx was to cleanse the coccyx wound with 1/4 strength Dakins solution, pack with 1/4 strength Dakins solution-soaked gauze followed by an Allevyn dressing, and a daily treatment for 30 days to the left hip was to cleanse with 1/4 strength Dakins solution, apply gauze soaked with Dakins and cover with an Allevyn dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the treatments to Resident #44 left hip, coccyx and right hip on 10/25/24 at 10:25 AM identified Licensed Practical Nurse (LPN) #5, and Registered Nurse (RN) #5 appropriately donned personal protective equipment indicated for enhanced barrier precautions which consisted of a gown, then LPN #5 performed hand hygiene utilizing Sani-Hand wipes and donned gloves, RN #5 also performed hand hygiene utilizing Sani-Hand wipes and donned 2 pairs of gloves (double gloving). While LPN #5 was to the left of Resident #44 preparing the supplies on a sterile field (Sani Hands alcohol-based hand wipes container noted to be on the table), RN #5 was on the right-side aiding in Resident #44's positioning. RN #5 removed the Allevyn dressing to the left hip which was dated 10/23/24 (2 days prior, physician orders directed daily dressing changes), removed the gauze packing from the wound, then removed the first pair of gloves, discarding all contents, exposing the second pair of gloves, then donned another pair of gloves over the first pair of gloves without the benefit of hand hygiene. LPN #5 cleaned the wound with 1/4 strength Dakins solution, discarded the gauze, changed her gloves without the benefit of performing hand hygiene, applied Dakins soaked gauze, covered the wound with an Allevyn dressing dated 10/25/24, then removed her gloves without performing hand hygiene. While RN #5 gently turned the resident to expose the coccyx, after performing the treatment to Resident #44's left hip, LPN #5 donned a pair of gloves without the benefit of hand hygiene, removed the Allevyn dressing dated 10/23/24, cleaned the area with 1/4 strength Dakin solution, discarded the dressing and gauze, changed her gloves without the benefit of hand hygiene, packed the wound with 1/4 Dakin solution soaked gauze, applied the Allevyn dressing dated 10/25/24 and removed her gloves without performing hand hygiene. Resident #44 was then repositioned to her left side, LPN #5 applied gloves, removed the Allevyn dressing dated 10/23/24 on the right hip, removed the gauze, discarded the dirty contents, cleaned the area with 1/4 Dakins solution, packed the wound with the 1/4 Dakins solution-soaked gauze, and applied the Allevyn dressing dated 10/25/24 without the benefit of changing gloves or performing hand hygiene (after performing the treatment to Resident #44's left hip and coccyx) when going from dirty to clean during a dressing change. Interview with LPN #5 on 10/25/24 at 10:48 AM identified she did not perform hand hygiene between glove changes because she did not want to leave her area to wash her hands and could not provide an explanation as to the reason she did not utilize the Sani Hands that were available and within reach. She also could not recall the reason she did not change her gloves when going from dirty to clean during the dressing change on the right hip. Interview with RN #5 on 10/25/24 at 10:50 AM identified double gloving was not a standard practice and didn't believe she touched anything, so she didn't believe she had to perform hand hygiene when changing gloves. Interview with the Infection Prevention Registered Nurse (RN) identified that the policy on hand hygiene during dressing changes was that hands should be washed between each glove change, gloves are changed when going from dirty to clean and double gloving is absolutely not practiced. Review of the Hand Washing Policy and Gloves Policy directed in part to wash hands after removing gloves, and that the use of gloves does not replace hand washing. Review of Procedure for Clean Dressing Technique Policy directed in part after removing an old dressing to remove gloves and wash hands, then apply clean gloves prior to cleaning the wound.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #38) reviewed for a limited Range Of Motion (ROM), the facility failed to apply hand splints per the physician's order. The findings include: Resident #38 's diagnoses included congestive heart failure, obesity, and diabetes. A physician order dated 8/21/23 directed a left resting hand splint and right grip roll hand splint to be applied with personal care at bedtime and removed in the morning with care. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #38 was severely cognitively impaired and dependent with upper body dressing, rolling left and right, with chair/bed to chair transfers, and had a functional limitation of range of motion on 1 side of the upper extremity. The Resident Care Plan dated 8/23/24 identified Resident #38 had neurological risks related to his/her history of a stroke and seizures. Interventions included to place and remove his/her left hand and right hand splints per physician order. Physician's orders dated 10/20/24 directed Resident #38's left resting hand splint and right grip roll hand splint were to be applied with care at bedtime and removed with care in the morning. An additional order directed a right resting hand split was to be applied every morning after care and removed at bedtime. Observation on 10/22/24 at 9:30AM identified Resident #38 in bed without the benefit of any hand splints, one hand splint was visible and stored on the dresser. Observation and interview with Nurse Aide (NA) #5 on 10/22/24 at 10:11 AM identified a hand splint stored on Resident #38's dresser. NA #5 indicated that she had provided care to Resident #38 but had not been instructed by the nurse to apply the hand splint, so she had not. NA #5 stated that there was only 1 hand splint available for Resident #38 in his/her room. NA #5 subsequently left the room without applying Resident #38's hand splint. Observations on 10/23/24 at 8:34 AM identified that a hand splint was on Resident #38's dresser in same location and position as the observation on 10/22/24. Resident #38 was not observed to be wearing a splint on his/her left or right hand. A second observation on 10/23/24 at 11:50 AM identified that Resident #38 was wearing a splint to the right hand. Interview with the Rehabilitation Director, Physical Therapist (PT) #2, on 10/23/24 at 1:50 PM identified that she was unaware that Resident #38 had two splint orders in the Electronic Medical Record (EMR). PT #2 indicated that the order dated 8/21/24 was entered without specific administration directions and this resulted in the order not appearing on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) which would have directed nursing staff to apply the hand splints, at bedtime, per the physician order dated 8/21/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Occupational Therapist (OT) #2 on 10/23/24 at 2:15 PM identified that Resident #38's current order, dated 8/21/23, should have been for a left hand resting splint and right grip roll hand splint to be applied with care at bedtime and removed with care in the morning. OT #2 indicated that the previous (older) order for the right hand splint to be applied in the morning and removed with care at bedtime should have been discontinued when the new order was generated on 8/21/23. OT #2 further identified that she was unaware the order entered on 8/21/23 had been entered without specific directions resulting in the order not appearing on the MAR or TAR to direct nurses to correctly apply both splints in the evening. OT #2 stated that Resident #38 not wearing his/her left and right hand splints as directed could result in the development of, or worsening of, his/her hand contractures. In an interview and clinical record review of current orders with Registered Nurse (RN) #5 on 10/23/24 at 2:45 PM, it was identified that RN #5 had erroneously entered the OT recommendation for a left resting hand splint and right grip roll hand splint to be applied and worn at bedtime without specific administration directions. Further review of the clinical record with RN #5 indicated that the 8/21/23 order did not appear on the MAR or TAR so the nursing staff would not have been directed to apply Resident #38's splints. RN #5 was unable to identify how she had entered the order incorrectly and stated, I made a mistake. RN #5 stated that she would put in a request for an occupational therapy evaluation to verify that the order was still appropriate for Resident #38 due to her not receiving a splint to the left hand since OT #2's recommendation on 8/21/23 (14 months earlier). Interview and review of the new Occupational Therapy Evaluation with OT #1 on 10/25/24 at 2:30 PM identified that although Resident #38 did not have a decline in ROM compared to the previous evaluation, new hand splint orders were recommended for Resident #38 to wear hand splints to both hands. Review of the Policy for Monitoring Resident with Splints directed, in part, to maintain the schedule of splint application and removal given by the Therapist and physician orders. Based on observations, medical recored review, staff interviews, and facility policy review for 1 of 3 residents reviewed for range of motion (Resident #38), the facility failed to implement utilization of physician ordered splints for a resident with limited ROM.

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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** 37721 Based on clinical record reviews, facility policy review and staff interviews for 1 of 8 residents reviewed for accidents and hazards (Resident #232), the facility failed to provide a safe and complete transfer from a chair to bed for a resident requiring assistance, resulting in a fall with major injury and for 1 of 3 sampled resident (Resident #71) who was reviewed for dignity, the facility failed to maintain an accident-free environment and for 2 of 8 residents (Resident # 24) who required supervision during meals, the facility failed to provide appropriate supervision for a resident on aspiration precautions. The findings included: 1. Resident #232 had diagnoses that included dementia with psychotic disturbance. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #232 was severely cognitively impaired, required hands on one-person moderate assist with bed mobility, transfers, toileting, and self-propelled using a wheelchair. The Resident Care Plan dated 7/3/24 identified Resident #232 was at risk for falls, had a history of falls, and a deficit in activities of daily living (ADL). Interventions directed to provide verbal reminders of individual limitation, provide assist of one with a rolling walker for transfers and ambulation as ordered. Physician orders dated 8/1/24 directed assist of one stand pivot transfers with a rolling walker. Physical Therapy Evaluation and Plan of Treatment dated 8/7/24 identified Resident #232 was referred for services due to a decline in decline in dynamic balance, functional mobility and strength. Static and dynamic sitting were assessed as 'Good'. A nurses note dated 9/26/24 at 7:42 PM identified at 7:00 PM, Resident #232 experienced an unwitnessed fall. Resident #232 was being assisted to bed and fell off the bed when Nurse aide, NA #1 assisted Resident#232 to a sitting position, turned to move the chair and heard a 'boom' when s/he hit the floor. Resident #232 sustained a forehead laceration and a swollen nose. Resident #232 had complaints of pain, there was no change to h/her mental status and was subsequently transferred to a community hospital. The facility Reportable Event dated 9/26/24 identified at 7:00 PM identified Resident #232 was sitting on a regular chair when NA #1 attempted to transfer h/her from chair to bed. After placing Resident #232 on the side of the bed in a seated position, NA #1 turned to move the chair out of the way when Resident #232 fell to the ground, hitting h/her head on the floor. The nurse and nursing supervisor were immediately notified. Upon assessment, Resident #232 was observed with a laceration to the forehead, swelling to the nose and complained of a headache. The head was kept immobile while pressure was applied to stop the bleeding. The Advance Practice Registered Nurse, APRN and responsible party were notified, and Resident #232 was transported to the community hospital for further evaluation, where she was subsequently admitted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital Discharge Summary dated 9/30/24 identified Resident #232 identified Resident #232 sustained a mechanical fall resulting in a subarachnoid hemorrhage along the right parietal, left parietal and left frontal regions (of the brain). Type 2 dens fracture (second or cervical 2 spine), [NAME] fracture (bone fracture of the cervical 1 spine), multiple facial fractures and minimally displaced fracture of the C 5 right lamina. Incidental findings included, splenic calcified aneurysms, grade 4 occlusion of the right vertebral artery and 1. 1 cm calculus in the renal pelvis. Resident #232 was admitted to the intensive care unit for hourly neurological testing and CT scans every (4) hours. On 9/29/24, Resident #232 had increased confusion/lethargy and poor oral intake. A stat CT head showed new onset intraparenchymal hemorrhage (a bleed that occurs within the brain parenchyma, or functional tissue in the brain caused by stroke or trauma). The responsible party was contacted, and the decision was made to change the code status to DNR/DNI. On 9/30/24, Resident #232 became more obtunded (reduced consciousness), was not following commands or moving extremities, making shallow breaths and gasping for air. At 10: 47 AM, Resident #232 was noted to be in asystole (no heart rate) and death was pronounced at 10:50 AM. The Medical examiner was notified, and accepted the case due to trauma as the etiology of the admission The Certificate of Death dated 9/30/24 identified Resident #232's immediate cause of death as hypertensive and arteriosclerotic cardiovascular disease with blunt injuries of the head as significant conditions contributing to death but not resulting in the underlying cause. The facility Reportable Event Summary dated 10/3/24 identified Resident #232 was evaluated on 9/5/24 and had good sitting posture and was able to hold position while sitting at the edge of the bed briefly as she has done many times before. Nothing changed in Resident #232's nightly routine. Based on hospital records it was likely Resident#232 had a syncopal episode (dizzy spell) that resulted in the fall. Staff Education Documentation Record dated 9/26/24 directed that Resident #232 must be laying in bed, not sitting, before attending to anything else and was signed by (5) NA staff including NA #1 and (2) LPN's. An interview with the Medical Director on 10/22/24 at 1:03 PM identified that while he was the Resident #232's primary physician, he was aware of the incident and reviewed the Reportable Event and Hospital Discharge Summary. The Medical Director identified Resident #232 was stable in the hospital until a subsequent brain hemorrhage resulted in a change of condition and subsequent death. The Medial Director further identified it was hard to know what could have occurred during hospitalization with the new onset of an additional brain bleed. However, the Medical Director felt the fall that occurred at the facility was avoidable and significantly contributed to Resident #232's death. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #1 on 10/23/24 at 9:00 AM identified she was the assigned nurse aide for Resident #232 during the 3:00 PM to 11:00 PM shift on 9/26/24 and that Resident #232 was well known to her. NA #1 identified she assisted Resident #232 in toileting and personal care in the bathroom and then wheeled h/her to the side of the bed closest to the window. NA #1 assisted Resident #232 with the transfer, using a gait belt, to the bed and left h/her in a seated position on the edge of the bed which was placed in the low position. NA #identified she then left Resident #232's side still in the seated position in bed, to move around the back of the wheelchair and turn around to place the wheelchair next to the dresser, a measured distance of 6' ft 8 from the middle of the bed to the front edge of the dresser. NA #1 identified she heard a 'boom', turned around and observed Resident #232 face down on the floor, against the back all with h/her head pointing towards the end of the bed. NA #1 observed blood coming from somewhere in the head region and immediately notified the nurse and Nursing Supervisor who rendered care. An interview with Medical Doctor, MD #2 on 10/23/24 at 11:35 AM identified he was Resident #232's primary physician and was notified of the incident and hospital transfer. MD #2 identified it was his opinion that the consequences of the fall resulting in injury would be trauma first, then comorbidities. MD #2 further identified the brain bleed would have most likely contributed to the death. An interview with the Director of Rehabilitation on 10/23/24 on 12:34 PM identified Resident #232 was assessed and determined to have 'good' dynamic sitting, meaning s/he can sit at the edge of the bed and hold h/herself up, but would require constant eyes on supervision when sitting on the bed. Staff were educated upon hire that when completing a transfer for a resident requiring moderate assist, the transfer was considered complete when the resident was placed from a sitting position on the bed to a laying position. Staff should not be leaving the resident until the transfer is completed and resident was left in a laying position. An interview with the Director of Nursing, DNS on 10/23/24 at 1:49 PM identified the root cause of injury was related to NA #1 not completing a full transfer. Resident #232 should have been transferred completely from a sitting position on the bed to a laying position before the aide left h/er side. The DNS further identified that although education had been completed, it was limited to just the staff on the unit at the time and limited to just resident #232 as the DNS thought the Staff Development nurse, RN #2 would have completed a more comprehensive training for facility staff. An interview and facility documentation with RN #2 on 10/23/24 at 2:00 PM identified she was responsible for staff development at the facility. RN #2 identified she provided fall prevention education for the facility on a continuous basis to staff prior to the incident. Staff were educated to never leave a resident who required hands on assistance in a sitting position without first laying them down on the bed when transferring to bed with one person assist. RN #2 further identified that following the event, she did not initiate any education to the remainder of the facility staff beyond what was provided to the initial (7) staff on 9/26/24. A second interview with NA #1 on 10/24/24 at 8:59 AM identified when placing Resident #232 to bed, s/he 'scooted' herself back into bed, so h/er feet were no longer touching the floor. NA #1 further identified that just a gait belt, not a rolling walker was used during the transfer and that due to the distance, she would not have been able to reach Resident #232 if s/he began to fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent interview with the Director of Rehabilitation on 10/25/24 at 11:30 AM identified Residents were assessed for sitting balance with both feet securely on the ground. For Resident #232, the trunk would become more unstable once the feet were off the floor. Although requested a facility policy or education for resident transfer from chair to bed was not provided. Occupational Safety & Health Administration Guidelines for Nursing Homes, 2009 recommends assisting the resident in standing by holding the gait belt while they push off a chair. Pivot the resident by gently guiding as they face the bed. Guide the resident to sit on the bed with their feet touching the floor. Once seated encourage them to scoot back. Once seated, assist the resident swing their legs onto the bed and guide them to lie down making sure they are comfortable and properly aligned. 2. Resident #71's diagnoses included glaucoma, falls, and breast cancer. The Resident Care Plan dated 7/13/24 identified Resident #71 had a fall with an intervention to have a walker at the bedside. Interventions included: Resident #71 had a history of suicidal thoughts or actions due to potential or actual mood and impaired coping. Interventions directed to remove all potential harmful items from the room, provide plastic utensils with all meals, and no knives. The quarterly Minimum Data set (MDS) assessment dated [DATE] identified Resident #71 was cognitively intact, independent with eating, toileting, personal hygiene, and transfers, and required supervision with bathing. An observation on 10/21/24 at 11:30 AM of Resident #71's room identified the radiator cover by Resident #71's bed had a metal piece that was broken inside of the vent and was protruding. A second observation of Resident #71's radiator cover identified bent sharp edges that were protruding out. Resident #71 reported the radiator had been like that since she/he was admitted over a year ago and maintenance came in the other day and put extra screws in the radiator cover, but 2 areas continue to protrude out with sharp, metal edges noted. Interview with the Director of Maintenance on 10/25/24 at 9:22 AM identified he had his assistant fix the radiator cover yesterday but it appeared to be more dangerous than it was and not fixed correctly. The Maintenance Director also identified it was not safe, and the radiator cover needed to be replaced not repaired. After surveyor inquiry, the Maintenance Director indicated he/she was going to the store to purchase a replacement for the radiator cover. 3. Resident #24 's diagnoses included dysphagia, gastro-esophageal reflux disease, and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was severely cognitively impaired, and required set up for eating, supervision/touch assist for transfers and toileting. Additionally, the MDS identified Resident #24 was on a mechanically altered diet and a therapeutic diet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 8/26/24 identified Resident #24 was on aspiration precautions and demonstrated some risk to potentially aspirate food or liquids as well as general problems with chewing and/or swallowing. Interventions included to provide assistance per physician's order based on therapy recommendations, to observe the resident during mealtimes for signs/symptoms of aspiration or difficulty swallowing and utilize safe swallowing techniques such as chin tuck, keep resident in an upright position at 90 degrees for meals and maintain an upright position for 30 to 45 minutes after eating. The physician's order dated 9/30/24 directed for aspiration precautions to be maintained every shift due to an aspiration risk that included Resident #24 was in line of sight/ supervision during meals to ensure use of slow rate, and small bites/sips every shift. The Nurse Aide (NA) task documentation identified Resident #24 was an assist of 1 for eating, with direction to supervise self-feeding. Observation and interview on 10/22/24 at 9:02 AM identified Resident #24 lying on her/his left side self-feeding, unsupervised, in her/his bed that was in the prone (flat) position, with the side rail up. The bedside table was parallel to the side of the bed with a breakfast tray on it, Resident #24 was reaching over the side rail with her/his right hand to feed her/himself oatmeal, and a plate with scrambled eggs and a cup of liquid was noted next to the oatmeal bowl. Resident#24 was not in view of staff. Interview with Nurse Aide #4 at that time, (who was in the hallway), who identified that Resident #24 preferred to eat like that. Observation and interview on 10/22/24 at 9:10 AM with Licensed Practical Nurse (LPN) #3 identified that she was not sure how Resident #24 usually ate because she works another shift. Subsequent to surveyor inquiry, LPN #3 assisted Resident #24 to a sitting position, with the head of the bed up, and the bedside table over the bed, no supervision was provided was provided to Resident #24. Observation on 10/23/24 at 8:54 AM identified Resident #24 laying on her/his left side self-feeding, unsupervised, in her/his bed that was in the prone (flat) position, with the side rail up. The bedside table was slightly over the bed, with Resident #24 eating oatmeal with her/his right hand, a cup of liquid and a plate containing French toast was noted next to the oatmeal bowl. Resident was not in view of staff. Observation on 10/24/24 at 8:58 AM identified NA #4 brought breakfast into Resident #24's room, sat the resident upright to eat in her/his chair and left the room. Interview with the Speech Language Therapist (SLT) #1 on 10/23/24 at 10:15 AM identified that an aspiration precaution order and line of sight meant that Resident #24 should be in view during medication administration and eat in the dining room or hallway where the staff can see Resident #24. Additionally, failure to supervise Resident #24 might result in a struggle with swallowing, aspiration or possibly choking. Interview and the NA care card review with Registered Nurse (RN) #5 on 10/24/24 at 12:32 PM identified that the facility policy for aspiration precautions meant that Resident #24 had an evaluation and order put in by SLT, and nursing staff were responsible for sitting Resident #24 upright for meals. Additionally, nursing staff would know orders were in place by checking the physician's orders and care card. (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 he Nurse Aide (NA) unit care card identified Resident #24 was an assist of 1 with Activities of Daily Living, a feed and a choking risk. RN #5 could not identify the reason physician's order were not being followed for keeping Resident #24 in line of sight/ supervision during meals to ensure use of slow rate, and small bites/sips every shift. Interview with NA #3 on 10/24/24 at 1:50 PM identified she was the regular NA for Resident #24 and was aware of the aspiration precautions as well as sitting the resident up for meals. However, she did not sit her/him up during the meal because she felt Resident #24 could be challenging and the regular charge nurse that usually assists was not working. The Aspiration Precautions Policy directed in part that the purpose of the precautions was to prevent aspiration for those residents who are deemed at risk per the speech pathologist, additionally the head of bed may be elevated to a minimum 30 degrees except during care, and supervision at meals may be identified and noted on the care plan. 48950 51102

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility policy and interviews for 1 sampled resident (Resident #139) reviewed for trauma informed care, the facility failed to ensure a resident with history of trauma was addressed to include identification of life event(s), triggers/stressors and management of care to prevent re-traumatization. The findings include: Resident #139's diagnoses included post-traumatic stress disorder (PTSD) and dementia. The Social Service Initial assessment dated [DATE] identified Resident #139 was alert, oriented, confused at times with a history of depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #139 was moderately cognitively impaired, required two person assist with activities of daily living and had an active diagnosis that included post-traumatic stress disorder, depression and anxiety. The Resident Care Plan dated 10/2/24 identified Resident had a diagnosis of depression, anxiety and was cognitively impaired. Interventions directed to explain what you are doing during care and to provide psychiatric consultation as needed. The Psychiatric Consultations dated 5/13/24 through 10/7/24 identify services were being provided to Resident #139 for confusion, anxiety and depression. Past psychiatric history identified depression. The Resident Care Plan and psychiatric consultations failed to reflect documentation of Resident #139's personal history of trauma, any triggers/stressors and how care was managed to prevent re-traumatization. An interview and clinical record review with Advanced Practice Registered Nurse, APRN #2 identified that while he never personally provided psychiatric services to Resident #139, he was part of a group that provided ongoing psychiatric support to Resident #139. APRN #2 identified the diagnosis of post traumatic stress disorder was included in Resident #139's problem list. But not mentioned in any consultations. APRN #2 further identified a resident with PTSD should be included as part of a psychiatric evaluation to obtain a history and identify triggers even with a resident with dementia to better manage their care. An interview with Social Worker, SW #1 on 10/24/24 at 1:19 PM identified an initial assessment specifically for PTSD was never completed for Resident #139 on admission or thereafter and that all services related to PTSD would be supported by psychiatric services. An interview with the DNS on 10/24/24 at 1:40 PM identified any history and triggers should be assessed by social services on admission and further managed by psychiatric services and medications. Although requested a policy for trauma informed care was not provided. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility education for Trauma Informed Care (no date) identified that trauma informed care is a way of giving behavioral health care where the caregiver understands trauma, how trauma impacts an individual, and how certain institutional practices may re-traumatize individuals. Key Elements include realizing the prevalence of trauma, providing safety to prevent re-traumatization by recognizing trauma symptoms, developing new coping skills, establishing clear treatment goals and provide support by encouraging participation with those with similar experiences.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, observation and staff interviews for 1 of 4 residents (Resident # 123) reviewed for physician visits, the facility failed to ensure electronic physician's orders were signed timely. The findings include: Resident #123's diagnosis included Congestive Heart Failure (CHF), acute respiratory failure and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #123 was cognitively impaired and was taking antidepressant, diuretic and anticonvulsant medication. An observation and record review with RN #1 and Unit secretary #1 on 10/24/2024 at 10:45 AM identified s/he was not able to find the resident's signed physician's orders (written or electronic signed by the physician for 30- or 60-day review and renew of orders). A review of Resident # 123's clinical record with Unit Secretary indicated s/he knows the physician reviewed the physician's orders because a progress note was written. RN #1 indicated the facility had only been utilizing the electronic system for a few months. Observation of the electronic record indicated in bold red lettering in the order section orders 55 days overdue. RN #1 and Unit secretary #1 could not recall any educational training for using the physicians order system in the new electronic medical record. RN #1 further indicated the Medical Director was the only physician using the electronic system at this time the other physicians sign the orders on paper. An interview and record review with Corporate Staff RN #8 on 10/24/2024 at 11:10 AM with RN #1 in attendance indicated she/he would have to check the system and see if Resident #123's physician's orders had been signed or in fact overdue. RN #8 further indicated the Medical Director had requested the use of the electronic system and already knew how to use it, so no training was needed for the physician for use at this time. RN #8 further indicated s/he would try to run a report of the Medical Directors residents' physician's orders for review. An interview with the DNS and the Staff Development Nurse RN#3 on 10/24/2024 at 11:40 AM indicated no educational training had been provided to the licensed staff regarding their role in ensuring the physician's orders are signed timely and how to determine if the orders are in effect for 30 days or 60 days. The DNS and Staff Development Nurse indicated they did not know this was an issue and indicated they would ensure the issue was resolved. On 10/25/2024 at 9:50 AM RN #8 indicated Resident #123's physician's orders were not signed by the physician and s/he also did not provide a report of the Medical Directors residents' physician's orders. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/2024 at 2:15 PM the facility provided an electronic print out of physician orders for Resident #123 as of 8/1/2024. Printed electronic orders were also provided dated 9/5/2024 (date of readmission to the facility) which indicated a telephone order taken from a physician by an RN on 9/5/2024 with no time indicated. Both physician's order sheets did not indicate the physician who signed the paper orders (the section Physician was left blank) but had signatures (illegible) in the signature section dated 8/15/2024 and no date on the readmission orders of 9/5/2024. In addition, neither order indicated the time frame the physician's orders were in effect for.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46046 Based on observation, clinical record review and staff interviews for 1 of 4 residents (Resident #123) reviewed for physician's orders, the facility failed to ensure staff were trained in the procedure for using the electronic physician order system and their responsibility in ensuring physician orders were signed timely. The findings include: An observation and record review with RN #1 and Unit secretary #1 on 10/24/2024 at 10:45 AM identified s/he was not able to find Resident # 123's signed physician's orders (written or electronic signed by the physician for 30- or 60-day review and renew of orders). A review of Resident # 123's clinical record with Unit Secretary indicated s/he knows the physician reviewed the physician's orders because a progress note was written. RN #1 indicated the facility had only been utilizing the electronic system for a few months. Observation of the electronic record indicated in bold red lettering in the order section orders 55 days overdue. RN #1 and Unit secretary #1 could not recall any educational training for using the physicians order system in the new electronic medical record. RN #1 further indicated the Medical Director was the only physician using the electronic system at this time the other physicians sign the orders on paper. An interview and record review with Corporate Staff RN #8 on 10/24/2024 at 11:10 AM with RN #1 in attendance indicated she/he would have to check the system and see if Resident #123's physician's orders had been signed or in fact overdue. RN #8 further indicated the Medical Director had requested the use of the electronic system and already knew how to use it, so no training was needed for the physician for use at this time. RN #8 further indicated s/he would try to run a report of the Medical Directors residents' physician's orders for review. An interview with the DNS and the Staff Development Nurse RN#3 on 10/24/2024 at 11:40 AM indicated no educational training had been provided to the licensed staff regarding their role in ensuring the physician's orders are signed timely and how to determine if the orders are in effect for 30 days or 60 days.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on staff interviews, review of the clinical record, and facility policy for 1 of 5 residents (Resident #33) reviewed for unnecessary medications, the facility failed to prevent the administration of an unnecessary medication for constipation. The findings include: Resident #33's diagnoses included osteoarthritis, chronic pain, and polyneuropathy. The admission Minimum Data Set assessment dated [DATE] identified Resident #33 was cognitively intact and required supervision or touching assistance with eating, partial/moderate assistance for rolling left and right, and was dependent with moving from lying to sitting on the side of the bed. A physician's re-admission order dated 8/26/24 directed to administer naloxegol oxalate 25 milligrams (mg) by mouth daily for Gastrointestinal (GI) upset. A nursing note dated 8/26/24 at 2:20 PM identified that MD #3 had been called following Resident #33's re-admission and all Resident #33's medications were reviewed and approved by MD #3. An Advanced Practice Registered Nurse (APRN) #1 note dated 8/26/24 at 12:19 PM identified that she was requested to see Resident #33 following his/her return from the hospital after 13 days of inpatient treatment of a urinary tract infection. The note further identified that medications were reviewed by APRN #1. The Resident Care Plan dated 8/27/24 identified Resident #33 was at risk for constipation related to decreased mobility and pain management and was at risk for pain related to neuropathy and chronic pain. Interventions included to maintain a bowel regime and have the Medical Doctor (MD) evaluate the drug regimen if indicated. Further interventions included to administer pain medications as ordered and monitor for potential side effects (altered mental status, constipation, and anxiety). Review of physician's orders dated 8/28/24 and APRN #1 orders dated 9/10/24 directed naloxegol oxalate (a medication for constipation due to opioid use) 25 mg by mouth daily for GI upset. Further review of the physician orders failed to direct the administration of any opioid medications. Review of the Medication Administration Records (MAR) dated 8/27/24 through 10/25/24 identified documentation that naloxegol oxalate 25mg was administered daily to Resident #33 from 8/27/24 through 10/25/24 (except on 10/8/24). The MAR failed to identify an active order for an opioid medication to be administered. Interview with APRN #1 on 10/25/24 at 12:00 PM identified that she evaluated resident medication orders for polypharmacy monthly, but that some of the attending physicians prefer to independently manage their own resident orders. She stated that MD #3 would make the determination of discontinuing medications for the reason of non-necessity for Resident #33. APRN #1 stated that administration of naloxegol oxalate was not necessary for a resident who was not receiving an opioid medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #3 on 10/25/24 at 1:00 PM identified that she reviewed and signed the re-admission orders for Resident #33, and that she preferred to manage her own resident medications. When she was unavailable, the facility nurses could utilize the APRNs. MD #3 stated that she evaluated her residents for polypharmacy with each visit and stated that she had seen Resident #33 in August and reviewed his/her medications. MD #3 was not aware that Resident #33 was on naloxegol oxalate in the absence of opioid medication administration. Subsequent to surveyor inquiry MD #3 stated that she would be in later in the day and after verifying that an opioid medication was not ordered she would discontinue the naloxegol oxalate. Review of the Physician visit policy directed, in part, that a comprehensive medical history and medical examination shall be completed for each resident within 48 hours of admission.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on staff interviews, review of the clinical record, and facility policy for 1 of 5 residents (Resident #33) reviewed for unnecessary medications, the facility failed to implement a stop date for a psychotropic (drugs used to treat mental illness) medication. The findings include: Resident #33 's diagnoses included depression, anxiety disorder, and insomnia. The admission Minimum Data Set assessment dated [DATE] identified Resident #33 was cognitively intact and required supervision or touching assistance with eating, partial/moderate assistance with personal hygiene, and was dependent with moving from lying to sitting on the side of the bed. The physician's re-admission orders dated 8/26/24 directed to administer trazodone 50 milligrams (mg) by mouth at bedtime for sleep and administer trazodone 25 mg by mouth 3 times a day as needed. The order lacked a stop date. A nursing note dated 8/26/24 at 2:20 PM identified that MD #3 had been called following Resident #33's re-admission and all of Resident #33's medications were reviewed and approved by MD #3. The Resident Care Plan dated 8/27/24 identified Resident #33 was at risk of alteration in mood and used psychotropic medications due to anxiety, depression and insomnia. Interventions included to monitor periods of anxiety, administer anti-anxiety medication per the physician order and monitor for effectiveness, and consult with the physician for medication adjustments as needed. Review of physician's orders in the clinical record identified that the physician's order for trazodone 25 mg by mouth three times a day as needed for anxiety was renewed by Advanced Practice Registered Nurse (APRN) #1 on 9/1/24 and lacked a stop date. The Medication Administration Records from September 2024 and October 2024 identified that Resident #33 had received 8 PRN (as needed) doses of trazodone 25 mg on 9/15/24, 9/17/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/28/24, and 10/12/24 which was greater than 14 days from the date the order was initially written, on 8/26/24, and greater than 14 days from the APRN renewal date on 9/1/24. A medication regimen review (MRR) resident list by the consultant pharmacist dated 9/27/24 identified that there were no recommendations to add a stop date to Resident #33's PRN Trazadone. Interview with APRN #1 on 10/25/24 at 12:00 PM indicated that the attending physician reviewed the admission/re-admission orders and that the physician who signed off the admission/re-admission orders was responsible for ensuring that an end date was in place for PRN psychotropic medications. APRN #1 stated that Resident #33's Medical Doctor (MD) #3 preferred to review and manage medications for her own residents, and that the pharmacy consultant usually identified if there were missing end dates for PRN psychotropic medications when the monthly Medication Regimen Review (MRR) was conducted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #3 on 10/25/24 at 1:00 PM identified that she reviewed and signed the re-admission orders for Resident #33. MD #3 stated that the PRN trazodone order did not require an end date and that her rationale for not adding the end date was that trazodone was not an antipsychotic medication so did not require an end date. MD #3 did not indicate if she was aware of the requirement for all PRN psychotropics to have a 14 day stop date. Review of the Antipsychotic Medication Use policy directed, in part, that the need to continue PRN orders for psychotropic medications beyond 14 days required the practitioner to document the rationale for the extended order and to include the duration of the PRN order within the order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37721 Based on observations, facility policy review and staff interviews, the facility failed to ensure medications were secured during medication administration, and failed to discard expired heparin flushes and the facility failed to store a narcotic liquid medication securely, ensure expired over the counter medications were not in the medication cart for use and failed to ensure an insulin bottle was labeled with the resident's name and the date the medication was opened. The findings included: 1. a. An observation on 10/22/24 at 8:35 AM during medication administration identified Licensed Practical Nurse, LPN #2 dispense (3) medications from their blister packs, pick up the medication cup with medications and a drink and began entering resident room [ROOM NUMBER] without first securing (3) medication blister packs left on top of the medication cart and locking the cart. Surveyor intervene before LPN #2 entered room [ROOM NUMBER]. An interview with LPN #2 on 10/22/24 at 8:35 AM identified medications should not be left on top of the medication cart and the cart secured before leaving the area. LPN #2 identified s/he did not secure the medications and medication cart because it was an oversight as she/he was nervous during observed medication administration by a surveyor. b. A second observation on 10/22/24 at 8:45 AM during medication administration identified LPN #2 dispense (4) medications from their blister packs, pick up a medication cup with medications and a drink and began entering resident room [ROOM NUMBER] without first securing (4) medication blister packs left on top of the medication cart and locking the cart. Surveyor intervene before LPN #2 entered room [ROOM NUMBER] and further medication observation suspended. An interview with the DNS on 10/24/24 at 1:40 PM identified she would expect nursing staff to ensure medications are secured in the medication cart and the medication cart locked before leaving the area. 2. Observation of 4th floor medication storage room on 10/24/24 at 11:30 AM, identified 50 expired 5 ml heparin lock flushes (30 expired 6/30/23 and 20 expired 7/21/23). Interview with Registered Nurse (RN) #5 on 10/24/24 at 12:10 PM identified s/he was unaware there were expired heparin flushes, she/he could not identify why the expired medications were there, and stated the facility did not currently have anyone with an intravenous device on the unit. RN #5 stated that expired and discontinued medications were brought to the Director of Nursing Services's office and placed inside the plastic bin in front of her desk for pick up by the pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Storage in the Facility-Storage of Medications policy directed, in part, that all medications and biologicals were to be stored safely, securely, and properly and that outdated medications are immediately removed from inventory and disposed of according to procedures for medication disposal. 3 a. An observation and interview on 10/25/2024 at 10:30 AM with the Nursing Supervisor RN #1 identified 1 of 4 medication refrigerators located in the 3rd floor medication room and an unlocked refrigerator with a lock box connected to the inside of the refrigerator with a bent chain on the top of the box. Further observations identified RN #1 was able to manually open the box without a key which contained a bottle of lorazepam oral solution (narcotic antianxiety medication) inside. RN #1 indicated the box /lock was broken and immediately called maintenance for a new box and relocated the narcotic to another unit double lock system. The narcotic count sheet and the remaining solution were found to be correct. b An observation of the medication cart located on the 3rd floor and interview with LPN # 6 on 10/25/2024 at 10:24 AM identified an open bottle of Cetirizine (an over-the-counter antiallergy medication) with an expiration date of 9/2024 (25 days past expiration date) which LPN #6 removed for disposal. Further observations identified an open bottle of Lantus insulin unlabeled without indication of who the medication was prescribed for and noted no date the insulin was opened. The facility policy labeled Medication Storage in the Facility, ID1: Storage of Medications notes medications dispensed by the pharmacy are to be stored in the container with the pharmacy label, outdated medications are to be immediately removed from inventory. The policy further indicated controlled substances requiring refrigeration are to be stored within a locked box within the refrigerator which is attached to the refrigerator. The policy also indicated when the original manufacturers seal is broken the container or vial needs to be dated with the date opened and drugs dispensed in the manufacturers original container has the manufacturers date of expiration, good to use until the expiration date is reached. 46046 51183

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observation, facility policy and interview for 1 of 2 residents (Resident #10) reviewed for dinning, the facility failed to honor resident's food choices. The findings include: Resident #10's diagnoses included dysphagia, hypertension, and hyperlipidemia. A physician's order dated 4/19/24 directed to provide a no added salt, regular texture, thin diet. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 as cognitively intact and required set up assistance with eating and maximum assistance with bathing and dressing. The Resident Care Plan dated 10/15/24 identified resident had a potential nutritional risk. Interventions included to provide a no added salt diet and regular thin diet with food preferences as possible. In the initial screening with Resident #10 on 10/21/24 11:40 AM she/he identified s/he does not get the foods s/he chooses and gets food items that s/he does not like. For example, s/he does not like chicken on a bun and received the food for dinner. Resident # 10 indicated s/he never ate a hamburger in her/his life, that was also served to her/ him. Resident # 10 also indicated s/he doesn't always get his/her 2 slices of toast for breakfast. An observation on 10/22/24 at 12:50 PM of the resident's lunch ticket noted extra gravy on the side, however, the resident did not get any gravy. Interview with Dietary Manager on 10/25/24 at 9:15 AM identified the process to determine Resident's food preferences is that a dietary staff member will interview the resident to determine food preferences, any dislikes, allergies, and portion sizes. The Dietary Manager also identified that each resident receives a menu and circles their food choices which goes into the Geri-menu software and a ticket is printed for each meal. The Dietary Manager stated that the dietary aides and the nurse's aides should be matching the ticket to the meal that is being served. There is not a dedicated dietary aide in the food line that checks to tickets. The Dietary Director was unsure why Resident #10 had issues with his/her menu choices. Further, he stated when that happens it is because the dietary aide has not checked the ticket. Review of the Resident Food Preferences policy, undated, directed in part, that upon the resident's admission or within 24 hours after admission the Dietician or nursing staff will identify a resident's food preferences.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observations of the breakfast, policy review and staff interviews for 2 of 6 residents reviewed for food (Residents #67 and # 146), the facility failed to follow the resident meal ticket which resulted in food items missing from the breakfast meal. The findings include: 1. Resident #67 was admitted with diagnoses that included diabetes mellitus and heart failure. The annual MDS assessment dated [DATE] identified Resident #67 was cognitively intact and independent with eating. A physician's order dated 9/30/2024 directed a heart-healthy regular-textured diet. A care plan dated 10/1/2024 indicated the resident had a potential nutrition risk related to diabetes mellitus and heart failure. Interventions included providing a cardiac regular texture diet with food preferences as possible. On 10/24/2024 at 9:10 AM during an observation with LPN #9 and RN #1 identified Resident #67 had received his/her breakfast tray that consisted only of two slices of toast on a white plate. Resident #67 questioned LPN #9 if that was all being served for breakfast that day. The meal ticket indicated the resident should have received 4 oz of apple juice, one packet of diet jelly or margarine, 4 oz of skim milk, 4 oz of scrambled egg whites, 6 oz of cream of wheat, one slice of rye toast and 6 oz of coffee. RN #1 then obtained a new breakfast tray for Resident #67. On 10/24/2024 at 9:50 AM, an interview with the Dietary Director indicated that the resident did not get eggs because the facility had run out of egg whites and that the resident should have been asked if s/he was agreeable to receiving regular scrambled eggs. Additionally, the Dietary Director indicated the resident should have received the other items on the ticket, such as the cream of wheat. However, the Dietary Director could not indicate why items had been omitted from the resident's dietary tray. 2. Resident #146 's diagnoses included dementia, severe protein-calorie malnutrition, and insomnia. The annual Minimum Data Set assessment dated [DATE] identified Resident #146 was severely cognitively impaired and independent with eating, dependent for personal hygiene, and independent with sit to stand. The Resident Care Plan dated 10/7/24 identified Resident #146 had a potential nutrition risk related to his/her dementia and history of malnutrition. Interventions included to provide a regular diet with thin liquids including food preferences as possible, and to set up and assist at meals as needed. The Nurse Aide (NA) care card in effect on 10/22/24 identified Resident #146 required set up for meals and was on a regular diet with thin liquids. (continued on next page)

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	075339	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lord Chamberlain Nursing & Rehabilitation Center	7003 Main Street Stratford, CT 06614

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/22/24 at 8:39 AM, identified Resident #146's breakfast plate was covered and on the bedside table. The plate was visible through the cover and contained 1 slice of French toast and 1 slice of white toast. There were no drinks with the meal. The printed meal ticket resting on top of the plate cover listed the items that should be included with Resident #146's breakfast meal: 2 slices of French toast, cranberry juice, milk, Maypo, and coffee. Resident #146 was in the hallway. Staff brought him/her into room, but Resident #146 didn't want to sit in his/her room, staff brought the plate of food into the hallway with his/her chair, and bedside table and encouraged Resident #146 to sit and eat. Staff cut up the food and provided Resident #146 a cup of apple juice. Resident # 146 started independently eating his/her food. Milk, cranberry juice, coffee, and Maypo were never provided to Resident #146 during his/her breakfast meal. 51183

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observations of the noon meal, review of facility policy and staff interviews for 1 of 6 residents reviewed for nutrition (Resident #82), the facility failed to provide appropriate food consistency for a resident on a pureed diet. The findings include: Resident #82 was admitted with diagnoses that included tongue cancer and a hip replacement. The quarterly MDS assessment dated [DATE] identified Resident #82 was cognitively intact and independent with eating. The MDS assessment also indicated the resident did not have a swallowing disorder but had been on a mechanically altered diet while a resident at the facility. A care plan dated 8/8/2024 identified that Resident #82 had a risk of swallowing difficulty, had a diagnosis of tongue cancer, and the resident requested pureed food. Interventions included monitoring the resident's response to the diet and serving requested foods if the diet allowed. An observation of Resident #82's lunch tray on 10/21/2024 at 1:03 PM identified the resident's meal ticket indicated a vegan puree diet consisting of pureed peas, pureed baked beans, and pureed spinach. An observation of the noon meal identified a plate with three different pureed items of a runny consistency whose edges touched each other and the rim of the plate. Resident #82 indicated her/his meals usually looked like that because the resident prefers to eat the same three things for every meal. An observation with the Dietary Manager with the surveyor on 10/23/24 at 12:05 PM identified the pureed food being served in the tray line was runny or thin in consistency and did not keep its form when plated. The Dietary Director indicated to the kitchen surveyor that chefs puree the food and then add cornstarch to thicken the food so that it is less watery. A follow-up interview with the Dietary Manager on 10/23/2024 at 1:00 PM indicated Resident #82's meal should not be a thin consistency and the pureed peas, pureed baked beans, and pureed spinach should not be running into each other on the plate. Additionally, the Dietary Director indicated that the pureed baked beans would not be thickened because it would mean the resident would get fuller faster and would end up eating less protein. A review of the resident's last dietary note dated 1/11/2024 indicated the resident's protein supplement was discontinued, the resident's weight was stable, and no new recommendations were made. The facility policy for puree meals notes puree textured meals should be blended to a pudding like consistency and should not be runny unless it is for an unthicken diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observations of the kitchen and dry storage area, facility policy review and interviews, the facility failed to ensure the kitchen and dry storage area were kept in a clean and sanitary condition, and food temperature thermometers were sanitized prior to taking the temperature of food items per facility policy and failed to ensure opened unlabeled food items/supplements were labeled when opened and discarded. The findings included: 1.a. Tour of the facility kitchen, observation and interview with the Dietary Manager on [DATE] starting at 10:10 AM and concluding at 11:10 AM identified an open paper bag containing cornstarch left open and not labeled, a large open bag of rice with rice spillage on the bag and surrounding area, an open unlabeled bag of brown sugar, a bag of opened unlabeled powdered cheese and a bin containing a large bag of breadcrumbs left open. Upon moving the bin off the shelf, a cobweb like debris was noted suspended from the back of the bin onto the back of the breadcrumb bag. The Dietary Manger disposed of the breadcrumbs further indicating the dry storage once opened should be placed in a covered container labeled and dated. b. Further observation of the kitchen identified an opened half bag of brownie mix with no date opened to air and a staff members personal beverage on one of the dry goods shelves. Additionally, noted flour and brown sugar spilled on the tops of cans and on the floor of the dry goods storage area. 2 unopened half gallons of milk in the walk-in refrigerator which expired on [DATE] (5 days old). Observation and interview with the Dietary Manager continued into the walk-in freezer to find an open box and bag of frozen egg patties per the Dietary Manager. Although the dietary manager was able to provide a daily list of duties for the dietary department staff, s/he was unable to show evidence staff was documenting the completion of each task throughout the day. The Dietary Manager further indicated the brownie mix should have been put into a covered container and labeled when opened and staff should not have personal items in the storage area. 2. An observation and interview on [DATE] at 12:15 PM identified Dietary Aide #1 using a clean piece of paper toweling to wipe the thermometer between each food item before temping. An interview with Executive Chef #1 indicated alcohol wipes should be used to sanitize the thermometer between food items and she/he would obtain and stock the steam table areas on each unit. On [DATE] at 9:30 AM the Dietary Manger indicated and provided evidence of dietary staff training regarding the food storage and food temperature procedures and cleaning of the thermometer. A facility policy labeled, Temping and sanitizing of thermometer notes the proper method for taking temperatures of potentially hazardous foods is to start with a clean calibrated and sanitized thermometer and once the thermometer has been placed into one food item upon removal the device must be sanitized using an alcohol wipe before temping the next item. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An observation and interview on [DATE] at 12:55 PM with LPN # 8 on the 3rd floor kitchen refrigerator found 2 opened bottles of a liquid high calorie supplement opened and unlabeled. LPN #8 indicated the supplements should not have been in the dining unit. LPN # 8 further indicated the supplement in the refrigerator, should have been dated when opened and would discard the remainder of the contents. [DATE] at 9:45 AM with LPN #8 indicated the liquid high calorie supplement should be discarded after 48 hours. A facility policy labeled Policy Interpretation and Implementation indicated in part dietary staff will store all food items not requiring refrigeration will be kept in a clean and dry area at all times free of contamination, condensation, leakage rodents and vermin. the policy further indicated all food items would be labeled and dated to allow for rotation of supplies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #38) reviewed for limited range of motion, the facility staff failed to wear appropriate Personal Protective Equipment (PPE) when direct care for a feeding tube was provided to a resident who required Enhanced Barrier Precautions (EBP). The findings include: Resident #38's diagnoses included dysphagia, placement of a feeding tube, and aphasia following a stroke. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #38 was severely cognitively impaired and was dependent for eating, personal hygiene, and rolling left and right. The Resident Care Plan dated 8/23/24 identified Resident #38 was at risk of alteration in nutrition related to requirement of tube feeding due to dysphagia and history of a stroke. Interventions included to administer the tube feeding per physician's order, perform feeding tube site care per physician's order, and maintain EBP every shift related to presence of a feeding tube. Physician's orders dated 10/1/24 directed to administer Glucerna 1.2 calorie tube feed around the clock at 50 milliliters (ml) per hour, check feeding tube for placement prior to starting the tube feed and maintain EBP related to the presence of an enteral feeding tube. Observation on 10/23/24 at 12:10 PM, identified signage on the door for EBP and a cart outside the door containing PPE. Licensed Practical Nurse (LPN) #1 was observed to enter the room without the benefit of wearing a gown (PPE). LPN #1 walked around the end of Resident #38's bed holding the end of the feed tubing in her left hand with her left arm reaching across the bed over Resident #38, then walked behind the privacy curtain and stood on the left side of Resident #38 who was seated in the wheelchair. When LPN #1 finished and opened the privacy curtain, the tube feeding tube was observed to be hooked up to Resident #38 and extended from the Resident #38's abdomen to the feeding pump located near the window on the right side of the bed. LPN #1 walked around the bed and restarted the feeding pump before she exited the room. Interview with LPN #1 on 10/23/24 at 12:15 PM identified that she was aware Resident #38 was on EBP due to presence of a feeding tube. LPN #1 stated she should have been wearing PPE when she was in hooking up Resident #38's tube feeding. Review of the Enhanced Barrier Precautions policy directed, in part, that EBP required the use of gown and gloves during specific high-contact resident activities including device care for indwelling medical devices which included feeding tubes. Signage would be posted on the door of a resident room which indicated the need for EBP, and a cart with appropriate PPE would be placed outside the resident's room.