STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075365	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Curtis Home St Elizabeth Center, The	380 Crown Street Meriden, CT 06450

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on interviews, observations, clinical record review, and facility policies for 1 of 5 sampled residents (Resident #8) reviewed for abuse, and for 2 of 2 residents (Resident #11 and Resident #45) reviewed for choices, the facility failed to ensure the resident right to choose was honored. The findings include: 1.Resident #8's diagnoses included anxiety, hypothyroidism, and asthma. The quarterly Minimum Set (MDS) assessment dated [DATE] identified Resident #8 as cognitively intact, independent with transfers, dressing, and personal hygiene. The Resident Care Plan dated 12/10/24 identified behavior/refusal of care issues. Interventions directed to provide emotional support as needed, explain potential negative outcomes, and provide positive reinforcement. Review of the nurse's note dated 12/16/24 identified that Resident #8's window had been screwed shut, Resident #8 verbalized being upset to staff, and he/she was anxious. Interview and observation with Resident #8 on 3/3/25 at 12:00 PM identified the window in his/her room had been screwed shut, a fan was not adequate, and he/she was upset due to his/her inability to open the window for fresh air. Resident #8 indicated that he/she had informed staff of his/her desire to independently open the window whenever he/she chose. An interview on 3/6/25 at 9:48 AM with Social Worker #1 identified that she was aware Resident #8's window had been screwed shut since 12/16/24. Re-interview with Resident #8 on 3/6/25 at 11:46 AM identified that he/she woke up sweating at night and wanted some fresh air, but his/her window had been screwed shut for over a month. Resident #8 complained that he/she was the only resident in the facility who was not allowed to open their window, and this was upsetting to him/her. An interview with the Director of Nursing on 3/6/25 at 1:39 PM identified that she was aware Resident #8's window had been screwed shut for the past couple of months. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 3/10/25 at 2:08 PM identified he had screwed Resident #8's window shut on 12/16/24 because the resident was leaving the window open on cold days making the room too cold for the roommate. The Administrator indicated Resident #8's window would remain screwed shut until the weather was warmer. Although Resident #8 had been upset by this action, the Administrator stated he failed to see he had done anything wrong by screwing the window shut, and that the resident had been educated. 2. Resident #11's diagnoses included coronary artery disease, congestive heart disease, and post-traumatic stress disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 had moderate cognitive impairment, was dependent for upper and lower body dressing, was independent in utilizing a manual wheelchair for mobility, and required moderate assistance for chair to bed and bed to chair transfers. The Resident Care Plan (RCP) dated 1/9/25 identified Resident #11 was at risk for changes in mood and behavior. Interventions included encouraging independence to the extent possible and encourage and allow open expression of feelings and/or needs. A nursing progress note dated 1/25/25 at 2:45 PM identified that Resident #11 had an altercation with another resident who entered his/her room without permission. The note further identified that Resident #11 was heard yelling at the other resident to leave his/her room and noted the intervention for the altercation was administering 25 milligrams (mg) of Trazadone to Resident #11 every 6 hours for the next 30 days. A Physician order dated 1/25/25 directed 25 mg of Trazadone by mouth to be administered every 6 hours as needed for agitation. An interview with Resident #11 on 3/3/25 at 1:58 PM identified that he/she did not like other residents entering his/her room and would like to keep his/her door shut. Resident #11 further identified that staff have informed him/her that the door to the room had to remain open. An interview with Licensed Practical Nurse (LPN) #5 on 3/5/25 at 7:31 AM identified that it was her preference that Resident #11's door was to stay open and that a stop sign was placed on his/her door to deter a wandering resident from entering the room. An interview with the Director of Nursing Services (DNS) on 3/6/25 at 10:47 AM identified she was unaware that Resident #11 would like his/her door shut and would inform staff that 15 minute checks could be provided to honor the Resident's choice to have his/her door shut. 3. Resident #45's diagnoses included hypersomnia (sleep disorder), Mitochondrial Encephalopathy, Lactic Acidosis, Stroke-like episodes (MELAS) Syndrome (a genetic stroke like disorder), and malignant neoplasm of the brain. The baseline Resident Care Plan (RCP) dated 3/1/24 identified Resident #45 was at risk for depression. Interventions included encouraging independence to the extent possible, if care was refused leave safely and reapproach at a later time and explain potential consequences/negative outcomes. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS) dated [DATE] identified Resident #45 had intact cognition, required set-up assistance with eating, used a manual wheelchair for mobility and required moderate assistance with chair to bed and bed to chair transfers. An interview with Resident #45 on 3/4/25 at 10:23 AM identified that facility staff got him/her up too early. Resident #45 indicated that when he/she had made his wishes known to staff on multiple occasions, staff denied his/her request and got him/her out of bed anyway. Interview and review of the Resident Care Card with Nurse Aide (NA) #4 on 3/6/25 at 12:05 PM identified she had been notified by Resident #45 on multiple occasions that he/she did not want to get out of bed and wanted to keep sleeping. NA #4 indicated that due to aspiration precautions, Resident #45 had to be taken out of bed despite his/her wishes. She further identified the shift started at 7:00 AM and there was an expectation to have all her assigned residents up for breakfast by 8:00 AM. NA #4 noted if Resident #45 wanted to go back to bed after he/she ate, she would assist him/her back in bed. Further, although the Resident Care Card indicated for Resident #45 to be out of bed for meals, it failed to indicate that aspiration precautions were in effect. A re-interview with NA #4 on 3/6/25 at 2:16 PM identified that she had incorrectly identified Resident #45 was on aspiration precautions and that Resident #45 could have stayed in bed per his/her request. An interview with Registered Nurse (RN) #2 on 3/6/25 at 2:38 PM identified the facility practice was to honor the resident's wishes, allow the resident to remain in bed, notify the RN, and reapproach the resident later. Although RN#2 indicated that the facility practice was to honor the resident's wishes, she could not honor Resident #45's request to stay in bed because he/she needed to get up to eat. An interview with the Director of Nursing Services (DNS) on 3/6/25 at 2:47 PM identified that she was aware of Resident #45's request to stay in bed past 7:00 AM. Although the DNS noted that he/she has the right to make the choice to stay in bed, she indicated it was better for his/her mental health to get out of bed. The Facility's Resident's [NAME] of Rights identified that a Resident has the right to treat living quarters as his/her home with no fewer rights than any other resident of the facility, has the right to make choices about aspects of his/her life that are significant to him/her, and has the right to refuse any visitor that he/she does not want to see. 51182

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51867 Based on interviews, review of the clinical record, and facility policy for 1 of 3 residents (Resident #45), reviewed for nutrition, the facility failed to notify the dietician and responsible party of a significant weight gain and significant weight loss. The findings include: Resident #45 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the brain, moderate protein-calorie malnutrition, and Irritable Bowel Syndrome (IBS). The baseline Resident Care Plan (RCP) dated 3/1/24 identified Resident #45 was at risk for nutritional deficits related to cancer, IBS, and diabetes. Interventions included monitoring body weight, dietician consults as needed, and offering alternative choices with dislikes. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 had intact cognition, required set-up assistance with eating, used a manual wheelchair for mobility, and required moderate assistance with chair to bed and bed to chair transfers. A physician order dated 2/29/24 directed Resident #45 to be weighed monthly on his/her shower day. A review of Resident #45's weight record indicated the following: an admission weight in March 2024 of 227. 2 pounds (lbs.), in April 2024 a weight of 272 lbs., a weight gain of 44.8 lbs. (16.5%) in 1 month; in May 2024 a weight of 266 lbs., in June 2024 a weight of 266 lbs., in July 2024 a weight of 264.8lbs., (missing weights in August and September), in October 2024 a weight of 228.0 lbs., a weight loss of 36.8 lbs. (14%) in 3 months, in November 2024 a weight of 226.6 lbs., in December 2024 a weight of 215 lbs. in January 2025 a weight of 214.4 lbs., and in February 2025 a weight of 206.4 lbs. a weight loss of 20.2 lbs. (9%) in 3 months. Review of nursing progress notes, Dietician progress notes, and the Dietician Communication Log failed to identify the Dietician or responsible party was notified regarding Resident #45's weight gains or losses. Interview and review of the clinical record with RN #2 on 3/5/25 at 10:54 AM identified that nursing staff does not track a resident's weight over time and that the dietician was independently responsible to review all resident's weight tracking. Although RN #2 indicated that nursing would notify the dietician if the resident had a significant weight loss or gain from the previous month, she was unable to explain why the dietician wasn't notified when Resident #45 was noted to have a significant weight gain from March 2024 to April 2024 (44.8 lbs. or 16.5% in 1 month). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/6/25 at 2:16 PM with the Dietician identified the facility had hired her in November 2024 so she could not comment on any of Resident #45's weight issues prior to her hire date. She indicated she was not aware of the 5.1% weight loss in 1 month from November 2024 when the resident weighed 226.6 lbs. to December 2024 when the resident weighed 215 lbs. Although she was the dietician at the time, she was not aware of the 3 month weight loss from November 2024 when the resident weighed 226.6 lbs. to February 2025 when Resident #45 weighed 206.4 lbs. a 8.9% weight loss. She indicated that if she had been aware of the weight loss after November 2024, she would not have done anything different as she could not trust the accuracy of any weights taken before she was hired. The Dietician stated that the facility practice was to notify her of a weight gain or weight loss greater than 5% but she had not been notified of Resident #45's weight changes. An interview on 3/6/25 at 2:57 PM with the Director of Nursing Services (DNS) identified if a weight was taken on a resident was suspected to be incorrect then a reweight should have been taken. A review of the Facility's Weight Policy identified that any Resident with a significant weight loss of 5% in one month or 10% in 3 months would be reported to the attending physician, the responsible party, and the Dietician.

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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** 51756 Based on review of clinical records, facility documentation, interviews, and facility policy for 2 of 5 sampled residents reviewed for abuse (Resident #15 and Resident #29) the facility failed to report allegations of abuse to the state agency in a timely manner. The findings include: 1. Resident #15's diagnoses included mild cognitive impairment, multiple sclerosis, and abnormalities of gait and mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #15 was moderately cognitively impaired and required moderate assistance of 1 staff to transfer from the bed to the wheelchair, from lying to sitting on the side of bed, and for toilet transfers. Physician's orders dated 6/4/24 directed the assistance of 1 staff for transfers from the wheelchair and for activities of daily living. The Resident Care Plan dated 6/5/24 indicated mobility impairment was a concern. Interventions included transferring the resident per the physician's order to a custom wheelchair and administer pain medications as needed. 2. Resident #29's diagnoses included Post Traumatic Stress Disorder (PTSD), history of alcohol abuse, depression, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #29 had short term and long-term memory deficits but was able to recall the current season, location of room, staff names and faces, and that he/she resided in a nursing home. Resident #29 was independent with dressing, toileting, eating, and required set up for personal hygiene. The Resident Care Plan dated 2/11/25 identified that Resident #29 frequently refused care from staff, could become easily agitated, was accusatory toward staff, administered his/her own medications, and was able to leave the facility independently to go shopping and for appointments. Physician's orders dated 3/1/25 identified that Resident #29 could self-administer medications and could go out on leave of absence independently. Interview with Resident #29 on 3/3/25 at 2:45 PM, identified that he/she witnessed NA #3 being rough and that the NA had thrown Resident #15 into his/her wheelchair during a transfer. Resident #29 indicated that he/she reported NA #3 to the DNS and Administrator at that time. According to Resident #29, NA #3, following being reported, was later confronted by Resident #29 about the way she treated Resident #15, and NA #3 stated to Resident #29 to shut the F*** up. Resident #29 indicated the incident happened several months ago and both incidents had been reported to the DNS and the Administrator at the time of the occurrences. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DNS on 3/3/25 at 3:00 PM she was informed by the surveyor that Resident #29 had reported he/she witnessed NA #3 throw Resident #15 into his/her wheelchair during a transfer from the bed to the wheelchair and that NA #3 had used profane language toward Resident #29. The DNS was further informed that Resident #29 indicated he/she had reported the incident to the DNS and Administrator. Although the DNS indicated Resident #29 frequently discussed concerns with her, she was unable to recall the incident and denied having a reportable event or grievance related to the allegations of abuse for either resident. The DNS indicated that Resident #29 had accusatory behaviors and tended to fixate on certain staff he/she did not like and would verbally confront those staff members. An interview with Resident #15 on 3/4/25 at 2:00 PM identified he/she had no recollection of any incidents of a nurse aide being rough. An interview with Social Worker (SW) #1 on 3/4/25 at 3:15 PM identified that she was not aware of any grievances from Resident #15 or Resident #29. There were no allegations of abuse or mistreatment for either resident. Re-interview (7 days after the initial interview) with the DNS on 3/10/25 at 1:25 PM identified that Resident #29's allegation of NA abuse towards Resident #15 had not been reported to the state agency following her interview with the surveyor on 3/3/25. The DNS stated she must have misunderstood that the allegations were allegations of mistreatment, and that even if a resident had a history of accusatory behaviors, the facility would still follow the protocols for reporting to the state agency for allegations of abuse. The DNS indicated that it was her responsibility to ensure allegations were reported. Subsequent to surveyor inquiry, Resident #15's allegation of physical mistreatment was reported to the state agency on 3/10/25, 7 days after the facility was made aware of the allegation. Resident #29's allegation of verbal mistreatment was reported to the state agency on 3/11/25, 8 days after the facility was made aware of the allegation. A review of the facility Abuse Policy directed in part, the Administrator and/or DNS ensure that alleged or suspected violations involving mistreatment, neglect, abuse, exploitation, misappropriation of property and injuries of unknown origin are investigated and reported. Alleged allegations involving abuse or injuries of unknow origin causing serious injury are reported to the state agency within 2 hours. Allegations of neglect, mistreatment, misappropriation that do not result in serious harm are reported within 24 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of clinical records, facility documentation, interviews, and facility policy for 2 of 5 sampled residents (Resident #15 and Resident #29) reviewed for abuse, the facility failed to investigate an allegation of abuse in a timely manner. The findings include: 1. Resident #15's diagnoses included mild cognitive impairment, multiple sclerosis, and abnormalities of gait and mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #15 was moderately cognitively impaired and required moderate assistance of 1 staff to transfer from bed to wheelchair, from lying to sitting on the side of the bed, and for toilet transfers. Physician's orders dated 6/4/24 directed the assistance of 1 staff for transfers from the wheelchair for activities of daily living. The Resident Care Plan dated 6/5/24 indicated that mobility impairment was an area of concern. Interventions included transfer resident per physician order to a custom wheelchair and administer pain medications as needed. 2. Resident #29's diagnoses included Post Traumatic Stress Disorder (PTSD), history of alcohol abuse, depression, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #29 had short term and long-term memory deficits but was able to recall the current season, location of his/her room, staff names and faces, and that he/she resided in a nursing home. Resident #29 was independent with dressing, toileting, eating, and required set-up assistance for personal hygiene. The Resident Care Plan dated 2/11/25 identified that Resident #29 frequently refused care from staff, could become easily agitated and accusatory of staff, administered his/her own medications and could leave the facility independently to go shopping and for appointments. Physician's orders dated 3/1/25 identified that resident could self-administer medications and could go out on leave of absence independently. Interview with Resident #29 on 3/3/25 at 2:45 PM, identified that he/she witnessed NA #3 being rough and that the NA #3 had thrown Resident #15 into his/her wheelchair during a transfer. Resident #29 indicated that he/she reported NA #3 to the DNS and Administrator at that time. According to Resident #29, NA #3, following being reported, was later confronted by Resident #29 about the way she treated Resident #15, and NA #3 stated to Resident #29 to shut the F*** up. Resident #29 indicated the incident happened several months ago and both incidents had been reported to the DNS and the Administrator at the time of occurrences. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DNS on 3/3/25 at 3:00 PM she was informed by the surveyor that Resident #29 had reported he/she witnessed NA #3 throw Resident #15 into his/her wheelchair during a transfer from the bed to the wheelchair and that NA #3 had used profane language toward Resident #29. The DNS was further informed that Resident #29 indicated he/she had reported the incidents to the DNS and Administrator. Although the DNS indicated Resident #29 frequently discussed concerns with her, she was unable to recall the incident and denied having a reportable event or grievance related to the allegation of abuse for either resident. The DNS indicated that Resident #29 had accusatory behaviors and tended to fixate on certain staff he/she did not like and would verbally confront those staff members. An interview with Social Worker (SW) #1 on 3/4/25 at 3:15 PM identified that she was not aware of any grievances from Resident #15 or Resident #29. There were no allegations of abuse or mistreatment for either resident. Re-interview with the DNS on 3/10/25 at 1:25 PM identified that although Resident #29's allegations of abuse towards Resident #15 and Resident #29 by NA #3 had been reported to her on 3/3/25 by the surveyor, she indicated that investigations had not yet been started. The DNS stated she must have misunderstood that the allegations were allegations of mistreatment, and that even if a resident had a history of accusatory behaviors, the facility would still follow their policy and procedure for investigating the allegations. The DNS indicated that it was her responsibility to ensure allegations were investigated. Subsequent to surveyor inquiry, an investigation was initiated for Resident #15's allegation, 7 days after the facility was made aware, and an investigation was initiated for Resident # 29's allegation, 8 days after the facility was made aware. A review of the facility Abuse Policy directed in part, the administrator and/or DNS ensure that all alleged or suspected violations involving mistreatment, neglect, abuse, exploitation, misappropriation of property and injuries of unknow origin are investigated and reported. Alleged allegations involving abuse or injuries of unknow origin causing serious injury are reported to the state agency within 2 hours. Allegations of neglect, mistreatment, misappropriation that do not result in serious harm are reported within 24 hours. An investigation will be documented in accordance with state law.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on interviews, review of the clinical record, and review of facility policy for 2 of 3 residents (Resident #8 and Resident #45), reviewed for nutrition, the facility failed to accurately code the Minimum Data Set (MDS) assessment for significant weight changes. The findings include: 1. Resident #8's diagnoses included anxiety, hypothyroidism, and asthma. a. A quarterly MDS assessment dated [DATE] identified Resident #8 had intact cognition, was independent with oral hygiene, dressing and transfers. Additionally, the MDS identified Resident #8 required set up assistance with eating, weighed 153 pounds (lbs.), and had no significant weight loss or gain. The Yearly Weight Record identified Resident #8 weighed 156.2 lbs. in February 2024, 161.7 lbs. in March 2024, and weighed 148.6 lbs. in April 2024 which was 13.1 lbs., a 8.1 percent (%) loss in one month. A Resident Care Plan dated 4/27/24 identified Resident #8 was at risk for nutritional deficits related to weight loss. Interventions included providing a diet as ordered, dietician consults as needed, Lactaid ice cream at lunchtime, monitor body weight (no specific frequency identified) and provide Glucerna supplement 8 ounces twice daily. An annual MDS assessment dated [DATE] identified Resident #8 had intact cognition, was independent with oral hygiene, dressing and transfers. Additionally, the MDS identified Resident #8 required set up assistance with eating and weighed 149 pounds (lbs.). The MDS failed to identify a significant weight loss of 13.1 lbs., 8. 1% from March 2024 to April 2024. b. The Yearly Weight Record document identified Resident #8 weighed 139.8 lbs. in August 2024, and in February 2024 weighed 156.2 lbs. which was a 16.4 lb., 10.49% weight loss in 6 months. The quarterly MDS assessment dated [DATE] identified Resident #8 had intact cognition, was independent with oral hygiene, dressing, and transfers. Additionally, the MDS identified Resident #8 required set-up assistance with eating, and weighed 140 lbs. The MDS failed to identify a significant weight loss of 16.4 lbs., a 10.49% loss from February 2024 to August 2024/6 months. Interview and review of the Yearly Weight Record with Registered Nurse (RN) #6, the MDS Coordinator, on 3/10/25 at 10:04 AM identified Resident #8's MDS was coded incorrectly and should have been coded to reflect the significant weight loss. RN #6 indicated that it was the facility practice and responsibility of the dietician to document weight and whether there was a significant weight loss or gain in section K of the MDS. 2. Resident #45's diagnoses included malignant neoplasm of the brain, moderate protein-calorie malnutrition, and Irritable Bowel Syndrome (IBS). (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The baseline Resident Care Plan (RCP) dated 3/1/24 identified Resident #45 was at risk for nutritional deficits related to cancer, IBS, and diabetes. Interventions included monitoring body weight, dietician consults as needed, and offering alternative choices with dislikes. An admission MDS assessment dated [DATE] identified Resident #45 had intact cognition, required set up assistance with eating, required moderate assistance with chair to bed and bed to chair transfers, and he/she had not had any significant weight changes. Physician's order in effect from 2/2024 through 2/2025 directed Resident #45 to be weighed monthly on shower days. A review of Resident #45's weight record indicated the following: in March 2024 a weight of 227.2 pounds (lbs.), in April 2024 a weight of 272 lbs., in May 2024 a weight of 266 lbs., in June 2024 a weight of 266 lbs., in July 2024 a weight of 264.8lbs., (missing weight in August and September) in October 2024 a weight of 228.0 lbs., in November 2024 a weight of 226.6 lbs., in December 2024 a weight of 215 lbs. in January 2025 a weight of 214.4 lbs., and in February 2025 a weight of 206.4 lbs. Review of the quarterly MDS assessment dated [DATE] identified Resident #45 weighed 266 lbs The MDS failed to note Resident #45 had a weight gain of 38.8 lbs., a 17.1% change in 3 months (227.2 lbs. on 3/3/24, 266 lbs. in May 2024). Review of the quarterly MDS assessment dated [DATE] identified Resident #45 weighed 227 lbs. The MDS failed to note Resident #45 had a 39.4 lb. weight loss, a 14.8% change in 6 months (266 lbs. in June 2024 and 226.6 lbs. in November 2024). Interview and review of the clinical record with RN #2 on 3/5/25 at 10:54 AM identified the Dietician was responsible to ensure weights and reweights were obtained, and that the dietician was solely responsible for weight tracking, not reliant on nurses to notify her unless there was a big 1 month change. An interview with the Dietician on 3/6/25 at 2:16 PM identified that she did not perform weight loss/gain calculations for Resident #45 for the 6/9/24 MDS because she was not working at the facility at that time. She further identified she did not perform weight loss/gain calculations for Resident #45 for the 12/6/24 MDS because she was not certain that weights taken before her hiring were correct. An interview with MDS Coordinator, Registered Nurse (RN) #6 on 3/11/25 at 10:07 AM identified that although she knew how to perform weight loss/gain calculations, she had not performed the calculations to code Resident #45's MDS weight change section for the 6/9/24 or 12/6/24 assessment. She further indicated she used the dietician's information to input data into Section K (the section on weights) of the MDS and was only responsible for the data entry, not accuracy. Although RN #6 indicated that she had used information provided by the Dietician to complete Resident #45's MDS's, she was unable to provide the Dietician's documentation. Review of the Resident Assessment Instrument (RAI) instruction manual (used to direct MDS processes) dated October 2023 directed, in part that a weight gain or loss of 5% in 30 days or 10% in 180 days should be coded accordingly as a significant weight loss or gain. (continued on next page)

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Curtis Home St Elizabeth Center, The	380 Crown Street Meriden, CT 06450

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	51182

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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** 51867 Based on interviews and review of the clinical record for the only sampled resident (Resident #58) reviewed for hospitalization , the facility failed to implement interventions in the Resident Care Plan (RCP) for the completion of a respiratory assessment, each shift, for resident with Congestive Heart Failure (CHF). The findings include: Resident #58's diagnoses included congestive heart failure, atrial defibrillation, type 2 diabetes and coronary bypass surgery. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #58 had intact cognition and was independent with bed mobility, toilet transfers, and transfers from the chair to the bed and bed to the chair. The RCP dated 12/17/24 identified a potential for respiratory distress/respiratory failure. Interventions included observation for signs and symptoms of increasing distress, increase in respiration rate, dyspnea, tachycardia, restlessness, anxiety or change in mental status. Additional interventions included performing a respiratory assessment every shift. The RCP dated 1/21/25 identified Resident #58 was at risk for alteration in skin integrity, weight gain, and changes in respiratory status related to generalized edema, with right hand prominent edema and increased weakness. Interventions included performing a respiratory assessment every shift, assistance of 2 with transfers, oxygen as directed and monitor vital signs and oxygen saturations every shift and as needed (PRN). Review of the Medication and Treatment Administration Records dated December 2024 and January 2025 failed to identify a respiratory assessment that had been completed every shift per the RCP. Review of nursing notes from 12/19/24 through 1/28/25 identified on 1/20/25 at 6:00 PM Resident #58 complained of his/her legs feeling weak and sniffles, lungs were clear, no cough, and no abnormal temperature were noted. A weekly note dated 1/25/25 (illegible time written) indicated Resident #58's lungs were clear with 2 plus bilateral lower extremity edema but failed to identify further each shift respiratory assessments. Interview and record review with the DNS on 3/11/25 at 9:40 AM identified the RCP indicated a respiratory assessment was to be completed each shift for Resident #58. She indicated that there was not a specific form for a respiratory assessment, this should be done by the registered nurse, and the assessment would be documented in the nurse's note section of the clinical record. The DNS reviewed the nursing notes but failed to identify that a respiratory assessment had been completed for Resident #58 from December 2024 and January 2025.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 sampled residents (Resident #28 and Resident #58) reviewed for edema and with diagnoses of Congestive Heart Failure (CHF), the facility failed to consistently obtain and document daily weights per the physician's order, for Resident #58, the Registered Nurse (RN) staff and Advanced Practice Registered Nurse (APRN) failed to ensure documentation of an assessment when a significant weight gain occurred, and for 1 of 3 sampled residents (Resident #45), reviewed for nutrition the facility failed to obtain weekly weights on admission per the facility policy and monthly weights per the physician orders. The findings include: 1. Resident #28's diagnoses included chronic systolic CHF, non-rheumatic tricuspid valve insufficiency, and paroxysmal atrial fibrillation (irregular heartbeat). The admission Minimum Data Set assessment dated [DATE] identified Resident #28 was cognitively intact, required substantial/maximal assistance for bed mobility, and was dependent with toileting and transfers. The Resident Care Plan dated 1/21/25 identified CHF relative to cardiac, nutrition, and hydration status. Interventions included monitoring body weight and completing weights as ordered. A physician's order dated 2/10/25 directed to weigh Resident #28 daily and notify the physician or the Advanced Practice Registered Nurse (APRN) if the resident's weight changed by 2 pounds or greater in 1 day or 5 pounds in 1 week. Review of Resident #28's Nurse Aide (NA) care card failed to indicate daily weights. Interview and clinical record review with Licensed Practical Nurse (LPN) #3 on 3/10/25 at 10:00 AM failed to identify documentation of daily weights in the clinical record or in the Medication Administration Record (MAR) for 3/7/25, 3/8/25 and 3/9/25. LPN #3 was unable to explain why daily weights were not completed. Additionally, LPN #3 indicated the charge nurse should have communicated the need for the weights with the NA and ensured the weight was obtained. LPN #3 indicated that she would have the NA obtain Resident #28's weight with the mechanical lift today. Registered Nurse (RN) #4's nurses note dated 3/10/25 at 10:50 AM identified the APRN was notified that Resident #28 had not been weighed on 3/7/25, 3/8/25 and 3/9/25. An interview with the nursing supervisor (RN #4) on 3/10/25 at 10:58 AM identified she did not know the reason Resident #28's daily weights were not completed on 3/7/25, 3/8/25 and 3/9/25, but that Resident #28's weight was just completed on 3/10/25 via the mechanical lift. RN #4 indicated that the weights should have been done daily per the physician's order and the charge nurse was responsible to have communicated with the NA and made sure the weights were obtained and documented daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and clinical record review with the DNS on 3/10/25 at 12:20 PM identified she was not aware that Resident #28 did not have daily weights completed and documented in the Medication Administration Record (MAR) on 3/7/25, 3/8/25 and 3/9/25. The DNS indicated that, although she was unsure or the reason Resident #28's weights were not completed and documented for those dates, the resident's weights should have been completed and documented daily in the MAR per the physician's order. The DNS indicated the charge nurse on 3/7/25, 3/8/25 and 3/9/25 on the 7:00 AM to 3:00 PM shift should have confirmed Resident #28's weight was taken by the NA and then documented the resident's weight in the MAR. Additionally, the DNS identified she planned to make a list for the nursing supervisors of all of the residents with daily weights ordered to ensure the weights were obtained and documented going forward. Interview with LPN #6 on 3/11/25 at 11:20 AM identified she was the charge nurse for Resident #28 on the 7:00 AM to 3:00 PM shift on 3/8/25. LPN #6 indicated that although she was aware that Resident #28 was a daily weight in the AM, the resident did not have his/her weight done on 3/8/25 because she and the NA's were too busy, and it was too difficult to get Resident #28's weight completed. LPN #6 identified that it would have been her responsibility to communicate with the NA to ensure the resident's weight was obtained, but that she failed to do so on 3/8/25. LPN #6 further indicated that she did not let anyone know that Resident #28's weight was not obtained as ordered by the physician on 3/8/25. 2. Resident #45's diagnoses included a terminal condition, moderate protein-calorie malnutrition, and irritable bowel syndrome (IBS). The baseline Resident Care Plan (RCP) dated 3/1/24 identified Resident #45 was at risk for nutritional deficits related to a terminal condition, IBS, and diabetes. Interventions included monitoring body weight, dietician consults as needed, and offering alternative choices with dislikes. An Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 had intact cognition, required set-up assistance with eating, used a manual wheelchair for mobility, and required moderate assistance with chair to bed and bed to chair transfers. a. A review of Resident #45's weight information identified an admission weight was taken on 3/3/24 and was 227.2 pounds (lbs.) but failed to identify weekly weights were taken thereafter per the facility policy. Additionally, Resident #45's weights were not documented monthly for August 2024 or September 2024. An interview with Registered Nurse (RN) #2 on 3/5/25 at 10:54 AM identified weights for Resident #45 were recorded on a weight documentation sheet when completed. She was unable to identify additional weekly weights that had been taken for 4 weeks in March 2024 or that weights had been taken for the months of August 2024 and September 2024. RN #2 was unable to explain the reason for the missing for Resident #45. b. A physician order dated 2/29/24 directed Resident #45 to be weighed monthly on shower day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #45's weights identified an admission weight of 227.2 pounds (lbs.) on 3/3/24, Resident #45 weighed 272 lbs. in April 2024 (a 44.8 lb./a 19/7% gain in one month from 3/3/24), weighed 266 lbs. in May 2024 (a 6 lb. weight loss from April 2024), 266 lbs. in June 2024, 264.8 lbs. in July 2024, 228.0 lbs. in October 2024 (a 36 lb./a 13.5% weight loss from July 2024), 226.6 lbs. in November 2024, 215 lbs. in December 2024 (a 11 lb./a 5.1% weight loss from November 2024), 214.4 lbs. in January 2025, and 206.4 lbs. in February 2025 (a 8 lb./a 3.7% weight loss from January 2025). One reweight in May 2024 was noted in Resident #45's weight record (272 lbs. initial and 266 lbs. reweight) identifying the facility failed to identify 5 of 6 opportunities to obtain a reweight for a weight change of 3 lbs. over/under the previous weight. An interview on 3/5/25 at 10:54 AM with Registered Nurse (RN) #2 identified she was not aware that reweights for Resident #45's weight gains/losses were not being completed and noted it was the expectation of Nurse Aides (NAs) to obtain reweights if there was a weight increase or decrease. RN #2 was unable to identify the reason that Resident #45's reweights were not completed per the facility policy. An interview on 3/6/25 at 2:57 PM with the DNS identified if a weight taken was suspected to be an incorrect weight, a reweight should be taken. 3. Resident #58 was admitted to the facility in April 2023 with diagnoses that included congestive heart failure, atrial defibrillation, type 2 diabetes and coronary bypass surgery. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #58 was cognitively intact and was independent with bed mobility, toilet transfers, and transfers from the wheelchair to a chair. The Resident Care Plan dated 12/17/24 identified a potential for respiratory distress/respiratory failure. Interventions included observing for signs and symptoms of increasing distress, increased respiration rate, dyspnea (difficulty breathing), tachycardia (rapid pulse), restlessness, anxiety or changes in mental status. Additional interventions included performing a respiratory assessment every shift. An Advanced Practice Registered Nurse (APRN) #1's progress note dated 1/21/25 identified Resident #58 had right arm swelling, mild shortness of breath, weakness and a heart rate of 48 to 52 beats per minute. Additionally, no respiratory distress was noted and APRN #1 directed to hold Resident #58's Metoprolol (a medication to treat hypertension and atrial fibrillation) for a heart rate of less than 60 beats per minute, complete a physical/occupational therapy screen, and complete daily weights for 7 days. The order failed to specify parameters for weight gains or losses or when the physician/APRN should be notified. The Resident Care Plan dated 1/21/25 identified Resident #58 was at risk for alteration in skin integrity, weight gain, and changes in respiratory status related to generalized edema, with right hand prominent edema and increased weakness. Interventions included performing a respiratory assessment every shift, assistance of 2 staff with transfers, oxygen as directed and monitor vital signs and oxygen saturations every shift and as needed (PRN). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record, Treatment Administration Record and nursing notes from 1/21/25 through 1/28/25 identified on 1/22/25 Resident #58 weighed 205.6 pounds (lbs.). On 1/23/25, Resident #58 weighed 206.2 lbs. Resident #58 was not weighed on 1/24/25, and on 1/25/25 he/she weighed 212.0 lbs. (a 5.8 lb. gain) in 2 days. On 1/26/25, Resident #58 weighed 208.5 lbs., the APRN was notified on 1/26/25 and directed to hold Resident #58's Amiodarone (a medication used to treat abnormal heart rhythms) and call the Cardiologist on 1/27/25 to update and discuss the episodes of bradycardia (slow heart rate). On 1/27/2025 Resident #58 weighed 218.5 lbs. (a 10 lb. weight gain in one day with no further re-weight to verify accuracy). Nursing notes failed to reflect a nursing assessment was completed on 1/27/25 when Resident #58 had a 10 lb. weight gain. APRN #1's order dated 1/27/25 directed to administer Lasix (a diuretic) 40 mg by mouth once. Interview with APRN #1 on 3/11/25 at 10:44 AM identified that although she saw Resident #58 on 1/27/25, she could not recall what was documented (there was no assessment documented in the clinical record). Interview with the DNS on 3/11/25 at 9:40 AM indicated that with a change in condition, a fall, or resident being sent to the hospital, an RN should have completed an assessment and subsequent nursing note. Review of the undated facility Weight Policy directed that weights will be completed as ordered and the charge nurse on each unit will be responsible for monitoring and tracking the weights as they are completed, weekly weight will be taken for 4 weeks following admission and then monthly, For any weight change of 3 lbs. over or under the last weight, the Nurse Aid (NA) must alert the charge nurse and the reweight must be completed with the NA and charge nurse. Further, the policy indicates, any resident with a significant weight loss of 5% in one month, or 10% in 3 months, will be reported to the attending physician, the responsible party, and the dietician. 51182 51867

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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 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** 51102 Based on observations, interviews, and clinical record review for 1 of 3 residents (Resident #19), reviewed for activities of daily living, the facility failed to provide podiatry services to a diabetic resident. The findings included: Resident # 19's diagnoses included diabetes mellitus type 2 with neuropathy, gout, and Parkinson's disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 was cognitively intact, required substantial/maximal assistance from staff for personal hygiene, and was dependent on staff for lower body dressing and transfers. The Resident Care Plan dated 1/7/25 identified Resident #19 was at risk for alteration in the metabolic process secondary to diabetes. Interventions included good foot care daily, proper footwear, podiatry care as needed, and podiatry to cut toenails. A physician's order dated 12/24/24 and currently in effect, allowed Resident #19 to be seen and treated by podiatry. The Wound/Ostomy Advanced Practice Registered Nurse (APRN) consultations dated 12/20/24 and 1/7/25 recommended a podiatry consult for toenail dystrophy (abnormal structure and appearance). The Wound/Ostomy APRN consultations dated 1/21/25 and 2/4/25 identified nail dystrophy. An e-mail dated 1/23/25 at 1:30 PM, with attachments, identified a correspondence between the podiatry service provider and the DNS related to podiatry enrollment requirements and which needed to be completed prior to Resident #19 receiving services. The e-mail instructed the DNS to send a copy to the Administrator of the Long Term Care (LTC) facility. Additionally, along with the completed form, the e-mail should specify that Attached are Veterans Affairs (VA) enrollments for podiatry. The facility will assume financial responsibility for podiatry care. An e-mail correspondence dated 1/24/25 at 11:38 AM identified the podiatry providers receipt of Resident #19's signed consent (dated 1/15/25) and face sheet as well as an intent to add Resident #19 to the podiatry service list. An e-mail correspondence from the podiatry service provider dated 2/20/25 at 2:04 PM identified Resident #19 was still not scheduled for podiatry services and a request from the podiatry service Account Manager requesting the Processing Department schedule Resident #19 for podiatry services was included. An e-mail dated 3/7/25 at 10:42 AM from the podiatry service provider to the DNS identified the podiatrist was at the facility on 12/9/24, 2/10/25 and 2/16/25. Additionally, the e-mail identified Resident #19 was signed up for podiatry services on 1/20/25, but was placed on a do not treat list pending verification of VA-covered services to be billed to the facility, and Resident #19 was removed from the do not treat list on 2/20/25. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/3/25 at 11:13 AM identified Resident #19 with toenails that were thick and excessively long (curling over). Interview and chart review with Registered Nurse (RN) #2 on 3/5/25 at 9:28 AM identified the facility policy directed Nurse Aids (NAs) to clip toenails, but if a resident was diabetic or presented with thick nails, the resident would be seen by the podiatrist who comes to the facility monthly. If the resident was a veteran, they would go out to the VA for podiatry services. RN #2 identified Resident #19 was on the list to see podiatry but could not produce a copy of the list, proof of when Resident #19 was on the list to be seen, or a date of when the podiatrist was due to return to the facility. A chart review with RN #2 failed to identify a signed consent for podiatry, at which point she stated Resident #19 was a veteran with 100% service-connected disability and would not have a consent with the in house podiatrist but rather goes to the Veterans Affairs (VA) for services. RN #2 could not identify when Resident #19's podiatry appointment was scheduled or if an appointment had been scheduled with the VA. Follow up interview with RN #2 on 3/5/25 at 9:56 AM identified she spoke with the VA, Resident #19 was overdue since it's been almost a year since his/her last appointment, clarifying that since he/she has been at the facility no podiatry services were provided or offered. Interview with Resident #19 on 3/5/25 at 10:53 AM identified he/she could not recall if podiatry services were offered upon admission to the facility but was told by the facility that he/she missed their scheduled appointment and would have to be rescheduled with the possibility of seeing the in-house podiatrist. Interview and contract review with the Director of Finance on 3/5/25 at 11:47 AM identified that the facility pays for all resident podiatry services, including veterans. Per the Department of Veterans Affairs contract that was effective 10/1/24, all rates include an additional $.50 per day for podiatry services so that veterans can receive their services in-house at the LTC facility. Subsequent to surveyor inquiry, an e-mail dated 3/7/25 at 10:50 AM from the podiatry service provider identified the next scheduled podiatry visit would be 4/18/25, since visits occurred every 60 days, including a request from the DNS for Resident #19 to be seen earlier. Interview with the DNS on 3/10/25 at 10:03 AM identified that every resident was referred to the in-house service for podiatry unless they were a short-term resident that was expected to be discharged within 2 weeks. The DNS identified Resident #19 was initially in the facility for short term rehabilitation and about 3 weeks after his/her admission it was determined that his/her stay would be extended. On 1/15/25 Resident #19 signed a podiatry consent, and all the paperwork was emailed to the podiatry provider. Somewhere along the line requirements from the podiatrist changed requiring that the Administrator be copied on the e-mail. The DNS stated she was unaware of the requirement, which prolonged Resident #19 receiving services. The DNS identified that all staff were aware that all residents receive in- house podiatry services, unless the admission was a short-term rehabilitation resident who had their own podiatrist in the community. Further, consents were signed upon admission and the resident was then put on the podiatry list by the admitting nurse, including veterans. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the podiatry service customer care and billing representative on 3/11/25 at 10:03 AM identified that facilities receive a packet with information regarding policy details including what information was needed for a resident to be seen, and comprised of a request for services form, resident face sheet including Power of Attorney (POA) information, insurance information, and physician orders. The Administrator notification was not a requirement of service on the podiatry service end but might be the cause of delay in treatment due to other factors on the facility end. Subsequent to surveyor inquiry, Resident #19 was seen by the podiatrist on 3/12/25, and received manual reduction, trimming of nails from 4/5 millimeters (mm) to 2 mm. Although requested, a facility policy for podiatry was not provided.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, review of clinical records, facility documentation, facility policies, and interviews for 1 of 4 residents (Resident #47) reviewed for accidents, the facility failed to provide adequate supervision to prevent a fall with injury and failed to follow the fall care plan interventions for injury prevention; and for the only sampled resident (Resident #36) reviewed for smoking, the facility failed to ensure a container being used for smoking materials was safe from potential fire hazard. The findings include: 1. Resident #47 was admitted to the facility in March 2024. Resident #47's diagnoses included dementia with behavioral disturbances, mood disturbance, anxiety, and large right cerebellar infarcts (stroke). The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 was severely cognitively impaired and required assistance of 1 for bed mobility, personal hygiene, and was a full mechanical lift for transfers. The Resident Care Plan dated 4/10/24 identified falls as an area of concern. Interventions included using a low bed with bilateral floor mats on each side of the bed, monitor for attempts to self-transfer, poor safety awareness in the environment, and potential hazards, assistance of 1 with care, and full mechanical lift for transfers. The Resident Care Plan was updated on 6/10/24 with a new intervention to have Resident #47's current low bed replaced with a floor bed (a bed that can be raised but could be lowered all the way to the floor) and high floor mats. A. The physician orders dated 6/12/24 directed to administer Eliquis (blood thinner) 2.5 milligrams (mg) twice a day, transfer via mechanical lift with assist of 2 staff, and assist of 1 staff with activities of daily living including self-feeding. An interim physician order dated 6/13/24 directed to change the low bed to a floor bed with floor mats on both sides of the bed. A review of nursing notes from 3/1/24 through 3/4/25 identified that Resident #47 had 4 falls from his/her bed on 3/25/24, 6/9/24, 6/24/24, and 1/16/25. A review of an RN assessment form completed by RN #5 on 6/24/24 at 4:30 AM following Resident #47's fall on 6/24/24 identified that NA #2 provided incontinent care to Resident #47 and reached for towels/washcloths at the end of the bed. Resident #47 was noted to have rolled off the bed between the bed and floor mat and hit his/her head. A laceration was noted to the left side of forehead, pressure was applied to area, and no change in level of consciousness was noted. The physician was notified and ordered to send Resident #47 to the emergency room (ER) to evaluate the head injury. The responsible party was made aware of the injury and the resident's transfer to the ER. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Accident and Incident Report completed by RN #5 dated 6/24/24 at 4:30 AM indicated that Resident #47's fall was witnessed by NA #2. NA #2 was unable to stop the fall or catch the resident. Resident #47 was unable to provide a statement due to his/her cognitive status. A written statement by NA #2 dated 6/24/24 at 4:30 AM indicated that NA #2 saw Resident #47 at 2:45AM and 4:30AM. Incontinent care was provided to Resident #47 at 2:45 AM with no agitation or restless behavior. NA #2 indicated at 4:30 AM she raised the bed with the mats still in place and went to grab towels and wash clothes at the end of the bed. Resident #47 rolled off the bed landing between the bed and the floor mat. NA #2 indicated she was unable to catch Resident #47 to prevent him/her from hitting the floor and immediately called the supervisor to come to Resident #47's room as he/she was bleeding from the head. A review of The Reportable Event Form submitted to the state agency by the DNS on 6/24/24 at 7:45 PM indicated that Resident #47 rolled off the bed while receiving care and sustained a laceration to his/her forehead. NA #2 raised Resident #47's bed in preparation to provide incontinent care. When NA #2 reached for wash clothes located at the foot of bed, Resident #47 quickly rolled over and fell out of bed between the bed and floor mats. Resident #47 sustained a laceration to the forehead, was sent to the ER, received 5 sutures, and returned to the facility. A review of Resident #47's ER discharge summary dated 6/24/24 at 8:54 AM identified that Resident #47 had an unwitnessed fall with a head strike. A CT scan was performed on the head that was negative for any bleeding. The laceration to the resident's forehead was repaired with 5 sutures. Interview with NA #2, (not currently employed at the facility) on 3/5/25 at 9:00 AM identified when Resident #47 fell on [DATE] it was her first time working the overnight shift, she normally worked second shift, and she had not received any orientation to the night shift routine. NA #2 stated in preparation for incontinent care she raised Resident #47's bed and went into the bathroom for water. While in the bathroom, waiting for the water to warm up, she heard a loud thud, saw the resident on the floor between the bed and floor mat, and noted Resident #47 was bleeding from his/her head. She indicated she immediately called for the nurse from the doorway who came to the room to assess Resident #47. NA #2 indicated that she was unaware she should not have left Resident #47 alone after raising the bed. NA #2 recalled writing a statement and possibly speaking to the DNS after the incident but was unable to identify why her current verbal statement differed from the statement she had written when Resident #47 fell on [DATE]. Although the facility documentation indicated that NA #2 had witnessed Resident #47's fall, her recollection was that she was in the bathroom when Resident #47 fell . Interview with the DNS on 3/5/25 at 11:00 AM indicated she spoke to NA #2 after Resident #47's fall. NA #2 wrote a statement regarding the incident and the DNS recalled that NA #2 indicated that she was at the foot of the bed when Resident #47 rolled out of bed onto the floor. Additionally, the DNS indicated that Resident #47 had a history of rolling out of bed suddenly and it was surprising how quickly he/she could move out of bed. Interview with RN #5 on 3/5/25 at 1:30 PM she identified that Resident #47 had to be sent to hospital because of bleeding from the head. RN #5 stated that NA #2 indicated she was at the foot of the bed gathering supplies when Resident #47 rolled out of bed striking his/her head. RN #5 stated she was aware that Resident #47 was in a high/low bed but did not recall the position of the bed at the time of the incident stating that NA #2 was nervous and upset following the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Re-interview with NA #2 on 3/6/25 at 1:15 PM identified that she was aware her verbal statement given on 3/5/25 differed from her original written statement dated 6/24/24. NA #2 could not recall what she had written in her statement but again denied being at the end of the bed and reiterated she did not see Resident #47 fall. Interview with PT #1 on 3/10/25 at 10:11 AM identified that she was aware of Resident #47's fall on 6/24/24. She indicated that Resident #47 had a high/low bed and if a staff member was giving or preparing for care with the bed in high position, as long as staff remained at the bedside, it would have been appropriate for staff to be at the foot of the bed. PT #1 further indicated it would not be appropriate to raise the resident's bed then step away as Resident #47 was a high risk for falls and had a history of falling out of bed. PT #1 stated that Resident #47 was screened after the fall on 6/24/24 but was not appropriate for therapy and remained at his/her baseline. B. An observation on 3/10/25 at 10:20 AM, identified that Resident #47's bed was by the window, the door to room was closed, and the divider curtain was pulled between residents. Resident #47's bed was in a high position, noted to be at the height of the windowsill, mats were noted on the floor at the bedside, and the over bed table was next to and to the right side of his/her bed. At the time of observation, no staff were in the room. At 10:20 AM NA #5 entered the room, and she proceeded to lower Resident #47's bed to the lowest position. Interview with NA #5 at 10:35 AM identified she was the NA assigned to Resident #47. NA #5 stated that when she went in to assist Resident #47 with breakfast around 8:45 AM, the bed was in a high position when she entered. After breakfast, she left the room without lowering the resident's bed stating she had planned to return and provide care at 10:30 AM. NA #5 further indicated that she should have put the bed in a low position. A review of the Fall Prevention Policy dated 6/2/14 directed, in part, that the facility will provide education on fall prevention to caregivers, patients and families and if a fall occurs, the facility will investigate the factors contributing to the fall and develop a plan of action to minimize further falls. In addition, the nurse will document the fall risk measures that have been instituted in the Resident Care Plan and nurse aide assignment. 2. Resident #36's diagnoses included dementia, schizoaffective disorder, and metabolic encephalopathy. The annual Minimum Data Set assessment dated [DATE] identified Resident #36 was severely cognitively impaired, had serious mental illness, currently used tobacco, was dependent with toileting, and required partial/moderate assistance with bed mobility and transfers. The Resident Care Plan dated 1/10/25 identified Resident #36 smoked. Interventions included smoking was allowed according to the supervised smoking schedule, smoke only in the designated smoking area with supervision, and ensure a smoking apron was used. A significant change Smoking Evaluation for Resident #36 dated 1/10/25 indicated the resident needed staff to light his/her smoking material and that he/she could independently and safely extinguish smoking materials. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation and Interview with NA #3 on 3/6/25 at 11:10 AM in the resident smoking area identified Resident #36 seated in his/her wheelchair. NA #3 applied Resident #36's smoking apron and lit his/her cigarette. Two receptacles were noted in the area, 1 gooseneck self-extinguishing device and 1 short metal can with a wide opening at the top labeled 'wastepaper container'. The wastepaper container was noted to have a large number of cigarette butts along with other waste including several paper packs of cigarette containers, a few clear plastic cups, and clear plastic packaging/bags. According to NA #3, the wastepaper container had been in place for several months, residents used both receptacles to extinguish their still lit cigarettes, and she had made the Administrator aware of the fire hazard yesterday, who indicated to her that he would correct the issue, but had not as yet. An interview with the Administrator on 3/6/25 at 1:30 PM identified he was aware that there was a tall ashtray and a short metal can in use at the facility's resident smoking area. The Administrator indicated that although he was recently out at the facility's resident smoking area and saw the short metal can, he did not look inside of it or remove it from the area. The Administrator identified that the short metal can was not a self-extinguishing device and that it should not have been utilized by residents to dispose of their still-lit cigarettes. The Administrator indicated that he would have the short metal receptacle removed from the facility's resident smoking area. Subsequent to surveyor inquiry an observation on 3/10/25 at 11:04 AM identified the wastepaper can had been removed from the facility's resident smoking area. Review of the facility policy, Smoking/Residents, dated 8/21/17, directed that the facility would ensure a safe smoking environment and maintain safe smoking practices. The policy further directed that residents may smoke only in the designated area at the designated times under the supervision of a staff member. 51756

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of employee files and interviews for 2 of 4 Nurse Aides (NA) (NA #3 and NA #5) the facility failed to ensure annual employee performance evaluations were completed. The findings include: Review of NA #3 and NA #5 employee files and interview with the Human Resource Coordinator on 3/11/25 at 10:30 AM failed to identify performance evaluations in the employee files. NA #3 was hired by the facility on 9/11/11 and is a current full-time employee. NA #5 was hired by the facility on 4/30/20 and is a current per diem employee. The Human Resource Coordinator stated that if evaluations had been completed, they would be located in the employee file or might be with DNS. The Human Resource Coordinator indicated that she could not recall the last time she received an employee evaluation from the Nursing Department. Interview with the DNS on 3/11/25 at 11:30 AM identified that she had not completed any NA evaluations on any NA employed at the facility. The DNS stated she has worked for the facility for [AGE] years and had never completed any nursing staff evaluations. The DNS indicated that she has just not had enough time to complete nursing staff evaluations, however, she stated that she had discussed the issue with the new administrator, and they recognized this was an issue. The facility is starting to work on a Quality Assessment Performance Improvement (QAPI) plan for annual nursing staff evaluations.

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51101 Based on observations and interviews, the facility failed to ensure the medication room was clean and sanitary. The findings include: In an interview and observation with RN #2 on 3/6/25 at 11:10 AM, identified that the medication room floor was dirty with a brown substance and littered with paper. The medication room counter was cluttered with brown boxes and papers. RN #2 identified that it was the responsibility of the housekeeping staff to keep the floor clean of the observed substances. Additionally, RN #2 stated that it is the responsibility of the nurses who access the medication room to ensure that it is free of clutter. In an interview and observation with Housekeeper # 1 on 3/6/25 at 11:31 AM, it was identified that it is the responsibility of housekeeping to keep the medication room clean. After bringing Housekeeper #1 to the medication room, it was identified that it was not her responsibility to clean the medication room and that it was the responsibility of the housekeeper on A-wing to complete. In an interview and observation with Housekeeper # 2 on 03/06/25 at 11:34 AM, it identified that it is the responsibility of housekeeping to keep the medication room clean. After bringing Housekeeper #2 to the medication room, it was identified that it was not her responsibility to clean the medication room. Additionally, she stated that she never enters that room and is only responsible for cleaning the nursing station, not the medication room. In an interview and observation with the Administrator on 3/6/25 at 11:50 AM, it identified that it is the responsibility of housekeeping to keep the medication room clean and that it should be done daily. After bringing the Administrator to the medication room, it was identified that the floors were dirty and needed to be cleaned and that the counters were also cluttered and dirty, needing to be organized and wiped down. Subsequent to surveyor inquiry, the Administrator stated that he would notify housekeeping to have the medication room cleaned. Although requested from the Administrator, a facility policy for housekeeping was not provided.

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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. 48950 Based on the tour of the Dietary Department/Nourishment Rooms, staff interviews, and review of the facility policies, the facility failed to ensure food items were sealed, labeled and dated when opened and the only nourishment refrigerator/freezer temperatures were documented. The findings included: 1. Tour of the Dietary Department on 3/3/25 at 10:40 AM during the initial walk through with the Dietary Director identified the following: a. 3 bags (16 ounce) each Penne pasta bag #1 was 3/4/ full, bag #2 was 1/2 full, bag #3 1/4 full were opened and failed to include the date opened. b. An opened 5 pound bag of heart shaped pasta that was 1/4 full failed to include the date opened. c. An opened 5 pound bag of elbow pasta that was 1/2 full failed to include the date opened. d. A 32-ounce opened bag of powdered sugar that was 1/2 full failed to include the date opened. e. An opened 5 pound bag of sugar that was 3/4 full failed to include the date opened. f. A package containing 2 frozen fish cakes was opened and failed to include the date opened. g. A 1 bag of romaine lettuce was opened, not sealed and failed to include the date opened. Interview on 3/3/25 at 11:00 AM with the Dietary Director identified that all items that were opened should be labeled with the date they were opened. Facility policy for Food Storage identified that all food items that are open will be clearly labeled with the month, date and year. 2. Tour of the only Nourishment Room on 3/5/25 at 10:45 AM identified that monitored freezer temperatures for February 2025 were documented for 2 of 28 days. Additionally, 16 of 28 days, freezer temperatures were identified with a check mark and lacked the actual temperatures obtained, and for 10 days there were no temperatures taken or documented. An interview with the Dietary Director on 3/5/25 at 11:00 AM identified that the dietary staff were responsible for monitoring the nourishment room freezer temperatures every evening and that the staff member who was monitoring and keeping a record was doing the logs incorrectly. Further, the Dietary Director indicated that she was unsure of the policy for monitoring the temperatures of the refrigerator/freezer. Review of the facility policy for Refrigerator & Freezer Temperatures identified that the evening shift for dietary staff was responsible for monitoring the freezer temperature on the logs accurately.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 51756 Based on facility documentation and staff interview regarding Payroll Based Journal (PBJ) submission, the facility failed to submit accurate PBJ staffing data for the 3rd quarter of 2024 (April 1, 2024, through June 30, 2024). The findings include: The PBJ 3rd quarter submission report for April 1, 2024, through June 30, 2024, triggered as having no Registered Nurse (RN) coverage for 8 consecutive hours a day, low weekend staffing, and no licensed nurses 24 hours a day. Interview with the Business Office Manager on 3/11/25 at 12:42 PM identified that she inadvertently submitted the incorrect data. She indicated that she reviewed the staff payroll list for the skilled nursing center and the Residential Care Home (RCH). She indicated that she unclicked (removed) the skilled nursing staff in error instead of the RCH nursing staff from the payroll list. She then submitted the data for PBJ that was for RCH nursing staffing and not the skilled nursing home staffing. She stated she realized that she unintentionally submitted the wrong data. Review of the mandatory submission of staffing information based on payroll data in a uniform format. The facility must submit direct care staffing information on the schedule specified by CMS, but no less than quarterly.

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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** 51102 Based on observations, interviews, and clinical record reviews for 1 of 2 residents, (Resident #4), reviewed for pressure ulcers, the facility failed to follow infection control standards to identify and provide precautions for a resident with wounds, and for the only sampled resident (Resident #36) reviewed for blood glucose monitoring. The facility failed to clean and disinfect the glucose meter after use. The findings included: 1. Resident #4's diagnoses included a pressure ulcer of the sacral region, rheumatoid arthritis, and urge urinary incontinence. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was severely cognitively impaired, and dependent on staff for hygiene, dressing, and transfers. The Resident Care Plan dated 2/18/25 identified Resident #4 had a stage 2 pressure area to her/his sacrum. Interventions included providing treatment as ordered, observing the area for good wound healing, and observing for signs and symptoms of infection. The Pressure Ulcer Progress Report initiated 2/20/25 identified a 0.8 centimeter (cm) x 0.8 cm stage 2 pressure ulcer on the sacrum. On 2/26/25 the stage 2 pressure ulcer on the sacrum measured 2.0 cm x 2.0 cm, and on 3/7/25 the stage 2 pressure ulcer on the sacrum measured 2.5 cm x 3.5 cm x 0.2 cm. (A stage 2 pressure ulcer was defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed without slough). The physician's orders dated 2/25/25 failed to identify an order for Enhanced Barrier Precautions (EBP). Review of the EBP resident list dated 2/26/25 failed to include Resident #4. Observations of Resident #4's room on 3/3/25 at 11:11 AM, 3/4/25 at 11:30 AM and 3/5/25 at 10:35 AM failed to identify an EBP sign posted outside the resident's room. Additionally, although there were precaution carts outside all the other resident rooms who had EBP signage, observation outside Resident #4's room failed to identify a precaution cart containing Personal Protective Equipment (PPE). Observation of LPN #2 on 3/5/35 at 10:35 AM identified she was performing a dressing change to Resident #4's sacral area without the benefit of a gown. Interview with Infection Preventionist Registered Nurse (RN) #3 on 3/5/25 at 1:35 PM identified the facility policy to institute EBP for residents with a history of Multi Drug Resistant Organism (MDRO), indwelling devices and large wounds. RN #3 defined a large wound as a measurement of 2.0 cm x 2.0 cm or greater. Resident #4 was not put on EBP when the wound was first identified on 2/20/25 because it measured 0.8 x 0. 8 cm, and RN #3 would not expect Resident #4 to have been put on EBP because the last measurement of the sacral wound taken on 2/26/25 was 2.0 cm x 2.0 cm, which she considered borderline. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DNS on 3/5/25 at 1:55 PM identified it was the facility policy to institute EBP for residents who had an MDRO, indwelling medical devices such as intravenous therapy, an indwelling catheter, or a large wound. She further identified that she defined large wounds to measure 2 cm or greater. Upon review of Resident #4's Pressure Ulcer Progress Report dated 2/26/25 which identified a stage 2 sacral wound measuring 2.0 cm x 2.0 cm, the DNS identified she would have expected the nursing staff to implement the policy and place Resident #4 on EBP. A follow up interview and record review with RN #3 on 3/10/25 at 10:48 AM identified she was using guidance for EBP criteria pertaining to large wounds measuring 2.0 cm x 2.0 cm from APIC (Association for Professionals in Infection Control and Epidemiology). Additionally, RN #3 identified that the residents sacral wound was measured on 3/7/25 and showed an increase in size to 2.5 cm x 3.5 cm x 0.2 cm, and that is when and why Resident #4 was placed on EBP's. RN #3 stated she would have to have to look to see exactly where in APIC this guidance was referenced. A follow up interview with RN #3 on 3/11/25 at 10:14 AM identified she could not produce a copy of the APIC guidance, and subsequent to surveyor inquiry, the facility policy on EBP would be amended to reflect wounds (previously written as large wounds). Review of the Infection Control- Enhanced Barrier Precautions Policy dated 7/19/22, directed, in part, that Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities. Nursing home residents with (the word large handwritten) wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with Multi Drug Resistant Organisms. Review of the updated Infection Control- Enhanced Barrier Precautions Policy dated 7/19/22 and revised 3/11/25, identified that the facility had no changed the policy from the original policy dated 7/19/25, but they had removed the handwritten word large. According to CDC documentation dated 6/28/24, Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection, and regardless of whether others in the facility are known to have MDRO colonization. 2. Resident #36's diagnoses included diabetes with other diabetic kidney complications, hyperglycemia, and metabolic encephalopathy. The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #36 was severely cognitively impaired, required moderate assistance from staff for washing, dressing, toilet use, and required supervision for meals. The Resident Care Plan dated 1/10/25 identified diabetes as an area of concern. Interventions included monitoring any signs and symptoms of hyper/hypoglycemia, monitor blood glucose and provide insulin as ordered, and administer insulin and medications as directed. Physician's orders dated 3/5/25 directed to obtain a fasting blood sugar daily at 6:30 AM and call the physician if the glucose level was greater than 350, administer an injection of Lantus 18 units at 9 AM, and Ozempic injections 0.5 milligrams (mg) once a week on Monday mornings. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 3/5/25 at 5:45AM of Registered Nurse (RN) #1 obtaining a blood glucose level for Resident #36 identified she cleaned the glucose meter prior to entering Resident #36's room. RN #1obtained a blood glucose level for Resident #36 at the bedside. RN #1 then proceeded back to medication cart in the hallway. RN #1 placed the meter on top of the medication cart without the benefit of cleaning or disinfecting prior to placing. Further observation identified RN #1 continued with her medication pass, and at 5:55 AM, RN #1 was observed placing the glucose meter in the top drawer of the medication cart without the benefit of cleaning the meter. Interview with DNS on 3/5/25 at 6:30AM identified that the blood glucose meters got wiped down with purple top disinfect wipes after each use and then are stored in the medication carts. Medication carts are supplied with 2 glucose meters. The DNS indicated that it was not the practice of the facility to put blood glucose meters back in the medication cart after use without first disinfecting the meter per the manufacturer's guideline. Interview with RN #1 on 3/5/25 at 6:45AM identified that blood glucose meters. are supposed to be cleaned before and after each use, but she had not cleaned the glucose meter after obtaining Resident #36's blood glucose level and prior to placing it back in the medication cart. RN #1 stated, after realizing she had forgotten to clean the glucose meter, she removed it from the cart and appropriately cleaned it prior to using it for another resident. RN #1 indicated that she just forgot and knew that the glucose meter could potentially be contaminated after use, and she should not have stored it in the medication cart prior to cleaning it first. Review of the facility Blood Glucose Monitoring policy directed, in part, to disinfect blood glucose meters per manufacturer guidelines using approved germicidal wipes to wipe down the meter after each use. 51756