STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075341	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Rehabilitation and Nursing Center	44 Maritime Drive Mystic, CT 06355

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for 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** 17723 Based on observations, review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #88) who experienced a change in condition, the facility failed to ensure that the physician was notified when the resident experienced symptoms of pain and swelling of the left hand. The findings include: Resident #88 was admitted to the facility in October 2024 with diagnoses that included type 2 diabetes mellitus, gout, and atrial fibrillation. The admission MDS assessment dated [DATE] identified Resident #88 was cognitively intact, required maximum assistance with lower body dressing, bathing, and toileting. Physician's progress notes dated 11/19/24 identified the resident was seen for hand pain to the right hand and noted the resident had superficial thrombophlebitis to the Left hand while at the hospital and recommended that Coumadin be switched to Lovenox(anticoagulant) to minimize the pricks to the fingers required for blood testing as a result of being on Coumadin. The note identified that Resident #88 refused. The Care Plan dated 12/9/24 identified Resident #88 was being treated for a leg wound with interventions for wound care and pressure relieving interventions. Additionally, the care plan indicated that the resident was at risk for skin breakdown Psychotherapy progress notes dated 1/13/25 identified Resident #88 expressed frustration with making physical progress and then suffering a physical ailment making it difficult to participate in therapies. Review of the nursing notes from 12/20/24 to 1/12/25 identified the resident had improved in ADL performance and had no complaints of pain. Nursing progress notes dated 1/13/25 at 1:45 PM identified Resident #88's left fingers were swollen and painful. An occupational therapy note dated 1/14/25 identified Resident #88 had left hand edema, redness and impaired range of motion of the fingers. Further, the note identified that nursing was notified. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physical therapy note dated 1/14/25 identified Resident #88 had edema and pain to the left hand that impacted the resident's ability to complete transfers and noted Resident #88 had asked nursing to utilize the mechanical lift for transfers out of bed to the wheelchair due to the edema and pain to the left hand. Observation on 1/16/25 at 1:31 PM identified Resident # 88 had swelling, redness, pain, and the inability to move the fingers on the left hand. Interview with the DNS on 1/21/25 at 12:45 PM identified that when the nurse identifies that a resident has experienced a change in condition or needs someone to assess the resident, the nursing supervisor should be notified. Interview with RN #5 on 1/22/25 at 10:34 AM identified that there was no documentation that the physician was notified of the swelling, redness, and pain. RN#5 further noted that if the symptoms were important enough to mention in a nursing note, then the doctor should have been notified of the changes to the left hand. Interview with MD#1 on 1/22/25 at 11:54 AM identified that if the condition noted is persistent, then the doctor should be notified and given the resident was experiencing swelling, it should have been reported. Any return or change should be reported so the provider has the opportunity to reevaluate interventions and treatments. Interview with PT #2 and OTA#1 on 1/23/25 at 11:14 AM identified that on January 14th the left hand became swollen, and Resident #88 had a decline in the ability to grasp the walker. Interview with the DNS on 1/23/25 at 1:03 PM identified that if a resident presents with a change, a new presentation, or an exacerbation of a resolved issue the expectation is that the staff communicates that to the doctor via the telephone or the communication binder. Interview with the DNS on 1/23/25 at 1:41 PM identified that chronic conditions that needed interventions intermittently should be included in the care plan and should be reported to the MD. The facility policy for notification of changes identified that the purpose of the policy is to ensure the facility promptly consults the resident's physician when there is a change requiring notification. Additionally, the policy identified that circumstances requiring notification included circumstances that require a need to alter treatment and indicated that those circumstances may include a new treatment or discontinuation of current treatment due to adverse consequences, acute condition, or exacerbation of a chronic condition.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on observation, review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #12) reviewed for respiratory care, the facility failed to ensure nebulizer equipment was stored/labeled properly and discarded when not in use. The findings included: Resident #12's diagnoses included high blood pressure, obesity, and depression. The quarterly MDS assessment dated [DATE] identified Resident #12 was cognitively intact, had no behaviors, required max assistance with bathing, dressing, and transfers. The assessment further identified that the resident did not ambulate and utilized a wheelchair for mobility. The care plan dated 1/13/25 identified Resident #12 had an inability to perform self-care, related to impaired mobility with interventions that included: aiding in any assistance when needed, providing quarter/half-length enablers (side rails) to assist with bed mobility and providing female caregivers. Observation of Resident #12's room on 1/16/25 at 11:50 AM identified a mask/tubing hanging from the light fixture above Resident #12's bed. The mask and tubing were attached to a nebulizer machine located in the resident's bedside table. Interview with Resident #12 indicated he/she had not had a breathing treatment in several months. Resident #12 was unable to recall a date or time frame of last nebulizer treatment received. Review of the Medication Administration Records (MAR) for the time periods of 11/1/24-11/30/24; 12/1/24-12/31/24 and 1/1/25-1/17/25, identified an order for Albuterol Sulfate solution 2.5 milligrams (mg) per 3 milliliters (ml). Give 3 milliliters, inhale orally every 6 hours as needed for shortness of breath had not been administered. Interview on 1/16/25 at 11:55 AM with LPN #1 identified Resident #12 had not been administered a nebulizer treatment since July of 2023. LPN #1 removed the mask/tubing and nebulizer machine from the room. Subsequently to surveyor inquiry, the order for the nebulizer medication-Albuterol sulfate nebulization solution (2.5mg/3ml) 0.083%-3ml, inhale orally via nebulizer every 4h as needed for shortness of breath (ordered on 6/30/23) was discontinued on 1/17/25. Interview on 1/22/25 at 9:55 AM with RN #1-unit manager of unit B2 and LPN #1, indicated no explanation of why the mask, tubing and nebulizer machine had been left in Resident #12's room, when it had not been used in months. Review of the Nebulizer Therapy policy directed, in part, that care of nebulizer equipment, include changing the tubing weekly or per facility policy. When not in use, once cleaned the equipment (mouthpiece/mask) should be stored in a zip lock bag.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #67) reviewed for dialysis, the facility failed to ensure four Minimum Data Set (MDS) assessments were accurately coded for dialysis. The findings include: Resident #67's diagnoses included end stage kidney disease, heart failure and diabetes. A review of the physician's orders identified Resident #67 has had an order for hemodialysis from February 2024 through January 2025 for every Tuesday, Thursday, and Saturday in the afternoon at the dialysis center. Review of the following MDS assessments identified they did not reflect that the resident was receiving hemodialysis treatments. 1. Admission MDS assessment dated [DATE] 2. Quarterly MDS assessment dated [DATE] 3. Quarterly MDS assessment dated [DATE] 4. Admission MDS assessment dated [DATE] An interview on 1/23/25 at 12:33 PM with the MDS Coordinator (RN #3) indicated dialysis should have been coded on the MDS assessments for Resident #67. RN #3 could not give a reason as to why the assessments did not reflect that the resident received hemodialysis treatments. According to RN #3, the MDS assessment process includes reviewing the nurses' notes, physician orders, any recent paperwork or documentation from the hospital, morning report meetings and the weekly risk management meetings, and all the information garnered is utilized in completing the MDS assessments. Additionally, RN #3 further identified that the resident is interviewed as a part of the process. Review of the MDS 3.0 Completion policy identified that residents are assessed using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan. According to RAI guidance when assessing a resident requiring dialysis, the assessment should thoroughly document the resident's dialysis needs, including the type of dialysis, frequency, access site and any complication and how it impacts the resident's functional ability. This information is typically captured through specific items within the MDS section of the RAI assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical record, review of facility policy/procedures and interviews for one of five sampled residents (Resident #88) reviewed for unnecessary medications and was receiving anticoagulant medication, the facility failed to ensure the care plan addressed the monitoring of possible side effects of anticoagulant medication and actions to take in the event of the need for emergent care. The findings included: Resident #88 was admitted to the facility in October 2024 with diagnoses that included type 2 diabetes mellitus, gout, and atrial fibrillation. The admission MDS assessment dated [DATE] identified Resident #88 was cognitively intact, required maximum assistance with lower body dressing, bathing, and toileting. It further identified the resident received anticoagulant medication. Review of Resident #88's care plan dated 10/31/24 failed to identify the resident was receiving anticoagulant medication and failed to have interventions in place to address monitoring for possible side effects and treatment in the event of an emergent occurrence. The physician's orders dated 12/28/24 directed to administer Coumadin (anticoagulant) in alternating doses of 3.5 mg and/or 4 mg by mouth one time a day. Review of the medication administration records (MAR) for November 2024, December 2024 and January 2025 (through 1/18/25) identified Resident #88 was administered Coumadin on a daily basis. Interview with the DNS on 1/21/25 at 8:02 AM identified that when a resident is receiving anticoagulant medication, the care plan should acknowledge the residents use of use of anticoagulant medication and interventions to address possible side effects of the medication as well as precautions that should be taken. The facility policy for high-risk medications- anticoagulants identified that the resident's plan of care shall alert staff to monitor for adverse consequences and indicated risks associated with anticoagulants to include bleeding and hemorrhage, fall in hematocrit or blood pressure, and thromboembolism. The policy further identified the plan of care should also include interventions to minimize the risk of adverse consequences. The facility policy for Comprehensive care plans identified it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical and nursing needs identified in the resident's comprehensive assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of clinical records, review of facility policy/procedures and interviews for two of three sampled residents (Resident #22 and Resident #101) observed with medications at the bedside, the facility failed to ensure that medications were administered according to acceptable standards of practice. The findings include: 1. Resident #22's diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), unspecified asthma, and dependence on supplemental oxygen. The quarterly MDS assessment dated [DATE] identified Resident #22 was cognitively intact, required moderate assistance for dressing, personal hygiene, and transfers, was independent with toileting hygiene, bed mobility and utilized a wheelchair for mobility. The care plan dated 10/1/24 identified Resident #22 had oxygen therapy related to COPD with interventions that included give medications as ordered by physician and monitor for signs and symptoms of respiratory distress and report to provider as needed. The monthly physician's order for January 2025 directed Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 micrograms (mcg) to inhale 1 puff orally twice daily and rinse after use for COPD and Fluticasone Propionate suspension 50 mcg one spray in both nostrils one time a day for allergies. Observation on 1/16/25 at 12:05 PM identified Resident #22 lying upright awake in bed wearing a nasal cannula and on the right side of the bed was a nightstand. The nightstand contained a plastic bag with a biohazard label containing: Fluticasone Propionate and Salmeterol 500/50 mcg (Advair Diskus) that was dispensed from the pharmacy used by the facility with the resident's name and a dispensed date of 10/1/2024, which indicated that there were 25 dosages left; Symbicort 160/4.5 mcg connected to a spacer which had no dosage remained; and Fluticasone Propionate 50mcg spray bottle with a label that identified the medication was dispensed from the hospital in which the resident was previously admitted from that was approximately half filled. Observation on 1/16/25 at 12:16 PM with the Unit Manager (RN #4) identified Resident #22 lying upright awake in bed wearing a nasal cannula and on the right side of the bed was a nightstand. The nightstand contained a plastic bag with a biohazard label containing: Fluticasone Propionate and Salmeterol 500/50 mcg (Advair Diskus) that was dispensed from the pharmacy used by the facility with the resident's name and a dispensed date of 10/1/2024, which indicated that there were 25 dosages remained; Symbicort 160/4.5 mcg connected to a spacer which had no dosage remained; and Fluticasone Propionate 50mcg spray bottle with a label that identified the medication was dispensed from the hospital where the resident was previously admitted from that was approximately half filled. RN #4 then took the bag containing the medications out of the resident's room. Resident #22 identified that the last time he/she used those medications were about a month ago and it was the nurses who left the medication there for convenience. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two of the medications within the bag (Fluticasone Propionate and Salmeterol 500/50 mcg (Advair Diskus) and Fluticasone Propionate suspension 50 mcg) was identified as Resident #22's prescribed medications. Review of Resident 22's clinical records failed to identify a physician's order directing self-administration of medication or a completed self-administration assessment. Review of the electronic Medication Administration Record (MAR) with the Charge Nurse LPN #3 on 1/16/25 at 12:25 PM identified Fluticasone Propionate suspension 50 mcg and Advair Diskus are scheduled for 9:00 AM were signed off as administered by LPN #3. Interview with LPN #3 on 1/16/25 at 12:25 PM identified that she had signed the MAR this morning after asking the resident if he/she had taken the inhaler and the nasal spray, as the resident is alert and could answer. LPN #3 further identified that she only administers Resident #22's oral (PO) medications, and the resident would administer the inhaler and the nasal spray (respiratory medications). LPN #3 identified she was aware that the medications were at the bedside as the resident prefers to administer his/her own inhaler and nasal spray. LPN #3 indicated she assumed the resident had an order for self-administration as the medications are left at the bedside for as long as the resident been on the unit since at least October of 2024. Interview with the Nursing Unit Manager (RN #4) on 1/16/25 at 12:16 PM identified medications should not be left at the resident's bedside without a physician's order and a self-administration assessment. RN #4 identified she was not aware of the resident having medications at the bedside as Resident #22 had never had a self-administration order since admission. Interview with the DNS on 1/17/25 at 1:35 PM identified on admission residents are screened for self-medication administration, in which Resident #22 had responded no to self-medication administration. The DNS added that if the resident wanted to self-administer medication an assessment is completed to assess what the resident can self-administer and whether the medication could be left at the bedside. The DNS added that if the medication was to be stored at the bedside, it should be in a locked box with both the resident and nurse having the key to the box. The further identified medications should not be stored at the bedside without having an order and an assessment completed. Interview with the Respiratory Therapist on 1/17/25 at 2:15 PM identified he was not aware that Resident #22 had the inhaler left at his/her bedside for the resident to self-administer and noted he/she requires the supervision of the nurse because the resident is non-complaint. He further identified that if the resident does not take the inhaler as ordered, it can result in bronchial spasm, decrease in saturation and increased shortness of breath. Review of the Resident Self-Administration of Medications policy identified that a resident may only self-administer medications, after the facility interdisciplinary team has determined which medication were safe to self-administer. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facilities. The policy further identified that all nurses and aides are required to report to the charge nurse on duty on duty any medication found at the bedside not authorized for bedside storage. 2. Resident 101's diagnoses included kidney disease, high blood pressure and gout. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment dated [DATE] identified Resident #101 was moderately cognitively impaired, required max assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident required a mechanically altered diet. The care plan dated 11/12/24 identified Resident #101 was at risk for self-care deficit related to need for assistance, with interventions that included providing the resident assistance with dressing, bathing, bed mobility and assist of 2 for transfers. Physician's order(s) dated 9/5/24 directed to administer protein liquid 30 milliliters (ml) one time a day at 9:00 AM. The nurse's quarterly assessment dated [DATE] at 2:12 PM identified Resident #101 did not want to self-administer his/her own medications. Observation on 1/16/25 at 12:04 PM in Resident #65's room, identified a medication cup containing 30 milliliters (ml or 1.014 fluid ounces) of a red colored liquid left in front of the resident on the overbed table. The resident was found sleeping at that time. Also noted, mupirocin ointment 2% in a plastic zip lock bag with Resident #101's name on it left on the dresser. Interview with the DNS on 1/17/25 at 1:37 PM indicated the self-administration assessments were completed when a resident wants to self-administer and upon admission to the facility, and when a resident is assessed and able to self-administer, they are provided with a lock box which is kept at the bedside. The resident and nurse would each have a key to the lock box. Residents should be assessed for self-administration upon admission and if requested and should have a physician's order in place for self-administration. Interview with Resident #101 on 1/17/25 at 1:49 PM identified the only medication left at bedside daily is the red stuff. The resident also indicated the nursing staff stand and watch the resident take the medications, except the red stuff. Resident #101 was unable to recall what the red liquid was. The resident felt that it was o.k., as he/she was able to self-administer the red liquid. Resident #101 did not know what the ointment was in the plastic bag. Interview with the DNS on 1/22/25 at 11:03 AM, indicated the process for evaluating a resident for self-administration of medications, included an evaluation for safety, and education. If the resident is found to be safe/competent to self-administer, then a doctor's order is obtained identifying the resident may self-administer. A lock box is then kept in the resident's room containing the medications. Both the nurse and resident have a key. Review of the Resident Self-Administration of Medications policy directed, in part, that a resident may only self-administer medications, after the interdisciplinary team has determined which medications were safe to self-administer. Each resident was offered the opportunity to self-administer medications during the routine assessment by the facilities interdisciplinary team. 48335

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on review of clinical records, review of facility documentation, review of facility policy, and interviews for one of three sampled residents (Resident #44) reviewed for activities of daily living (ADL), the facility failed to ensure showers were provided as scheduled. The findings include: Resident #44's diagnoses included muscle weakness, difficulty walking, and abnormalities of gait and mobility. The annual MDS assessment dated [DATE] identified Resident #44 was moderately cognitively impaired, required supervision with bed mobility, supervision with toileting, required partial to moderate assistance with bathing and utilized a walker and wheelchair for mobility. The care plan dated 1/3/25 identified Resident #44 had an ADL self-care performance deficit with interventions that included: provide resident with level of care for bathing and showering, break tasks into sub tasks if needed, and shower and bath on specified day/shift. Interview with Resident #44 on 1/17/24 at 3:00 PM identified that in the last two months he/she has only received two showers. Review of the nurse aide care card indicated Resident #44 was scheduled for a shower every Tuesday and Saturday on the second shift. Review of the Nurse Aide (NA) charting documentation for November 2024, December 2024 and January 2025 identified Resident #44 was showered twice in the last three months when he/she is scheduled to be showered twice weekly. Additionally, the documentation failed to identify the reason why the showers were not conducted. Interview with NA#4 on 1/23/24 at 9:35 AM identified she works both 1st and second shift and that each day the Nurse Aide care tasks prompts them if a shower/bath is scheduled and if it is not given, they mark N/A. If the shower is conducted, they document yes and if the resident refuses the shower, there is an area to document the refusal. She further noted that if for any reason the resident is unavailable for the scheduled shower, there is an area to document that. Additionally, NA #4 noted that she has worked with Resident #44 and noted that the resident does not refuse showers. She further noted if a resident refuses a shower, he/she should be reapproached and that also should be documented. Interview with the DNS on 1/23/25 at 12:54 PM identified that she was unsure what the N/A meant in the nurse aide documentation but if a resident did not get showered on a specific day and time, the expectation would be that it was documented, and the resident reapproached. The nurse on the unit should also be notified. The DNS further identified that each resident is expected to be showered according to their scheduled shower day and time and if that cannot be done or a resident does not like their scheduled time, then they need to make efforts to accommodate the resident's request. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities of Daily Living (ADLs) policy identified care, and services will be provided for the following activities of daily living included bathing, dressing, grooming and oral care. The policy further identified that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 47900

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observation, review of the clinical records, review of facility policy, review of facility documentation, and interviews for one of four sampled residents (Resident #22) reviewed for accidents, the facility failed to ensure that medications were administered as prescribed by the physician. The findings include: Resident #22's diagnoses included respiratory failure, chronic obstructive pulmonary disease (COPD), asthma, and dependence on supplemental oxygen. The quarterly MDS assessment dated [DATE] identified Resident #22 was cognitively intact, required moderate assistance for dressing, personal hygiene, transfers, and independent with toileting hygiene and bed mobility. The assessment further identified the resident utilized a wheelchair independently for mobility. The care plan dated 10/1/24 identified Resident #22 had oxygen therapy related to COPD with interventions that included give medications as ordered by physician and monitor for signs and symptoms of respiratory distress and report to provider as needed. Review of the physician's orders from October/2024 through January 17, 2025, directed to administer Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 micrograms (mcg) to inhale 1 puff orally twice daily and rinse after use for COPD and Fluticasone Propionate suspension 50 mcg one spray in both nostrils one time a day for allergies. Observation on 1/16/25 at 12:16 PM with the Unit Manager (RN #4) identified Resident #22 lying upright awake in bed wearing a nasal cannula and on the right side of the bed was a nightstand. The nightstand contained a plastic bag with a biohazard label containing: Fluticasone Propionate and Salmeterol 500/50 mcg (Advair Diskus) that was dispensed from the pharmacy used by the facility with the resident's name and a dispensed date of 10/1/2024, which indicated that there were 25 dosages remained; Symbicort 160/4.5 mcg connected to a spacer which had no dosage remaining; and Fluticasone Propionate 50mcg spray bottle with a label that identified the medication was dispensed from the hospital where the resident was previously admitted from that was approximately half filled. RN #4 then took the bag containing the medications out of the resident's room. Resident #22 identified that the last time he/she used those medications were about a month ago and it was the nurses who left the medication there for convenience. Observation and review of the medication cart on the B wing unit with the Nursing Unit Manager (RN #4) on 1/16/25 at 12:17 PM identified Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 mcg dispensed from the pharmacy on 12/1/24 with 59 dosages remaining but failed to identify Fluticasone Propionate suspension 50 mcg suspension spray. RN #4 and the Charge Nurse (LPN #3) reviewed the medication storage room which contained overstock supplies, also failed to identify any Fluticasone Propionate suspension 50 mcg spray and Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 mcg belonging to Resident #22. (continued on next page)

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	075341	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pendleton Rehabilitation and Nursing Center	44 Maritime Drive Mystic, CT 06355

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the MAR with the Charge Nurse (LPN #3) on 1/16/25 at 12:25 PM identified that she had signed the MAR that morning after asking the resident if he/she had taken the inhaler and the nasal spray, as the resident is alert and could answer. LPN #3 further identified she only administered oral medication to the resident and that the resident does his/her respiratory medication such as the inhaler and the nasal spray. LPN #3 identified that when supplies are running low, the resident would let the nurse know to reorder the medication. Interview with the Pharmacy Technician on 1/21/25 at 10:21 AM identified Fluticasone Propionate 50mcg nasal spray was last dispensed to the facility on [DATE] for a physician order dated 7/10/24, however the order was discontinued on 7/22/24. She further identified that Fluticasone Propionate 50mcg spray was then reordered and dispensed on 1/17/25 and contains a total of 120 sprays, which would last a total of 2 months. The Pharmacy Technician further identified Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 microgram was dispensed to the facility on [DATE] containing 60 quantity (dosage) and on 12/1/24 containing 60 dosages. She added each of the Fluticasone-Salmeterol medication dispensed contained a 30-day supply as the resident was ordered to receive the medication twice daily and medication is due to be reorder but the pharmacy has not received a refill order from the facility since the last dispense date of 12/1/24. The Pharmacy Technician further identified that medication is not automatically dispensed to the facility, and the facility must reorder medications via fax, telephone call or electronically. Review of Resident #22's Medication Administration Record (MAR) for Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 microgram (mcg) is schedule to be administered at 9:00 AM and 9:00 PM identified the resident received the medication: From October 2, 2024, through October 31, 2024, a total of 50 times From November 1, 2024, through November 30, 2024, a total of 56 times From December 1, 2024, through December 31, 2024, a total of 60 times. From January 1, 2025, through January 16, 2025, a total of 31 times. Based on the MAR from October 2, 2024, to January 16, 2025, the resident received Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 mcg a total of 196 dosages when the pharmacy dispensed only a total of 120 dosages to the facility from October 1, 2024, to January 16, 2025. Review of Resident #22's Medication Administration Record (MAR) for Fluticasone Propionate suspension 50 mcg identified it was scheduled to be administered at 9:00 AM identified the following: From October 2, 2024, through October 31, 2024, a total of 26 times. From November 1, 2024, through November 30, 2024, a total of 28 times From December 2, 2024, through December 31, 2024, a total of 30 times. From January 1, 2025, through January 16, 2025, a total of 16 times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the MAR from October 2, 2024, to January 16, 2025, the resident received Fluticasone Propionate suspension 50 mcg a total of 100 dosages when the pharmacy last dispensed the medication on 7/10/24 a bottle containing a total of 120 spray to the facility. Interview with the Pharmacist on 1/21/25 at 10:38 AM identified that an adverse effect of the resident not taking his/her Advair Diskus Inhalation (Fluticasone-Salmeterol) Aerosol Powder Breath Activated 500-50 mcg as ordered can result in the worsening of the resident's COPD diagnosis. He further identified that if the resident is not taking the Fluticasone Propionate nasal spray as order that the resident allergies would not be resolved, his/her symptoms will continue. Interview with the DNS on 1/22/25 at 9:58 AM identified that the MAR should be signed at the time when the medication is administered to the resident. The DNS further identified that medications are ordered by the nurses on the unit. She indicated that Resident #22 would have other pharmacies delivery medication to the facility in the past and the resident was educated but is unable to identify if the resident had received any outside medications recently. The DNS added that the pharmacy was unable to provide a written dispensary report of the medications but when she called the pharmacy, they provided the same information that the nasal spray was not ordered until 1/17/25 and the inhaler was ordered on 10/1/24 and 12/1/24. Interview with the Charge Nurse (LPN #5) on 1/21/25 at 11:38 AM identified that when asked if she had administered Resident #22's inhaler and nasal spray as ordered, would the medications supply be completed and did she recall having to reorder any of the medications given that the pharmacy last sent the inhaler on 12/1/24, which she responded the supply on hand would have been completed and that she could not recall reordering any of those medications for the resident. She indicated that she was with the resident whenever she had administered his/her inhaler and nasal spray medication, and medications are ordered when the resident has only 3 days' supply left. Review of the Medication Administration policy identified medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice. The policy further identifies to observe resident consumption of medication and sign MAR after administration.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for one of five sampled residents (Resident #18), reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was administered as requested by the resident upon admission. The findings include: Resident #18 was admitted to the facility in June of 2024 and had diagnoses that included cervical disc disorder with myelopathy, unspecified dementia, and chronic obstructive pulmonary disease (COPD) with exacerbation. The quarterly MDS assessment dated [DATE] identified Resident #18 was cognitively intact, and the assessment further identified Resident #18 pneumococcal vaccination was not up to date. Review of the Immunization Report identified Resident #18 received pneumococcal conjugate (PCV 13) historically (prior to admission to the facility) on 12/7/2015 and pneumococcal polysaccharide (PPV23) historical on 12/4/2017. Review of the Pneumococcal Immunization Informed Consent form for pneumococcal vaccination identified that Resident #18 legal representative gave the facility permission to administer the pneumococcal vaccine PCV 20 on 6/29/24. Review of Resident #18 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision. Interview with the Infection Preventionist Nurse (RN #2) and the Regional Clinical Manager (LPN #2) on 1/21/25 at 12:01 PM identified RN #2 was responsible for reviewing the immunization consent forms after they were signed by the resident or responsible party, obtain the physician's order for the appropriate vaccine and herself or the nurse on the resident unit would then administer the vaccine. Both RN #2 and LPN #2 identified that Resident #18 had not received the vaccine nor was the resident's pneumococcal vaccine history and request for the PCV 20 vaccine discussed with the physician. RN #2 identified that based on Resident #18's pneumococcal vaccination history he/she would be eligible for the PCV 20 vaccine, however she would need to consent with the physician given that the resident had received two of the pneumococcal series. RN #2 further identified she could not recall discussing Resident #18's pneumococcal vaccination with the resident's primary physician. Interview with MD #1 (Resident #18's primary physician) on 1/22/24 at 11:00 AM identified he had no recollection of anyone calling him regarding Resident #18's had requested to receive the PCV 20, as if he did, he would have approved the resident to receive the vaccine. MD #1 further added he would not go ahead an order a pneumococcal vaccine for a resident who had received two of the pneumococcal vaccine series but if the resident requested and consented, he would have approved the order for the resident to receive the vaccine as he is aware that the guidance have changed. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pneumococcal Vaccine (series) policy identified each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. Also, following assessment for any medical contraindications the immunization may be administered in accordance with physician-approved standing orders. The policy further identified they can get PCV20 or PCV21 if they have received both PCV13 (but not PCV 15, PCV20, or PCV21) at any age and PPSV23 at or after the age [AGE] years old.