STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075356	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Health and Rehabilitation Center	76 West Rocks Road Norwalk, CT 06851

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #42) reviewed for falls, the facility failed to develop and implement a comprehensive care plan for a resident who had a history of repeated falls on admission and was identified as a moderate fall risk. The findings include: Resident #42 was admitted to the facility on [DATE] with diagnoses that included syncope and collapse, Alzheimer's disease, and repeated falls. The admission fall risk assessment dated [DATE] identified Resident #42 had a history of 1 - 2 falls within the last 3 months, was taking diuretics, hypoglycemic agents, antihypertensives, and psychotropics more than 3 times weekly, had an inadequate vision pattern, and a gait analysis included: inability to independently come to a standing position, loss of balance while standing, requiring a hands-on assist to move from place to place, utilizing an assistive device, and had a decrease in muscle coordination. The fall risk assessment further identified that Resident #42 was at a moderate risk for falls. The admission MDS dated [DATE] identified Resident #42 had intact cognition, required supervision or touching assistance to ambulate 10 feet, required a walker as an assistive device and had sustained a fall in the last month and the last 2 - 6 months, prior to admission The care plan dated 10/22/23 and 4/10/24 failed to identify a focus, goals, or interventions related to Resident #42's history of falls and moderate risk for falls. The nurse's note dated 6/14/24 at 2:23 AM identified that Resident #42 was observed lying on the floor on his/her left side complaining of severe (10/10) left hip pain extending to the left leg. According to the resident he/she lost balance while walking with a cane to the bathroom and landed on his/her left hip. The resident was sent to the emergency department at 1:45 AM. The RN Assessment of Incident document dated 6/14/24 identified the care plan intervention(s) implemented was for PT/OT evaluation. The reportable event form dated 6/16/24 identified that Resident #42 was admitted to the hospital due to a left hip fracture. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 6/20/24 at 9:26 PM identified Resident #42 was readmitted from the hospital back to the facility via stretcher around 3:48 PM. A fall risk assessment dated [DATE] identified Resident #42 was taking diuretics, hypoglycemic agents, antihypertensives, nonsteroidal anti-inflammatory medications, narcotics, psychotropics, and sedatives/hypnotics more than 3 times weekly, had an inadequate vision pattern, had total incontinence in the last 14 days, was confined to a chair and disoriented, and a gait analysis included: inability to independently come to a standing position and decrease in muscle coordination. The fall risk assessment further identified that Resident #42 was at a high risk for falls. The significant change MDS dated [DATE] identified Resident #42 had moderately impaired cognition, had a one-sided lower extremity impairment, and a chair/bed-to-chair transfer was not attempted due to medical condition or safety concerns. The care plan dated 7/17/24 identified Resident #42 had an actual fall with major injury. Interventions included a PT consult for screen, status post fall. Interview and review of the clinical record with the DNS on 8/27/24 at 9:38 AM failed to provide documentation that a comprehensive care plan was developed addressing Resident #42's history and risk for falls, prior to his/her fall with injury on 6/14/24. The DNS identified that she would have expected a care plan to be in place identifying Resident #42's risk for falls and appropriate interventions. The DNS indicated that the nursing supervisor can initiate a care plan, but typically it is the responsibility of the MDS coordinator, in collaboration with the interdisciplinary team, to develop the comprehensive care plan. Interview and review of the clinical record with the MDS coordinator (LPN #3) on 8/27/24 at 10:52 AM failed to provide documentation that a comprehensive care plan was developed addressing Resident #42's history and risk for falls, after admission to the facility. LPN #3 identified that she created a care plan after Resident #42 sustained an actual fall with injury when he/she returned to the facility on [DATE], but she was not aware that Resident #42 was a moderate risk for falls when he/she was admitted to the facility, or she would have created a fall care plan. LPN #3 further indicated that the RN supervisor usually starts the interim care plan, and then she would update the on-going comprehensive care plan. The Comprehensive Care Plan policy directs the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completion of the comprehensive MDS assessment. All care assessment areas triggered by the MDS will be considered in developing the plan of care, and other factors identified by the interdisciplinary team, or in accordance with the resident's preferences will also be addressed in the plan of care. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #42) reviewed for falls, the facility failed to ensure quarterly fall risk assessments were completed, per the facility policy. The findings include: Resident #42 was admitted to the facility on [DATE] with diagnoses that included syncope and collapse, Alzheimer's disease, and repeated falls. The admission fall risk assessment dated [DATE] identified Resident #42 had a history of 1 - 2 falls within the last 3 months, was taking diuretics, hypoglycemic agents, antihypertensives, and psychotropics more than 3 times weekly, had an inadequate vision pattern, and a gait analysis included: inability to independently come to a standing position, loss of balance while standing, requiring a hands-on assist to move from place to place, utilizing an assistive device, and had a decrease in muscle coordination. The fall risk assessment further identified that Resident #42 was at a moderate risk for falls. The quarterly MDS dated [DATE] identified Resident #42 had intact cognition, was independent walking 150 feet, and had not sustained any falls since admission to the facility. The nurse's note dated 6/14/24 at 2:23 AM identified that Resident #42 was observed lying on the floor on his/her left side complaining of severe (10/10) left hip pain extending to the left leg. The resident was sent to the emergency department at 1:45 AM. The fall risk assessment dated [DATE] identified Resident #42 was taking hypoglycemic agents, antihypertensives, and nonsteroidal anti-inflammatory medications more than 3 times weekly, and a gait analysis included utilizing an assistive device. The fall risk assessment further identified that Resident #42 was at a low risk for falls. The nurse's note dated 6/20/24 at 9:26 PM identified Resident #42 was readmitted from the hospital back to the facility via stretcher around 3:48 PM. A fall risk assessment dated [DATE] identified Resident #42 was taking diuretics, hypoglycemic agents, antihypertensives, nonsteroidal anti-inflammatory medications, narcotics, psychotropics, and sedatives/hypnotics more than 3 times weekly, had an inadequate vision pattern, had total incontinence in the last 14 days, was confined to a chair and disoriented, and a gait analysis included: inability to independently come to a standing position and decrease in muscle coordination. The fall risk assessment further identified that Resident #42 was at a high risk for falls. Interview and review of the clinical record with the DNS on 8/27/24 at 9:38 AM failed to provide documentation that quarterly fall risk assessments were completed for Resident #42 following the admission fall risk assessment dated [DATE] and prior to the post-fall risk assessment dated [DATE] (9 months). The DNS identified that she would expect the fall risk assessments to be completed by the nurse on admission, quarterly, and after a fall occurs, per the facility policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Risk policy directs the facility to have an objective tool to assess fall risk potential of each resident. The nurse will assess the resident upon admission, significant change of condition, and quarterly for their fall/risk potential, using the fall risk assessment form.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46040 Based on review of facility documentation, facility policy and interviews, the facility failed to ensure annual performance evaluations were completed for nurse aide staff for 2023. The findings included: During a review of performance evaluations for facility nurse aide staff on 8/26/24 for 2023 and 2024, the facility failed to provide any documentation of performance evaluations completed for NA #1 and NA #2 for 2023. Subsequent to this review, an additional request was made to the DNS provide additional annual performance evaluations for NA #1 and NA #2 for 2023. Interview with the DNS on 8/27/23 at 11:00 AM identified she was unable to locate any annual performance evaluations for nurse aide staff that had been completed in 2023. The DNS identified she was new to the facility and had completed annual evaluations for 2024 but was unable to locate any evaluations for nursing staff for 2023. The DNS further identified that she identified that the evaluations had not been completed and implemented an annual performance evaluation policy in 6/2024 to ensure that the annual evaluations were completed going forward. The facility annual performance evaluation policy, dated 6/27/24, directed that the purpose of the policy was to ensure a consistent approach was followed for conducting annual performance reviews and that job related skills, knowledge, and employee competencies would be evaluated. The facility assessment policy directed that the purpose of the assessment was to determine what resources were needed to competently care of residents of the facility. The policy further directed that facility resources needed to provide competent care included staff training, education, and competencies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #39) reviewed for pressure ulcers, the facility failed to ensure appropriate infection control techniques were implemented during a dressing change for a resident on enhanced barrier precautions. The findings include: Resident #39 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, bladder cancer, and dementia. The care plan dated 5/20/24 identified Resident #39 required a suprapubic catheter due to neurogenic bladder from bladder cancer. Interventions included to monitor for signs/symptoms of urinary tract infections. Further review of the care plan failed identify interventions related to potential alteration in skin integrity or enhanced barrier precautions. The quarterly MDS dated [DATE] identified Resident #39 had severely impaired cognition, was frequently incontinent of bowel and always incontinent of bladder and required maximal assistance from staff with transfers, bathing, and toileting. The MDS failed to identify Resident #39 required a suprapubic catheter for bladder. A physician's order dated 8/4/24 directed Resident #39 required enhanced barrier precautions be maintained at all times related to use of a suprapubic catheter. Review of a facility transmission-based precautions list dated 8/1/24 identified Resident #39 was on enhanced barrier precautions due to a suprapubic tube in place. Review of the clinical record identified Resident #39 developed a newly identified pressure injury to the sacrum on 8/13/24. A wound care physician note dated 8/14/24 identified Resident #39 was seen for an initial exam of an unstageable sacral pressure ulcer which measured 2.8cm x 2.5cm x 0.2cm. Treatment plan identified the wound would be dressed daily and as needed with Santyl, Calcium Alginate, and a dry clean dressing. The physician's orders dated 8/24/24 directed new wound orders to the sacral pressure ulcer included cleans daily with saline, then apply santyl ointment followed by Bactroban (an antibiotic ointment) and a dry clean dressing. Observation of RN #2 on 8/26/24 at 11:13 AM completing Resident #39's pressure ulcer dressing change identified the following. A sign posted on Resident #39's room door identified (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	STOP. Enhanced barrier precautions. Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for high contact resident activities including wound care (any skin opening requiring a dressing). RN #2 was observed placing a treatment cart directly outside of Resident #39's door and using Resident #39's bedside table to set up an area for the dressing change. RN #2 was observed using gloves to set up the table but was not wearing a gown. After setting up the table in Resident #39's room, RN #2 removed his gloves, stepped outside the doorway, moved the treatment cart to access a hand sanitizing dispenser located directly outside of Resident #39's room, and then donned a new pair of gloves. RN #2 did not don a gown during this observation. At 11:16 AM, RN #2 was observed removing Resident #39's previous dressing. A small amount of feces was observed on a brief pad and on the resident's skin at the rectum, directly below the dressing. Immediately following observation of the dressing removal, this surveyor inquired if Resident #39 had any transmission-based precautions in place. RN #2 identified that Resident #39 was on enhanced barrier precautions. The surveyor inquired what type of PPE was required, and RN #2 identified I should have put on a gown and mask. RN #2 stopped the dressing change, removed his gloves, left the room, and used the hand sanitizer outside of the room. At 11:19 AM, RN #2 reentered the room after donning a gown. RN #2 donned a face mask and gloves. RN #2 continued with the removal of the old dressing and cleansed the wound with saline and a 4 x 4 gauze pad, which RN #2 had opened after removing the old dressing. RN #2 removed his gloves and went to the hand sanitizer dispenser directly outside of Resident #39's room. With the gown on RN #2 opened the treatment cart and obtained Santyl ointment and reentered Resident #39's room and donned a new pair of gloves. While observing RN #2 during this observation, the DNS was also observed at the nurse's station on the unit. At 11:22 AM, RN #3 applied santyl ointment to Resident #39's wound with his right gloved hand using his index finger. RN #2 removed the right glove and donned a new glove to the right hand without performing hand hygiene. RN #2 used the right gloved hand to apply Bactroban ointment with gloved right index finger. RN #2 wiped the remaining ointment onto an unsoiled portion of Resident #39's brief pad and opened a clean dressing pad package, without touching the dressing inside and removed the right hand glove and disposed of it in the trash. At 11:24 AM, RN #2 used his ungloved right hand and placed the opened dressing package on Resident #39's bed, partially applied a new right glove to his fingers but not the thumb, removed the adhesive with his left gloved hand, and applied the clean dressing with his left gloved and partially gloved right hand, and removed the right glove. No hand hygiene was observed. RN #2 then identified he would need to find a marker to label Resident #39's dressing time/date. RN #2 identified he had a pen in his pocket that he could use. RN #2 used his right ungloved hand to reach into his left upper chest pocket while pulling the gown away to attempt to access his pocket. RN #2 pulled a blue pen out, attempted to label the dressing with the pen but was unsuccessful, and placed the pen back into the same left upper chest pocket. RN #2 removed the left glove, gathered the dressing supplies and packages from the bedside table, and removed his gown and mask with his ungloved hands. RN #2 then disposed of these items, exited the room to use the hand sanitizer dispenser outside Resident #39's door, obtained a marker from the treatment cart and labeled Resident #39's new dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 immediately following the observations identified that he was aware that Resident #39 was on enhanced barrier precautions but was focused on the dressing supplies and did not remember to don a gown. RN #2 identified that he was an agency nurse, and it was only his second day working in the facility. RN #2 further identified that he did not think to use Resident #39's sink for hand hygiene or bring in a separate hand sanitizer dispenser to allow him to remain in the room for the duration of the dressing change. RN #2 also identified he did not think reaching into his pocket under his gown for a pen was an issue, since he did not have a glove on his hand, but identified he should have performed hand hygiene prior reaching into his pocket. Although requested, the facility failed to provide any policies related to dressing changes, donning and doffing personal protective equipment (PPE), and hand hygiene. The facility policy on Enhanced Barrier Precautions (EBP) in skilled nursing directed that EBP expanded the use of PPE to include use of gown and gloves during high contact resident care activities that provided opportunities for transfer of multidrug resistant organisms (MDROs) to staff hands and clothing. The policy further directed EBP was indicated for residents who had wounds and/or any indwelling medical devices even if the resident was not known to be colonized with a MDRO, and these devices included urinary catheters. The policy also directed high contact resident care activities that included wound care to any skin opening requiring a dressing.

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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** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 5 residents (Resident #3,14, 27, 30 and 209) reviewed for vaccinations, the facility failed to provide documentation that the resident or resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization, and that the resident either received the pneumococcal immunization according to the CDC guidelines or did not receive the pneumococcal immunization due to medical contraindication or refusal. The findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included mild cognitive impairment, anxiety disorder, and cognitive communication deficit. Resident #3 had a resident representative who was identified as the responsible party, and Resident #3 was identified as being older than [AGE] years. The quarterly MDS dated [DATE] identified Resident #3's pneumococcal vaccination was up to date. The immunization record indicated Resident #3 had the pneumococcal vaccination, Prevnar-13 (PCV13) administered 7/14/21. 2. Resident #14 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, alcohol dependence with withdrawal and had a history of myocardial infarction. Resident #14 had a resident representative who was identified as the responsible party. Resident #14 was identified as being older than [AGE] years. The quarterly MDS dated [DATE] identified Resident #14's pneumococcal vaccination was identified as being up to date. Resident #14's immunization record identified Resident #14 had the PCV13 on 2/23/18. 3. Resident #27 was admitted to the facility on [DATE] with diagnoses that included dementia, muscle weakness, and diabetes type 2 without complications. Resident #27 had a resident representative who was identified as the responsible party. Resident #27 was identified as being older than [AGE] years. The quarterly MDS dated [DATE] identified Resident #27's pneumococcal vaccination was identified as being up to date. Resident #27 immunization record identified Resident #27 had PCV13 on 5/8/18. 4. Resident #30 was admitted to the facility on [DATE] with diagnosis that included osteoarthritis of the knee, anxiety disorder, and dysphagia. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 had a resident representative who was identified as the responsible party. Resident #30 was identified as being older than [AGE] years. The quarterly MDS dated [DATE] identified Resident #30's pneumococcal vaccination was identified as being up to date. Resident #30 immunization record identified Resident #30 had PCV13 administered on 4/7/21. 5. Resident #209 was admitted [DATE] with diagnoses that included dementia, anxiety disorder and repeated falls. Resident #209 had a resident representative who was identified as the responsible party. Resident #209 was identified as being older than [AGE] years. The immunization record for Resident #209 identified no immunization history. Interview with the DNS on 8/26/24 at 10:45AM identified she is currently aware of the lack of pneumococcal vaccinations offered and administered at the facility. The DNS indicated she thought the Infection Control Nurse was managing the pneumococcal vaccines per CDC guidelines. It is her expectation that immunizations are discussed with the resident or their representative upon admission and a follow-up with the supervisor or Infection Control Nurse if the information is not obtained. For Residents #3, 14, 27, 30, and 209, the DNS could not provide documentation that a subsequent pneumococcal vaccination had been offered, declined, or administered, or if education was provided to the residents or their representatives. In an interview with Administrator and the DNS on 8/27/24 at 6:50AM the Administrator identified that vaccinations were discussed during the Medical/Staff meetings on a quarterly basis, however only RSV and Shingles were discussed. The Administrator had no recall of whether or not pneumonia vaccinations were discussed and did not provide minutes of the meeting to clarify the agenda. Interview with the Medical Director on 8/26/24 at 10:18 AM identified he thought residents who had a previous pneumovax in addition to Prevnar 13 were exempt from subsequent pneumococcal vaccinations. The Medical Director further indicated the responsibility to offer vaccinations was given to the Infection Control Nurse and she offers the pneumococcal vaccine yearly. The Medical Director and the DNS failed to provide evidence of previously administered pneumovax which he indicated was in the medical record as well as the Infection Control Nurses office. The undated policy for pneumococcal vaccine identified that it is the facility's policy to offer its residents, staff and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has been (previously) immunized. The type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations. Usually only one (1) pneumococcal polysaccharide vaccination (PPSV) is needed in a lifetime, however based on an assessment and practitioner recommendation, additional vaccines may be provided. A series of vaccinations will be offered to immunocompetent adults 65 (years of age), depending on current vaccination status and practitioner recommendation: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If no previous vaccination (or vaccination status is unknow): PCV13 first, then PPSV23 one year later. If previously received PPSV23 at age [AGE] years: PCV13 at least 1 year after receipt of PPSV23. If previously received PPSV23 before age [AGE] years who are now aged 65: PCV13 at least 1 year after receipt of PPSV23, then PPSV23 after 5 years of previous vaccination (no earlier than one year of PVC13). The policy also states the resident's medical record must include documentation that indicates at a minimum that the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization as well as the resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal. The CDC recommendations dated 3/15/23 for adults [AGE] years or older are: If no prior vaccination either PCV20 or PCV15 and after 1 year PPSV23. If PPSV23 only (any age) after 1 year PCV20 or after 1 year PCV15. If PCV13 only (any age) after 1 year PCV20 or PPSV23. If PCV13 (at any age) & PPSV23 less than [AGE] years of age, if greater than 5 years PCV20 or PPSV23. A CDC foot note indicates for residents who received PCV13 at any age & PPSV23 at greater than [AGE] years of age, if greater than 5 years, PCV20 is to be considered as the provider may choose to administer PCV20 to adults greater than [AGE] years old who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of [AGE] years.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 5 residents (Resident #3, 14, 27, 30 and 209) reviewed for COVID-19 immunizations, the facility failed to provide documentation that the resident, or resident representative was provided with current COVID-19 information regarding additional doses, including education and risks or potential side effects, or offered subsequent COVID-19 vaccinations. The findings include: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses that included mild cognitive impairment, anxiety disorder, and cognitive communication deficit. Resident #3 had a resident representative was identified as the responsible party. Resident #3's immunization record identified the resident received a COVID-19 vaccine Step 1 on 6/22/22. No subsequent COVID-19 vaccinations, offerings or education were identified. 2. Resident #14 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, alcohol dependence with withdrawal and had a history of myocardial infarction. Resident #14 had a resident representative who was identified as the responsible party. Resident #14's immunization record identified the resident received the initial COVID-19 vaccine on 1/29/21, a second COVID-19 vaccine on 8/3/22, and a 3rd COVID-19 vaccine on 12/22/23. No subsequent COVID-19 vaccinations, offerings or education were identified. 3. Resident #27 was admitted to the facility on [DATE] with diagnoses that included dementia, muscle weakness, and diabetes type 2 without complications. Resident #27 had a resident representative who was identified as the responsible party. Resident #27's immunization record indicated the resident received the 2nd dose of COVID-19 on 12/22/23. No subsequent COVID-19 vaccinations, offerings or education were identified. 4. Resident #30 was admitted to the facility on [DATE] with diagnosis that included osteoarthritis of the knee, anxiety disorder, and dysphagia. Resident #30 had a resident representative who was identified as the responsible party. Resident #30's immunization record identified Resident #30 received the COVID-19, dose 2, on 4/7/21. No subsequent COVID-19 vaccinations, offerings or education were identified. 5. Resident #209 was admitted [DATE] with diagnoses that included dementia, anxiety disorder and repeated falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075356	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Health and Rehabilitation Center	76 West Rocks Road Norwalk, CT 06851

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #209 had a resident representative who was identified as the responsible party. The immunization record identified no immunization information. Interview with the DNS on 8/26/24 at 10:45 AM indicated she thought the Infection Control Nurse managed the COVID-19 vaccines per CDC guidelines. It is her expectation that immunizations are discussed with the resident or their representative upon admission and a follow made with the supervisor or Infection Control Nurse if the information is not obtained. For Residents #3, 14, 27, 30, and 209, the DNS did not provide documentation subsequent COVID-19 vaccinations had been offered, declined, administered or if education was provided to the residents or their representatives. Interview with the Medical Director on 8/26/24 at 10:18AM identified he was unaware that subsequent COVID-19 vaccinations were not being offered. The Medical Director further indicated going forward the facility will utilize the recently approved combined Influenza/COVID vaccine and indicated the responsibility to offer vaccinations was given to the Infection Control Nurse. Although requested, a policy on COVID-19 vaccinations was not provided.