STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Sheriden Woods	321 Stonecrest Drive Bristol, CT 06010

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy/procedures, and interviews for two of three sampled residents (Residents #2 and #37) reviewed for pressure ulcers, the facility failed to ensure that a resident at risk for the development of a pressure injury and had an existing pressure injury had patient-centered preventative interventions and treatments that were implemented based on the resident's diagnoses and positioning risk factors contributing to the development and worsening of a pressure injury. The findings include: Resident #2 was readmitted to the facility in September 2025. Diagnoses included Type 2 diabetes mellitus without complications, Sjogren syndrome, chronic combined systolic (congestive and diastolic (congestive) heart failure. A review of physician's orders for the period of 9/26/25 through 10/7/25 identified an order that directed to apply triad paste to the buttocks for wound/skin care. The care plan dated 10/2/25 identified Resident #2 was at risk for skin breakdown related to decreased mobility and moisture with interventions that included an alternating pressure mattress (APM) set at 200 lbs., inspect skin for redness, irritation or breakdown during care, offer turning and repositioning approximately every 2 hours and as needed (PRN) and complete weekly skin inspections. The Norton Plus Assessment (determines the risk of developing pressure ulcers), dated 10/6/25 identified Resident #2 scored 11 which indicated Resident #2 was at high risk. The annual MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition, utilized a wheelchair, was dependent for transfers, showering and toileting hygiene, was always incontinent of bladder and frequently incontinent of bowel, was at risk for developing a pressure injury but did not have any unhealed pressure ulcers/injuries, or other ulcers, wounds or skin problems and had a pressure reducing device for chair, pressure reducing device for bed, and application of nonsurgical dressings and applications of ointments/medications. The wound nurse's progress note dated 10/7/25 at 5:24 PM identified Resident #2 was seen for wound care. Buttocks inspected- blanchable erythema with small, superficial denuded areas. Presentation consistent with MASD (moisture associated skin deterioration). The note further indicated the APRN was updated and a foam dressing was added to the triad paste. The note identified the APM was in place and a ROHO cushion was requested from therapy. The physician's order dated 10/7/25 directed to apply triad paste to buttock followed by foam dressing every day on night shift for wound/skin care, apply ROHO cushion to the wheelchair and (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	check proper cushion and placement every shift. The nursing progress note dated 11/7/25 at 3:13 PM identified Resident #2's coccyx had blanchable erythema with protective dressing in place. The nursing progress note dated 12/5/25 at 3:27 PM identified Resident #2 had loose, liquid bowel movements with malodorous odor and indicated the sacral area was noted with skin irritation consistent with incontinence associated dermatitis with an order for triad ointment in place. The physician's order dated 1/28/26 directed wound/skin care to apply triad paste to buttock followed by foam dressing every day, every night shift. Interview with Resident #2 on 2/19/2026 at 2:16 PM identified complaints of a rectal/back sore and indicated the soreness was related to having to sit in wet briefs due to staffing constraints on some days. Observation at this time noted the APM was set at 250 lbs. and identified a container of Aquaphor ointment on the side table. Resident #2 indicated that he/she had been provided with incontinent care but had not been out of bed. Resident #2 identified that she/he required the use of a Hoyer and two staff members for transfers. Observation of Resident #2 on 2/26/26 at 11:17 AM identified Resident #2 was still in bed and had not been cleaned up for the day. Resident #2 indicated that he/she had not been changed since night shift and was waiting for staff to come in. Resident #2 identified that the Aquaphor is on the bedside table, so it is readily accessible but indicated that it is not being placed on the rectum and that the rectum and back continue to have pain to the point that staff has started placing pillows on each side under his/her hips to alleviate some of the pressure at his/her request. Interview with NA #4 on 2/26/26 at 12:08 PM identified that this was the first time that day that she was providing care to Resident #2. NA #4 indicated that she approached the resident's room around 10:00 AM and a visitor was present, so she decided to reapproach later. NA #4 identified she could not identify when the resident had last been provided with incontinent care and indicated she asked the nurse for direction on patient care because the unit was so fast paced. NA #4 had provided most care prior to the nurse notifying this surveyor that care was being provided and indicated that the wound dressing had been saturated with urine. Observation of Resident #2 on 2/26/26 at 12:10 PM identified the old dressing was in the trash and it was dated 2/26/26, 11-7. Observation of Resident #2's skin identified a wound to the sacral/coccyx area on the lower back just above the buttocks that had an open area present with yellow drainage and slough (devitalized tissue) present. The wound edges were irregular and partially macerated, and the surrounding skin was discolored and scarred. Interview with LPN #6 on 2/26/26 at 12:13 PM identified Resident #2's dressing was placed on the night shift. She further noted that it needed to be changed due to being saturated with urine. LPN #6 indicated that this was the first time she had been into Resident #2's room for care. Interview with the Medical Director on 2/26/26 at 12:57 PM identified that he did not make decisions regarding wound care treatment and that if staff comes across a wound, it would be referred to the wound nurse and the wound APRN. The Medical Director indicated that he was not aware if the APM setting impacted wound healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Supervisor RN#2 on 2/26/26 at 1:07 PM identified that every resident in the facility gets a weekly skin check. RN#2 indicated the order should be placed on admission and would coordinate with the resident's shower day and prompt the nurse to complete the weekly skin check. RN#2 reviewed Resident #2's clinical chart which failed to identify an order for a weekly skin audit and failed to identify weekly skin audits. RN#2 identified that any new skin problem would immediately get referred to the wound nurse and indicated that although the wound nurse put a treatment order in on 10/7/25, there was not an assessment or monitoring of Resident #2's sacrum. RN #2 identified that the wound APRN had not seen Resident #2 for the sacral wound. Interview with LPN #11 on 2/27/26 at 6:35 AM identified she worked nights (11 pm to 7 am shift) and completed wound care on Resident #2. LPN #11 indicated the treatment had been in place for a long time and the nursing supervisor or the wound nurse would be notified of wound deterioration. Interview with the Staff Development Nurse (RN#1) on 2/27/26 at 6:55 AM identified new skin problems found should be reported to the nursing supervisor who would do an assessment that included measuring the wound. Interview with APRN#1 on 2/27/26 at 11:09 AM identified she referred to Resident #2's sacral area as a Stage 2 because it was in a previous note. APRN#1 indicated that when she looked at the wound, she thought it was being monitored. APRN#1 identified the wound should be monitored by nursing and should have been seen by the wound nurse. After surveyor inquiry a physician's order dated 2/26/26 directed to cleanse the stage 2 pressure wound to the sacrum with normal saline followed by triad cream and cover with a foam dressing. It further noted to change the dressing daily on the evening shift and as needed. Interview with the Corporate Nursing Director (LPN#3) identified that the initial assessment of a wound should include measurements, assessment, drainage amount and should be monitored. Interview with the wound RN on 3/2/26 at 10:59 AM identified Resident #2 was being seen for other wounds but had not been seen until 3/1/26 by the wound APRN. The wound RN indicated that every resident should have weekly skin checks by nursing and wounds should be referred to the wound nurse. The wound RN identified the original treatment was placed for a macerated area caused by incontinence. Interview with APRN #2, (wound APRN) on 3/2/26 at 3:54 PM identified she observed Resident #2's sacral area yesterday for the first time. APRN#2 indicated that she should have seen the area earlier and that the area looked like incontinence that had recurred. APRN #2 identified that people with moisture associated skin issues are 33 percent more susceptible to developing a pressure injury. Review of the clinical record failed to identify that the resident's wound(s) to the buttocks/sacral areal that was identified on 10/7/25 as MASD was monitored and assessed on a weekly basis. The record failed to note size, drainage and/or changes (deterioration) with the wound. The wound subsequently developed into a questionable stage 2 pressure injury. The dressing order was not changed from the time of its inception on 10/7/25. The wound nurse did not assess the wound and therefore the wound was not evaluated by the facility's wound APRN. The resident was also observed to not receive timely incontinent care on 2/26/26. All of these factors may have contributed to the development and worsening of a pressure injury wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Pressure Ulcer Risk Assessment identified risk factors that increase a resident's susceptibility to develop or to not heal pressure injuries included impaired/decreased mobility and decreased functional ability, exposure of skin to urinary and fecal incontinence, altered skin status over pressure points, conditions such as diabetes mellitus, and indicated that documentation in the medical record addressing MD notification if a new skin alteration noted with change of plan of care and initiation of a pressure or non-pressure related to the type of alteration in skin if new skin alteration noted. The facility policy for Prevention and Management of Pressure Injuries identified assessment to include observation of the resident's skin daily with care, body audits completed weekly by the licensed staff and pressure injuries are to be assessed and documented on at least weekly and with a significant change in the wound until it is resolved. The policy indicated that an RN assessment is required weekly for all wounds (pressure and non-pressure) and identified if a wound is not showing progress toward healing within 2-4 weeks, the resident's clinical condition, interventions and treatment plan will be evaluated for possible modifications. The facility's policy for Pressure Injury/Non-pressure Wound Risk Management identified that residents who score at risk for skin impairment or have actual skin impairment are provided with care to address risk factors and goals of treatment and interventions include reposition approximately every 2 hours or more frequently and to check resident for incontinence approximately every 2 hours or per individualized plan of care Resident #37 was admitted to the facility in January of 2026 with diagnoses of Parkinson's disease, thoracogenic scoliosis, kyphosis, and severe protein calorie malnutrition. The admission nurse's progress note dated 1/21/26 at 5:57 PM identified Resident #37's skin was intact with a deep tissue injury (DTI) noted to the left heel and multiple age indeterminant compression fractures at thoracic (T) 6, T8, T10, T 11 and Lumbar (L) 1 was noted in the hospital. The Norton Plus Assessment (used to predict risk for pressure ulcer development) completed on admission dated 1/21/26 identified the resident had a score of 16 which is indicative of the resident being at medium risk for the development of a pressure ulcer. The admission MDS assessment dated [DATE] identified Resident #37 had moderate cognitive impairment, was dependent on staff for lower body dressing, and transfers, utilized a manual wheelchair and required maximal assistance for bed mobility, toileting hygiene, and upper body dressing. The assessment further identified Resident #37 was occasionally incontinent of urine and always continent of bowel and was at risk for developing pressure ulcers and had two stage 2 pressure ulcers with treatments that included pressure reducing device for chair and bed, nutrition or hydration intervention and application of a dressing to feet. The Resident Care Plan (RCP) dated 1/21/26 identified Resident #37 was at risk for skin breakdown with interventions that included inspecting the skin for redness, irritation or breakdown during care, pressure reducing cushion/mattress as needed, offload heel as tolerated, weekly skin inspections, toileting and incontinent care as needed and nutrition/hydration assessment. Review of Resident #37's initial care plan failed to identify a resident specific intervention related to the positioning of the resident and based on his/her diagnoses of thoracogenic scoliosis and kyphosis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's order dated 1/21/26 directed to complete skin checks every Tuesday on shower/bath day on the 7:00 AM to 3:00 PM shift, apply protective ointment to intact skin for incontinent care by cleansing the area and pat dry thoroughly. The physician's order failed to direct care/treatment regarding positioning related to Resident #37's thoracogenic scoliosis and kyphosis diagnosis. The Norton Plus assessment dated [DATE] identified a score of 12 which is indicative of the resident being at a high risk for the development of a pressure ulcer. Review of the weekly skin audit dated 2/2/26 at 11:34 AM identified Resident #37 had no new skin impairments since the last review. Review of the initial pressure injury evaluation dated 2/3/26 at 2:40 PM identified Resident #37 had a facility acquired stage 2 pressure injury to the left inferior mandible measuring 1.2 centimeters (cm) in length by 2.0 cm in width by 0.3cm in depth with small amounts of serosanguinous drainage. The evaluation failed to identify the current treatment that was implemented. Review of the RCP dated 2/3/26 identified Resident #37 had a stage 2 pressure ulcer underneath the chin with interventions that included alternating pressure mattress at cycle 10 for 165lbs, a ROHO cushion to the wheelchair, wound treatment daily and as needed, dietary consultation and to check skin integrity every shift. However, the interventions identified on the care plan did not specifically address the pressure ulcer underneath the chin to prevent the area from worsening. The nursing progress note created by RN #6 dated 2/3/26 at 2:19 PM from the Wound APRN (APRN #2) note identified Resident #37 was seen by APRN #2 for wound care and the following impression and plan was identified: an area to the left inferior mandible that had a dusky dull red color stage 2 pressure injury measuring 1.0 centimeter (cm) in length by 2.0 cm in width and 0.3 cm in depth with scant to absent serous drainage, no odor, peri wound unremarkable without evidence of pressure and recommended to start wound care to the left anterior mandible daily and as needed with checks to rinse the area with normal saline apply hydrogel saturated gauze and cover with dry gauze, then unfold kerlix and fold so that there is at least 4-5 inches of fluff and place under mandible. The note further identified the recommendation was reviewed and approved by APRN #1. The APRN #1's progress note dated 2/6/26 at 12:30 PM identified the wound consult was appreciated and reviewed and to initiate comprehensive wound care as ordered to left inferior chin to shave daily and cleanse the wound with normal saline, dry, then apply Medihoney followed by superabsorbent dressing daily and as needed, and to apply fluffed Kerlix roll in between chest and chin for cushioning to offload pressure. Review of the physician's order dated 2/6/26 directed wound care to the left inferior chin, to shave daily and cleanse open area on chin with normal saline pat dry then apply Medihoney alginate followed by foam dressing daily and as needed, then apply fluffed kerlix roll in between chest and chin for cushion. Review of the Treatment Administration Record (TAR) from the period of 2/3/26 to 2/6/26 identified the dressing to the chin (left inferior mandible) was first started on 2/7/26 as indicated on the TAR. Therefore, the facility failed to implement the recommendation identified by the wound APRN on 2/3/36 until 2/6/26 nor had the facility implemented any other treatments when the area to the left inferior mandible was initially identified on 2/3/26. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the follow-up weekly Pressure Injury Evaluation dated 2/9/26 identified Resident #37 had a stage 2 pressure injury to the left inferior mandible measuring 2.0 cm in length by 3.0 cm in width by 0.4 cm in depth with small amount of serosanguinous drainage. The nursing progress note created by RN #6 dated 2/9/26 at 2:49 PM from APRN #2 note identified Resident #37 was seen by APRN #2 for wound care and the following impression and plan was identified: the left inferior mandible had a dusky dull red stage 2 pressure injury measuring 2.0 cm in length by 3.0 cm in width by 0.3 cm in depth with scan to absent serous drainage and no odor. APRN #2 recommended to continue with current wound care. The nursing progress note created by RN #6 dated 2/17/26 at 3:55 PM from APRN #2 note identified Resident #37 was seen by APRN #2 for wound care and the following impression and plan was identified: the left inferior mandible had a dusky dull red stage 4 pressure injury measuring 2.0 cm in length by 3.0 cm in width by 0.4 cm in depth with a gray center that was hard to touch and presumably bone with scan to absent serous drainage, no odor and peri wound unremarkable. APRN #2 recommended to continue with current wound care. Interview with the Wound Nurse (RN #6) on 3/2/26 at 11:08 AM identified he works 16 hours weekly as the wound nurse and oversees the infection control nurse. He identified that Resident #37 had asked him to look at his/her chin when he identified the resident had a stage 2 pressure injury to the area. RN #6 further identified he saw a travel pillow at the resident's bedside, and a neck collar which the resident uses to place around his/her neck due to his/her kyphosis. He indicated when he called the resident's family to notify them of the open area to the chin, they indicated to him it was not new and that the resident had a scab to the area and utilized a travel pillow around his/her neck. RN #6 identified that the admission assessment did not identify a scab or an open area to the mandible, so the wound was then identified as a facility acquired pressure injury. RN #6 identified the resident did not have a physician's order in place for the use of the collar nor the neck pillow. He further identified the resident did not have any interventions for his/her chin touching the chest on admission as they did not identify it as a risk for the development of a pressure ulcer until it was developed. He identified that the pressure injury dated 2/17/26 for the mandible was identified as a stage 2 but should have been a stage 4. Interview with the Nursing Supervisor (RN #4) on 3/2/25 at 1:00 PM identified that the skin check is completed on admission by the nursing supervisor and the charge nurse as the LPN's are not allowed to assess. RN 4 identified that she cannot recall seeing an open area to the resident's mandible (chin) area on admission, just skin issues to his/her heel and coccyx as indicated in the notes. She identified Resident #37 was able to hold his/her head up, and the resident neck did tilt forward but it did not rest on his/her chest. RN #4 identified the resident family member had brought in a neck pillow and collar in which the resident would position around his/her neck, however there were no physician's order or interventions in place on admission for his/her neck usage and that she had put in an order for occupational therapy (OT) evaluation. Interview with the Occupational Therapist (OT #2) in the presence of the Director of Rehabilitation (PT#2) on 3/2/26 at 12:30 PM identified that Resident #37's family member brought in a neck collar which Resident #37 wore at home but did not like to use. OT #2 indicated that the neck collar was not the appropriate size for the resident to use, and if used by the resident it would have caused pressure to the area. She identified the resident was on therapy for strengthening, and she would perform exercises and stretches to strengthen the resident's neck. OT #2 identified resident had a 2-inch gap between his/her neck and chest, and she had been trialing the resident with different adaptive (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acute pressure on the periphery measuring 3.5 cm in length by 3.5 cm in width, and 0 cm in depth with moderate amounts of serosanguinous drainage and no odor and recommends to make sure there is a pillow between the resident and the back of the wheelchair, place a ROHO cushion in wheelchair, limit out of bed time to two hours daily, resident to be positioned side to side when in bed except for meals, discontinue current treatment to coccyx wound and start the following daily; rinse the wound with normal saline apply hydrogel saturated gauze and cover with superabsorbent dressing. The note further identified the recommendation was reviewed and approved by APRN #1. The RCP dated 2/3/26 identified Resident #37 had a stage 2 pressure ulcer underneath the chin with interventions that included alternating pressure mattress at cycle 10 for 165lbs, a ROHO cushion to the wheelchair, wound treatment daily and as needed, dietary consultation, heel boots on always and to check skin integrity every shift. Review of the physician's order dated 2/6/26 directed wound care to coccyx to rinse area with normal saline, apply hydrogel saturated gauze and cover with superabsorbent dressing on daily on Monday, Wednesday and Thursday and as needed; alternating pressure mattress to set to cycle 10, 165 pounds and to check function and setting every shift, check placement of the gauze roll in between the chin and chest every shift and replace as needed; and apply ROHO cushion to wheelchair and to check placement and inflation every shift. The physician's order and care plan failed to reflect the recommendation made by APRN #2 2/3/26 to limit out of bed time to two hours daily, resident to be positioned side to side when in bed except for meals was implemented nor did the clinical records identified the recommends were not accepted by the attending provider. The nursing progress note created by RN #6 dated 2/17/26 at 3:55 PM from the APRN #2 note identified Resident #37 was seen for wound care and the following impression and plan was identified: an unstageable pressure injury to his/her coccyx with thinning yellow eschar with early granulation buds now noted measuring 2.8 cm in length by 3.0 cm in width by 0.1 cm in depth with moderate amounts of serosanguinous drainage and no odor. APRN #2 recommended to continue with current wound care. Interview with the Wound APRN (APRN #2) on 3/2/26 at 4:01 PM identified that based on the location of the mandible pressure ulcer it would not take a long time for the pressure ulcer to worsen. She further identified the resident had a previous injury to the area prior to admission and utilized a neck pillow which was not known until after the resident was admitted to the facility. When asked if the pressure ulcers were unavoidable APRN #2 identified that there are several contributing factors that can lead to the worsening and the development of the pressure ulcer. APRN #2 identified positioning was one of the contributing factors for this resident to develop and for the worsening of the pressure injury. APRN #2 identified she had not seen a positioning plan in place for the resident as the resident was utilizing a wheelchair he/she used in another facility that was not appropriate for the resident. She further identified the cushion that was in the wheelchair as thick enough and had recommended the ROHO cushion. Review of the Prevention of Pressure Injury policy identified assessing the resident on admission (within eight hours) for existing pressure injury risk factors and repeating the risk assessment weekly and upon any changes in condition. Review of the Prevention and Management of Pressure Injuries policy identified the facility is (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dedicated to preventing pressure injuries and to developing a preventative plan of care based on individual needs. The policy identifies the necessary treatment, and services will be provided to promote healing, prevent infection and prevent new pressure injuries from developing. The policy further identified on admission/readmission a comprehensive assessment of the resident will be completed which will include the following: a head-to-to-toe skin assessment in a manner that respects the resident's dignity and a comprehensive clinical assessment to identify specific physical and functional risk factors associated with pressure ulcer development. In addition, the policy indicated that in Connecticut, an RN assessment is required weekly for all wounds (pressure and non-pressure) and upon identification of any new wounds.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure a control drug reconciliation process was in place. The findings includeReview of the 2024, 2025, control drug and receipt program identified 9 yellow control drug and receipt disposition records in the 2025 binder that were not matched up with the white control drug and receipt disposition record (CDR.) Oxycodone IR tab 5mg CDR#1399084 Received 11/27/25Oxycodone IR tab 5mg CDR#1399086 Received 11/27/25Pregabalin Cap 200mg CDR#1493284 Received 1/21/26Oxycodone IR tab 5mg CDR#1505372 Received 10/25/25Morphine ER tab 30mg CDR#1399082 Received 11/27/25Morphine ER tab 30mg CDR#1399083 Received 11/27/25Oxycodone tab 10mg CDR#1399088 Received 11/27/25Lorazepam Conc. 2mg/ml 30ml CDR#1462405 8/23/25Morphine Conc. 20mg/ml 30ml CDR#1462406 8/23/25Review of the 2024 reconciled control drug receipt dispositions identified:Morphine Sol 100mg/5ml received 11/12/24 with a remainder of 14.5ml with no evidence of where the remainder of the medication was located.Lorazepam tab 1mg Received 11/26/24 with a remainder of 23 tablets with no evidence of where the remainder of the medication was located.Interview on 3/2/26 at 3:15pm with the DNS identified the process of control drug receipt dispositions has been a mess since she started in October of 2025. The process is they are supposed to get the yellow copy of the narcotic sheet and put it in a binder until the white copy comes to them in the nursing office to match up. The DNS further identified she had delegated the control reconciliation to first the RN#6(IP) who would come on the weekend to organize and then to RN#3 who is per diem who has been auditing and organizing the control drug dispositions. Some of the medications may have gone home with the residents and sometimes they take the white sheet home. The DNS further identified that she knows she is ultimately responsible for all the medication in the building but will not take responsibility for the medications before she started in October. The DNS herself has not reconciled the medication.Interview on 3/2/26 at 3:20PM with RN#3 identified she has been coming in to work on the organization of the control drug system. She completes audits and has identified several medications in which she did not have a white sheet to match the yellow sheet in the 2025 book and has not been able to locate the medication on the floor. Further RN#3 identified she could not locate the white sheet for the above medications, nor has she located the above medications on the floor. RN#3 further identified she could not locate the destruction log from 2024. Interview on 3/2/26 at 3:30PM with LPN#3(Corporate) identified she was unaware there were issues with the narcotic reconciliation as no one had brought it to her attention. When the facility changed ownership in December of 2025 LPN#3 said the DNS was in the position of DNS so there would not be a need to change ownership of the narcotic medication. Review of the medication reconciliation policy directed the narcotic book should be audited on a consistent basis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 1 of 5 sampled resident (Resident #114) reviewed for unnecessary medication, the facility failed to follow up on the consultant pharmacist's recommendations. The findings include: Resident #114's diagnoses included neurocognitive disorder with Lewy bodies, dementia, anxiety disorder, and mood disorder.The quarterly MDS assessment dated [DATE] identified Resident #114 was severely cognitively impaired, had no behavior, independent for bed mobility, transfers, dressing, and personal hygiene. required limited assistance with bed mobility, transfers, dressing and personal hygiene. The assessment further identified that the resident ambulated short distances. The care plan dated 4/25/24 identified Resident #114 utilized psychotropic medication related to anxiety with interventions that included administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift, monitor document and report as needed any adverse reactions of psychotropic medications unsteady gait, tardive dyskinesia, shuffling gait, rigid muscles. Review of the drug regimen review dated 4/22/24 identified a recommendation to check the valproic acid level but did not have indication that the recommendation was reviewed by the physician or APRN.Review of the clinical record failed to identify a valproic acid level for 2024 or 2025. Review of the drug regimen review dated 9/17/24 identified a recommendation for an AIMS (Abnormal involuntary movement scale) test due to the resident being on psychotropic medication.Review of the clinical record identified an AIMS test dated 12/7/24. Review of the drug regimen review dated 7/18/25 identified a recommendation for adding behavioral monitoring with appropriate target behaviors.Review of the clinical record failed to identify the initiation of behavior monitoring for target behaviors prior to 11/7/25 (approximately 3.5 months after the recommendation was made). Interview on 3/2/26 at 11:45AM with the Regional Director for the consultant pharmacist company identified the medication reviews are completed monthly. The recommendations are sent via fax or email and should be followed up on within 30 days and if the recommendation is not followed up on the pharmacist does not always place the recommendation on the next review. Interview on 3/2/26 at 12:10 PM with the DNS identified the medication reviews are received from pharmacy via email and then given to the APRN to review in her book. The reviews should be followed up on within 30 days before the next monthly review. Interview on 3/2/26 at 1:00PM with the APRN identified she receives reviews sporadically in the APRN book kept in the nursing supervisor's office. She goes through and reviews them frequently throughout the week while she is in the facility. If a review is not followed up on by her, then it would mean that she did not receive the drug review. Review of Drug Regimen Review Policy directed that the attending physician, or licensed designee shall respond to the Drug Regimen Review within 30 days or more promptly. The prescriber designee shall act upon the drug regimen review in a timely manner of 30 days or less, shall document on the drug regimen review whether he/she agrees or disagrees with the recommendation and provide a brief rationale if no change is to be made.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, review of facility documentation, review of facility policy and interviews, the facility failed to ensure residents were provided a substantial evening snack daily. The findings include:Observation of the dietary department's dry storage room on 2/19/26 at 11:15 AM identified one box of crackers and seven 1-liter bottles of cola on a shelf identified as the snack shelf. Observation on 2/27/26 at 12:30 PM identified there were no more snacks available to residents. Observation of the snack cart identified there was a coffee carafe present, a basket with one package of crackers, but nothing else on the cart. Interview with FSD on 3/02/2026 at 2:07 PM identified that snacks were received on Thursdays and ran out by Mondays with the new budget. Observation of the snack cart on 3/02/2026 at 1:45 PM identified a coffee carafe, a ginger ale bottle and a half pack of crackers on the bottom of the cart. Interview with FSD at this time identified the kitchen aides refill the cart from the storage room but on observation of the storage room there are 6 bottles of cola and 4 bottles (liters) of ginger ale without any chips, cookies, crackers or any other snacks in the room. Observation of the refrigerator in the cafe on 3/2/26 at 2:30 PM identified there were less than 20 containers of Jello, pudding or fruit cups in the refrigerator. Interview with the Food Service Director (FSD) on 3/02/2026 at 2:50 PM identified there had been a cut in the budget for the snacks and the budget is $315 weekly for snacks for a facility resident capacity of 125. Interview with the Administrator on 3/2/26 at 3:00 PM identified they were working with alternative options for snacks with the new budget and that she was aware of the lack of snacks as the FSD had verbalized her concerns.Interview with the dietician on 3/02/2026 at 3:31 PM identified snacks have significantly declined since the ownership transition. The dietician indicated that she has spoken with the FSD regarding the lack of snacks and indicated the purchase of more snacks was not approved. The dietician identified that if there is a diabetic or if a resident didn't eat meals the alternate ways of getting the calories in the resident is essential but indicated she could add in the snacks for supplementation, but they aren't always available.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy and interviews, the facility failed to ensure food items were stored or prepared in accordance with professional standards to ensure food service safety. The findings include:Observation of the walk-in refrigerator on 2/19/2026 at 10:15 AM identified the following: Two turkeys thawing on the second shelf with visible drainage from the thawing turkeys on the shelf above cartons of liquid eggs and cartons of milk. [NAME] Slaw dressing marked as received on 10/21/24 and marked as opened 11/2 without a year. Unable to locate an expiration date on the top, container, or bottom.Barbeque (Boom Boom) Sauce marked as received into the facility 10/21/24 and marked as opened 11/6 without a year listed. Unable to locate an expiration date or directions for use after opening.Ranch salad dressing received into the facility 9/22/25 and opened 11/6 without a year. Unable to locate an expiration date.An opened jar of maraschino cherries jar with visible crusting around the cap. Unable to locate an open date, expiration date, or received date.Jar of relish marked received into the facility 10/2025 and labeled as opened 10/11/25. Unable to locate an expiration date. Teriayki sauce marked as received into the facility 6/25 but not marked with an open date and not able to locate an expiration date.Interview with FSD on 2/19/26 at 10:25 AM identified that meat items should be thawed on the bottom shelf of the walk-in refrigerator. The FSD indicated that she was unaware of how long a food item, condiment, could be used after opening if there was no expiration date. The FSD identified the jars should be labeled with the date the item was opened. Interview with the FSD on 2/19/2026 at 1:01 PM identified she conducted an online search that states the condiments should be good for 6-9 months after opening but identified that since the items were marked with a month and a day without year and were received into the facility in 2024 that the items should have been discarded. The FSD indicated that the facility did not have a policy regarding shelf life of food items. The facility policy for Management of Food Items Without Manufacturer Expiration Dates identified all food items stored, prepared, and served to residents are safe, properly labeled and within appropriate time frames for use. The policy indicated that any food item received without a clearly indicated manufacturer expiration date shall be dated, monitored, and discarded according to established food safety standards to prevent foodborne illness. The policy identified that receiving staff shall immediately label the item with date received and use by date if there is no expiration date.The facility refrigerated food storage guide identified foods such as mayonnaise, BBQ Sauce, Mustard, Ketchup etc can be stored 60 days from date opened or manufacturers expiration date (whichever comes first) with special instructions to refrigerate immediately, covered securely and date 60 days or by expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, review of facility policy, and interviews for three sampled residents (Residents #37, Resident #77 and Resident #117) reviewed for infection surveillance, failed to appropriately track and place a resident with an open wound on Enhanced Barrier Precautions (EBP), the facility failed to appropriately cohort residents with a known Multidrug Resistant Organism (MDRO) colonization per facility policy, the facility failed to review the infection prevention control program policies and procedures at least annually, the facility failed to ensure environmental rounds were conducted by the department heads on a quarterly basis, the facility failed to ensure that the infection control surveillance data collected monthly was analyzed for trends, and failed to follow the policy and procedural measures developed by the facility to prevent the growth of Legionella and other water borne pathogens in the building water system and for one sampled (Resident #49) on droplet precautions, the facility failed to ensure PPE was stocked for use on the outside of the EBP and contact precautions rooms and failed to ensure staff performed appropriate hand hygiene in between residents, failed to ensure staff utilized the proper PPE when entering droplet precautions rooms, and failed to ensure equipment was cleaned following use on a droplet precaution resident and before use on another resident. The findings include: Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews Resident #49 was admitted to the facility January 2026 with diagnoses that included unspecified fracture of the lower end of right radius subsequent encounter for closed fracture with routine healing, long term use of anticoagulants and difficulty in walking. The annual MDS assessment dated [DATE] identified Resident #49 had intact cognition, required set up/clean up assistance with position changes, and partial/moderate assistance with toileting and personal hygiene. Physician's orders dated 2/20/26 directed droplet precaution pending respiratory 4-plex result, discontinue if negative. The care plan dated 2/20/26 identified Resident #49 had new onset of cough and congestion with interventions to include droplet precautions pending result of the respiratory viral panel. Nursing progress note dated 2/20/26 at 1:44 PM identified Resident #49 was seen by the MD and was noted with congested cough with rhonchi and placed on droplet precautions. Added to the care plan 2/25/26 identified a fever and signs/symptoms of upper respiratory illness with interventions to follow facility protocol for contact/droplet precautions. Observation on 2/24/26 at 1:50 PM identified Resident #49 had a posted droplet precautions sign outside of the room to the right of the door above the room number placard. NA #10 entered the room without donning personal protective equipment (PPE) with a chair scale. NA #10 placed the chair scale next to the resident who was seated in a recliner and was actively coughing. The resident transferred to the chair scale with NA #10 touching the resident's shoulder as he/she sat on the chair scale. At 1:55 PM NA #10 exited the room and walked the chair scale to another resident's room. NA #10 did not perform hand hygiene before exiting Resident #49's room or prior to entering the next resident's room and she did not perform any cleaning or disinfection of the chair scale. The resident in the room she entered refused to be weighed. Further observations noted NA #10 enter another room and used the chair scale to weigh a resident but did not perform hand hygiene or cleaning/disinfecting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the chair scale. Interview with NA #10 on 2/24/26 at 2:10 PM identified that there were no residents on droplet precautions and would not answer questions concerning PPE and when it should be donned and doffed and when hand hygiene should be performed. Observation of LPN #2 on 2/24/2026 at 2:08 PM coming out of Resident #49's room (droplet precautions) without any PPE and placing the thermometer back into the cart without wiping it down or cleaning it. Resident #49's temperature was 100.5 degrees Fahrenheit. Interview with LPN #2, NA #10 and NA #11 on 2/24/2026 at 2:11 PM identified that PPE must be worn in droplet precaution rooms or evidence-based precaution (EBP) rooms, hand hygiene should be performed in between residents and the scale and other equipment used should be wiped down with bleach wipes after use in the droplet precaution room. NA#10 indicated that he had not put on PPE nor performed hand hygiene in between residents. NA#10 indicated that he was only pulling the scale into the resident room and did not have contact significant enough to perform hand hygiene. NA#10 identified he did not know if the scale should be cleaned in between residents but did identify that after the contact precaution room it should have been wiped down. LPN#2 indicated that the precautions carts located outside of precaution rooms should be stocked by the supervisors or the infection control nurse. Observation of precaution carts on one unit on 2/24/2026 at 2:15 PM identified the precaution cart outside of room [ROOM NUMBER] (EBP) had only gowns in the bottom drawer with no other PPE. Precaution cart outside of room [ROOM NUMBER] (EBP) only had gowns in the bottom. Precaution cart outside of room [ROOM NUMBER](EBP) only had gowns in the bottom drawer. Precaution cart outside of room [ROOM NUMBER] had one gown in the bottom drawer and one box of gloves on the top of the cart. Neutropenic precaution cart outside of room [ROOM NUMBER] had gowns in the bottom drawer and a ripped box of gloves on the top of the cart. Droplet precaution cart outside of room [ROOM NUMBER] had a box of masks on the top of the cart and 2 boxes of gloves on the shelf to the right of the room door. Interview with the Nursing Supervisor (RN#2) on 2/24/2026 at 2:20 PM identified she would expect the precaution rooms to have the appropriate PPE available for use in the precaution carts and that equipment used should be wiped down after the droplet precaution room but could not identify if equipment should be wiped down between non precaution residents. RN#2 indicated that she asked the per diem nurse, RN #9, to fill the precautions carts that morning. Interview with RN#9 on 2/24/26 at 2:25 PM identified that she had been working on the precaution carts throughout the day but had not yet finished due to having to assist the wound APRN on rounds. Interview with corporate nurse, LPN#3 on 2/24/26 at 2:31 PM indicated that the precaution carts should be stocked, not could not identify who was responsible to make sure they were stocked. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 2/25/26 at 1:10 PM identified that precaution carts should be stocked with necessary PPE. The DNS indicated in the event the facility needed additional PPE; they could obtain it from a sister facility. The DNS identified the Infection Prevention nurse, and the night (11p-7a) supervisors were responsible to stock and check that the carts are stocked appropriately. The DNS indicated that the stock closet and the DNS office contained PPE. Review of facility documentation (Inservice attendance for Covid outbreak, hand hygiene, mandatory surgical mask wearing in common and patient care areas, proper donning and doffing PPE) dated 10/27/25 identified that education had been provided to facility staff and NA#10, NA#11 and LPN#2 had been educated on these topics. Review of in-service attendance for infection control with a targeted group of all staff dated 6/2025 identified LPN#2 and NA#10 had received education on infection control and hand hygiene at that time. Facility policy for precautions to prevent transmission of infectious agents identified droplet precautions as a transmission-based precaution and indicated they may be implemented based on the clinical presentation until the infectious etiology had been determined. The policy identified that if any equipment cannot be dedicated to the room, it must be cleaned and disinfected before use on another resident. Facility policy in place prior to 2/24/26 identified protocol for hand hygiene identified In general, hand hygiene should be performed prior to and following direct contact with patients/resident and indicated examples of situations when hand hygiene is indicated included: before and after direct patient/resident contact; After completing tasks at one patient/resident area before moving to another station; After contact with items/surfaces at patient/resident areas; When working with a resident on isolation precautions. Review of the new facility policy for transmission-based precautions put in place 2/24/26 subsequent to surveyor inquiry. This policy identified that when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution and that the signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and /or instructions to see a nurse before entering the room. Signs and notifications comply with the resident's right to confidentiality or privacy. When transmission -based precautions are in effect, non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, or digital thermometer will be dedicated to a single resident when possible, indicating that if re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident. Droplet precautions section of the policy identified that residents on droplet precautions are placed in a private room if possible. When a private room is not available, residents may share a room with a resident infected with the same microorganism or with limited risk factors, if single or cohorting is not available, decisions regarding resident placement are case by case after considering infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risks to other residents. New policy for hand hygiene and handwashing identified All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Use an alcohol-based hand rub containing at least 62% alcohol or alternatively, soap and water for the following situations to include: before and after direct contact with residents. after contact with a resident's intact skin. after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident. after removing gloves. before and after entering isolation precaution settings. Review of the facility's EBP log for February 2026, failed to identify that Resident #37 was included on the EBP list even though the resident has 2 pressure injuries with drainage that requires dressing changes. Resident #37 was admitted to the facility in January of 2026 and had diagnosis of Parkinson's disease, thoracogenic scoliosis, kyphosis, and severe protein calorie malnutrition. The physician's order dated 1/21/26 directed for wound care to coccyx to apply triad paste followed by a superabsorbent bordered dressing on Monday, Wednesday and Thursday and as needed if soaked or dislodged. The Resident Care Plan (RCP) dated 1/21/26 identified Resident #37 had a community acquired pressure ulcer to the coccyx at a stage 2 and to the left heel and is at risk for pressure ulcers with intervention that included complete treatments as ordered, apply left heel lift boot while in bed, check skin integrity, turn and reposition every 2 hours, encourage food and fluids, weekly visit with the wound nurse and keep off back except for meals. The RCP dated 2/3/26 identified Resident #37 had a stage 2 pressure ulcer underneath the chin with interventions that included alternating pressure mattress at cycle 10 for 165lbs, a ROHO cushion to the wheelchair, wound treatment daily and as needed, dietary consultation, heel boots on at all times and to check skin integrity every shift. Review of the nursing progress note provided by the Wound APRN (APRN #2) dated 2/3/26 at 2:19 PM identified Resident #37 coccyx wound has a stage 2 pressure injury that has deteriorated and is now unstageable with evidence of acute pressure on the periphery and measures 3.5 cm in length by 3.5 cm in width, 0cm in depth with moderate amounts of serosanguinous drainage and no odor. The note further identified an area to the left inferior mandible that has a dusky dull red color stage 2 pressure injury measuring 1.0 cm in length by 2.0 cm in width and 0.3 cm in depth with scan to absent serous drainage, no odor, peri wound unremarkable without evidence of pressure. In addition, the note identified to start wound care for the left anterior mandible daily and as needed with checks for dressing to rinse with normal saline apply hydrogel saturated gauze and cover with dry gauze, then unfold kerlix and fold so that there is at least 4-5 inches of fluff and place under mandible. The note (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further identified the recommendation was reviewed and approved by APRN #1. Review of the physician's order for the period of January 21, 2025, through February 23, 2026, failed to identify an order that directed EBP for wound care. Observation and interview on 2/26/26 at 1:03PM with RN #1 failed to identify a posted signage outside of the room on the wall or door that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as dressing, bathing, showering, device care or care of a urinary catheter. RN #1 identified when a resident is placed on EBP a signage is place on the outside of the room indicating the type of precaution and PPE to be worn. RN #1 further identified if the signage is placed above the name plate it is for the resident at the door and below the name plate is for the resident at the window. RN #1 identified if the resident is sent to the hospital and is expected to return the signage would remain until they return and remove depending on the resident's readmission orders. Interview with the Infection Preventionist nurse (RN #6) on 2/26/26 at 1:05 PM identified when a resident is on EBP, an order for EBP would be placed in the physician's order and an EBP signage would be placed outside of the resident's room. RN #6 identified Resident #37 should have been placed on EBP due to his/her pressure ulcer which had moderate drainage. He identified it was the responsibility of the IP and wound nurse to input the order, but it just got missed. Review of the Enhanced Barrier Precautions policy and procedure identified enhanced barrier precautions will also be implemented for resident with wounds, or indwelling medical devices regardless of their MDRO colonization status that reside on a unit or wing where a resident known t be infected or colonized with a novel a targeted MDRO resides. The policy further identifies that signage will be posted on the door or wall outside of the resident room indicating the need for EBP. Review of the Enhanced Barrier Precautions policy identifies EBP may be indicated (when contact precautions do not otherwise apply) for residents with chronic wounds (4-12 weeks with minimal to no improvement with treatment) and/or indwelling medical devices regardless of MDRO colonization. The policy further identified signs are posted on the door or wall outside of the room indicating the type of precautions and PPE required. Review of the facility's EBP log for February 2026, which contains the list of residents with a MDRO, and the facility unit roster with the Infection Preventionist nurse (RN #6) on 12/24/26 at 12:31 PM identified Resident #77 and Resident # 177 were roommates with one resident colonized with a Center for Disease Control and Prevention (CDC) targeted MDRO and the other resident was identified without an MDRO. The EBP log for February 2026 identified Resident #117 had a colonization history that included extended-spectrum beta-lactamases (ESBL) and Carbapenem-resistant enterobacterales (CRE) while Resident #77 was not included in the EBP log as he/she had no history of an MDRO. The facility unit roster identified that Resident #77 shared room with Resident #117 who had a known history of a colonized MDRO of CRE and ESBL. Resident #77's diagnoses included urinary tract infection, Escherichia coli, dementia, type 2 diabetes mellitus, and bipolar disease. The admission MDS assessment dated [DATE] had moderately impaired cognition, required set-up assistance with personal hygiene, supervision with ambulation and independent with toileting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene, upper body dressing. The assessment further identified Resident #77 was occasionally incontinent of urine and always continent of bowel. Review of Resident #77's demographic sheet identified that Resident #77 and Resident #177 became roommates on 11/20/2025. Resident #177's diagnoses included extended-spectrum beta-lactamases (ESBL), carrier of Carbapenem resistant enterobacterales (CRE) and schizoaffective disorder the bipolar type. The annual MDS assessment dated [DATE] identified Resident #177 25 had moderately impaired cognition, required supervision with toileting hygiene, dressing, personal hygiene, transfers, and independently utilized a wheelchair for locomotion. The assessment further identified Resident #177 was occasionally incontinent of urine and frequently incontinent in bowel. Interview with RN #6 on 2/26/26 at 1:05 PM identified the EBP and MDRO log is completed by the IP nurse when a resident with an MDRO is admitted to the facility or identified with the resident stay. RN #6 identified the IP nurse is responsible for updating the EBP log and providing a copy to admissions and to each nurse's unit in the facility. RN #6 identified he had cohort Resident #77 with Resident #117 together because Resident #77 had no open wounds or indwelling devices. He identified that both residents used the same bathroom in their room but thought it was okay to cohort them together because Resident #77 did not have an open wound or an indwelling device. RN #6 identified he was not aware that the facility's policy indicated that residents with CRE should only be cohort with another resident with CRE. He further identified there is another resident with CRE in the facility who does not share room because they have indwelling devices. Review of the Multidrug-Resistant Organism (MDRO) policy identified in the room cohorting section that residents with the same MDRO and same strain (if known) may be roomed together. Review of the Cohorting Residents with Communicable Disease policy identified in the cohorting section of the policy that it is the practice of grouping residents infected or colonized with the same infectious organism together in a designated area. Review of the Control of Multidrug-Resistant Organism (MDRO) Infection and Colonization policy identifies residents with similar MDRO infections can be cohorted whenever possible, and if a cohorted room is not available, a roommate will be carefully selected. The policy further identified that residents who have CRE should be placed in a single room or cohorted with a roommate with CRE. Review of the facility's Infection Control Program Policies and Procedure manual from May 2024 through February 2026 on 2/24/26 at 12:31 PM with the Infection Preventionist (RN #6) failed to identify that the policies and procedures manual was reviewed in the year 2024 and 2025. Interview with RN #6 on 2/26/26 at 1:05 PM identified that they were unable to locate documentation that the policy and procedures manual was reviewed in the year 2024 and 2025. RN #6 indicated that he started working at the facility in April of 2025 as a full time IP nurse until October 2025. He identified that it was the responsibility of the then IP nurse to ensure that the infection control policies and procedures were reviewed and signed off annually. Interview with the DNS on 3/2/26 at 3:15 PM identified the polices and procedure manuals was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed annually as it is responsibility of the administration to ensure it was completed. Review of the facility environmental round documentation on 2/24/26 at 12:31 PM with the Infection Preventionist (RN #6) failed to identify quarterly environmental round documentation that was completed in January of 2026. Interview with RN #6 on 2/24/26 at 12:31 PM identified environmental rounds are completed quarterly by the department heads. He further identified it is the responsibility of IP nurse to ensure it was completed. RN #6 identified he works only 16 hours weekly as the wound nurse and provides oversight of the infection control program, as the facility has a nurse who works full as the IP nurse. He then indicated it was her responsibility to have it completed in January 2026 when it was due to be completed. Review of the Environmental Rounds policy identifies it is the policy of this facility that the Infection Preventionist or his/her designee, charge nurses or supervisors to complete unit rounds on a regular basis, but at least quarterly. The policy further identifies the IP will train and accompany department heads to do rounds of their department initially, thereafter, it will be distributed to the supervisor of each area, and the department heads will submit completed environmental rounds to the IP. Review of the infection control program for the period of April 2024 to February 2026 on 2/24/26 at 12:31 PM with the Infection Preventionist (RN #6) failed to provide documentation of monthly surveillance infection report analysis of infection trends were completed for the period of October 2024 to December 2024; January 2026 and quarterly infection reports that include first quarter of 2025. Interview with RN #6 on 2/24/26 at 12:31 PM and on 2/26/26 at 1:05 PM identified that he was unable to locate any of the monthly surveillance infection reports analysis of infection for the period of October 2024 to December 2024, January 2026 and the quarterly report for the first quarter of 2025after searching thoroughly throughout the facility. RN #6 identified the monthly infection control surveillance data is analyzed to identify the rate of healthcare/facility acquired infections and community acquired infections within the facility, and at the end of each month the total infection rate is calculated using a formula. He identified the facility had an IP nurse during 2024; however, he was unable to locate their records as it was their responsibility to track, identify and analyze infection rates within the facility monthly. RN #6 identified he works 16 hours weekly as the wound nurse and oversees the IP nurse who works full time and it was her responsibility to complete the monthly infection analysis. He identified that the IP nurse was responsible for completing an infection report quarterly and the information is presented at the quarterly medical staff meeting, however, he was unable to locate the first quarter infection control report. Review of the Surveillance for Infections policy is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associate infections, to guide appropriate interventions, and to prevent future infections. The policy further identified monthly collection of information from individual resident infection reports and enter line listing of infections by resident for the entire month; and summarize monthly data for each nursing unit by site and by pathogen and monthly/quarterly identify predominant pathogens or sites of infection among residents in the facility or in particular units by recording them month to month and observing trends. In addition, the monthly/quarterly compares incidence of current infections to previous data to identify trends and patterns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility Water Management Plan with the Director of Maintenance on 2/27/26 at 2:07 PM identified that the facility water management plan policy included: monthly flushing of the identified low flow areas for 20 minutes and the, eyewash stations are to be flushed, quarterly cleaning of the ice machines, annually water management meeting, and annually water sampling testing. When requested documentation of the implementation of the water management plan the Director of Maintenance indicated that he had no documentation as the plan was not implemented. The facility provided a legionella water sampling testing result dated 3/3/25 which was collected on 2/19/25 that noted the following result for sample collected at the Whispering pine soiled hopper hot which detected 8.4 CFU/ml (colony forming unit) of L. anisa (Blue-white Legionella sp.). Interview with The Director of Maintenance on 2/27/26 at 2:07 PM identified the facility has a contract with an outside company who is responsible for collecting water sample testing and updating and revising the water management plan. He identified that he had received the February 2025 water sampling in January 2026 because the facility had not paid their bill with the company. The Director of Maintenance identified as well as the contracted company that missed the positive sampling result culture when reviewed in January/2026 until identified by the surveyor. He further identified the water lines in the resident's rooms and resident areas on the closed unit was only flushed on February 13, 2026, by the construction company, however, it was not flushed prior as well as any other unused or low flow area within the facility. The Director of Maintenance identified he started working at the facility in September of 2025 and was instructed if any plumbing part break that he was to retrieve the part from the closed unit then shut off the pipe in that area. In addition, he is unable to locate any documentation of the plan implementation prior to his nor did he implement the policy. The Director of Maintenance identified he had a meeting with the water management contracted company about 10 days ago, who informed him that he will need to maintain logs of the flushes of low flow/unused areas, cleaning of the ice machine, flushing of the eye washing stations and annual meeting. He indicated that he is awaiting the log from the company, had their first water management meeting in January 2026, which needs to be done annually, and the ice machine was cleaned by a company 2 weeks ago. In addition, he was able to locate water sampling results for 2024 due lack of payment by the facility, however, he identified that water samples were completed in February/2026 and the facility is awaiting the results. Interview with the Administrator and Director of Maintenance on 2/17/26 at 3:15 PM identified that they had made contact with the contracted company for the facility's water management regarding the positive result in 2025, which they provided guidance for localized remediation of the fixture, not to use the outlet, and they will test the site on 3/20/26. The Administrator identified that the medical director will be contacted as the facility is currently undergoing a respiratory outbreak for guidance. Interview with the Administrator on 2/17/26 at 3:15 PM identified that the facility will be testing for Legionella antigen urine test with anyone with a confirmed case of pneumonia who received antibiotic treatments without resolution. Review of the Facility Water Management plan and policy identified that the plan includes the management and validation of the plan, updating the water management plan and water sample culture analysis. The Water Management Plan policy further identified that the environmental assessment (which includes flushing, eye washing, ice machine), sampling and management plan and associated sampling results on the facility premises for at least three years.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, review of facility policy, facility documentation, and interview for three of five sampled residents (Resident #5, Resident #8 and Resident #50) reviewed for immunizations, the facility failed to ensure that the COVID-19 booster vaccine was administered as requested by the resident/responsible party and offered on admission. The findings include:F887 Based on review of the clinical records, review of facility policy, facility documentation, and interview for three of five sampled residents (Resident #5, Resident #8 and Resident #50) reviewed for immunizations, the facility failed to ensure that the COVID-19 booster vaccine was administered as requested by the resident/responsible party and offered on admission. The findings include: 1. Resident #5 was admitted to the facility in January of 2026 and had diagnoses that included chronic kidney disease, type 2 diabetes mellitus and chronic obstructive pulmonary disease. The admission MDS assessment dated [DATE] identified Resident #5 was cognitively intact. The assessment further identified that Resident #5 was not up to date with the Covid-19 vaccination. Review of Resident #5 immunization and clinical records with the Infection Preventionist (IP) nurse (RN #6) on 2/24/26 at 12:31 PM failed to identify that the Covid-19 vaccine was offered and/or assessed for past immunization. Interview with RN #6 on 2/24/26 at 12:31 PM identified that he was unable to provide any documentation of Resident #5's Covid-19 vaccine records, as the consent forms was not reviewed with the resident. RN #6 identified consents are obtained on admission by the admitting supervisor and it is then reviewed by the IP nurse. The IP nurse wound then check on the CT wiz, which is a database that maintains patients vaccination records, to ensure that the resident had not received the vaccination prior to admission. RN #6 further identified after the resident vaccination history is check then the appropriate vaccine is ordered by the physician for inoculation. He further identified the facility has a full time IP nurse who was responsible for reviewing the vaccine as he only works 16 hours weekly as the wound nurse and to oversee the IP nurse. RN #6 identified he will review the vaccine consents with the resident on 2/24/26 as it should have been completed on admission. Review of the COVID-19 Vaccination policy identifies the Covid-19 vaccination will be offered to all residents unless the vaccine has been medically contraindicated, or the resident has been previously immunized. The resident will be asked to sign a consent prior to administration. The policy further identifies that resident's and staff have the right to decline or not are not required to receive the vaccination and information will be documented in medical record. 2. Resident #8 was admitted to the facility in November of 2025 and had diagnoses that included urinary tract infection, chronic obstructive pulmonary disease and type 2 diabetes mellitus. The admission MDS assessment dated [DATE] identified Resident #8 was cognitively intact. The assessment further identified that Resident #8 was not up to date with the Covid-19 vaccination. Review of the Resident admission Vaccination Education form dated 11/28/25 identified Resident #8 provided the facility with consent and information regarding the influenza and the pneumococcal vaccine. However, the COVID-19 vaccine section of the form was not completed as to whether the resident had given consent or refused the vaccine. Review of Resident #5 immunization and clinical records with the Infection Preventionist (IP) nurse (RN #6) on 2/24/26 at 12:31 PM failed to identify that the Covid-19 vaccine was offered and/or assessed for past immunization. Interview with RN #6 on 2/24/26 at 12:31 PM identified that he was unable to provide any documentation of Resident #8's Covid-19 vaccine records, as on the Covid-19 section of the vaccination form was not reviewed or completed with the resident. He further identified the facility has a full time IP nurse who was responsible for reviewing the vaccine as he only works 16 hours weekly as the wound nurse and to oversee the IP nurse. He identified the covid-19 vaccine consent should have been followed upon to check if the resident would like to receive the Covid-19 (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	booster vaccine when assessed on admission. Subsequently to surveyor's inquiry, a nurses note dated 2/24/26 T 5:10 PM written by RN #6 identified Resident #8 was eligible for the covid 2025-2026 vaccine and was offered and the resident declined. Review of the COVID-19 Vaccination policy identifies the Covid-19 vaccination will be offered to all residents unless the vaccine has been medically contraindicated, or the resident has been previously immunized. The resident will be asked to sign a consent prior to administration. The policy further identifies that resident's and staff have the right to decline or not are not required to receive the vaccination and information will be documented in medical record.3. Resident #50 was admitted to the facility in October of 2025 and had diagnoses that included dementia, depression, and hypertension. The admission MDS assessment dated [DATE] identified Resident #50 had severely impaired cognition. The assessment further identified that Resident #8 was not up to date with the Covid-19 vaccination. The nurse's progress note dated 11/17/25 at 2:44 PM written by RN #6 identified Resident #50 was eligible to receive Covid, influenza and PCV20 (pneumococcal vaccine) and was discussed with resident responsible party who provided the facility with verbal consent for the vaccine, APRN was updated and will stagger the vaccine administration. Review of the physician's order for the period of November 2025 through February 24, 2026, failed to identify an order that directed the administration of the covid-19 2025-2026 booster vaccine. Review of Resident #50's clinical records with the Infection Preventionist (IP) nurse (RN #6) on 2/24/26 at 12:31 PM failed to identify that he/she received the vaccination or documentation that the resident refused the vaccine. Interview with RN #6 on 2/24/26 at 12:31 PM identified he had approached Resident #50 to administer the Covid-19 2025-2026 booster vaccine and the resident had refused. He written on the consent form resident refused but failed to document on the consent that the responsible party had given consent to administer the vaccine. RN #6 identified that a physician's order should have been put in electronic record, and the administration records should have indicated that the resident had refused. He further identified the facility has a full time IP nurse who was responsible for reviewing the vaccine and to follow-up on the refusals, as he is responsible for the wounds and oversees the IP nurse with only working 16 hours weekly. Review of the COVID-19 Vaccination policy identifies the Covid-19 vaccination will be offered to all residents unless the vaccine has been medically contraindicated, or the resident has been previously immunized. The resident will be asked to sign a consent prior to administration. The policy further identifies that resident's and staff have the right to decline or not are not required to receive the vaccination and information will be documented in medical record.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy/procedure, and interviews for two of six sampled residents (Resident #9 and Resident #79) reviewed for advance directives, the facility failed to ensure a physician's order was in place and consents were obtained regarding the resident's wishes regarding advance directives and decisions related to cardiopulmonary code status. The findings include: Resident #9's diagnoses included systemic lupus erythematosus, depression and hypothyroidism. The quarterly MDS assessment dated [DATE] identified Resident #9 was cognitively intact and was independent with dressing, personal hygiene, bed mobility, transfers and ambulation. The care plan dated [DATE] identified Resident #9 had an established advance directive with a wish to be a DNR (do not attempt cardiopulmonary resuscitation)/ DNI (do not intubate)/RNP (Registered Nurse may Pronounce death) with interventions that directed to not administer cardiopulmonary resuscitation (CPR) and to review advance directives with resident and/or healthcare decision maker quarterly. A review of the clinical record identified an Advance Directive Declaration Code Status form signed by Resident #9's responsible party dated [DATE] and signed by the APRN on [DATE]. The form identified an elected code status of DNR and DNI. A review of physician's orders for the period of [DATE], through February 24, 2026, failed to identify the election of a code status of DNR and DNI. Interview with LPN #4 and LPN #7 on [DATE] at 1:38 PM identified that if Resident #9 had a life-threatening emergency where the decision to administer CPR or withhold CPR, they would check the resident's code status. LPN #4 identified the code status is found in the banner/dash section of the electronic medical record, in the resident's physical clinical record under the advance directive section and in the physician's orders. LPN #7 identified that code status consents are obtained on admission by the charge nurse or the nursing supervisor from the resident or the resident's responsible party. After which the Code Status form is signed by the physician or APRN. A physician's order is then placed into the electronic medical record. Review of the current physician's orders with LPN #7 identified that there were no orders addressing the resident's code status. LPN #7 identified that in an emergency the physician's order is the first place they would check and if there was no order for code status, she would start CPR while another staff member would check the code status form and if the form identified that the resident is a DNR/DNI compression would then cease. Interview with the DNS on [DATE] at 9:30 AM identified that if a resident had a life-threatening emergency, the nurse is to check the physician's orders in the electronic medical record. The DNS further identified that code status is obtained on admission and is signed by the resident or the resident's responsible party, following that a physician's order is obtained and the code status form placed in the APRN's book to be signed. The DNS identified that the physician's order should match the code status consent obtained from the resident/resident responsible party and in the event the code status was not obtained/unknown the resident would be considered a full code and in the event of an emergency, CPR would be performed. The Advance Directive policy identified that if a resident has an advanced directive, copies of the documents are obtained and maintained in the resident's medical record and are readily retrievable by any facility staff. The policy further identified that the DNS or designee notifies the attending physician of advance directives or changes to the advance directive so that appropriate orders can be documented in the resident's medical record and plan of care. Resident #79 was admitted to the facility in November of 2025 and had diagnoses that included Type 2 diabetes mellitus, multiple sclerosis, and paraplegia. The physician's order dated [DATE] directed a code status of full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive including cardiopulmonary resuscitation (CPR)).The admission MDS assessment dated [DATE] identified Resident #79 was (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact, was dependent on staff for toileting hygiene, dressing, personal hygiene, putting on/taking off footwear, transfers and was non-ambulatory. The care plan dated [DATE] identified Resident #9 had an established advance directive with a wish to receive CPR (cardiopulmonary resuscitation) with interventions that included review advanced directive with resident and/healthcare decision maker quarterly and support resident decision for CPR. Review of Resident #79's physical chart and the electronic health record failed to identify a signed Advance Directive Declaration Code Status form signed by the resident/resident representative to indicate what the resident's wishes were pertaining to code status. Interview with LPN #4 and LPN #7 on [DATE] at 1:38 PM identified that if Resident #79 had a life-threatening emergency where the decision to administer CPR or withhold CPR, they would check the resident's code status. LPN #4 identified the code status is found in the banner/dash section in the resident's electronic medical record, in the resident's physical clinical record under the advance directive section and in the physician's orders. LPN #7 identified that code status consents are obtained on admission by the charge nurse or the nursing supervisor from the resident or the resident's responsible party. After which the Code Status form is signed by the physician or APRN. A physician's order is then placed in the electronic medical record. LPN #7 reviewed the current physician's order and identified Resident #79 had an order for full code (CPR). LPN #7 could not locate a completed Advance Directive Declaration Code Status form for Resident #79.Interview with Person #1 (Resident #79's responsible party) on [DATE] at 10:45 AM identified that he/she had not received any contact from the facility regarding advance directives/code status. Person #1 identified the facility had reached out to him/her various times regarding different consents which he/she provided to the facility over the phone. Person #1 identified Resident #79's code status wishes were DNR/DNI, and he/she had no notes regarding the advance directive. Interview with the Social Worker (SW #1) on [DATE] identified she had reached out to Person #1 on [DATE] regarding the advance directive and discharge planning. She further identified that she should have reached out to Person #1 from admission regarding the advance directive if nursing was unable to obtain consent. Interview with the DNS on [DATE] at 9:30 AM identified that if a resident has a life-threatening emergency, the nurse is to check the physician's order. The DNS further identified that code status is obtained on admission and is signed by the resident if able or the resident's responsible party, a physician's order obtained and the code status form is placed in the APRN's book for it to be signed. The DNS identified the physician's order should match the code status consent obtained from the resident/resident responsible party and in the event a code status was not obtained the resident would be a full code. The DNS further identified that Resident #79 should have a consent in the chart by now, since he/she was admitted to the facility in November/2025. The admission Procedure Advance Directive policy identified that prior to or upon admission the Director of Admissions or designee will provide each resident and/or responsible party with written information regarding the resident's rights under state law to make decisions regarding his or her medical care including the right to accept or refuse treatment and to formulate an advance directive. The Advance Directive policy identified that if a resident has an advanced directive, copies of the documents are obtained and maintained in the resident's medical record and are readily retrievable by any facility staff. The policy further identified that the DNS or designee notifies the attending physician of advance directives or changes to the advance directive so that appropriate orders can be documented in the resident's medical record and plan of care.

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	075350	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Sheriden Woods	321 Stonecrest Drive Bristol, CT 06010

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #114) reviewed for abuse, the facility failed to ensure the allegation of abuse was reported to the state survey agency in a timely manner. The findings include: Resident #114's diagnoses included neurocognitive disorder with Lewy bodies dementia, major depressive disorder, and mood disorder.The quarterly MDS assessment dated [DATE] identified Resident #114 was moderately cognitively impaired, had no behaviors, required limited assistance for bed mobility, transfers, dressing, and personal hygiene. The assessment further identified the resident utilized a wheelchair for mobility. The care plan dated 10/3/25 identified Resident #114 was at risk for refusing care and not waiting for assistance with transfers related to behavior problems with interventions that included assistance of two staff for care and transfers, introduce self to resident, explain what you are going to do, use calm, gentle, approach, and work slowly. A late entry nurse's note from the DNS dated 11/3/25 at 8:30AM identified Resident #114 was alleged to have been slapped on his/her left arm by a NA while providing care. The NA was removed from the schedule upon receiving report of the allegation and a body audit was performed and no injuries were noted. The Accident and Investigation report dated 11/3/25 identified statements from NA #1, #2, and #3 pertaining to the allegation of physical abuse. NA#3's statement identified that on Friday 10/31/25 at about 8:30PM, NA#3, NA#2, and NA#1 went into Resident #114's room to provide care. Resident #114 did not want to get changed and was combative swinging his/her arms and feet. NA#3 held Resident #114's arms so NA#2 could change his/her brief. NA#1 assisted in holding the resident's arms and slapped Resident #114 hard on the arm and used an expletive (F word). NA#3 identified she should have reported it on Friday when it happened. NA#2's statement identified she was providing incontinent care while NA#3 held Resident #114's left hand because he/she was agitated and cursing. NA#1 slapped Resident #114 with her hand she and NA#3 told NA#1 to calm down since they were more familiar with Resident #114. Resident #114 was on NA#3's assignment. The statement further identified that she did not report the incident because she thought NA #3 would report it because Resident #114 was on her assignment. NA#1's statement identified she was helping with Resident #114's care. She noted that the resident started fighting and she grabbed his/her hand twice to stop the resident from hitting NA #3. She further noted that she kept grabbing Resident #114's hands until the brief was changed. The statement noted that the resident continued to resist by kicking and slapping NA #3. Once the change occurred, she noted they all left the room. The Nursing Supervisor's (RN #7) note dated 11/3/25 identified that on 11/2/25 toward the end of the 3pm to 11pm shift, NA #3 reported that NA #1 slapped Resident #114 during the provision of care. The note further noted that NA #2 confirmed what NA #3 had reported. She further noted that the incident had occurred on 10/31/25 and there were no noted signs or symptoms of injury. The Social Worker's progress note dated 11/3/25 identified Resident #114 was in bed and reported he/she had a good weekend. The Social worker asked Resident #114 if he/she had any concerns or complaints related to care he/she had received over the last few days and Resident #114 reported no concerns. The social worker asked the resident if there were any staff members that had been treating him/her differently than usual or if care had not been done well, Resident #114 did not recall the reported event. The skin audit dated 11/3/25 by completed by RN#1 identified no new skin impairments.RN #1's nursing note dated 11/7/25 identified that the allegation of abuse was substantiated because it was witnessed by two staff members. Interview with NA #2 on 2/23/26 at 12:36 PM identified that during the provision of incontinent care to Resident #114, the resident was combative and refusing care. She acknowledged that she was aware that Resident #114 had the right to refuse care, but his/her brief and sheet were soaked with urine and felt it was to the resident's benefit to be cleaned up. She (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further identified that she witnessed NA #2 slap the resident's arm several times. Additionally, she noted that she had not reported the incident because she thought NA #3 was going to report it, although they had not discussed the reporting of the incident. She noted that she should have reported the incident at the time she witnessed the incident. She further noted that she was put on leave following the reporting of the incident and subsequently fired. Interview with the DNS on 2/27/26 at 9:14AM identified she was notified of the allegation of abuse on 11/3/25 via text message from RN #7. The DNS identified she immediately started the investigation. NA#1, NA#2 and NA#3 worked on 11/1/25, and 11/2/25 in the facility due to the fact the allegation had not been reported. Statements were obtained from NA#1, NA#2, and NA#3, who were subsequently terminated. RN#7 was given a final written counseling regarding the incident and remains employed at the facility. The facility reported the incident to the police and to the state survey agency. Review of the facility policy directed to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation or reports of abuse, neglect or exploitation occur.

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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** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of two sampled residents (Resident #45) reviewed for medication administration, the facility failed to ensure medications were passed on time. The findings include: Resident #45's diagnoses included hypertension, type 2 diabetes, cirrhosis of liver, seizures. The quarterly MDS assessment dated [DATE] identified Resident #45 was cognitively intact, had no behaviors, required limited assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified the use of a walker for mobility. The care plan dated 1/21/26 identified Resident #45 was at risk for seizures with interventions that included caution patient to lie down and push call button if experiencing a prodromal or aural warning, keep call light within reach, medications as ordered. Review of the active physician's orders for March 2026 directed to administer Keppra Oral tablet 500mg 1 tablet two times a day for withdrawal seizures, Bactrim DS oral tablet 800-160mg twice daily, Glipizide 5mg in the morning and Gabapentin oral tablet 600mg three times a day for pain. Interview on 2/19/26 at 11:00AM with Resident #45 identified that medications are passed late on a consistent basis. Some medications are given close to the time the next dose is due and morning medications can sometimes be passed in the afternoon. Review of the point click care (electronic program) order summary report for the period of 1/1/26 through 2/26/26 identified:1/1/26 Bactrim due at 9:00AM was administered at 11:52AM 1/1/26 Glipizide due at 9:00AM was administered at 11:52AM 1/1/26 Keppra due at 10:00AM was administered at 11:52AM 1/4/26 Bactrim due at 9:00AM was administered at 11:42AM 1/4/26 Glipizide due at 9:00AM was administered at 11:42AM1/4/26 Keppra due at 10:00AM was administered at 11:42AM1/6/26 Keppra due at 5:00PM was administered at 7:32PM 1/7/26 Bactrim due at 9:00AM was administered 10:47AM1/7/26 Keppra due at 5:00PM was administered at 11:44PM 1/8/26 Keppra due at 10:00AM was administered at 11:52AM 1/9/26 Keppra due at 10:00AM was administered at 1:21PM 1/10/26 Glipizide due at 9:00AM was administered at 10:30AM1/10/26 Bactrim due at 9:00AM was administered at 10:30AM1/13/26 Glipizide due at 9:00AM was administered at 12:30PM1/13/26 Keppra due at 10:00AM was administered at 12:30PM1/14/26 Bactrim due at 9:00AM was administered at 12:25PM 1/14/26 Glipizide due at 9:00AM was administered at 12:25PM 1/14/26 Keppra due at 10:00AM was administered at 12:25PM1/16/26 Glipizide due at 9:00AM was administered at 10:24PM 1/16/26 Bactrim due at 9:00AM was administered at 10:25AM 1/17/26 Glipizide due at 9:00AM was administered at 12:13PM 1/17/26 Bactrim due at 9:00AM was administered at 12:13PM 1/17/26 Keppra due at 10:00AM was administered at 12:13PM 1/20/26 Keppra due at 5:00PM was administered at 6:25PM 1/21/26 Glipizide due at 9:00AM was administered at 11:21AM 1/21/26 Bactrim due at 9:00AM was administered at 11:21AM 1/21/26 Keppra due at 10:00AM was administered at 11:21AM 1/23/26 Glipizide due at 9:00AM was administered at 10:32AM 1/23/26 Bactrim due at 9:00AM was administered at 10:34AM1/23/26 Keppra due at 5:00PM was administered at 6:42PM 1/24/26 Bactrim due at 9:00AM was administered at 1:11PM 1/24/26 Glipizide due at 9:00AM was administered at 1:11PM 1/24/26 Keppra due at 10:00AM administered at 1:11PM1/25/26 Glipizide due at 9:00AM administered at 11:30AM1/25/26 Bactrim due at 9:00AM administered at 11:30AM1/25/26 Keppra due at 10:00AM administered at 11:30AM 1/26/26 Glipizide due at 9:00AM administered at 11:17AM 1/27/26 Keppra due at 10:00AM administered at 11:28AM 1/30/26 Bactrim due at 9:00PM was administered at 11:11PM1/31/26 Glipizide due at 9:00AM administered at 12:12PM 1/31/26 Keppra due at 10:00AM administered at 12:12PM 2/2/26 Keppra due at 10:00AM administered at 11:21AM2/3/26 Glipizide due at 9:00AM administered at 11:11AM 2/5/26 Bactrim due at 9:00AM administered at 11:43AM2/5/26 Glipizide due at 9:00AM administered at 11:43AM2/5/26 Keppra due at 10:00AM administered at 11:43AM2/7/26 Glipizide due at 9:00AM administered at 12:17PM2/7/26 Keppra due at 10:00AM administered at 12:19PM 2/8/26 Bactrim due (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:00AM administered at 10:56AM2/8/26 Keppra due at 5:00PM was administered at 7:25PM2/9/26 Keppra due at 10:00AM was administered at 2:31PM 2/9/26 Bactrim due at 9:00AM was administered at 2:31PM2/9/26 Glipizide due at 9:00AM was administered at 2:31PM 2/10/26 Keppra due at 10:00AM was administered at 11:16AM2/11/26 Bactrim due to at 9:00AM administered at 10:42AM 2/11/26 Keppra due at 10:00AM administered at 10:42AM 2/12/26 Bactrim due at 9:00AM administered at 12:10PM2/12/26 Glipizide due at 9:00AM administered at 12:10PM2/12/26 Keppra due at 10:00AM administered at 12:10PM 2/13/26 Glipizide due at 9:00AM administered at 12:32PM 2/13/26 Bactrim due at 9:00AM administered at 12:32PM 2/13/26 Keppra due at 10:00AM administered at 12:32PM 2/13/26 Keppra due at 5:00PM administered at 7:39PM 2/13/26 Gabapentin due at 8:00PM administered at 9:43PM 2:14/26 Gabapentin due at 8:00AM administered at 10:49AM2/14/26 Bactrim due at 9:00AM administered at 10:49AM 2/14/26 Glipizide due at 9:00AM administered at 10:49AM 2/14/26 Gabapentin due at 8:00PM administered at 9:15PM 2/15/26 Gabapentin due at 8:00AM administered at 9:22AM2/16/26 Gabapentin due at 8:00AM administered at 11:30AM2/16/26 Bactrim due at 9:00AM administered at 11:30AM 2/16/26 Keppra due at 10:00AM administered at 11:30AM2/16/26 Gabapentin due at 2:00PM administered at 4:37PM 2/17/26 Gabapentin due at 8:00AM administered at 2:23PM 2/17/26 Glipizide due at 9:00AM administered at 2:23PM 2/17/26 Gabapentin due at 2:00PM administered 4:16PM 2/18/26 Gabapentin due at 8:00AM administered at 12:28PM 2/18/26 Bactrim due at 9:00AM administered at 12:28PM 2/18/26 Glipizide due at 9:00AM administered at 12:28PM2/18/26 Keppra due at 10:00AM administered at 12:28PM 2/19/26 Gabapentin due at 8:00AM administered at 9:26AM2/19/26 Keppra due at 5:00PM administered at 6:23PM 2/20/26 Gabapentin due at 8:00AM administered at 11:17AM2/20/26 Bactrim due at 8:00AM administered at 11:17AM2/20/26 Glipizide due at 9:00AM administered at 11:17AM 2/20/26 Keppra due at 10:00AM administered at 11:17AM 2/21/26 Gabapentin due at 8:00AM administered at 9:45AM2/23/26 Gabapentin due at 8:00AM administered at 2:16PM 2/23/26 Glipizide due at 9:00AM administered at 2:16PM 2/23/26 Bactrim due at 9:00AM administered at 2:16PM 2/23/26 Keppra due at 10:00AM administered at 2:16PM 2/25/26 Gabapentin due at 8:00AM administered at 10:48AM 2/25/26 Bactrim due at 9:00AM administered 10:48AM 2/25/26 Glipizide due at 9:00AM administered at 10:48AM 2/26/26 Gabapentin due at 8:00AM administered at 9:37AM Observation on Resident #45's unit on 3/2/26 at 10:15AM identified LPN#1 completing the morning medication pass. Interview with LPN#1 on 3/2/26 at 10:20 AM, identified that she used to be responsible for administering medications to 38 residents but recently the unit was split up between two nurses and now she is responsible for 15 residents. She noted that she started the medication pass at 7:30 AM and still had 9 residents remaining to administer medications. LPN #1 attributed the delay in the medication administration to staff and resident interruptions. She further noted that on other days, it was most likely short staffing or interruptions. Interview on 3/2/26 at 12:00PM with the DNS identified she was unaware that medications were being passed late on a consistent basis, and if medications were late, she would expect the nursing supervisor to be made aware and the provider to be notified in case medications need to be rescheduled. Interview on 3/2/26 at 12:50PM with RN#2 (nursing supervisor) identified she was unaware that medications were being passed late on a consistent basis as she would expect the nurse to notify her if medications were going to be late. She only knew of one recent episode in which a nurse went home early due to being sick, which was on 2/27/26. She further noted that if medications are being passed late, she would need to reach out to the provider in case they needed to be rescheduled.Interview on 3/2/26 at 1:00PM with APRN#1 identified she was unaware of medications being passed late and noted that it was concerning because medications may need to potentially be rescheduled due to the potential of being given near the next dose. The medication administration protocol identified to verify orders, avoid distractions and interruptions when preparing and administering medications to reduce the risk of medication errors.

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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** Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #2) who was incontinent, dependent on staff for care, and had a pressure injury, the facility failed to ensure the timely provision of care allowing the resident to go without incontinent care for over five hours. The findings include:Resident #2 was readmitted to the facility in September 2025. Diagnoses included Type 2 diabetes mellitus without complications, Sjogren syndrome, chronic combined systolic (congestive and diastolic (congestive) heart failure. The Norton Plus Assessment (determines the risk of developing pressure ulcers), dated 10/6/25 identified Resident #2 scored 11 which indicated Resident #2 was at high risk. The annual MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition, utilized a wheelchair, was dependent for transfers, showering and toileting hygiene, was always incontinent of bladder and frequently incontinent of bowel, was at risk for developing a pressure injury but did not have any unhealed pressure ulcers/injuries, or other ulcers, wounds or skin problems and had a pressure reducing device for chair, pressure reducing device for bed, and application of nonsurgical dressings and applications of ointments/medications.The care plan dated 10/2/25 identified Resident #2 was at risk for skin breakdown related to decreased mobility and moisture with interventions that included an alternating pressure mattress (APM) set at 200 lbs., inspect skin for redness, irritation or breakdown during care, offer turning and repositioning approximately every 2 hours and as needed (PRN) and complete weekly skin inspections. The wound nurse's progress note dated 10/7/25 at 5:24 PM identified Resident #2 was seen for wound care. Buttocks inspected- blanchable erythema with small, superficial denuded areas. Presentation consistent with MASD (moisture associated skin deterioration). The note further indicated the APRN was updated and a foam dressing was added to the triad paste. The note identified the APM was in place and a ROHO cushion was requested from therapy. The physician's order dated 10/7/25 directed to apply triad paste to buttock followed by foam dressing every day on night shift for wound/skin care, apply ROHO cushion to the wheelchair and check proper cushion and placement every shift.The nursing progress note dated 12/5/25 at 3:27 PM identified Resident #2 had loose, liquid bowel movements with malodorous odor and indicated the sacral area was noted with skin irritation consistent with incontinence associated dermatitis with an order for triad ointment in place. The physician's order dated 1/28/26 directed wound/skin care to apply triad paste to buttock followed by foam dressing every day, every night shift.Interview with Resident #2 on 2/19/2026 at 2:16 PM identified complaints of a rectal/back sore and indicated the soreness was related to having to sit in wet briefs due to staffing constraints on some days. Observation at this time noted the APM was set at 250 lbs. and identified a container of Aquaphor ointment on the side table. Resident #2 indicated that he/she had been provided with incontinent care but had not been out of bed. Resident #2 identified that she/he required the use of a Hoyer and two staff members for transfers. Observation of Resident #2 on 2/26/26 at 11:17 AM identified Resident #2 was still in bed and had not been cleaned up for the day. Resident #2 indicated that he/she had not been changed since night shift and was waiting for staff to come in. Resident #2 identified that the Aquaphor is on the bedside table, so it is readily accessible but indicated that it is not being placed on the rectum and that the rectum and back continue to have pain to the point that staff has started placing pillows on each side under his/her hips to alleviate some of the pressure at his/her request.Interview with NA #4 on 2/26/26 at 12:08 PM identified that this was the first time that day that she was providing care to Resident #2. NA #4 indicated that she approached the resident's room around 10:00 AM and a visitor was present, so she decided to reapproach later. NA #4 identified she could not identify when the resident had last been provided with incontinent care and indicated she asked the nurse for direction on patient care because the unit was so fast paced. NA #4 had provided (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most care prior to the nurse notifying this surveyor that care was being provided and indicated that the wound dressing had been saturated with urine.Observation of Resident #2 on 2/26/26 at 12:10 PM identified the old dressing was in the trash and it was dated 2/26/26, 11-7. Observation of Resident #2's skin identified a wound to the sacral/coccyx area on the lower back just above the buttocks that had an open area present with yellow drainage and slough (devitalized tissue) present. The wound edges were irregular and partially macerated, and the surrounding skin was discolored and scarred. Interview with LPN #6 on 2/26/26 at 12:13 PM identified Resident #2's dressing was placed on the night shift. She further noted that it needed to be changed due to being saturated with urine. LPN #6 indicated that this was the first time she had been into Resident #2's room for care.Interview with the Medical Director on 2/26/26 at 12:57 PM identified that he did not make decisions regarding wound care treatment and that if staff comes across a wound, it would be referred to the wound nurse and the wound APRN. The Medical Director indicated that he was not aware if the APM setting impacted wound healing.Interview with the Nursing Supervisor RN#2 on 2/26/26 at 1:07 PM identified that every resident in the facility gets a weekly skin check. RN#2 indicated the order should be placed on admission and would coordinate with the resident's shower day and prompt the nurse to complete the weekly skin check. RN#2 reviewed Resident #2's clinical chart which failed to identify an order for a weekly skin audit and failed to identify weekly skin audits. RN#2 identified that any new skin problem would immediately get referred to the wound nurse and indicated that although the wound nurse put a treatment order in on 10/7/25, there was not an assessment or monitoring of Resident #2's sacrum. RN #2 identified that the wound APRN had not seen Resident #2 for the sacral wound.Interview with LPN #11 on 2/27/26 at 6:35 AM identified she worked nights (11 pm to 7 am shift) and completed wound care on Resident #2. LPN #11 indicated the treatment had been in place for a long time and the nursing supervisor or the wound nurse would be notified of wound deterioration.Interview with the Staff Development Nurse (RN#1) on 2/27/26 at 6:55 AM identified new skin problems found should be reported to the nursing supervisor who would do an assessment that included measuring the wound.Interview with APRN#1 on 2/27/26 at 11:09 AM identified she referred to Resident #2's sacral area as a Stage 2 because it was in a previous note. APRN#1 indicated that when she looked at the wound, she thought it was being monitored. APRN#1 identified the wound should be monitored by nursing and should have been seen by the wound nurse.After surveyor inquiry a physician's order dated 2/26/26 directed to cleanse the stage 2 pressure wound to the sacrum with normal saline followed by triad cream and cover with a foam dressing. It further noted to change the dressing daily on the evening shift and as needed. Interview with the Corporate Nursing Director (LPN#3) identified that the initial assessment of a wound should include measurements, assessment, drainage amount and should be monitored.Interview with the wound RN on 3/2/26 at 10:59 AM identified Resident #2 was being seen for other wounds but had not been seen until 3/1/26 by the wound APRN. The wound RN indicated that every resident should have weekly skin checks by nursing and wounds should be referred to the wound nurse. The wound RN identified the original treatment was placed for a macerated area caused by incontinence.Interview with APRN #2, (wound APRN) on 3/2/26 at 3:54 PM identified she observed Resident #2's sacral area yesterday for the first time. APRN#2 indicated that she should have seen the area earlier and that the area looked like incontinence that had recurred. APRN #2 identified that people with moisture associated skin issues are 33 percent more susceptible to developing a pressure injury.The facility's policy for Pressure Injury/Non-pressure Wound Risk Management identified that residents who score at risk for skin impairment or have actual skin impairment are provided with care to address risk factors and goals of treatment and interventions include reposition approximately every 2 hours or more frequently and to check resident for incontinence approximately every 2 hours or per individualized plan of care

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	075350	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Sheriden Woods	321 Stonecrest Drive Bristol, CT 06010

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #79) reviewed for foot care, the facility failed to ensure the resident received podiatry services for trimming of toenails. The findings include:Resident #79 was admitted to the facility in November of 2025 and had diagnosed that included type 2 diabetes mellitus, multiple sclerosis, and paraplegia. The admission MDS assessment dated [DATE] identified Resident #79 was cognitively intact, dependent on staff for dressing, personal hygiene, putting on/taking off footwear, transfers and was non-ambulatory. The care plan dated 11/21/25 identified Resident #79 had diabetes with interventions that directed podiatry consult as ordered and skin audits per facility protocol. The care plan further identified the resident requires assistance with dressing, bathing hygiene, transfers, total care except feeding, oral care and dressing with interventions directed assist with one person for activities daily living skills at bed level and give the resident sufficient time to accomplish each task. Review of the monthly physician's order for November 2025 identified an order that directed podiatry care as needed, diabetic foot care every evening shift, and weekly skin checks on shower days every Mondays and Thursdays on the evening shift. The physician's order for December/2025 through February 23, 2026, identified an order that directed podiatry care as needed, and weekly skin checks on shower days every Mondays and Thursdays on the evening shift. Observation on 2/24/26 at 9:17 AM identified Resident #79 lying in bed with his/her feet uncovered with the toenails on the left foot that appeared to need trimming. Review of Resident #79 clinical records failed to identify the resident had been seen by the podiatrist since his/her admission. Review of the weekly skin checks for the period of November/2025 through February 24, 2026, did not identify any issues or concerns with Resident #79's toenails.Observation and interview with NA #6 on 2/26/26 at 11:50 AM identified Resident #79 [NAME] in bed with his/her overbed table in front of him/her. NA #6 let the resident know what she was about to do prior to preceding to remove his/her sock and the following was noted: on the left foot: the 1st, 2nd and 3rd toenail extended greater that 0.5 centimeters (cm) over the tip of the toe and on the right foot the 1st toenail was thick at the tip, the 2nd and 3rd toenail all extended greater that 0.5 cm over the tip of the toe. NA #6 identified she provides care to the resident and had noticed that his/her toenails needed to be trimmed. She indicated that she had reported it to the nurse two weeks ago but was unable to recall the name of the nurse who she had told about the resident's toenails. The resident interjected and indicated he/she had told one the staff about his/her toenails needing trimming and was told that he/she would need to be placed on the podiatry list. Observation and interview with the Charge Nurse (LPN #4) on 2/26/26 at 12:02 PM identified the same as the observation with NA #6. LPN #4 identified she was unaware that the resident's toenails needed trimming. LPN #4 further identified that nails are checked on the resident's weekly skin checks which are completed on their shower days, and Resident #79 is completed on the evening shift. She further indicated that if she had been made aware, she would have placed the resident on the podiatrist list. Interview with the Unit Secretary on 2/26/26 at 12:13 PM identified she is responsible for scheduling physician's appointments including podiatry for the residents since being hired 3 months ago. The Unit Secretary identified nursing communicates with her via email or verbally for any resident who needs an appointment scheduled and was only told on 2/26/26 by the morning supervisor that Resident #79 needed to be placed on the podiatry list. She identified the podiatrist who usually comes monthly and sends over a list of the residents who will be seen prior to their visit. She reviewed past podiatrist visits and identified that Resident #79 had not been seen for the period of December/2025 through February/2026.A review of the Podiatrist's service dates at the facility for the period of December 1, 2025, through February 26, 2026, identified that the Podiatrist visited the facility a total of 3 times to provide podiatry services.Review of the physician's order dated 2/24/26 identified an order that (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directed an appointment needed for podiatry consult.Interview with the evening shift Nursing Supervisor (RN #5) on 2/27/26 at 9:12 AM identified she was told by the ADNS to place an order for podiatry consult for Resident #79. She further identified that she was not made aware Resident #79 toenails needed trimming nor did the ADNS tell her the reason why the resident needed to have a podiatry appointment. Interview with the ADNS on 2/27/26 at 12:30 PM identified she was stopped in the hallway by Resident #79's family member asking if Resident #79 could be seen by the podiatrist as he/she has not had a visit for a while now, then she informed the supervisor to schedule a podiatrist appointment. Observation and interview with the DNS on 2/27/26 at 12:58 PM identified Resident #79 lying in bed. The DNS removed the resident's non-skid socks from both feet and the following was noted: On the right foot the great toenail tip was thick and measured approximately 1 centimeter (cm), the 2nd toenail tip measured approximately 1.0 cm, the 4th toenail tip measured approximately 1 cm. On the left foot the great toenail tip measured approximately 1.5 cm, the 2nd toenail tip measured approximately 1cm and the 3rd toenail tip measured approximately 1cm. The DNS identified resident's skin including nails are checked weekly on their shower days by the nurse and the nurse aide who provides the shower. The DNS identified that there was no way that the staff did not notice Resident #79's toenails. Interview with the evening shift Charge Nurse (LPN#5) on 3/2/26 at 9:52 AM identified Resident #79 weekly skin checks were completed on Mondays in which the nurse would look at the resident's entire body including their nails. She identified that she had completed a few of the weekly body skin checks but did not look at the resident's toenails as she did not remove Resident #79's socks when performing the skin check. She indicated that she also works the night shift and the evening shift, and none of the nurse aide reported to her that Resident #79's toenail needed trimming. Review of the Foot Care policy identified residents receive appropriate care and treatment to maintain mobility and foot heath. The policy further identified overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions, for example diabetes, peripheral vascular disease and immobility are referred to qualified professionals.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #102) reviewed for pain, the facility failed to ensure the resident received pain medication timely. The findings include: Resident #102's diagnoses included primary osteoarthritis left shoulder, pain disorder with related psychological factors, chronic pain syndrome, unilateral primary osteoarthritis right knee. The quarterly MDS assessment dated [DATE] identified Resident #102 was cognitively intact, had no behaviors, required limited assistance with bed mobility, independent to supervision or touching assistance with transfers, partial to moderate assistance with dressing and independent with personal hygiene. The assessment further identified that the resident utilized a walker and a wheelchair for mobility.The care plan dated 2/26/26 identified Resident #102 was at risk for pain related to being on pain medication therapy with interventions that included administer analgesic medications as ordered by the physician, monitor and document side effects every shift, review following administration for pain medication efficacy, assess whether pain intensity is acceptable to resident. Physician's order active February 2026 directed to administer Morphine sulfate oral solution 20mg/ml give 0.25ml every 8 hours as needed for pain which was discontinued on 2/19/26 at 3:59PM and restarted the same date to be every 6 hours. Interview on 2/19/26 at 11:30AM with Resident #102 identified the resident had requested the as needed Morphine from LPN#9 for a pain level of 6 at 10:00AM that morning now the pain had increased and Resident #102 was still waiting for the medication.Interview on 2/27/26 at 11:30AM with LPN#9 identified he recalled Resident #102 requesting the as needed Morphine on 2/19/26 between 10:00AM and 11:00AM in fact he believed the resident may have stopped him in the hall returning from a smoke break (which started at 10:00AM.) LPN#9 identified that when resident #102 requested the medication he stopped administering medication to the next patient and went to Resident #102 to pass the medication and went within 5 minutes to pass the medication to Resident #102. Review of the MAR for February 2026 identified LPN#9 administered the as needed Morphine to resident#102 at 12:31PM on 2/19/26. Interview on 3/2/26 at 10:25AM with Resident #102 identified he/she recalls receiving the Morphine on 2/19/26 approximately two hours after initially requesting the medication which was after 12:00PM, and after the resident spoke with the surveyor. Resident #102 further identified he/she had not received the as needed Morphine from LPN#1 that morning after requesting it at 10:00AM. Interview on 3/2/26 at 10:30AM with LPN#1 identified Resident #102 had requested the as needed Morphine around 10:00AM however she had not had time to pass it and had forgotten about it. LPN#1 asked Resident #102 what his pain level was during the interview as Resident #102 was present and Resident #102 responded a 10 plus.Interview on 3/2/26 at 1:00PM with APRN#1 identified she was unaware of residents needing to wait an extended period to receive their pain medication. She would expect if the nurse were busy completing a task that the resident should not wait longer than 15 minutes unless there is an emergency in which the nurse was attending to. Review of the MAR for March 2026 identified LPN#1 passed Resident #102 the ass needed Morphine at 10:46AM on 3/2/26 for a pain level of 7. Review of the Civita Pain Assessment and Management policy implemented in the facility by RN#1 (staff development,) directed pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. Implementing pain management strategies for pharmacologic interventions may be prescribed to manage pain. Strategies may be employed when establishing the regime include combining long-acting medications with as needed or breakthrough pain. Review of the Civita Pain Medications policy directed to administer pain medications as ordered.

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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** Based on review of clinical records, review of facility documentation, review of facility policy/procedure, and interviews for one of five sampled residents (Resident #5) reviewed for immunizations, the facility failed to ensure that the resident was offered and/assessed for pneumococcal and influenza immunization upon admission as per facility's policy. The findings include:Resident #5 was admitted to the facility in January of 2026 and had diagnoses that included chronic kidney disease, type 2 diabetes mellitus and chronic obstructive pulmonary disease. The admission MDS assessment dated [DATE] identified Resident #5 was cognitively intact and had not received the influenza vaccine as it was not offered. Review of Resident #5 immunization and clinical records with the Infection Preventionist (IP) nurse (RN #6) on 2/24/26 at 12:31 PM failed to identify that the influenza and the pneumococcal vaccine was offered and/or assessed for past immunization. Interview with RN #6 on 2/24/26 at 12:31 PM identified that he was unable to provide any documentation of Resident #5's pneumococcal and influenza vaccine records, as the consent forms was not reviewed with the resident. RN #6 identified consents are obtained on admission by the admitting supervisor and it is then reviewed by the IP nurse. The IP nurse wound then check on the CT wiz, which is a database that maintains patients vaccination records, to ensure that the resident had not received the vaccination prior to admission. RN #6 further identified after the resident vaccination history is check then the appropriate vaccine is ordered by the physician for inoculation. He further identified the facility has a full time IP nurse who was responsible for reviewing the vaccine as he only works 16 hours weekly as the wound nurse and to oversee the IP nurse. RN #6 identified he will review the vaccine consents with the resident on 2/24/26 as it should have been completed on admission. Review of the Procedure for Pneumococcal Vaccination of Residents policy identifies each resident, or their responsible party will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. The records that accompany the residents also will be used to determine immunization status. The policy further identifies the pneumococcal conjugate vaccine will be offered to all eligible residents, and the risk and benefits will be provided to the resident or the resident's legal representative prior to administration of the vaccine, and the resident or resident's legal representative has the rift to refuse the vaccine. Review of the Immunization of Residents policy identifies all eligible resident will be offered the influenza and pneumococcal vaccines unless medically contraindicated. The policy further identifies the resident or the resident's legal representative will be provided education regarding the pros and cons of the vaccine prior to administration and the resident or resident's legal representative has the right to refuse the vaccine.