STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075368	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Heights Health Care Center, Inc	172 Rocky Rest Road Shelton, CT 06484

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, interviews, review of the clinical record, and facility policy in 1 of 3 dining rooms (Laurel dining room) observed for Residents (Resident #31, #42, #44, #45, #52, #93 and Resident #99) who were dining, the facility failed to provide a dignified dining experience. The findings include: 1. Resident #31's diagnoses included Alzheimer's disease, dysphasia, ventricular tachycardia and anxiety disorder. The Resident Care Plan dated 6/24/24 identified Resident #31 was at an increased risk for decreased nutritional status. Interventions included adaptive equipment per physician's order, diet as ordered, and different foods/fluids to be offered and encouraged. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #31 was severely cognitively impaired and was dependent on staff for eating, toileting and transfers. The Resident Care Card (Individualized Resident Assignment) identified Resident #31 was to be fed in his/her room or in the dining room. Observation on 8/16/24 at 12:34 PM identified NA #7 feeding Resident #31 in the dining room not at eye level with the resident and standing over him/her. Observation on 8/16/24 at 12:40 PM identified Licensed Practical Nurse (LPN #8) feeding Resident #31 in the dining room, not at eye level with the residents and standing over him/her. At 12:45 PM LPN #8 was offered a chair by another staff member and refused stating I am ok. 2. Resident #42's diagnoses included Alzheimer's disease, feeding difficulties, and dysphagia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #42 was severely cognitively impaired and was totally dependent on staff for eating. The Resident Care Plan dated 7/27/24 identified that Resident #42 required assistance with activities of daily living (ADL) due to diagnosis of Alzheimer's disease but failed to identify the assistance required with dining. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 8/15/24 directed to assist Resident #42 to eat all meals. Observation on 8/19/24 at 12:55 PM identified RN #2 standing over Resident #42 above eye level and assisting the resident to eat his/her lunch. There were nine (9) empty chairs noted to be available in the dining room. 3. Resident #44's diagnoses include unspecified dementia, dysphasia, muscle contracture, and generalized muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #44 was moderately cognitively impaired, required set up for eating, and needed partial/moderate assistance for toileting and transfers. The Resident Care Plan dated 8/14/24 identified Resident #44 had the potential for a nutritional decline. Interventions included encouraging foods/fluids and offering different foods/fluids. The Resident Care Card (Individualized Resident Assignment) identified Resident #44 feeds him/herself in the dining room. Observation on 8/16/24 at 12:40 PM identified a Licensed Practical Nurse (LPN #8) feeding Resident #44 in the dining room, not at eye level with the residents and standing over Resident #44. 4. Resident #45's diagnoses included dementia, dysphasia, hypertension and glaucoma. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #45 was severely cognitively impaired and required substantial/maximal assistance for eating and toileting and partial/moderate assistance for transfers. The Resident Care Plan dated 7/3/24 identified Resident #45 was at risk for decreased nutritional status. Interventions included offering different foods/fluids. The Resident Care Card (Individualized Resident Assignment) identified Resident #45 feeds him/herself with setup assistance in the dining room. Observation on 8/14/24 at 12:38 PM identified Nursing Assistant (NA) #4 feeding Resident #45 in the dining room not at eye level and standing over the resident. 5. Resident #52's diagnosis included multiple sclerosis, Alzheimer's disease, and feeding difficulties. A physician's order dated 7/16/24 directed to assist Resident #52 for eating. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #52 was moderately cognitively impaired and required partial to moderate assistance for feeding. The Resident Care Plan dated 7/25/24 identified that Resident #52 required assistance with Activities of Daily Living (ADLs). Interventions included assistance with meals as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 8/13/24 at 12:30 PM, 8/14/24 at 12:45 PM, 8/15/24 at 12:30 PM, 8/16/24 at 12:50 PM and 8/19/24 at 1:00 PM identified Resident #52 in the dining room, seated alone, against a wall, while other residents were seated together at tables. Resident #52 had an overbed table that held his/her lunch which had been set up by staff and he/she was feeding him/herself. Empty space at other tables was available. Interview with the ADNS on 8/19/24 at 12:29 PM identified that Resident #52's wheelchair did not fit under any of the dining tables. Interview with NA #13 on 8/19/24 at 1:30 PM identified that Resident #52 had been sitting by his/herself for several months, the Resident Care Card did not indicate that the resident needed to be seated alone, and NA #13 did not know of any reason why Resident #52 could not be seated with other residents. 6. Resident #93's diagnoses included Alzheimer's disease, dysphagia, and cognitive communication deficit. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #93 was severely impaired and was dependent for feeding. The Resident Care Plan dated 7/25/24 identified that Resident #52 required assistance with Activities of Daily Living (ADL). Interventions included assisting with mouth care, encouraging the resident to independently eat, and assist Resident #93 to complete the meal as needed. Observation on 8/19/24 at 12:20 PM identified Resident #93 in the dining room, seated alone, against a wall, while other residents were seated together at tables. Resident #93 had an overbed tray table in front of him/her. RN #2 was noted to be standing over the resident above eye level and assisting him/her to eat. There were nine (9) empty chairs noted to be available in the dining room as well as empty space available at other tables. 7. Resident #99's diagnoses included generalized muscle weakness, unspecified feeding difficulties, dementia, and type 2 diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #99 was moderately cognitively impaired, required set up for eating, and was dependent on staff for toileting and transfers. The Resident Care Plan in effect on 8/14/24 identified Resident #99 had the potential for a nutritional decline. Interventions included encouraging fluids and encouraging the resident to eat their meal independently and that assistance was needed to complete the meal. The Resident Care Card (Individualized Resident Assignment) identified Resident #99 feeds him/herself with setup and assistance. Observation on 8/14/24 at 12:38 PM identified Nursing Assistant (NA #4) feeding Resident #99 in the dining room not at eye level and standing over the resident. An interview with Nurse Aid (NA) #4 on 8/14/24 at 12:48 PM identified that she stood to feed a couple residents because that was her preference when assisting residents at mealtime. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nurses (DNS) on 8/16/24 at 1:00 PM identified it was the facility policy for staff to sit while feeding residents at mealtime. An interview with NA #7 on 8/16/24 at 2:25 PM identified that it was the facility policy to sit while feeding a resident but could not find a chair. Observation of the dining room at the time of the observation identified four empty chairs available. An interview with the MDS Coordinator (LPN #8) on 8/19/24 at 11:41 AM identified that she was unaware of the facility policy on feeding residents, but it was not unusual for her to help with feeding. LPN #8 identified she prefers standing to feed in the dining room and resident rooms because she felt like there was better leverage and it was her personal preference because it was more comfortable. Interview with the ADNS on 8/19/24 at 12:29 PM identified that Resident #42, 52 and # 93 should have been assisted to eat by a staff member who was in a seated position and not standing over the residents. Additionally, the ADNS indicated that residents should be seated together at a table and not isolated by themselves. She indicated that there was one table that was higher than the others and that she would see if Resident #52 and Resident #93's wheelchairs would fit under that table. If their wheelchairs were unable to be placed at the higher table, she would notify maintenance staff to see what could be done to accommodate both residents to dine at a table with others. Review of the Feeding Policy dated 12/7/23 directed that assistance during feeding was provided in a dignified and respectful manner, and staff should not stand while feeding the resident. Review of the Feeding policy dated 12/7/23 directed, in part, do not stand when feeding resident. Although requested. A facility policy regarding placing residents at dining tables for meals was not provided. 51102 51183 51313

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51182 Based on interviews, review of clinical records, and facility policy for 2 of 3 residents, (Resident #23 and Resident #29) reviewed for abuse, the facility failed to report incidents of unknown origin to the State Agency. within the 24-hour time requirement. The findings include: 1. Resident #23's diagnoses included dementia, abnormal posture, muscle weakness, and congestive heart failure. The annual Minimum Data Set assessment dated [DATE] identified Resident #23 had severely impaired cognition and was dependent with eating, oral hygiene, toilet use, showering, personal hygiene, and chair/bed to chair transfers. a. A facility Reportable Event form dated 2/2/24 at 6:00 PM identified Resident #23's family reported a 1.0 centimeter (cm) by 1.0 cm bruise on Resident #23's left shoulder. Although the facility conducted investigations, they were not able to determine a root cause for the bruise. The facility did not report the injury of unknown origin to the State Agency. b. A facility Reportable Event form dated 8/6/24 at 7:00 PM identified that Registered Nurse (RN) #2 reported an incident of discoloration on Resident #23's third and fourth fingers on his/her right hand and his/her left leg. Although the facility conducted investigations, they were not able to determine a root cause for the bruise. The facility did not report the injury of unknown origin to the State Agency. 2. Resident #29's diagnoses include dementia, chronic obstructive pulmonary disease, and cerebral infarction. The annual Minimum Data Set assessment dated [DATE] identified that Resident #29 had moderately impaired cognition, required substantial/maximal assistance with eating, and was dependent with oral hygiene, toilet use, showering, personal hygiene, and chair/bed to chair transfers. a. A facility Reportable Event form dated 5/28/24 at 1:30 PM identified that Nurse Aide (NA) #5 reported a discolored area on Resident #29's fourth finger of the left hand. Although the facility conducted investigations, they were not able to determine a root cause for the bruise. The facility did not report the injury of unknown origin to the State Agency. b. A facility Reportable Event form dated 6/26/24 at 12:30 PM identified Resident #29's family reported 2 bruises measuring 1.0 centimeter (cm) by 2.0 cm and 0.3 cm by 0.7 cm on the Resident #29's left inner forearm. Although the facility conducted investigations, they were not able to determine a root cause for the bruises. The facility did not report the injury of unknown origin to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DNS on 8/19/24 at 12:26 PM (in the presence of two Corporate RNs), identified that the DNS did not report the incidents of Resident #23 and Resident #29 injuries of unknown origin to the State Agency because he only reported fractures and big origins and was not aware of the need to report injuries of unknown origin to the State Agency. Review of the facility's Reportable Events Policy identified that any injuries of unknown origin should be reported to the Department of Public Health (State Agency) no later than 2 hours after the allegation is made if the event includes abuse or serious bodily injury or not later than 24 hours after the allegation if the events do not involve abuse or cause serious bodily injury.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on review of the clinical record, facility policy, and interviews for 3 of 4 sampled residents (Resident #44, #56, and #85) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure residents were free of facial hair. The findings include: 1. Resident #44's diagnoses included dementia, contracture of right-hand muscle, and generalized muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #44 was moderately cognitively impaired and required moderate assistance with personal hygiene, set up assistance with eating, and supervision with oral hygiene. The RCP in effect on 8/10/24 identified Resident #44 required assistance with ADL's. Interventions included assistance with personal hygiene, set up assistance with eating and supervision with oral hygiene. Intermittent observations throughout the day on 8/13/24, 8/14/24 and 8/15/24, identified Resident #44 with visibly long, black facial hair noted below the lower lip. Physicians order in effect from 7/1/24 through 8/15/24 directed a body audit to be performed every week by a licensed nurse on their shower day (Friday) and document results on the Body Audit Form. Review of Resident #44's clinical record from 7/3/24 to 8/15/24 identified that Resident #44's body audit audits were performed on 7/3/24, 7/10/24, 7/17/24, 7/24/24, 7/31/24, and 8/7/24 with no new concerns or refusals noted on the Body Audit Forms. 2. Resident #56's diagnoses included dementia, generalized muscle weakness and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #56 was severely cognitively impaired, required moderate assistance with personal hygiene, set up assistance with eating, and supervision with oral hygiene. The Resident Care plan (RCP) in effect on 8/1/24 identified Resident #44 required assistance with ADL's due to the resident's cognitive status. Interventions included assistance as needed to meet toileting needs, feeding as needed, and keeping commonly used items within reach. Intermittent observations throughout the day on 8/13/24, 8/14/24 and 8/15/24, identified Resident #56 with visibly long, white facial hair noted below the lower lip. Physicians order in effect from 6/15/24 through 8/15/24 directed a body audit to be performed every week by a licensed nurse on their shower day (Friday) and document results on the Body Audit Form. Review of Resident #56's clinical record from 6/26/24 to 8/15/24 identified that Resident #56's body audits were performed on 6/29/24, 7/6/24, 7/13/24, 7/20/24, 7/27/24 and 8/3/24 without any issues or refusals being identified. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #85's diagnoses included dementia, muscle weakness and hypertension. The quarterly MDS assessment dated [DATE] identified Resident #85 was cognitively intact and required set up assistance with eating and moderate assistance with personal hygiene. The RCP in effect on 8/1/24 identified Resident #85 needed staff assistance with ADL's. Interventions included assisting as needed to meet toileting needs, mouth/dental care, feeding, and keeping commonly needed items within reach. Intermittent observations throughout the day on 8/13/24 and 8/14/24, identified Resident #85 with visibly long, white facial hair noted below the lower lip. Physicians order in effect from 7/1/24 through 8/15/24 directed a body audit to be performed every week by a licensed nurse on their shower day (Friday) and document results on the Body Audit Form. Review of Resident #85's clinical record from 7/2/24 to 8/12/24 identified that Resident #44's body audits were performed on, 7/2/24, 7/6/24, 7/8/24, 7/13/24, 7/20/24, 8/10/24 and 8/12/24 with no new concerns or refusals noted on the Body Audit Forms. Interview and observation with NA #6 on 8/15/24 at 2:40 PM indicated that she was taking care of Resident #44, Resident #56 and Resident #85. NA #6 identified that she normally assists residents with shaving and grooming on their shower days and as needed. NA #6 further stated that some residents are combative and resistant to care resulting in difficulty to provide needed care appropriately. NA #6 identified that she normally reports care refusal to a licensed nurse and re-approaches the resident at a different time to provide the needed care. Interview and record review with LPN #5 on 8/15/24 at 2:50 PM identified that all nursing staff provide resident care including shaving of residents. LPN #5 indicated that sometimes residents refuse and are combative with care. LPN #5 was not sure when Resident #44, Resident #56 and Resident #85 had last been shaved, and was unable to provide any documentation that Resident #44, Resident #56 and Resident #85 had refused to be shaved. Subsequent to the surveyor's inquiry, Resident #44's, Resident #56's and Resident #85's facial hair was shaved. Interview with DNS on 8/16/24 at 9:50 AM identified that the nurse aides are expected to help all residents that require assistance with ADLs, and he has seen residents refuse or become combative with care. The DNS identified that refusal of care should be documented in resident's clinical record. Further, the DNS identified that body audits are done on a weekly basis and any areas of concern should be noted on the Body Audit Form. Review of the facility's AM care/ADLs policy identified in part, that individualized assistance is provided to residents in preparation for daily activities according to their wishes and plan of care. Nursing staff will assist with care for each resident daily as needed and resident's individual preferences and choices will be honored and included in the morning routine. The procedure includes shaving residents if needed unless otherwise indicated.

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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** 48950 Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #75) reviewed for dental services, during the clinical record review, it was noted that the facility failed to ensure blood pressures were taken prior to the administration of an antihypertensive (blood pressure reduction) medication . The findings include: Resident #75 was admitted to the facility on [DATE] with a diagnosis that included dementia and hypertension. The Social Services admission assessment dated [DATE] identified Resident #75 had vascular dementia and was confused and forgetful at times. The Resident Care Plan (RCP) in effect on 8/2/22 identified Resident #75 with cardiovascular disease. Interventions included administering medications as ordered, obtaining weights and vital signs as ordered. A physician's order dated 8/3/22 directed facility staff to take Resident #75's blood pressure prior to the administration of lisinopril 20 milligrams (mg) by mouth and to hold (not administer) the medication for a systolic blood pressure (SBP) that was less than 110 millimeter of mercury (mmHg). Review of the Medication Administration Records from 8/3/22 to 8/14/24 failed to identify that facility staff had regularly taken Resident #75's blood pressure prior to each administration of lisinopril over the last 24 months. An interview and record review with LPN #3 on 8/14/24 at 12:35 PM identified that he did not obtain Resident #75's blood pressure prior to administering lisinopril in the morning. LPN #3 stated that he did not obtain vitals because the order did not direct to take a blood pressure prior to administering the lisinopril. LPN #3 indicated that the blood pressure breakdown attachment (directive) may have been inadvertently omitted when the order was initially placed, however, LPN #3 stated that physicians' order should have been followed for the administration of lisinopril for Resident #75. Subsequent to surveyor's inquiry on 8/14/24, the blood pressure breakdown was added to the lisinopril 20 mg physician order, the APRN and Resident #75 representative were updated, and a normal blood pressure reading was obtained. Interview and record review with the DNS on 8/16/24 at 9:50 AM identified that the floor nurse was responsible for obtaining blood pressures for residents who have an order to obtain a blood pressure prior to administering the medication. The DNS could not explain why the blood pressure breakdown was not added to the medication order but identified that the physician's order should have been followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 8/16/24 at 10:00 AM identified that Resident #75 was stable and did not present with any acute issues since he/she was admitted to the facility. APRN #1 further indicated that Resident #75 could have experienced a further drop in blood pressure resulting in dizziness or a syncope attack if the lisinopril had been administered with a systolic blood pressure of less than 110. Physician's order policy provided did not specify that physician's orders should be followed. 50250

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #42) reviewed for pressure injuries, the facility failed to ensure off-loading for a dependent resident according to the plan of care and failed to ensure a hospice recommendation was reviewed by a provider. The findings include: Resident # 42's diagnoses included Alzheimer's disease, Lupus, peripheral vascular disease, and diabetes. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #42 was severely cognitively impaired, was dependent with eating, required substantial/maximal assistance with rolling left and right, was dependent for bed to chair transfer, and was at risk for pressure ulcer development. a. The Resident Care Plan dated 5/24/24 identified Resident #42 was at risk for pressure injuries. Interventions included to follow the facility protocol for treatment of pressure injuries, offload heels as appropriate, and turning and repositioning per nursing standards of care and facility policy. Physician's orders in effect from 8/1/24 to 8/13/24 directed booties be placed to Resident #42's bilateral heels, at all times, for heel protection, remove booties for care, and check for placement every shift. Registered Nurse (RN) #1 hospice note dated 8/8/24 identified that Resident #42 had a new open area to the right heel where a previously noted deep tissue injury had occurred. New orders were recommended for treatment. A renewed physician's order dated 8/9/24 directed facility staff to treat Resident #42's unstageable left heel pressure ulcer. Review of the physician's orders from 8/8/24 through 8/13/24 failed to identify a physician order related to the newly identified open right heel wound per the hospice recommendation. RN #1 hospice note dated 8/13/24 identified that Resident #42 had a macerated right heel wound measuring 4.5 centimeters (cm) by 5 cm by 0.1 cm and RN #1 placed a pillow for offloading. Recommendations included, in part, to make sure heel booties were in place bilaterally. Observation on 8/13/24 at 2:59 P.M. identified a pillow was in place behind Resident #42's heels, dressings were in place to both feet including the heels and a heel bootie was noted in place to the left foot only. A physician's order dated 8/14/24 directed to discontinue booties to bilateral heels and a new order was added for offloading heels at all times for protection. A physician order dated 8/14/24 directed to apply skin-prep (protective barrier) to the right heel every shift for a prior right heel Deep Tissue Injury (DTI). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry nurse's note dated 8/14/24 at 11:30 AM identified a right heel wound heel area measuring 4.0 centimeters (cm) by 6.0 cm by 0.0 cm. A clarification nurse's note written by LPN #7 dated 8/14/24 at 11:37 AM identified a prior right heel DTI that was reported to the wound care specialist, with initiation of treatment with skin-prep every shift, and further noted Resident #42 would be seen by the wound care specialist the following day. A Doctorate of Nurse Practice wound note dated 8/15/24 at 8:44 AM identified a new unstageable pressure injury to the right heel containing 100% eschar (non-viable tissue) and measuring 4.0 centimeters (cm) by 6. 0 cm by 0.0 cm with no drainage. Treatment recommendations included to apply betadine (topical wound treatment) to the base of the wound, then secure with a dry clean dressing daily and as needed. A physician's order dated 8/15/24 discontinued skin-prep to the right heel every shift for prior right heel DTI. A physician's order dated 8/16/24 directed to cleanse the right heel with normal saline followed by betadine and a protective dressing daily and as needed for an unstageable pressure injury. Observations on 8/16/24 at 6:15 AM, 6:30 AM, 6:45 AM, 7:00 AM, and 7:15 AM identified Resident #42 lying supine in bed, knees bent and leaning to the right on a pillow, both feet were on the mattress and the heels failed to be offloaded. Continued observations at 7:30 AM and 7:45 AM identified Nursing Assistant (NA) #8 provided care and dressed Resident #42. When NA #8 left, Resident #42 was noted to be lying on his/her left side with the left outer heel and right inner heel on the mattress and not offloaded. (1 and 1/2 hours since the observation began.) During observations on 8/16/24 at 8:00 AM, 8:15 AM, 8:30 AM, 8:45 AM, 9:00 AM, and 9:15 A.M (1 hour and 15 minutes) Resident #42 was noted to be out of bed and in an adaptive custom wheelchair with both heels offloaded and free floating. Out of bed observations on 8/16/24 at 9:30 AM, 9:45 AM, 10:00 AM, 10:15 AM, 10:30 AM, 10:45 AM, 11:00 AM, At 11:35 AM, 11:45 AM, 12:45 PM, 1:15 PM, and 1:30 PM identified Resident #42 in his/her wheelchair. Although Resident #42's pillow was still placed on the wheelchair leg rests, the pillow had shifted and was no longer providing pressure relief. Resident #42's heels were resting against the pillow without the benefit of offloading from 9:30 AM through 1:40 PM (4 hours and 10 minutes). Direct observations identified a failure to offload Resident #42's heels according to the physician order and Resident Care Plan. Interview with NA #8 on 8/16/24 at 11:45 A.M. identified she did not place the pillow behind Resident #42's legs. NA #8 indicated NA's are instructed to not place items in the wheelchair with residents. Interview with LPN #6 on 8/16/24 at 1:20 P.M. identified she did not place the pillow behind Resident #42's legs, and further indicated pillows are ineffective in reducing pressure if directly against the feet. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/16/24 at 1:40 PM Resident #42 was transferred back to bed, positioned on his/her back and both heels were noted to be in direct contact with the mattress without the benefit of offloading. Observation and interview with LPN #6 and #7 on 8/16/24 at 1:40 P.M. identified Resident #42 lying supine in bed, without heel offloading. LPN #6 was observed performing a dressing change to the bilateral heels. On observation Resident #42's heel wounds extended from the lower Achillies (back of the ankle) over the back of the heel to the edge of the sole of the residents foot. LPN #7 indicated she had placed the pillow in the wheelchair but did not place the pillow behind Resident #42's feet and that the pillow must have shifted. LPN #7 indicated that the pillow should not have been behind or touching Resident #42's heels. LPN #7 indicated that the facility practice was to identify the need for offloading on the Treatment Administration Record (document directing licensed nurses sign as complete) and the NA Resident Care Card (Individualized Resident Assignment) which was updated by herself (LPN #7) or the MDS Coordinator following new concerns/orders discussed during the facility morning report. A review of the NA Resident Care Card failed to identify offloading. Subsequent to surveyor the Resident care card was updated to include offloading. Review of the Positioning policy directed, in part, that residents are to be repositioned every 2 hours and as needed, and that the Resident Care Plan and Resident Care Card would indicate the resident need for assistance with positioning. b. The 5/8/24 Resident Care Plan (RCP) identified Resident #42 was receiving hospice level of care for anticipated death due to Alzheimer's disease with interventions including encourage rest periods as needed and repositioning for comfort as needed. Review of the Hospice recommendation document by Registered Nurse (RN) #1 dated 8/8/24 identified a prior right heel suspected deep tissue injury (DTI) that had appeared to have re-opened. A recommendation for the right heel wound included the application of calcium alginate (an absorptive topical wound treatment) followed by a padded covering and gauze wrap to be changed daily and as needed. The recommendation was signed as reviewed by facility LPN #10; however, no order was noted in the physician's orders. Further clinical record review failed to identify that the physician had been made aware of the new recommendation. Review of the Hospice recommendation document dated 8/13/24 by RN #1 identified Resident #42 had a macerated right heel wound measuring 4.5 centimeters (cm) by 5 cm by 0.1 cm and a pillow was placed for offloading. Recommendations included, in part, to make sure heel booties were in place bilaterally. This document was signed as reviewed by facility LPN #6. A physician order dated 8/14/24 directed to discontinue heel booties and a new order was added directing heel offloading at all times for protection. Interview with the Hospice Registered Nurse (RN) #1 on 8/16/24 at 11:40 AM indicated he first identified Resident #42's right heel wound on 8/8/24 and made a wound care recommendation. RN #1 indicated that a visit note, in triplicate, is written at the completion of each facility visit, 2 copies are provided to the facility supervisor (one for the chart and another for the supervisor use), and 1 copy is kept by the hospice provider. Further RN #1 indicated he had frequent care discussions with LPN #7 which worked well for him. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with LPN #7 on 8/19/24 at 2:18 PM identified that Resident #42 had a hospice recommendation dated 8/8/24 for the right heel that was never addressed or implemented. LPN #7 indicated, per the facility policy, the floor nurse should have called the APRN, clarified if the recommendation would be accepted or declined, and add a new order if approved. LPN #7 indicated this had not occurred and the ball was dropped. Further, a review of a body audit dated 8/14/24 failed to identify the wound. LPN #7 stated if a wound was evident on 8/8/24 and 8/13/24 and a body audit had been completed on 8/14/24, the area should have been identified during the body audit. Subsequent to surveyor inquiry the facility began education with facility staff. Review of the facility education, with an effective date of 8/13/24 identified that all hospice recommendations are brought to the supervisor/infection control nurse after each visit and the supervisor/infection control nurse would review the recommendations with the facility APRN/MD for confirmation. Review of the Handling and Implementation of Hospice Recommendations policy directed, in part, that hospice recommendations would be reviewed by the facility APRN/MD (provider) in a timely manner, that if a recommendation was deemed clinically inappropriate the provider would document the rationale for non-implementation, and documentation should clearly state whether a recommendation was accepted, modified, or declined, along with the clinical rationale.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility policy, and interviews for 3 of 5 residents (Resident #8, #33 and #46) reviewed for a limited range of motion, the facility failed to apply positioning devices according to the physician orders and rehabilitation plan of care. The findings include: 1. Resident #8's diagnoses included osteoarthritis, contractures, rheumatoid arthritis, and post-traumatic stress disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 was severely cognitively impaired and required partial/moderate assistance with eating, substantial/maximal assistance with upper body dressing, and was dependent for toileting, and transfers. The Resident Care Plan dated 7/22/24 identified Resident #8 had rheumatoid arthritis. Interventions included to monitor/document and report to the physician, any joint stiffness, decline in mobility, and contracture formation/joint shape change. Physician orders in effect from 8/1/24 to 8/14/24 directed to apply a left elbow splint to be on after care every morning (AM), off prior to bedtime (PM) and to check skin before and after application every shift. A review of the Resident Care Card (Individualized Resident Assignment) for Resident #8 identified and instructed the left elbow splint be applied after AM care every morning and off prior to PM care at bedtime and to check the skin before and after application every shift. Observations of Resident #8 on 8/14/24 at 10:00 AM and 8/16/24 at 10:56 AM noted the resident to be up in his/her wheelchair, after morning care, with no left elbow splint applied. Observation of Resident #8 on 8/16/24 at 12:13 PM identified the DNS applying the left elbow splint on the resident (several hours after Resident #8 received morning care). An interview with the DNS on 8/16/24 at 12:18 PM identified he does not usually apply the splints and that the nurse aid was responsible for applying the splints, per policy it should be applied in the morning and taken off at bedtime. It was not applied because there was a float or new nurse aid, and they have a hard time applying the split due to the contracture. The DNS identified the nurse aid would know to apply the left elbow splint on Resident #8 per the Resident Care Card and should have done so as part of Resident #8's AM care. An interview and record review with the Occupational Therapist (OT #1) on 8/19/24 at 9:17 AM identified deficits associated with not applying the splint include potential decreased range of motion and potential increase in the current contracture. 2. Resident #33's diagnoses included cerebral infarction, hemiplegia of the left side (loss of function on 1 side) and left hand muscle contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual Minimum Data Set (MDS) assessment dated [DATE], identified Resident #33 had no cognitive impairment and was dependent with bed mobility, toileting, and transfers. The Resident Care Plan dated 7/8/24 identified contractures of left upper and left lower extremities related to history of cerebrovascular accident (CVA/stroke). Interventions included left hand resting splint per physician orders. Physician's orders in effect from 8/1/24 through 8/13/24 directed a left palm guard to be worn after AM care and off prior to PM care. The Nurse Aide Resident Care Card (Individualized Resident Assignment) for Resident #33 identified a left palm guard as ordered. The Medication Administration Record (MAR's) dated August 2024 identified a palm guard to be worn after AM care and off prior to PM care. Check skin before and after application and every shift, every morning and at bedtime. Observations on 8/13/24 at 1:10 PM, 8/14/24 at 9:30 AM, and 8/15/24 at 12:40 PM failed to identify Resident #33's left hand palm guard in place. Although observations of Resident #33 not wearing his/her left hand splint on 8/13/24 at 1:10 PM, 8/14/24 at 9:30 AM, and 8/15/24 at 12:40 PM failed to identify placement of Resident #33's left hand palm guard hand, review of the facility MAR documentation dated 8/13/24, 8/14/24 and 8/15/24 identified staff signatures indicating that Resident #33 was wearing his/her left palm guard. Interview and observation with NA #4 on 8/16/24 at 10:00 AM identified that Resident #33 did not have his/her left hand palm guard in place. NA #4 indicated that she was not aware that Resident #33 required a left hand palm guard as she did not normally work on Resident #33's unit. Further, NA #4 was unable to locate the palm guard in Resident #33's room. Interview, observation and record review with LPN #1 on 8/16/24 at 10:06 AM identified that although Resident #33 did not currently have the left hand palm guard in place she had signed the Medication Administration Record indicating placement. LPN #1 was unable to identify the current location of Resident 33's left hand palm guard and would have to contact the Occupational Therapist (OT). Interview and observation with OT #1 on 8/16/24 at 12:15 PM identified that Resident #33 did not have the left hand palm guard hand splint in place but that he/she should have. OT #1 indicated that Resident #33 was to wear the left hand palm guard daily to maintain functional positioning of his/her left hand and that if the resident was refusing to wear the palm guard or the left hand palm guard was missing, nursing should have documented the information and notified her. After locating Resident #33's left hand palm guard, OT #1 placed it on the resident and indicated that she would need to re-educate and conduct an in-service with the nurse aides and nurses regarding Resident #33's hand splint placement. 3. Resident #46's diagnoses included contracture of the left hand, CVA (stroke) with spastic hemiplegia, and intercranial injury. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 had short-term and long-term memory problems, and was totally dependent on staff for eating, bathing, dressing, and toileting. Additionally, the MDS identified impaired functional range of motion on one side for both upper and lower extremities. Review of the Resident Care Plan dated 8/14/24 failed to identify Resident #46's left-hand contracture or the need for a left palm guard. The Resident Care Card (Individualized Resident Assignment) for Resident #46 identified left hand palm guard to be on after morning care and off prior to evening care. A current Physician order in effect on 8/15/24 directed facility staff to apply a left palm guard after morning care and remove prior to evening care. Observations on 8/15/24 at 11:20 AM, 12:09 PM, 12:44 PM, and 2:35 PM identified Resident #46 in his/her room, the left hand palm guard had not been applied to the resident's left hand and was noted to be located on the resident's nightstand. Observation on 8/16/24 at 10:46 AM identified Resident #46 attending an activity program without the benefit of the left palm guard. The palm guard was noted to be located on the nightstand in the same location as noted on 8/15/24. Interview with NA #3 on 8/16/24 at 11:41 AM identified that Resident #46's palm guard was not applied because Resident #46 can become combative, and she required assistance to place the palm guard. Subsequent to surveyor inquiry, NA #3 and NA #7 applied Resident #46's palm guard. Interview with LPN #4 on 8/16/24 at 11:43 PM identified that the physician's order directed a left palm guard be placed every morning after AM care. LPN #4 identified that she was responsible to ensure that the NA had placed Resident #46's palm guard but she had not yet had the opportunity to check for placement. LPN #4 indicated that NA #3 was responsible for Resident #46's palm guard placement and had not reported that the resident had refused palm guard placement during her shift. Additionally, since the physician's order directed the left palm guard be placed after morning care, then Resident #46 should have had the palm guard in place prior to attending the activity. Interview with the Rehabilitation Director (PT #1) on 8/19/24 at 12:12 PM if the palm guard was not worn as ordered, the resident's fingernails could cause open areas in the palms of the hands, maceration (skin breakdown) due to sweat. Additionally, PT #1 identified that if splints are not applied as directed, joint contractures could worsen. Review of the Splints and Orthotic Devices policy directed, in part, to obtain an order for the device and should include the type of device and wear schedule. The resident's care plan and care card will reflect the use of the device. Nursing staff will be educated on the proper application, wearing schedule and any special care related to the device being used. In addition, therapy and nursing staff that have been educated on the device will apply and remove per physician's orders and that devices are given to residents to maintain range of motion, enable proper joint alignment, enhance functional ability and prevent further deformity. 50249 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51102

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for the only sampled resident (Resident #17) reviewed for accidents, the facility failed to complete a safe transfer with the mechanical lift. The findings include: Resident #17's diagnoses included left sided hemiplegia and hemiparesis (muscle weakness) following a cerebral infarction (stroke), abnormalities of gait and mobility, and need for assistance with personal care. A physician's order dated 2/8/23 directed to transfer Resident #17 via total mechanical lift, that Resident #17 was non-ambulatory, and that Resident #17 was independent with adaptive wheelchair with left leg rest (use both leg rests for transport). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #17 was moderately cognitively impaired, in a wheelchair, and required total dependance with toileting hygiene, bathing, and chair to bed transfers. Additionally, the MDS did not identify any previous falls. The Resident Care Plan dated 4/26/24 identified Resident #17 was a fall risk due to multiple risk factors. Interventions included to transfer per physician orders, encourage Resident #17 to ask and wait for staff assistance for transfers, and to use a wheelchair for mobility. Review of the Reportable Event Form dated 5/27/24 at 2:30 PM identified that Resident #17 was assisted to the floor from the mechanical lift and the facility's disposition was to exchange the mechanical lift pad (sling). A nurse's note dated 5/27/24 at 3:19 PM identified that Resident #17 was slowly lowered to the floor because the clip attachment of the mechanical lift pad had become loosened (during a transfer using the mechanical lift machine). Interview with Nurse Aide (NA) #1 on 8/15/24 at 3:00 PM identified that both herself and NA #4 were using the mechanical lift during a transfer of Resident #17 on 5/27/24 when the pad became unclipped from the lift. NA #4 was able to hold Resident #17 and Resident #17 was lowered to the floor. NA #1 further indicated that there was a chipped opening in one of the top clips of the mechanical lift pad that had not been noticed prior to the transfer. NA #1 demonstrated where the chipped opening was on a black clip of a mechanical lift pad. NA #1 identified that the black clip was not the same clip that was used during the incident. Interview with the Director of Maintenance on 8/16/24 at 9:21 AM identified that maintenance does not check the mechanical lift pads routinely, however the pads are checked prior to use by the staff member performing the transfer via the mechanical lift. Maintenance checks the mechanical lift machine monthly and an outside medical supply company completes annual assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 8/16/24 at 9:55 AM identified that he had taken the mechanical lift pad after the incident on 5/27/24 to try and identify the problem. The DNS further indicated that the mechanical lift pad appeared intact and that the clip was not broken. Additionally, the DNS indicated that the pad was taken out of circulation, even though there was no default with the pad. Observation with two surveyors on 8/16/24 at 10:15 AM demonstrated the completion of a safe transfer for a resident using the mechanical lift by NA #4 and NA #5. Interview with NA #4 on 8/16/24 at 10:30 AM identified that both herself and NA #1 were using the mechanical lift during a transfer of Resident #17 on 5/27/24 when the pad became unclipped from the lift. NA #4 identified that the mechanical lift pad had been inspected in the morning before it was used, and that Resident #17 continued to sit on the pad throughout the day. Resident #17 was being transferred from the chair to the bed in the afternoon for incontinent care. NA #1 had pulled Resident #17 back in the mechanical lift and the mechanical lift pad became unclipped. NA #4 was able to hold Resident #17 and Resident #17 was lowered to the floor. NA #4 demonstrated where the chipped opening was on the gray clip of a mechanical lift pad that another resident was sitting on. NA #4 identified that the gray clip was the same clip that was used during the incident. Interview with the Northeast Regional Territory Manager for the medical supply company used by the facility on 8/16/24 at 11:30 AM identified that mechanical lift pads with gray clips were recalled approximately [AGE] years ago and should not be in use. The Northeast Regional Territory Manager further indicated that the gray clips could become dislodged from the mechanical lift machine even if a resident sneezes. Additionally, he identified that the gray clips could become dislodged with or without a chipped opening on the clip. The Northeast Regional Territory Manager identified that when the gray clips are compared to the black clips, there is a slant in the opening of the black clip that secures it to the mechanical lift machine. The gray clips do not have slanted openings. The Northeast Regional Territory Manager identified that the facility would have been notified several times over a 2 year period regarding the recall of the mechanical lift pads with gray clips. Interview with the Administrator on 8/16/24 at 11:45 AM identified that the facility purchased the mechanical lift pads directly through the medical supply company. The Administrator further indicated that a complete sweep of the facility would be completed to ensure all mechanical lift pads with gray clips were removed. Review of the Sling Inspection policy updated 12/2/21 directed, in part, that the integrity of a sling will be visually and manually inspected by the nursing assistant prior to use on a resident for a mechanical lift transfer. If any alteration in the integrity of the sling is noted, the sling must not be used and immediately removed from service.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, record reviews, facility documentation, facility policy and interviews for 3 of 6 residents (Resident #30, Resident #53 and Resident #105), reviewed for Nutrition, the facility failed to provide a nutritional supplement for a resident with known weight loss. The findings include: 1. Resident #30's diagnoses included type 2 diabetes mellitus, dysphagia and chronic kidney disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #30 was significantly cognitively impaired, required set-up or clean-up assistance with eating and extensive assistance of 2 staff for transfers and toileting. The Resident Care Plan dated 5/2/24 identified significant weight loss with fortified cereal added. Interventions included to provide supplements as ordered and encourage Resident #30 to eat as much of his/her meal independently and assist with completing his/her meal as needed. A Nutritional assessment dated [DATE] identified Resident #30's weight on 5/1/24 was 94.4 pounds and that he/she, over the last 6 months, had a significant weight loss of 38.6 pounds (29% loss) and had chronic severe malnutrition. A physician's dietary supplement order dated 7/30/24, directed to provide fortified cereal, 180 milliliters (ml) in the morning. A Dietician's note dated 7/30/24 at 12:41 PM identified Resident #30 at a weight of 88.4 pounds a decrease of 8.6 pounds in 1 month (8.9% loss) with Resident #30 receptive to hot cereal in the morning. Observation and interview with Resident #30 on 8/16/24 at 8:20 AM identified the resident was seated in his/her room in a wheelchair with a plate of scrambled eggs and a banana on the overbed table in front of him/her. Fortified cereal was not observed. Resident #30 indicated he/she would like to have fortified hot cereal, but cereal had not been served for breakfast. Interview and record review with Dietary Aide (DA) #1 on 8/16/24 at 8:25 AM identified that she had served Resident #30 his/her breakfast but failed to include fortified cereal. DA #1 reviewed the Dietary Roster (form directing staff what to serve) kept on the steam table and verified that fortified cereal was listed for Resident #30 to receive for breakfast. Dietary Aide #1 further identified that she had made a mistake and should have reviewed the Dietary Roster when serving Resident #30 his/her breakfast. Interview and observation with the Administrator on 8/16/24 at 8:28 AM identified that Resident #30 did not have fortified cereal on his/her tray table. The Administrator indicated that if the fortified cereal was listed on the Dietary Roster, it should have been served to Resident #30 with his/her breakfast. Subsequent to surveyor inquiry, the Administrator obtained a bowl of fortified cereal for Resident #30 from Dietary Aide #1, and Resident #30 was served at 8:32 AM. (continued on next page)

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	075368	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gardner Heights Health Care Center, Inc	172 Rocky Rest Road Shelton, CT 06484

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation with the Administrator on 8/16/24 at 8:40 AM identified that Resident #30 had consumed 100% of the fortified cereal and Resident #30 stated It was good!. Interview and record review on 8/16/24 at 11:15 AM with Dietician #1 identified that Resident #30 had significant weight loss and had a physician's orders for fortified cereal in the morning, 180 ml. Dietician #1 indicated, based on the Fortified Cereal Recipe she provided, that a 6 oz. (180 ml.) serving of Fortified Cereal contained 487 kilocalories (kcal.). Dietician #1 further identified that there was no area for percentage of intake documentation included with the current nutritional supplement order on Resident #30's medication administration record (MAR) and that she tracked that information to determine ongoing nutritional recommendations. Dietician #1 identified that she would need to get the current order for the nutritional supplement corrected by the nurse. 2. Resident # 53's diagnoses included Alzheimer's disease and adult failure to thrive. The quarterly Minimum Data Set assessment dated [DATE] identified Resident # 53 was severely cognitively impaired and required supervision or touching assistance with eating, substantial/maximal assistance with oral hygiene, and was dependent for personal hygiene. The Resident Care Plan (RCP) in effect from 2/20/24 through 2/29/24 identified Resident #53 was at risk for a nutritional decline and had weight loss. Interventions included providing the diet as ordered, offering to set up meals, and to offer and encourage different foods/fluids (supplements were not included in the RCP). A Dietician's note dated 4/9/24 at 2:37 PM identified the resident had a weight loss of 5.6 pounds (lbs.) over 1 month (3.5%) and 10.6 lbs. over 6 months (6.4%) not a significant weight loss, that his/her food intake was good, eating 75-100% of meals, and that it is recommended Resident #53 receive 180 ml fortified cereal every morning for additional calories, and to continue the diet as ordered. A physician's order dated 4/9/24 directed to provide 180 ml of fortified cereal every morning and the amount consumed was to be documented. The physician order section identified a diet slip dated 4/9/24 with all copies, white, pink and yellow still attached. The slip directed that the Dietary Department provide fortified cereal 180 ml. The slip lacked a nurse signature or date the Dietary Department was sent notification. A nurse's note dated 4/10/24 at 5:12 PM identified that the Resident Representative for Resident #53 and the facility Advanced Practice Registered Nurse (APRN) were updated on the resident's weight loss and recommendation from the Dietician. A physician's order dated 8/6/24 directed to discontinue administration of 120 ml of house supplement in the afternoon, and to start a new order to administer 120 ml of house supplement two times a day. A Nutritional Assessment by the Dietician dated 8/13/24 identified, Resident #53 had continued weight loss, which was now significant, and that the house supplement had been increased to twice a day. Observation of Resident #53 on 8/19/24 at 8:45 AM, identified that Resident # 53's breakfast had been delivered and consisted of French toast, bacon, a small cup of sliced strawberries, and a glass of juice. Fortified cereal had not been provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Dietary on 8/19/24 at 9:25 AM, identified that the Dietary Roster did not include an entry for Resident #53 to receive fortified cereal. It was further identified that when a diet slip is received in the kitchen, the Director of Dietary updates the diet roster with the necessary information and fortified cereal is entered into the far right column and highlighted in green. Observation and interview with Licensed Practical Nurse (LPN) #4 and LPN #8 on 8/19/24 at 9:35 AM identified the Director of Dietary approached LPN #4 requesting a copy of the fortified cereal dietary request form. LPN #8 indicated that the facility process was to verify the order in the computer, sign the slip, bring the white copy to the kitchen, and then file the other copies of the slip in the chart, but that the white slip had not been sent, and remained in the clinical record. Subsequent to surveyor inquiry, the unsigned dietary slip dated 4/9/24 was signed by LPN #4 and brought to the kitchen by LPN #8. Interview with NA #3 on 8/19/24 at 10:00 AM, identified that Resident #53 had eaten his/her full breakfast, and that there was no fortified cereal served with his/her meal. NA #3 further identified that when documenting the meal intake in the clinical record, it does not specify food items that are to be provided. Although Resident #53 had not received fortified cereal for breakfast, a review of the Medication Administration Record on 8/19/24 at 11:35 AM, identified in the LPN #4 had documented that Resident #53 had consumed 180 ml of fortified cereal (100%) that morning. Interview with the Director of Nursing Services (DNS) on 8/19/24 at 1:00 PM, identified that the facility process to notify the Dietary Department of changes in supplementation was to fill out the dietary slip, the nurse would sign and bring the white section to the kitchen to add to the Dietary Roster and file the other copies in the clinical record. The DNS identified that NA would know to provide fortified cereal to the residents because the nurse would see the order and that they did not update the NA Resident Care Card (Individualized Resident Assignment) to include fortified cereal. 3. Resident #105's diagnoses included severe protein calorie malnutrition, anxiety, and chronic obstructive pulmonary disease. The Resident Care Plan dated 6/3/24 identified a problem with malnutrition and dietary intake. Interventions included to provide the diet as ordered, refer to the Dietician as needed, assist with eating if needed, and fortified foods as ordered. The admission Minimum Data Set assessment dated [DATE] identified Resident #105 was cognitively intact, required partial to moderate assistance with transfers, and was completely independent with eating. A physician's order dated 7/27/24 directed to provide Resident #105 with 180 milliliters (ml) of fortified cereal in the morning. Review of facility weight documentation identified that Resident #105 weighed 150 pounds on 7/3/2024. On 7/31/2024 Resident #105 was noted to weigh 137 pounds, a 13 pound weight loss in 1 month (8.67% loss) had occurred. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and review of the Medication Administration Record (MAR) on 8/16/24 at 8:48 AM identified Resident #105 in bed, asleep with his/her breakfast on the tray table. Resident #105 was without the benefit of fortified cereal (or any cereal). A Review of the Medication Administrations Record (MAR) identified a directive that Resident #105 should be provided with fortified cereal. Although the notation indicated that Resident #105 had consumed 100% of his/her fortified cereal, the nutritional supplement had not been provided. Interview with the Dietary Director on 8/16/24 at 8:50 AM identified that meals were provided per the Dietary Roster, located on the steam table. The Dietary Director indicated that the Dietary Roster failed to identify that Resident #105 was to receive fortified cereal and if the cereal was required, the directive would have been prepopulated on the Dietary Roster. Review of physician's order dated 7/27/24 with the Dietary Director directed facility staff to provide fortified cereal to Resident #105. Observation of the steam table with the Dietary Director failed to identify the availability of any fortified cereal. Subsequent to surveyor inquiry the Dietary Director indicated that Resident #105 would be provided with fortified cereal. Review of the undated Nutritional Supplementation Program policy directed, in part, that high calorie supplements should be documented in the administration record and that the Dietician's progress notes should address parameters for identification of nutritional risk, goal and approach, and that all disciplines should continue to monitor for progress towards the goal, adjusting the care plan as necessary. Additionally, the Dietician should assure that the resident is identified on the nourishment roster as to the supplement order and proper amount, and that a supplementation program should strive to increase overall intake and thereby improve the nutritional support offered to the resident with goals of supplementation consumption and weight gain. Review of the Resident Profile/Care Cards policy directed, in part, that care cards will be updated as needed with changes to guide caregivers in providing resident with assistance with care in order to achieve and maintain their highest practical level of well-being. 51101 51183

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51101 Based on observations, staff interviews, facility documentation and facility policy related to the dishwasher temperatures in the Dietary Department, the facility failed to identify when dishwasher temperatures were below the manufacturers guidelines. The findings include: On 8/16/24 at 9:45 observation of the dishwashing room in the Dietary Department with the Dietary Manager identified Dietary Aide (DA) #3 approximately half way through scraping and putting dirty dishes from breakfast through the dishwasher. The Dietary Manager identified the dishwashing machine was a high temperature machine. The wash cycle temperature was observed to reach 141 degrees Fahrenheit, (should be above 150 degrees Fahrenheit, per manufactures guidelines and posting on the front of the dish machine). On 8/16/24 at 9:56 AM, dishwasher temperature logs were reviewed with the Dietary Manager and identified on 8/1/24, 8/2/24, 8/3/24, 8/4/24, 8/5/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/10/24, 8/11/24, 8/12/24, 8/13/24, 8/15/24, and 8/16/24 the wash temperatures were recorded at 140 degrees Fahrenheit, (should be above 150 degrees Fahrenheit, per manufactures guidelines). The temperature logs failed to reflect any follow up regarding the low temperatures. Interview with the Dietary Manager at that time identified that the temperature log sheet noted wash temperatures should be 140 degrees or above (a discrepancy from the dishwasher machine indicating the wash temperature should be above 150 degrees) and that was the reason there low temperatures were not identified. Subsequent to surveyor inquiry on 8/16/24, the facility used paper services for lunch, the vendor of the dishwashing machine was contacted, arrived at the facility and serviced the dishwasher. Interview with the vendor on 8/16/24 at 3:23 PM identified he assessed the dishwasher machine and stated everything was working normal on heat but did increase setpoint for heat from 153 degrees Fahrenheit to 163 degrees Fahrenheit to maintain a reading of above 150 degrees. While the vendor was on site, the wash cycle was reading at 160 degrees Fahrenheit. After surveyor inquiry of low dishwashing temperatures, Dietary staff were in-serviced on 8/16/24 that before putting dirty dishes through the dishwasher, it needed to be cycled about 4 times and the wash temp on the machine needed to be 150 degrees Fahrenheit or greater. The rinse temperature should be 180 degrees Fahrenheit or greater. If the dishwasher machine fails to meet these requirements during a cycle, dishwashing is to stop, and Dietary Manager or [NAME] Supervisor are to be notified. Interview on 8/16/24 at 1:35 PM with DA #3 identified that he documented dishwashing temperatures on 8/3/24, 8/5/24, and 8/15/24 and did not recognize the temperatures were low because on the Dish Machine Temperature Log stated a minimum temperature of 140 degrees Fahrenheit was acceptable. He did not notice the label on the dishwasher machine with manufactures guidelines instructing dishwashing wash cycle to be 150 degrees or greater. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 8/19/24 at 9:10 AM with the Dietary Manager identified that she did not notice the sticker on the dishwashing machine with manufacturer guidelines of wash temperatures of 150 degrees or more. The temperature log stated the minimum temperature required was 140 degrees Fahrenheit. The Dietary Manager stated she assumed the paper log was correct as it was the way the log had been since she began her employment at the facility.