STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075373	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire House Health Care Facility & Rehab Center	3396 E Main Street Waterbury, CT 06705

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #34) reviewed for care planning, the facility failed to ensure Resident #34 was notified of physician ordered testing and updated on ultrasound results. The findings include: Resident #34's diagnoses included chronic venous hypertension of the right and left leg and chronic embolism, thrombosis of unspecified deep veins of lower extremities and anxiety. The annual Minimum Data Assessment (MDS) assessment dated [DATE] identified Resident #34 was cognitively intact and required a mechanical lift for transfers with the assistance of 2 staff members, moderate assistance for bed mobility, and was totally dependent on staff for dressing, personal hygiene and bathing. The Resident Care Plan dated 3/11/25 identified Resident #34 was at risk for deep vein thrombosis (DVT) (blood clot) and anxiety with interventions to administer anticoagulant as ordered (blood thinner) monitor and report lab values, avoid prolonged immobility or bed rest, report any signs and symptoms of DVT, encourage verbalize thoughts and feelings related to anxiety, help resident identify events that precipitate anxiety and discuss interventions and provide support and reassurance. A physician's order dated 4/4/25 written by Advanced Practice Registered Nurse (APRN) #2 directed to obtain a venous and arterial ultrasound of Resident #34's bilateral lower extremities for DVT and peripheral vascular disease (PVD). An interview with Resident #34 on 4/14/25 at 2:35 PM identified that he/she was not updated prior to when tests were ordered nor was he/she informed of the results of tests. Resident #34 stated this occurs frequently related to blood work and other diagnostic tests. Resident #34 indicated that this month someone came to perform an ultrasound on his/her legs and he/she was not informed ahead of time of the test or the reason it was being done. Resident #34 stated that he/she was self-responsible and should be updated on all of his/her care. In addition, Resident #34 indicated that he/she had been waiting to hear the results of the ultrasound that had been completed on his/her legs. Resident #34 stated that he/she informed Licensed Practical Nurse (LPN) #2 on 4/11/25 that he/she wanted to speak to someone about the ultrasound results. Resident #34 indicated that LPN #2 stated she would update APRN #2 regarding her request. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #2 on 4/15/25 at 1:52 PM identified that Resident #34 did inform her on Friday, 4/11/25 that he/she wanted to speak to the APRN regarding the ultrasound results. LPN #2 indicated that she did not contact APRN #2 or write anything in APRN #2's communication book about Resident #34's request. LPN #2 stated that she had forgotten about the request and recalled when APRN #2 came into the facility on 4/15/25 that APRN #2 inquired about the results as she did not have the results and requested that LPN #2 retrieve the ultrasound report. A review of the clinical record on 4/16/25 at 9:00 AM identified that the report was completed on 4/8/25 at 1:14 PM. An interview with APRN #2 on 4/16/25 at 9:30 AM identified that she was not aware that Resident #34 was asking about the results of the ultrasound. APRN #2 stated that she had spoken to Resident #34 on 4/15/25 and provided an update on the results (7 days after the results were complete). APRN #2 stated that she was not aware that Resident #34 had concerns that he/she was not always informed about his/her care and test results. In addition, APRN #2 stated that the radiology company does not always provide the results and/or report timely. APRN #2 indicated that they would do a better job in keeping Resident #34 informed of test and test results. A review of Resident Rights policy directed, in part, that a resident has the right to participate in one's own care, receive adequate and appropriate care, and be informed of all changes in medical conditions. A review of Care Planning-Interdisciplinary Team policy directed, in part, that the resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions of to the resident's plan of care. Ongoing changes in residents status shall be updated by Nursing and/or IDT as needed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #1) reviewed for edema, the facility failed to notify the Advanced Practice Registered Nurse (APRN) of a weight gain for a resident with congestive heart failure (CHF) and for 1 of 3 residents (Resident #219) reviewed for nutrition, the facility failed to notify the family/responsible party of a significant weight loss. The findings include: 1. Resident #1 had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic kidney disease, and CHF. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact, used a wheelchair, was independent with eating, required substantial/maximal assistance with bed mobility, and was dependent with transfers. The Resident Care Plan (RCP) dated 2/4/25 identified Resident #1 was at risk for cardiac/respiratory distress related to complications from chronic diastolic CHF. Interventions included to monitor for edema per physician order, weigh Resident #1 per physician order and notify the physician/APRN for a weight gain of 2 pounds (lbs.) or more in a day or 5 lbs. or more in a week. A physician order dated 3/4/25 directed to obtain a weekly weight every evening shift (3:00 PM to 11:00 PM) every Sunday and to notify the physician/APRN for a weight gain of 2 pounds (lbs.) or more in a day or 5 lbs. or more in a week regarding CHF. Review of weights in the clinical record identified Resident #1's weekly weights were as follows: weighed 238. 6 lbs. on 3/4/25, not weighed on 3/11/25, 239.7 lbs. on 3/16/25, not weighed on 3/23/25, 235.6 lbs. on 3/30/25, 235.6 lbs. on 4/1/25, 236.6 lbs. on 4/6/25, 244.3 lbs. on 4/13/25 (a 7.7 lb gain in 1 week), and 238.9 lbs. on 4/20/25. Nursing notes failed to identify documentation that Resident #1 had a weight gain of 7.7 lbs. between 4/6/25 (236.6 lbs.) and 4/13/2025 (244.3 lbs.) or that the APRN had been updated about the weight gain of 5 lbs. or more in a week. The Treatment Administration Record from 4/1/25 through 4/30/25 identified the physician order to notify the physician/APRN for a weight gain of 2 pounds (lbs.) or more in a day or 5 lbs. or more in a week was signed off by the licensed nurses on all 3 shifts on 4/13/25 and 4/14/25. Interview with APRN #2 on 4/17/25 at 3:05 PM identified she had not been notified of Resident #1's 7.7 lbs. weight gain on 4/13/25 and that had she been notified of the weight gain she would have investigated to see if it was a true weight gain and if it was a true weight gain, what the underlying cause of the weight gain was. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #2 on 4/22/25 at 2:10 PM identified she entered weights into the electronic medical record and compared the weight to the previous weights and when there was a difference of 4 to 5 lbs., she would request a reweight. LPN #2 identified daily weights were typically obtained on the night shift (11:00 to 7:00 AM) and if there was an increase of 3 lbs. it was put into the APRN communication book. LPN #2 identified Resident #1's weights were obtained on evening shift (3:00 PM through 11:00 PM) and so she wouldn't know if Resident #1 had a weight gain. LPN #2 identified that a weight gain was sometimes passed on in report but that even if a weight gain wasn't passed on in report it would be in the APRN communication book so that the APRN could address it. Review of the Congestive Heart Failure Program policy directed, in part, heart failure screening would be initiated with nursing staff in identifying signs and symptoms of CHF which includes: weight gain, edema, cough, shortness of breath, and licensed nursing staff will notify the physician regarding any patient condition changes and document finding in the clinical record. 2. Resident #219's was admitted to the facility in April 2025 with diagnoses that included failure to thrive, protein-calorie malnutrition, and dementia. Review of the Weight and Vitals Summary identified that Resident #219 weight on 4/2/25 was 199.4 pounds (lbs.) and on 4/8/25 Resident #219 weighed 189.5 (9.9 lb./4.96% loss in 1 week) Resident #219 continued to lose weight, further, identifying a weight of 176.7 on 4/15/25 (a 22.7 lb./11.3% loss in 2 weeks). The Resident Care Plan (RCP) dated 4/3/25 identified the resident's nutritional status was compromised secondary to a diagnosis of dementia and failure to thrive. Interventions included to monitor resident for signs and symptoms of dysphagia/aspiration during meals, weigh the resident per physician orders, and assess by mouth intake every meal. A physician's order dated 4/3/25 directed to weigh Resident #219 every morning at 6:00 AM. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #219 was severely cognitively impaired and required substantial/maximal assistance for oral hygiene, toileting, dressing and personal hygiene. Also, identified was that Resident #219 was dependent for showering, transferring, and independent for eating. Further, identified was Resident #219 weighed 190 pounds. A Dietician note dated 4/9/25 identified that Resident #219 was on a pureed diet, weight was 187 pounds, intake was variable, and weight was trending downward with a 12-pound weight loss since admission. A Dietician note dated 4/16/25 identified that intake was 50%, weight was trending downwards with a 20-pound weight loss since admission. Interview with Licensed Practical Nurse (LPN) #3 on 4/16/25 at 10:05 AM identified that there was no documentation that the family was notified regarding Resident #219's significant weight loss. Interview with the Director of Nursing (DNS) on 4/16/25 at 10:55 AM identified that the facility policy was for the Dietician to notify the family of a significant weight loss. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dietician on 4/16/25 at 11:40 AM identified that she thought that nursing staff was responsible for notifying the family of a significant weight loss. Further, identifying she did not know the policy, and did not notify the family of Resident #219 significant weight loss. Review of the facility policy for Weight Assessment and Intervention identified the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Also, identified that the Dietician will discuss undesired weight loss with the family.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews for 1 of 2 resident lounges and the dining room, the facility failed to ensure wheelchairs were stored in a non-resident area in order to provide a homelike environment. The findings include: Observation on 4/14/25 at 12:30 PM identified there were 9 standard wheelchairs (non-electric) being stored in the dining room while residents were dining and having their lunch in the same room. Observation on 4/15/25 at 11:45 AM identified 8 standard wheelchairs (non-electric) being stored in the dining room while residents were dining and having their lunch in the same room. Observation on 4/22/25 at 8:12 AM identified Resident #21 sitting in their wheelchair, eating breakfast, and watching television in the Hampshire Unit Lounge. Present in the lounge were 7 standard wheelchairs (non-electric) and 1 electric wheelchair (plugged in and charging). Observation and interview with Nurse Aide (NA) #7 on 4/22/25 at 8:15 AM identified that the wheelchairs were normally stored in the Hampshire Unit Lounge. NA #7 stated that Resident #21 regularly sits in the lounge and eats his/her meals there. Additionally, the interview identified that the wheelchairs were not stored in resident rooms they belong to as there was not enough space. Observation and interview with the DNS on 4/22/25 at 9:20 AM identified 7 standard wheelchairs (non-electric) and 1 electric wheelchair (plugged in and charging) in the Hampshire Unit Lounge. The DNS indicated that the Hampshire Unit Lounge was used for residents to watch television, eat meals, and store wheelchairs as there was not enough space in resident rooms. Additionally, it identified 9 standard wheelchairs (non-electric) being stored in the resident dining room. The DNS stated that the wheelchairs should not be stored in these locations and that he would meet with the Administrator and Maintenance Director to find an alternate storage area for the wheelchairs. Subsequent to surveyor inquiry, observation of the Hampshire Unit Lounge and the dining room on 4/22/25 at 10:15 AM identified that there were no wheelchairs being stored there, and they were moved to an empty office for storage. Although a policy on the storage of durable medical equipment, specifically wheelchairs, was requested, one was not provided.

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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** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #1) reviewed for mistreatment, the facility failed to report an allegation of misappropriation of property to the State Agency. The findings include: Resident #1's diagnoses included chronic obstructive pulmonary disease, cervical radiculopathy, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition, used a wheelchair, was independent with eating, and was dependent with personal hygiene and wheeling of his/her wheelchair. The Resident Care Plan (RCP) dated 11/5/24 identified Resident #1 required visits for socialization and mental stimulation to maintain leisure interests. Interventions included to provide transportation to and from recreational programs and/or courtyard visits, provide materials for independent leisure pursuits, and invite, encourage, and assist Resident #1 to group activities of assessed potential interest when available. A facility Grievance/Concern Form dated 1/20/25 identified Resident #1 reported to the Director of Social Services (Dir of SS) that he/she was missing $14.00 which had been in an envelope on his/her nightstand and not in the locked box. The form identified a room search was done, nursing staff were spoken to but the $14.00 was not found. The form identified the action taken to resolve the concern was to keep all money in the locked box, to secure the locked box to a shelf, to keep the locked box key in the Social Service office, and Resident #1 was in agreement with these actions. Resident #1 would notify Dir of SS when money was needed, and the Dir of SS would unlock the locked box. The form identified $14.00 was reimbursed to Resident #1 on 1/28/25. The form further identified Dir of SS was the staff member who completed the investigation on 1/22/25, was the staff member who notified Resident #1 through a 1 to 1 discussion of the grievance resolution on 1/22/25, and that Administrator signed the form on 2/6/2025. Review of the State Agency reportable event website identified the State Agency was not notified of an allegation of misappropriation of money regarding Resident #1. Interview with Director of Nursing Services (DNS) on 4/17/25 at 9:10 AM identified when money was reported missing, staff would search the room and building to see if it could be located and if the money was not found he would refer to the Administrator for replacement. If it was determined that the resident had access to money or had possession of money that was then missing, it would be reported to the State Agency. The DNS further identified that he was not aware of Resident #1's report of missing money. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dir of SS on 4/17/25 at 9:20 AM identified that after Resident #1 had initially reported money missing on 1/20/25, Resident #1 had made a comment that he/she might have lost the money, but the Dir of SS identified she could not recall specifics. The Dir of SS identified as a result of Resident #1's comment that he/she may have lost the money she did not consider the missing money as misappropriation. The Dir of SS further identified Resident #1 had last remembered having the money when going out for an appointment, and Resident #1 was accompanied to the appointment by a Nurse Aide. Interview with the Administrator on 4/17/25 at 9:35 AM identified he had not reported Resident #1's report of missing money to the State Agency because he could not confirm that Resident #1 had money missing. The Administrator identified Resident #1 had provided differing amounts of possible money missing, but that $14. 00 was consistently the amount reported. The Administrator identified there had been too many unknowns and so he had chosen to reimburse the money, put interventions in place, and did not report to the State Agency Review of the Abuse prohibition policy and procedures directed, in part, any resident may express/file a concern , complaint, or grievance concerning treatment, care, management of funds, loss of clothing, theft of property, violation of rights, etc. without fear of threat or reprisal in any form; all reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated; should an alleged or suspected case of misappropriation of resident property be reported, the facility will notify the state agency within 2 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** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #1) reviewed for mistreatment, the facility failed to identify and thoroughly investigate an allegation of misappropriation of money. The findings include: Resident #1's diagnoses included chronic obstructive pulmonary disease, cervical radiculopathy, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition, used a wheelchair, was independent with eating, and was dependent with personal hygiene and wheeling of his/her wheelchair. The Resident Care Plan (RCP) dated 11/5/24 identified Resident #1 required visits for socialization and mental stimulation to maintain leisure interests. Interventions included to provide transportation to and from recreational programs and/or courtyard visits, provide materials for independent leisure pursuits, and invite, encourage, and assist Resident #1 to group activities of assessed potential interest when available. The RCP failed to identify documentation of Resident #1 missing money or initiation of interventions for the resolution of a grievance/concern reported on 1/20/2025. A facility Grievance/Concern Form dated 1/20/25 identified Resident #1 reported to the Director of Social Services (Dir of SS) that he/she was missing $14.00 which had been in an envelope on his/her nightstand and not in the locked box. The form identified a room search was done, nursing staff were spoken to but the $14.00 was not found. The form identified the action taken to resolve the concern was to keep all money in the locked box, to secure the locked box to a shelf, to keep the locked box key in the Social Service office, and Resident #1 was in agreement with these actions. Resident #1 would notify Dir of SS when money was needed, and the Dir of SS would unlock the locked box. The form identified $14.00 was reimbursed to Resident #1 on 1/28/25. The form further identified Dir of SS was the staff member who completed the investigation on 1/22/25, was the staff member who notified Resident #1 through a 1 to 1 discussion of the grievance resolution on 1/22/25, and that Administrator signed the form on 2/6/2025. Additionally, review of the facility Grievance/Concern Form and clinical record (nursing notes, social service notes) dated 1/20/25 failed to identify a thorough investigation was completed/documented regarding Resident #1's missing money (failed to identify documentation of the names of nursing staff members interviewed by Dir of SS and Administrator, the date/time/location of the appointment when Resident #1 recalled last seeing the money, the differing amounts of money that Resident #1 reported missing during the investigation, the amount of money that Resident #1 had in his/her possession during the investigation, and staff members with access to Resident #1's room on all 3 shifts. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dir of SS on 4/17/25 at 9:20 AM identified Resident #1 wasn't sure if he/she lost the money after reporting that it had been in an envelope on his/her nightstand, that Resident #1 remembered last seeing the money on the day he/she went to an appointment with a Nurse Aide (NA). The Dir of SS identified she had not written down the names of staff members she had spoken to during her investigation of Resident #1's missing money or the date of the appointment Resident #1 went to, and she could not remember specifics. The Dir of SS further identified the Administrator had spoken to the NA that accompanied Resident #1 to his/her appointment and she could not remember what the Administrator had told her was said in that conversation. Interview with Administrator on 4/17/25 at 9:35 AM identified he and the Dir of SS had conducted a 2-day investigation of Resident #1's report of missing money. The Administrator identified Resident #1 had possession of over $150 and could not confirm the amount missing and would say differing amounts, but that it was most consistently $14.00 missing. The Administrator identified that Resident #1 only used his/her money to purchase coffee when out at an appointment, but that they could not determine the last time Resident #1 had coffee. The Administrator identified he did not speak to the NA that accompanied Resident #1 to the appointment on the date the money was last seen because he could not confirm who the NA was that went to the appointment with Resident #1. The Administrator identified he had spoken to Resident #1, the Dir of SS, the Maintenance Director, the Nursing Scheduler, and the Director of Nursing Services as part of his investigation, but had not interviewed any other staff members (NAs) as part of his investigation, and that he could not identify the reason he had not documented any of the investigation. Interview with the Dir of SS on 4/17/25 at 9:50 AM identified she had conducted Resident #1's room search to search for the missing money, she had spoken to the charge nurse on the unit on 1/20/25 to determine where Resident #1 kept his/her money, and she had spoken to one of the NAs. The Dir of SS could not identify the reason she had not documented any of the findings of her investigation. Review of the Abuse prohibition policy and procedures directed, in part, all reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated and the investigation shall consist of an interview with the person reporting the missing items, interview with any witnesses that may have knowledge of the missing items, interviews with staff members (on all 3 shifts) having contact with the resident, and a search of the resident's room.

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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** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #1) reviewed for falls, the facility failed to develop and implement a comprehensive care plan for a resident at risk for falls and for the only sampled resident (Resident #38) reviewed for activities of daily living, the facility failed to ensure that the care plan was followed for assist of two for direct care. The findings include: 1. Resident #1 had diagnoses that included chronic obstructive pulmonary disease, cervical radiculopathy, and congestive heart failure. A Physical Therapy evaluation dated 4/18/23 identified Resident #1 presented with impairments in functional strength, mobility and activity tolerance due to recent surgery and Resident #1 had a fall on 7/18/23. A fall risk assessment completed after Resident #1 fell and dated 7/18/23 identified Resident #1 was at risk for falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition, had functional limitation in range of motion to both lower extremities, used a walker, required setup or clean-up assistance with personal hygiene, partial/moderate assistance with transfers, and supervision or touching assistance with walking 10 feet. The Resident Care Plan (RCP) dated 1/24/24 identified Resident #1 had alteration in mobility related to generalized weakness and deconditioning. Interventions included to encourage Resident #1 to view limitations realistically, provide assistance with bed mobility as needed or as requested, and to instruct Resident #1 regarding safe ambulation, wheelchair propulsion, and transfers as needed. The RCP failed to identify Resident #1 was at risk for falls despite having a history of falls, related to deconditioning and a previous history of falls A nursing note by Registered Nurse (RN) #5 on 2/14/24 at 9:30 PM identified Resident #1 had been lowered to the floor, by the Nurse Aide, on the way back from the bathroom when Resident #1 became weak. The RCP dated 2/4/25 identified on 2/15/24 Resident #1 was updated and Resident #1 was identified as a risk for falls secondary to decreased endurance/strength, generalized weakness. Interventions included to utilize the wheelchair for bathroom transfers on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts due to Resident #1 reported feeling weaker later in the day and during the night, use proper footwear, and keep area clutter free and well lit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #5 on 4/22/25 at 8:45 AM identified she was responsible for completing the RCPs, and LPN #5 identified she was unaware Resident #1 did not have an active fall risk care plan in place prior to Resident #1 falling on 2/4/25. LPN #5 reviewed the clinical record and identified Resident #1 had a fall risk care plan that was identified as resolved on 3/9/23 by another staff member and LPN #5 could not identify the reason the fall risk was resolved. LPN #5 identified that once a resident was identified as a fall risk it would remain on the RCP and only those interventions identified as no longer relevant would be resolved, and current relevant interventions put in place. LPN #5 identified that following a fall in July of 2023 Resident #1's care plan should have been updated to include a fall risk and appropriate interventions, and Resident #1 should have had a fall risk care plan in place prior to the time of his/her fall on 2/14/24. 2. Resident #38's diagnoses included adjustment disorder with anxiety and depressed mood and psychotic disorder with delusions due to known psychological condition. The annual Minimum Data Assessment (MDS) dated [DATE] identified Resident #38 was cognitively intact, required maximum assistance from staff for dressing and was totally dependent on staff for shower transfers with the use of a mechanical lift. The Resident Care Plan dated 4/7/25 identified behavioral problems with accusatory behaviors and confabulation as an area of concern. Interventions include to provide two staff members for direct care, activities for short periods of time, and keep task demands simple and refer to psychological services as needed. Observations on 4/14/25 at 10:00 AM and 4/17/25 at 10:30 AM identified Nurse Aide (NA) #3 entered Resident #38's room, provided morning care (washing/dressing) alone, without the benefit of a 2nd staff member per the RCP. Additional observation on 4/17/25 at 1:00 PM, identified NA #3 entered Resident #38's room, provided incontinent care, and changed Resident #38's incontinent brief alone, without the benefit of a 2nd staff member per the RCP. An interview and review of care plan with Registered Nurse (RN) #5 on 4/17/25 at 10:37 AM identified that the care plan directed two staff members for direct care. RN #5 indicated that this would include all activities of daily living assistance. RN #5 indicated that the two staff members for all direct care was still an active intervention for Resident #38 and staff should have two staff members present when providing care. An interview and review of Resident # 38's care card (a card that directs NA care for residents) with NA #3 on 4/17/25 at 11:00 AM identified the care card directed two staff members for direct care. NA #3 stated she was unaware that Resident #38 still required two staff members. NA #3 indicated that when Resident #38 transferred from another unit to she thought that Resident #38 no longer required two staff members for direct care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #5 on 4/17/25 at 2:15 PM identified that she provided Resident #38 with a bed bath on 4/16/25 on the 3:00 PM to 11:00 PM shift and stated that she was aware that Resident #38 required two for assistance for direct care due to accusatory behaviors but did not have another person assist. NA #5 indicated that there were only 2 NAs that work on the unit on the 3:00 PM to 11:00 PM shift, each take one end of the hallway, and it was almost impossible to have another staff person in the room when providing direct care to Resident #38. NA #5 indicated that she left the door open with the curtain pulled because she did not have another staff member to assist. A review of Resident #38's care card dated 4/21/25 directed to have two staff members present for direct care. A review of Care Planning policy directed, in part, the team is responsible for the development of an individualized comprehensive care plan for each resident. Ongoing changes in residents' status shall be updated by Nursing and/or IDT as needed. As care plans are updated, staff shall follow the updated plan of care and as updated on the Care Card as applicable.

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 2 residents (Resident #29) reviewed for care planning, the facility failed to document family notification regarding a change of condition. The findings include: Resident #29 was admitted to the facility in March 2025 with diagnoses that included diabetes, Parkinson's disease and Alzheimer's disease. A Resident Care Plan dated 3/19/25 identified Resident #29 was at risk for impaired cognition related to Parkinson's disease with interventions to observe for memory loss, impaired vision and rigidity. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 was severely cognitively impaired and required partial/moderate assistance with eating, rolling side to side, sitting, and walking. Additionally, the MDS identified Resident #29 required maximal assistance with oral hygiene and was totally dependent with bathing, and personal hygiene. An Advanced Practice Registered Nurse (APRN) note dated 4/7/25 identified that Resident #29 was assessed for congested cough with thick white secretions. Additionally, the APRN directed to obtain a two-view chest x-ray. A radiology report dated 4/7/25 at 10:40 PM identified that Resident #29 had an impression of modest left basilar pneumonia. A nursing note dated 4/7/25 at 11:02 PM identified that the chest x-ray results showing modest left basilar pneumonia were reviewed with the on-call APRN and a new order was obtained for Doxycycline (an antibiotic) 100 milligrams (mg) every 12 hours for five days. An interview, clinical record review, and facility documentation review on 4/17/25 at 10:31 AM with the DNS failed to identify the family/responsible party was notified of Resident #29's congested cough with thick secretions, obtaining a chest x-ray, the results of the chest x-ray and the treatment of an antibiotic. Additionally, the DNS noted the nurse or nurse supervisor was responsible for notifying the family/responsible party of a significant change in condition and documenting the notification in the clinical record. Review of the daily nursing supervisor report identified that notification to Resident #29's family was attempted, and a message was left. Additionally, the DNS identified on 4/17/25 at 10:31 AM that the daily nursing supervisor report was not part of the resident's clinical record and the nurse should have documented the notification of Resident #29's family. A phone interview on 4/22/25 at 11:22 AM with Registered Nurse (RN) #4 identified that it was the nurse supervisor's responsibility to update the family member for a significant change of condition. Additionally, RN #4 stated that she attempted and left a message with Resident #29's family member regarding the change in condition. RN #4 stated that she did not know she needed to document in the resident's clinical record the notification to the family member or reasonable party. (continued on next page)

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F 0658 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Notification Change in Condition, Change in Treatment/Services Policy, dated 8/2017, identified the facility will inform the resident, resident's physician and resident's family/legal representative when there is a change of condition, and the change of condition progress note will be carried on the 24 hour report in the electronic record.

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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** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 1 resident (Resident #15) reviewed for a non-pressure skin condition, the facility failed to supervise Resident #15 to ensure proper technique when Resident #15 was self performing wound care and for 1 of 3 residents (Resident #219) reviewed for nutrition, the facility failed to follow the physician order for daily weights. The findings include: 1. Resident #15 had diagnoses that included cellulitis of the left lower limb, chronic respiratory failure with hypoxia, and lymphedema. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was cognitively intact, used a motorized wheelchair, required supervision or touching assistance with eating, and was independent with personal hygiene and transfers. The Resident Care Plan (RCP) dated 2/11/25 identified Resident #15 was at risk for alteration in skin integrity. Interventions included to report any new areas, provide treatments as ordered, and follow facility skin care protocol. An Advanced Practice Registered Nurse (APRN) progress note written by APRN #2 dated 4/2/25 identified Resident #15 was seen for complaints of significant left foot pain. The note identified Resident #15 reported dry skin to the left plantar aspect, Resident #15 used a nail file as an attempt to file the skin and subsequently requested numbing medication for that area. The note identified an erythematous patch was observed on the left plantar foot that was warm, had peeling skin, and some open areas. The note identified the plan for treatment for cellulitis of the left foot was starting antibiotics (Doxycycline) and Lidocaine pain cream. A physician's order dated 4/2/25 directed to administer Doxycycline (antibiotic) 100 milligrams (mg) by mouth every 12 hours for 7 days for treatment of cellulitis and to apply Lidocaine jelly to the plantar aspect of the left foot 4 times a day for 5 days. A nursing note written by Registered Nurse (RN) #1 on 4/3/25 at 10:37 AM identified Resident #15 had an open area to the left plantar foot that measured 0.4 centimeters (cm) long by 0.4 cm wide by 0.1 cm deep and a dressing was applied. The note identified Resident #15 reported using a callus removing tool on his/her left foot that he/she would refrain from using while the open area was healing. The note identified Resident #15 would be added to the podiatry list and wound care rounds, and Resident #15 was in agreement with being seen by podiatry and for wound rounds. A physician's order dated 4/3/25 directed for wound care to the plantar left foot: Cleanse with Normal Saline (NS) or sterile water (SW), apply Calcium Alginate (topical wound dressing) followed by (f/b) a dry clean dressing (DCD), change every other day and as needed (for soiled or non-intact dressing). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/14/25 at 2:30 PM identified Resident #15 performed his/her own wound care to the left plantar foot. Upon entering the room Resident #15 was sitting on his/her bed with the left leg on the bed. While not wearing gloves, Resident #15 removed the soiled dressing on the bottom of his/her left foot and placed it on top of the bed. Resident #15 then picked up the tube of Lidocaine cream sitting on his/her overbed table, removed the cap and set the cap down next to a circular area of dried brown substance on the overbed table. Resident #15 then applied a dime size amount of cream onto the fingers of his/her hand and Resident #15 then applied the Lidocaine cream to the open area on the plantar aspect of the left foot. Resident #15 then picked up the soiled dressing from the bed and used it to wipe the excess Lidocaine cream from his/her fingers, then picked up the cap and replaced it on the Lidocaine cream tube. Resident #15 then opened a package containing a piece of Calcium Alginate and placed the Calcium Alginate on the plantar aspect of the left foot over the Lidocaine cream. Resident #15 was then observed to open a small adhesive foam dressing and placed it on the left foot covering the bottom half of the Calcium Alginate, and Resident #15 then opened a second small adhesive foam dressing and placed it over the top half of the Calcium Alginate dressing. Resident #15 then identified that he/she was done with the dressing change. Interview with Licensed Practical Nurse (LPN) #2 on 4/14/25 at 3:10 PM identified Resident #15 performed his/her own wound care to the left plantar foot, and that RN #1 was responsible for providing education to Resident #15 on wound care. LPN #2 identified she signed off the wound care order in the electronic medical record (EMR) and that the order was not written as a self-administration order for Resident #15 to complete his/her own wound care and an assessment had not been completed for self-performance of wound care. LPN #2 identified she had observed Resident #15 providing wound care to his/her wound from start to finish one day and that Resident #15 did not use clean technique when doing his/her own wound care. LPN #2 identified she had not told the wound nurse, Supervisor or anyone else that Resident #15 had poor technique when performing his/her wound care, and LPN #2 further identified she had not written a note documenting her observation. Interview with RN #1 on 4/14/25 at 3:18 PM identified she was not aware Resident #15 was performing his/her own wound care, and that she had not provided Resident #15 with education on performing his/her own wound care, but that she had provided education to Resident #15 about using an electric pumice stone to his/her left plantar foot. RN #1 identified she had done the wound care for Resident #15's left plantar foot and had explained what she was doing as she applied the dressing to the foot, but that she had not explained the process with the intent for Resident #15 to do his/her own wound care. Interview with the Director of Nursing (DNS) on 4/14/25 at 3:30 PM identified he was not aware Resident #15 was performing his/her own wound care. The DNS identified Resident #15 should have been evaluated and provided with education prior to completion of his/her own wound care/dressing changes to ensure he/she was able to complete their own wound care/dressing change and the APRN would have given an order for self administration/dressing change. Interview with APRN #2 on 4/15/25 at 3:00 PM identified she could not recall if she had discussed self-administration of the Lidocaine cream with Resident #15, and that she was not aware that Resident #15 was performing his/her own wound care. APRN #2 identified she would indicate in her order if a resident could self-administer a medication or treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound progress note written by APRN #3 and dated 4/15/25 identified Resident #15 was seen for consultation for the left plantar foot related to lymphedema. The note identified Resident #15 had a full thickness lymphatic wound to the left plantar foot which measured 0.2 centimeters (cm) long by 0.2 cm wide by 0.3 cm deep with 100% granulation of the wound base and a moderate amount of serosanguinous drainage. The note identified the treatment was to cleanse the wound f/b applying Calcium Alginate to the base of the wound f/b securing with a dry clean dressing and change every other day and as needed. Interview with LPN #2 on 4/17/2025 at 2:35 PM identified Resident #15 had already completed his/her own wound care the first time LPN #2 went to do the treatment, and LPN #2 identified she began to let Resident #15 perform his/her own wound care/dressing change after the second time she went in to perform the wound care and Resident #15 was already in the process of doing it. LPN #2 identified when she observed Resident #15 perform a complete dressing change she observed that Resident #15 did not use appropriate infection prevention technique. LPN #2 identified she had not documented refusals of wound care by Resident #15, she had not documented that Resident #15 told her he/she had already done the wound care. Subsequent to surveyor inquiry a nursing progress note by LPN #2 dated 4/17/25 at 6:54 PM identified Resident #15 requested treatment supplies to perform an as needed dressing change to his/her left plantar foot. The note identified LPN #2 provided education to Resident #15 that he/she was unable to perform his/her own dressing change and needed a nurse to change the dressing to prevent infection, promote healing, and to reduce complications. The note identified Resident #15 refused the dressing change by the nurse. Interview with APRN #3 on 4/15/2025 at 12:32 PM identified she was not aware Resident #15 was performing his/her own wound care. APRN #3 identified it would be up to the nursing staff to provide education to Resident #15 if they thought he/she could do his/her own wound care, and as long as Resident #15 was cleared by the nursing department to be competent in performing his/her own wound care then it was allowable. Review of the Medication Self-Administration Evaluations provided 4/22/2025 identified 4 Medication Self-Administration Evaluations were completed for Resident #15 on the dates of 10/14/2019, 12/24/2020, 1/7/2021, and 1/19/2021. The evaluations identified on 10/14/2019 Resident #15 was approved to perform tracheostomy self-care and change his/her own inner cannula of the tracheostomy. The evaluations identified on 12/24/2020 Resident #15 was approved to self-administer erythromycin (antibiotic) eye ointment three times a day for 7 days. The evaluations identified on 1/7/2021 Resident #15 was approved to self-administer Calmoseptine (topical barrier cream). The evaluations identified on 1/19/2021 Resident #15 was approved to self-administer an unidentified medication. Review of the 4 Medication Self-Administration Evaluations failed to identify an evaluation for self-administration of Lidocaine jelly or self-care of the treatment to his/her left plantar foot. Although requested the facility was unable to provide additional self-administration evaluations for Resident #15 since the date of 1/19/2021 or self-care education for the application of treatments to his/her left plantar foot. Review of the Dressing, Non-Sterile policy directed, in part, dressings are applied by licensed nursing personnel, and hands are washed/sanitized prior to starting the procedure, after removal of the soiled dressing, and following completion of the procedure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #219 was admitted to the facility in April 2025 with diagnoses that included failure to thrive, protein-calorie malnutrition, and congestive heart failure. The Resident Care Plan (RCP) dated 4/3/25 identified Resident #219's nutritional status was compromised secondary to a diagnosis of dementia and failure to thrive. Interventions included to monitor resident for signs and symptoms of dysphagia/aspiration during meals, weigh the resident per physician orders, and assess by mouth intake every meal. A physician's order dated 4/3/25 directed to weigh Resident #219 every morning at 6:00 AM. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #219 was severely cognitively impaired and required substantial/maximal assistance for oral hygiene, toileting, dressing and personal hygiene. Also, identified was that Resident #219 was dependent for showering, transferring, and independent for eating. Further, identified was Resident #219 weighed 190 pounds. Although physician orders directed daily weights at 6:00 AM, review of the Weight and Vitals Summary identified daily weights were only taken 7 of 15 days from 4/2/25 through 4/16/25 (Missing dates from the Weight and Vitals Summary are 4/3/25, 4/6/25, 4/7/25, 4/11/25, 4/12/25, 4/13/25, 4/14/25, and 4/16/25). Interview with Licensed Practical Nurse (LPN) #3 on 4/16/25 at 10:05 AM identified that the physician order for weighing Resident #219 was to be completed every morning at 6:00 AM, and that Resident #219 was not weighed daily. LPN #3 also identified that 8 days were missing for April 2025 out of 15 days that required the resident to be weighed daily. An interview with the Dietician on 4/16/25 at 10:27 AM identified that Resident #219 was to be weighed daily but it had not been completed or documented daily. An interview with the Director of Nursing (DNS) on 4/16/25 at 10:55 AM identified that Resident #219 was not weighed daily according to physician orders. Review of the facility policy for Weight Assessment and Interventions identified that the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Also, identified weights will be recorded in the electronic medical record under the individual's medical record.

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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** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #17) reviewed for pressure ulcers, the facility failed to ensure the wound consultant recommendations were followed up by the facility. The findings included: Resident #17's diagnoses included pressure ulcer of the sacral region, dementia with severe anxiety and mild neurocognitive disorder with behavioral disturbances. The annual Minimum Data Assessment (MDS) dated [DATE] identified Resident #17 was mildly cognitively impaired, required maximum assistance for personal hygiene, assistance of 2 staff members for bed mobility, and was bedfast most of the time. The Resident Care Plan dated 2/18/25 identified skin Integrity as an area of concern with an unstageable pressure ulcer on the coccyx. Interventions included to follow skin care protocols, physical therapy/occupational therapy (PT/OT) consultation for positioning, low air loss pressure mattress, treatment as order, dietary consultation as needed, and pressure redistribution devices as ordered. The RCP did not include that Resident #17 had refusals regarding getting out of bed to the wheelchair and repositioning when in bed. A wound consultant note dated 2/18/25 from APRN #3 identified an initial consultation visit for Resident #17's coccyx wound. APRN #3 identified a new unstageable coccyx wound measuring 3 centimeters (cm) by 1.5 cm by 0.1 cm. The wound bed with 100% slough (dead tissue) with moderate amount of serosanguineous (thin, light pink in color) drainage. The treatment was to apply Santyl ointment (wound debridement) followed by Calcium Alginate to the base of the wound and cover with a dry, clean dressing. APRN #3's assessment/plan for Resident #17 was all recommendations remain in effect until discontinued, revised or replaced with additional recommendations and to optimize nutrition and PT to re-evaluate support surfaces. Observations on 4/14/25 at 10:45 AM, 12:00 PM, 2:00 PM and 3:15 PM identified Resident 17 was lying flat on his/her back on a low air loss mattress. Interview with Resident #17 on 4/14/25 at 10:45 AM, noted he/she had a sore on his/her bottom and indicated that he/she did not like to get out of bed and spent most of the time in bed. Resident #17 indicated that he/she lies flat on his/her back except when eating, then the Nurse Aide (NA) raises the head of the bed. Interview with OT #1 on 4/16/25 at 10:18 AM identified that she was not made aware of any recommendations by the wound consultant to evaluate Resident #17 for support surfaces or positioning for a new wound. OT #1 was unable to locate any screens or evaluations for Resident #17. OT #1 indicated if she was made aware that therapy would have evaluated Resident #17 for any possible new interventions. (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	Interview and clinical record review with the DNS on 4/17/25 at 11:30 AM identified that he was not aware of the wound consultant's recommendation for therapy to evaluate Resident #17 for support surfaces and was unsure if RN #1 (Infection Preventionist) was made aware of the recommendations. A review of the APRN #3 (wound consultant) note with the DNS identified that there was also recommendations for dietary and PT consultation in her 2/18/25 note that had not been addressed. Interview with RN #1 (the Infection Preventionist) on 4/17/25 at 12:00 PM identified that she was not aware of the recommendations by APRN #3. Interview with the wound consultant, (APRN #3) on 4/22/25 at 11:49 AM identified that she was familiar with Resident #17 and that she visits him/her weekly for the coccyx wound. APRN #3 recalled that she had made a recommendation for PT and the Dietitian to evaluate Resident #17. She indicated that she was not aware that therapy had not seen Resident #17. APRN #3 indicated that her expectation would be that Resident #17 would have been seen by therapy, and they would be aware of the new wound. APRN #3 indicated that she was aware that Resident #17 does not get out of bed to his/her wheelchair. She was aware that Resident #17 had a low air mattress in place but indicated that due to lying flat on his/her back most of the time, it makes it difficult for Resident #17's wound healing. A review of Resident/Patient Screens policy indicated, in part, that rehabilitation screens will be performed for residents/patients who demonstrate a significant change in functional ability upon referral from nursing or at least annually. A rehabilitation screen will be completed to identify indications of functional loss that would suggest a need for an evaluation.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 3 of 8 sampled residents (Resident #10, Resident #58 and Resident #219) reviewed for dining, the facility to provide adequate supervision during mealtime for residents with a history of aspiration. The findings include: 1. Resident #10 had diagnoses that included dysphagia (swallowing disorder), blindness and Alzheimer's dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had moderately impaired cognition, was highly visually impaired, and independent with eating. The Resident Care Plan dated 3/12/25 identified Resident #10 had a problem related to aspiration (inhaling of foreign substances) and dysphagia, Interventions included to sit upright for meal intake, direct supervision to provide verbal cues during mealtime and alternate solids with liquids after each bite. Physician orders dated 4/11/25 directed a puree diet with thin liquids, upright position at 90 degrees while eating and to remain upright 30-45 minutes after eating before laying down. Aspiration precautions, direct supervision with feeding with all intake for (1) small bites, (2) chew each bite thoroughly, (3) avoid talking/laughing with food in mouth and alternate solids and liquids after each bite. An observation on 4/15/25 at 8:32 AM identified Resident #10 was in his/her room alone, seated upright and eating independently from a breakfast tray. The assigned Nurse Aide, (NA #10) was observed exiting the room, leaving Resident #10 unsupervised eating breakfast. An observation and interview with LPN #1 on 4 /15/25 at 8:32 AM identified that while physician orders directed to provide direct supervision with feeding, Resident #10 was safe to eat alone with supervision provided as needed. An interview with speech language pathologist (SLP) #1 on 4/15/25 at 9:04 AM and 4/17/25 at 10:40 AM identified Resident #10 required direct supervision, defined as close supervision with only one resident 100% of the time. This level of supervision was necessary for Resident #10 while eating due to inattention to tasks, visual impairments and need for cueing to alternate fluids and solids. SLP #1 identified she was responsible for providing education to nursing staff with the expectation that this education would be reinforced across shifts and all relevant staff. Additionally, SLP #1 would also add any recommendations for supervision and feeding guidelines into the electronic medical record (EMR) to be reviewed and signed by the physician. Once the order was signed, nursing staff were responsible for ensuring the information was provided to both dietary and nursing staff. SLP #1 further identified it was not safe for Resident #10 to be eating alone in the room as it posed a risk of aspiration and choking due to the resident's level of dysphagia. Additionally, SLP #1 noted there were inconsistencies in communication between nursing and dietary staff at times when ensuring the correct supervision/feeding guidelines for all residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with NA #1 on 4/15/25 at 9:15 AM identified Resident #10 was safe to be left alone to eat if awake and alert. Otherwise, staff would have to remain with her. Education pertaining to supervision feeding guidelines was subsequently provided to all staff by SLP #1. An interview and facility documentation review with the DNS on 4/17/25 at 9:54 AM indicated SLP #1 was responsible for inputting any supervision/feeding guidelines into the EMR. Once signed by the physician, nursing staff were expected to transfer this information onto a dietary report within the EMR. However, the dietary report did not include Resident #10's supervision/feeding guidelines as required and should have. The DNS subsequently added the correct information onto the dietary report. An interview with NA #10 at 4/17/25 at 11:18 AM identified she was the assigned NA for Resident #10 on 4/15/25 during the 7:00 AM to 3:00 PM shift. NA #10 identified dietary staff delivered the breakfast tray to Resident #10 on 4/15/25 and she periodically checked in on Resident #10 while distributing other resident meal trays. NA #10 acknowledged she had since learned (subsequent to surveyor inquiry) this practice was not permitted due to safety concerns and she was to stay with Resident #10 to ensure Resident #10 took small bites. Interview and facility documentation review with the FSD on 4/17/25 at 1:33 PM and 4/17/25 2:18 PM identified dietary aides were responsible for assembling and distributing meal trays to the residents. Any resident requiring supervision during meals was not to be served until appropriate supervision was in place. The FSD identified information regarding supervision/feeding guidelines was found on a dietary report, which he was responsible for reviewing. The information was expected to populate on the meal tickets to alert the dietary staff. However, all of Resident #10's supervision/feeding guidelines were not included on the recently printed meal following the corrected changes made to the dietary report. A subsequent interview with the DNS on 4/17/25 at 2:28 PM identified once the correction was made to the dietary report, all changes should have automatically printed onto the dietary slips. The DNS was unable to explain the malfunction, adding all information regarding a resident's supervision and feeding guidelines should be included on the dietary slips to alert staff. 2. Resident #58's diagnoses included dementia, dysphagia, and gastro-esophageal reflux disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was severely cognitively impaired and required substantial/maximal assistance with bed mobility, toileting, and transfers. The Resident Care Plan dated 1/28/25 identified potential for aspiration and weight loss with oral dysphagia. Interventions included aspiration precautions, assist resident with cutting up food into bite size pieces and intermittent distant supervision after meal set up. The Nurse Aide (NA) care card for Resident #58 directed aspiration precautions, assist with eating and cutting up food into bite sized pieces and intermittent distant supervision after meal set up. A Nutrition assessment dated [DATE] identified Resident #58 was on a regular diet and to avoid hard candy, blueberries, and grapes due to a risk for choking and a history of dysphagia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 4/8/24 directed intermittent distant supervision with intake following meal set up and to assist the resident with cutting up his/her food into bite size pieces. The order directed to avoid items such as hard candy, nuts, and grapes due to increased risk of choking. Review of the facility's Supervision Education for Eating directed that for Intermittent Distant Supervision, the caregiver was checking in on the resident intermittently and from a distance while they are eating. Observation on 4/14/25 at 12:40 PM identified Resident #58 was alone in his/her room, seated in his/her wheelchair and was served a napkin with utensils, two beverages, a plate of whole slices of turkey, shredded cabbage, and mashed potatoes by a Dietary Aide (DA). The food served was placed in front of the resident on the tray table, the DA uncovered the plate of food and proceeded to leave the room. Resident #58 was noted to be unable to cut the turkey with the fork and knife and he/she began eating the mashed potatoes with his/her fingers. Resident #58 ate very little of his/her meal and was unsupervised, unassisted, and not checked on by staff for the entire meal. At 1:22 PM a DA returned and picked up Resident #58's utensils, cups, and plate. Review of the facility tray ticket on 4/16/25 failed to identify Resident #58 required intermittent distant supervision and was on aspiration precautions. The ticket also failed to indicate that Resident #58 needed the meal set up and his/her food cut into bite size pieces. Observation, interview, and review of facility documentation with DA #1 on 4/16/25 at 12:38 PM identified Resident #58 was alone in his/her room, seated in his/her wheelchair and was served a napkin with utensils, two beverages, and a plate of whole boneless chicken breast, mixed vegetables, and rice by DA #1. The food served was placed in front of the resident on the tray table, DA#1 uncovered the plate of food and proceeded to leave the room. Resident #58 was observed by to begin eating on his/her own but was unable to cut the chicken breast. DA #1 indicated that although she had served Resident #58 his/her lunch, she was unaware what level of assistance or supervision the resident needed during mealtime. Review of Resident #58's tray ticket with DA #1 failed to identify Resident #58 was on aspiration precautions, intermittent distant supervision and needed his/her food cut into bite size pieces. DA #1 indicated she would need to ask her food service manager for more information. Observation, interview, and review of facility documentation with LPN #1 on 4/16/25 at 12:46 PM identified it was the responsibility of herself or the NA to check on and assist Resident #58 after meals were served. LPN #1 indicated she thought Resident #58 was on intermittent supervision with meals, but she was not sure. LPN #1 identified that some DA's would deliver meals and cut resident's food, but she was unsure how that was communicated to the DA's. Review of Resident #58's tray ticket with LPN #1 failed to identify Resident #58 was on aspiration precautions, intermittent distant supervision and needed his/her food cut into bite size pieces. LPN #1 indicated if DA #1 was not knowledgeable of Resident 58's needs, she should only serve the meal and it would be her or the NA's responsibility to set up, cut up the food into bite size pieces and intermittently supervise the resident during mealtime. LPN #1 indicated mealtimes were a busy time and many of the NA's were in the dining room or feeding other residents. Subsequent to surveyor inquiry, on 4/16/25 at 12:48 PM LPN #1 cut up Resident #58's chicken breast into bite size pieces and the resident began to eat the chicken breast. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the clinical record with SLP #1 on 4/16/25 at 12:52 PM identified Resident #58 required intermittent distant supervision at mealtime, was on aspiration precautions and staff should cut her food into bite size pieces. SLP #1 indicated the DA should just serve the resident's meal and it would be up to the NA or nurse to set up and cut up the resident's food. SLP #1 identified for a resident on intermittent distant supervision she would expect staff to be knowledgeable of the resident's needs and to be checking on the resident frequently throughout the meal to provide the needed assistance, cueing and supervision. Review of Resident #58's tray ticket with SLP #1 failed to identify Resident #58 was on aspiration precautions, intermittent distant supervision and needed his/her food cut into bite size pieces. SLP #1 indicated that although listing Resident #58's care specific information on the tray ticket would be helpful for staff and safer for the resident, the resident's mealtime needs and levels of supervision were not being communicated to staff. SLP #1 identified staff needed more training and she was unsure of the reason there was a lack of communication but would need to address it with the dietary department. Review of the facility diet type report list dated 4/17/25 failed to indicate Resident #58 required intermittent distant supervision and was on aspiration precautions. The report list also failed to indicate that Resident #58 needed meal set up and his/her food cut into bite size pieces. Interview and review of facility documentation with the Director of Nursing Services (DNS) on 4/17/25 at 9:54 AM identified the DA would know a resident had a need for mealtime assistance and supervision by referring to the tray ticket or diet type report. Review of Resident #58's tray ticket and the facility's diet type report with the DNS failed to identify Resident #58 was on aspiration precautions, intermittent distant supervision and needed his/her food cut into bite size pieces. The DNS indicated the SLP puts her recommendations in the system and nursing staff are supposed to include the information in the dietary report once the order is obtained. Additionally, the DNS identified that after the DA delivered Resident #58's meal, it would be up to the NA or nurse to set up and cut up the resident's food and provide intermittent supervision. The DNS identified it would be his expectation that resident's mealtime needs and levels of supervision were communicated to staff via the tray ticket and diet type report, and he would need to address the issue further with the dietary department. Interview and review of facility documentation with the Director of Dietary (DD) on 4/17/25 at 1:33 PM identified nursing puts the residents diet information and recommendations in the system, and it should print directly onto the tray ticket. Review of Resident #58's tray ticket and the facility's diet type report with the DD failed to identify Resident #58 was on aspiration precautions, intermittent distant supervision and needed his/her food cut into bite size pieces. The DD indicated he was unsure why the information was not there but that he was able to add the necessary information on the resident's tray ticket and the facility's diet type report. The DD identified that although the DA's deliver resident's meals, they should not be delivering meals to residents on aspiration precautions. The DD indicated after the DA delivered a resident's meal it would be up to the nursing staff to provide the needed assistance and supervision and he needed to update Resident #58's information and provide more education to the dietary staff. Subsequent to surveyor inquiry, on 4/17/25 at 3:00 PM, the DD provided an updated tray ticket for Resident #58 which indicated intermittent supervision and aspiration precautions. 3. Resident #219 was admitted to the facility in April 2025 with diagnoses that included failure to thrive, protein-calorie malnutrition, and dementia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 4/2/25 directed that Resident #219 be monitored for aspiration precautions every shift. The Resident Care Plan (RCP) dated 4/3/25 identified Resident #219's nutritional status was compromised secondary to a diagnosis of dementia. Interventions included that Resident #219 was to be monitored for sign and symptoms of dysphagia/aspiration during meals times, weigh Resident #219 as per physician orders, and assess intake at every meal. A Speech Language Pathologist (SLP) note written by SLP #1 and dated 4/4/25 identified Resident #219 was to continue with a pureed diet, thin liquids and total assistance with feeding if resident was not initiating on his/her own. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #219 was severely cognitively impaired and required substantial/maximal assistance for oral hygiene, toileting, dressing and personal hygiene. Also, identified was that Resident #219 was dependent for showering, transfers, and was on a mechanically altered diet. A SLP #1 note dated 4/15/25 identified that Resident #219 continued with aspiration precautions, add distant supervision with all ground items following diet upgrade, and upgrade to ground texture from a pureed diet. Review of the Care Card on 4/17/25 at 12:20 PM identified Resident #219 was on distant supervision with all items following a diet upgrade and resident continued with aspiration precautions. An observation made on 4/17/25 at 12:31 PM of Resident #219 in his/her room with meal tray in front of the resident which contained ground pork with peppers, mashed potato, mixed broccoli, ground cupcake and beverages, staff was not observed with in eyesight of the resident. An interview with Licensed Practical Nurse (LPN) #3 on 4/17/25 at 12:33 PM identified that she was not aware that Resident #129 was on distant supervision, and that means that a staff member needs to be in eyesight of the resident. Also, identifying that Resident #219's tray should not be left in front of him/her without a staff member within eyesight. Further, identifying that she was unsure who provided the tray and placed it in front of Resident #219 which was within Resident #219's reach. An interview with the Director of Food Services on 4/17/25 at 1:33 PM identified that the dietary aids pass out the trays to the residents on the units, that a dietary aid can pass trays to residents on distant supervision. Also, he identified that tray tickets for residents requiring distant supervision or aspiration precautions were not labeled with that information. The Director of Food Service provided a copy of the tray ticket which did not identify distant supervision or aspiration precautions for Resident #219. An interview with SLP #1 on 4/17/25 at 1:50 PM identified that distant supervision means a resident was in the line of sight of a staff member during mealtime. Also, identifying that nursing was responsible for transcribing the order for distant supervision. Further, identifying that there was a lack of communication with the dietary department and that all levels of supervision, cues and strategies should have been listed on the resident's tray ticket. SLP #1 identified that dropping a tray in front of a resident on distant supervision was not safe because the resident could be injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation in the dining room and on the nursing unit noted a sign was posted which labeled Supervision Education for Eating identifying that distant supervision was when a caregiver is to be supervising a resident from a distance but 100% of the time. Review of the Policy/Procedure for aspiration precautions identified that Physicians, Speech Language Pathologist, or Nurses may recommend aspiration precautions for any resident who was at eminent risk of aspiration or who has recorded a change of diet consistency/method that may put a resident at a higher risk until safety can be assessed. Also, identified that monitoring of a resident for pocketing of food.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 5 of 6 residents (Resident #1, Resident #2, Resident #15, Resident #219 and Resident #269) reviewed for respiratory therapy, the facility failed to date oxygen tubing per facility policy (Resident #2, Resident #15, Resident #219 and Resident #269) and failed to appropriately store nebulizer tubing for a resident with pneumonia (Resident #2) and chronic respiratory failure (Resident #269) and failed to complete every shift oxygen saturations (Resident #1). The findings include: 1. Resident #1 had diagnoses that included chronic obstructive pulmonary disease (COPD), asthma, and Congestive Heart Failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact, used a wheelchair, was independent with eating, required substantial/maximal assistance with bed mobility, and was dependent with transfers. The Resident Care Plan (RCP) dated 2/4/25 identified Resident #1 was at risk for alteration in respiratory status with potential for poor airway clearance, dsypnea, fatigue, and respiratory distress related to asthma and Resident #1 refused to wear oxygen tubing at times. Interventions included to administer oxygen at bedtime per physician order, apply oxygen as ordered and monitor oxygen saturation (blood oxygen level) as indicated, and report signs and symptoms of respiratory distress such as labored breathing, increased anxiety, and audible wheeze. A physician order dated 3/4/25 directed to check oxygen saturation every shift (11:00 PM through 7:00 AM, 7:00 AM through 3:00 PM, and 3:00 PM through 11:00 PM) and as needed related to CHF. Additionally, the physician order directed to apply oxygen at 2 to 4 liters per minute via nasal cannula as needed for oxygen saturation below 92% and call the Medical Doctor (MD)/Advanced Practice Nurse (APRN) immediately to notify regarding Resident #1's condition. A physician order dated 3/13/25 directed to apply oxygen at 2 liters per minute at bedtime related to hypoxia (low level of oxygen in the body) and remove oxygen in the morning. Review of oxygen saturation documentation for April 2025 in the electronic medical record identified Resident #1's oxygen saturation was 94% on room air at 10:23 AM on 4/1/25; 96% on room air at 11:44 AM on 4/2/25; 94% on room air at 10:43 AM on 4/3/25; 95% on room air at 11:00 AM on 4/4/25; 94% on room air at 6:57 PM on 4/5/25; 94% on room air at 1:25 PM on 4/6/25; 96% on room air at 10:14 PM on 4/6/25; 95% on room air at 10:04 AM on 4/7/25; 96% on room air at 10:12 AM on 4/8/25; 95% on room air at 9:52 AM on 4/9/25; 96% on room air at 10:07 AM on 4/10/25; 94% on room air at 10:41 AM on 4/11/25; 95% on room air at 10:41 AM on 4/12/25; not documented on 4/13/25; 95% on oxygen via nasal cannula at 2:10 AM on 4/14/25; 95% on room air at 9:37 AM on 4/14/25; 95% on room air at 9:45 AM on 4/15/25; 96% on room air at 9:31 AM on 4/16/25. The oxygen saturation failed to identify documentation of oxygen saturation on every shift each day. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 4/16/25 at 11:50 AM identified documentation of oxygen saturation was found only within the electronic medical record, but the supplemental documentation prompt was missing from Resident #1's order for monitoring the oxygen saturation every shift so while the nurses were signing the order every shift, they were not documenting Resident #1's oxygen saturation every shift and there was no way to verify Resident #1 was maintaining oxygen saturations above 92% on every shift. The DNS identified the nurses should have entered the oxygen saturations into the electronic medical record every shift and that all residents with oxygen orders should have an order in place directing to change/label/date the oxygen tubing every week. The DNS was unable to identify the reason there were missing orders to change/label/date oxygen tubing every week. DNS identified he was unsure if education had been provided to licensed nursing staff on entering orders for vital signs including oxygen saturation. 2. Resident #2's diagnosis included pneumonia, dependence on supplemental oxygen and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and was dependent with bed mobility, toileting, and transfers. The MDS did not identify Resident #2 utilized oxygen at that time. A Resident Care Plan (RCP) dated 2/21/25 identified Resident #2 had a risk for cardiac issues. Interventions included oxygen and pulse oximetry as ordered and observe for signs or symptoms of respiratory distress. A physician's order dated 4/1/25 directed to apply oxygen at 2 to 4 liters per minute via nasal cannula as needed for oxygen saturation below 92%. A physician's order dated 4/14/25 directed oxygen at 2 liters to maintain oxygen saturations greater than or equal to 92% and may wean as tolerated. Additionally, the physician order directed Duoneb one unit dose every 8 hours via nebulizer around the clock for 5 days. Observations on 4/14/25 at 11:00 AM and 4/15/25 at 9:30 AM identified Resident #2 was in bed and was receiving continuous oxygen via nasal cannula. The oxygen tubing was unlabeled and undated, and the nebulizer mask was stored uncovered and placed inside the top drawer of the bedside table and the nebulizer tubing was unlabeled and undated. Interview and observation with LPN #1 on 4/15/25 at 1:26 PM identified Resident #2's oxygen and nebulizer tubing were unlabeled and undated, and the nebulizer mask was uncovered and stored in the top drawer of the bedside table. LPN #1 indicated Resident #2 was on continuous oxygen due to a current diagnosis of pneumonia and the resident was utilizing the nebulizer on a regular basis. LPN #1 identified it was the responsibility of the 11:00 PM to 7:00 AM nurse to change, label and date respiratory equipment weekly and she was unable to indicate the reason the respiratory equipment was kept this way and the appropriate maintenance was not done. 3. Resident #15 had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and tracheostomy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was cognitively intact, used a motorized wheelchair, had shortness of breath or trouble breathing when lying flat, received oxygen therapy, suctioning and tracheostomy care, required supervision or touching assistance with eating, and was independent with personal hygiene and transfers. The MDS failed to identify Resident #15 had received respiratory therapy 1 day (2/6/25) between 2/1/25 through 2/8/25. The Resident Care Plan (RCP) dated 2/11/25 identified Resident #15 was at risk for alteration in respiratory status with potential for poor airway clearance, dsypnea, fatigue, and respiratory distress related to Resident #15's tracheostomy. Interventions included administer oxygen as ordered and monitor oxygen saturation as indicated. A physician order dated 4/8/25 directed to administer oxygen therapy 6 liters per minute (lpm) to 8 lpm via a tracheostomy mask every shift (11:00 PM through 7:00 AM, 7:00 AM through 3:00 PM, and 3:00 PM through 11:00 PM). Observation on 4/14/25 at 12:45 PM identified Resident #15 was wearing oxygen set at 8 lpm with tubing that was unlabeled and undated connected to a tracheostomy mask. Observation on 4/15/25 at 1:25 PM identified Resident #15 was wearing oxygen set at 8 liters per minute (lpm) with tubing that was unlabeled and undated connected to a tracheostomy mask. Resident #15 also had a portable oxygen tank on his/her wheelchair with oxygen tubing attached that was unlabeled and undated. Physician orders dated 4/16/25 failed to identify a physician order directing to change, label and date oxygen tubing every week. Interview with the DNS on 4/16/25 at 11:50 AM identified that all residents with oxygen orders should have an order in place directing to change, label, and date the oxygen tubing every week. The DNS was unable to identify the reason there were missing orders to change/label/date oxygen tubing every week and was unsure if education had been provided to licensed nursing staff on entering orders for vital signs including oxygen saturation or for the changing of oxygen/nebulizer tubing. Subsequent to surveyor inquiry a physician order dated 4/18/25 was obtained which directed to change oxygen tubing every week on Wednesday on the 11:00 PM through 7:00 AM shift. Although requested no education was provided regarding licensed nursing staff on entering orders for vital signs including oxygen saturation or for the changing of oxygen/nebulizer tubing. 4. Resident #219's diagnosis included chronic obstructive pulmonary disease, congestive heart failure, and lung cancer. A physician order dated 4/2/25 directed for Resident #219 to be administered 2 liters of oxygen via nasal cannula continuously. The Resident Care Plan (RCC) dated 4/3/25 identified that Resident #219 had alteration in respiratory status with potential for poor airway clearance, dyspnea, fatigue, and respiratory distress. Interventions identified that Resident #219 was to be administered oxygen as physician ordered, report signs and symptoms of respiratory distress, and assist to reposition for maximum airflow. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #219 was severely cognitively impaired and required substantial/maximal assistance for oral hygiene, toileting, dressing and personal hygiene. Also, identified was that Resident #219 was dependent for showering, transferring, and received oxygen therapy. On 4/14/25 at 12:58 PM an observation was made that Resident #219 was receiving 2 liters of oxygen via nasal cannula and the oxygen tubing was not labeled or dated. On 4/15/25 at 1:00 PM a second observation was made that Resident #219 was receiving 2 liters of oxygen via nasal cannula and the oxygen tubing was not labeled or dated. An interview and observation with Licensed Practical Nurse (LPN) #4 on 4/15/25 at 1:20 PM identified that she could not tell when the oxygen tubing for Resident #219 was last changed because the oxygen tubing failed to have a label present on the tubing which would indicate when the tubing was changed. LPN #4 further identified that the oxygen tubing was supposed to be changed on Sundays which was 2 days ago. LPN #4 identified that the policy stated tubing was to be changed on Sunday night by the 11:00 PM to 7:00 AM shift and she was unsure of the reason it wasn't changed. 5. Resident #269's diagnosis included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and chronic atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] was cognitively intact and required substantial/maximal assistance with transfers and was dependent with bed mobility and toileting. The MDS indicated Resident #269 required oxygen therapy. A Resident Care Plan (RCP) dated 3/13/25 identified Resident #269 had COPD and a history of pneumonia. Interventions included to administer medications and oxygen, monitor oxygen saturations, and complete respiratory assessments per MD order and as needed. A physician's order dated 4/8/25 directed to administer oxygen at 2 to 4 liters/minute via nasal cannula every shift and for oxygen saturation below 90%. A physician's order dated 4/8/25 directed to administer Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg/ml/0.083% (albuterol sulfate), 3 milliliters inhale orally via nebulizer every 4 hours as needed for dyspnea (shortness of breath) and wheezing. Observations on 4/14/25 at 10:40 AM and 4/15/25 at 11:24 AM identified Resident #269 was in his/her room and was receiving continuous oxygen via nasal cannula. The oxygen and nebulizer tubing were unlabeled and undated, and the nebulizer mask was stored uncovered and placed on top of the bedside table. Interview and observation with LPN #1 on 4/15/25 at 1:28 PM identified Resident #269's oxygen and nebulizer tubing were unlabeled and undated, and the nebulizer mask was uncovered and stored on top of the bedside table. LPN #1 indicated Resident #269 was on continuous oxygen and used the nebulizer on an as needed basis. LPN #1 identified it was the responsibility of the 11:00 PM to 7:00 AM nurse to change, label and date respiratory equipment weekly and she was unable to indicate the reason the respiratory equipment was kept this way and the appropriate maintenance was not done. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry, an observation on 4/16/25 at 10:04 AM identified Resident #2's oxygen tubing and nebulizer tubing was labeled/dated and the nebulizer mask was bagged and being stored on top of the bedside table. Interview with the DNS on 4/16/25 at 11:10 AM identified oxygen and nebulizer tubing should be changed weekly and should be labeled, dated and stored appropriately. The DNS indicated it was the responsibility of the nurse on the overnight shift and the nurse should have made sure the oxygen and nebulizer tubing was changed, labeled, and dated and the nebulizer mask was bagged. The DNS identified he was unsure why the respiratory equipment was found without the appropriate maintenance, and he would need to provide more education to the nursing staff. Review of the policy for Oxygen Administration identified that oxygen tubing should be dated, changed weekly or if needed earlier.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interviews and review of 2 of 3 Nurse Aide (NA) employee files (NA #1 and NA #9), the facility failed to ensure the required annual performance evaluations were completed. The findings include: 1. NA #1's date of hire was 5/15/19. No performance evaluations were identified in the employee's personnel file. Although requested, the facility could not provide any annual evaluations for NA #1. Review of the facility time punch documentation provided for NA #1 identified she had worked in the facility on 4/8/25, 4/9/25, 4/11/25, 4/14/25, 4/15/25, 4/16/25, 4/18/25, and 4/19/25. 2. NA #9's date of hire was 8/13/20. No performance evaluations were identified in the employee's personnel file. Although requested, the facility could not provide any annual evaluations for NA #9. Review of the facility time punch documentation provided for NA #9 identified she had worked in the facility on 4/8/25, 4/9/25, 4/10/25, 4/14/25, 4/15/25, 4/16/25, 4/17/25, 4/19/25, and 4/20/25. An interview and review of the employee files for NA #1 and NA #9 with the Director of Nurses (DNS) on 4/22/25 at 12:40 PM identified that performance evaluations would be in the employee's personnel file and that he was aware that the evaluations had not been completed. The DNS indicated that human resources (HR) would have tracked and informed him when the performance evaluations were due, and it would have been his responsibility complete them for NA#1 and NA #9. The DNS identified that he was working on a new system with the HR department to complete the evaluations on a more consistent annual schedule. The DNS identified that it was the policy of the facility that performance evaluations be completed annually and that he would work on getting them completed. Although requested, a written facility policy on performance evaluations was not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility policy, for 2 of 5 residents, (Resident #12 and Resident #269) reviewed for unnecessary medications, the pharmacist failed to identify behavior monitoring was not completed for residents receiving antipsychotic medication. The findings include: 1. Resident #12's was re-admitted to the facility in August 2024 with diagnoses that included vascular dementia, major depressive disorder and anxiety. A Resident Care Plan (RCP) dated 8/28/24 identified Resident #12 was at risk for potential adverse effects of psychotropic drug use related to being prescribed psychotropics for depression and/or anxiety. Interventions included to monitor target behaviors, gradual dose reduction as ordered, and to refer to psychiatry/social services as needed. Physician orders dated 8/28/24 directed Quetiapine (Seroquel) (an antipsychotic medication) 75 milligrams (mg) at bedtime. Additional physician orders directed Risperidone 1.0 mg twice a day. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 was severely cognitively impaired and was dependent for toileting, showering/bathing and required supervision with eating and oral hygiene. Additionally, the MDS identified Resident #12 was prescribed antipsychotic and antidepressant medication. Physician orders dated 9/30/24 directed to discontinue all Risperidone orders and administer Risperdal (Risperidone) 1.25 mg twice a day. Physician orders dated 10/7/24 an currently in effect directed increasing Seroquel from 75 mg to 100 mg at bedtime. Physician orders dated 1/16/25 and currently in effect directed the addition of Risperidone 1.375 mg once a day at 5:00 PM (Risperidone 1.25 mg once at 9:00 AM was continued). Interview and record review with the DNS on 4/16/25 at 11:23 AM identified target behaviors with behavior monitoring was to be included electronically for a resident receiving an antipsychotic medication, either on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) by the nurse receiving the order from the physician. Additionally, the DNS noted Resident #12 was prescribed an antipsychotic (Seroquel) due to the behavior or yelling out (per psychiatric progress notes from 12/18/24 to current), but was unable to provide documentation the facility was monitoring for that behavior every shift per facility policy. Pharmacy medication review dated 9/30/24 recommended to include a specific behavior that can be quantitatively and objectively documented by the nursing staff, and the physician agreed with the recommendation, however no target behavior or behavior monitoring was implemented. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent monthly pharmacy medication reviews on 10/21/24, 11/21/24, 12/20/24, 1/21/25, 2/16/25 and 3/20/25 failed to note the pharmacist recommended to include target behaviors and implement behavior monitoring per the 9/30/24 pharmacy recommendation. Interview with the Pharmacist on 4/17/25 at 10:18 AM identified his recommendations were for a supporting diagnoses for the use of an antipsychotic, periodically reviews for target behaviors and behavior monitoring, but could not state a quantitative period of time that he reviews for target behaviors and behavior monitoring. 2. Resident #269's diagnoses included bipolar disorder, anxiety disorder, and mood disorder. Physician's orders in effect from 12/21/24 through 2/20/25 identified behavior monitoring every shift for psychoactive medication use (Seroquel). The physician's order specified to monitor and document the number of behavior episodes during each shift for identified target behaviors of anxiety, sadness, insomnia, mood swings and labile mood. Physician's orders in effect from 2/20/25 through 4/8/25 identified that Resident #269 had been receiving Quetiapine (Seroquel) daily. Although the physician's orders continued to direct the administration of Quetiapine, further review of the Medication Administration Record (MAR), Treatment Administration Record (TAR) and nursing notes from 2/20/25 through 4/16/25 failed to identify target behavior monitoring was being completed for Resident #269. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #269 was cognitively intact and required substantial/maximal assistance with transfers and was dependent with bed mobility and toileting. The MDS indicated Resident #269 was receiving an antipsychotic medication. The Resident Care Plan dated 3/13/25 identified psychotropic drug use. Interventions included to monitor for decline in mood and behavior and maintain behavior tracking sheet. Review of the consultant pharmacist medication regimen review (MRR) dated 3/21/25 failed to indicate any recommendations to the facility after the pharmacy review of medications was completed. A Psychiatric progress note dated 4/16/25 identified Resident #269 was being assessed to evaluate mood symptoms, anxiety, psychosis and to review current medications. The progress note indicated that Resident #269 was to be monitored for anxiety, and emerging psychiatric or behavioral concerns and to continue current medications (Quetiapine) as ordered. Interview and review of the clinical record with the DNS on 4/16/25 at 11:15 AM identified that due to Resident #269 being prescribed the antipsychotic Quetiapine, the admitting nurse and physician should have identified Resident #269's target behaviors and ordered behavior monitoring. The DNS indicated that Resident #269 had target behavior monitoring ordered and completed prior to 2/20/25. The DNS identified that although Resident #269 was re-admitted to the facility on [DATE] and continued to have Quetiapine ordered and administered daily, the order for target behavior monitoring had been missed and it would have been the responsibility of the charge/admitting nurse to do. Additionally, the DNS indicated the consulting pharmacist that completed the MRR for Resident #269 on 3/21/25 should have identified the lack of target behavior monitoring and made the necessary recommendations to the prescriber and facility. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of the clinical record with the consulting pharmacist on 4/22/25 at 10:20 AM indicated that although he conducted medication regimen reviews (MRR's) monthly at the facility, review of the clinical record for Resident #269 failed to show that target behaviors were identified, and behavior monitoring was being completed at the facility since 2/20/24. The consultant pharmacist identified he was unsure of the reason behavior monitoring was no longer being completed since Resident #269 continued to receive Quetiapine daily. The consulting pharmacist indicated the facility should have identified target behaviors for Resident #269 and continued to complete behavior monitoring every shift. The consulting pharmacist further identified that although he completed an MRR for Resident #269 on 3/21/25, he made no recommendations to the facility for that audit because he did not notice behavior monitoring had not been re-ordered and completed for the resident. Review of the facility policy, Consultant Pharmacist Services Provider Requirements, undated, directed the consultant pharmacist would review the medication regimen of each resident while incorporating federally mandated standards of care in addition to other applicable professional standards in their monthly review. The policy directed the consultant pharmacist would communicate to the responsible prescriber and the facility leadership actual problems detected related to medication orders including recommendations for changes in monitoring of medication therapy as well as regulatory compliance issues. The policy further directed the consultant pharmacist would review MAR's and physician orders monthly to ensure proper documentation of orders and administration of medications to residents. Review of the facility policy, Behavior Monitoring, undated, directed that residents receiving antipsychotic medications will have specific target behaviors identified and monitored every shift. The policy directed that the number of episodes for each target behavior, interventions, outcomes, and side effects would be recorded each shift. The policy identified Seroquel (Quetiapine) as an antipsychotic medication.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility policy, for 2 of 5 residents (Resident #12 and Resident #269) reviewed for unnecessary medications, the facility failed to identify and monitor target behaviors for residents receiving antipsychotic medications. The findings include: 1. Resident #12 was re-admitted to the facility in August 2024 with diagnoses that included vascular dementia, major depressive disorder and anxiety. A Resident Care Plan (RCP) dated 8/28/24 identified Resident #12 was at risk for potential adverse effects of psychotropic drug use related to being prescribed psychotropics for depression and/or anxiety. Interventions included to monitor target behaviors, gradual dose reduction as ordered, and to refer to psychiatry/social services as needed. Physician orders dated 8/28/24 directed Quetiapine (Seroquel) (an antipsychotic medication) 75 milligrams (mg) at bedtime. Additional physician orders directed Risperidone 1.0 mg twice a day. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 was severely cognitively impaired and was dependent for toileting, showering/bathing and required supervision with eating and oral hygiene. Additionally, the MDS identified Resident #12 was prescribed antipsychotic and antidepressant medication. Physician orders dated 9/30/24 directed to discontinue all Risperidone orders and administer Risperdal (Risperidone) 1.25 mg twice a day. Physician orders dated 10/7/24 an currently in effect directed increasing Seroquel from 75 mg to 100 mg at bedtime. Physician orders dated 1/16/25 and currently in effect directed the addition of Risperidone 1.375 mg once a day at 5:00 PM (Risperidone 1.25 mg once at 9:00 AM was continued). Interview and record review with the DNS on 4/16/25 at 11:23 AM identified target behaviors with behavior monitoring was to be included electronically for a resident receiving an antipsychotic medication, either on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) by the nurse receiving the order from the physician. Additionally, the DNS noted Resident #12 was prescribed an antipsychotic (Seroquel) due to the behavior or yelling out (per psychiatric progress notes from 12/18/24 to current), but was unable to provide documentation the specific target behavior (yelling out) was monitored every shift per facility policy. 2. Resident #269's diagnoses included bipolar disorder, anxiety disorder, and mood disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders in effect from 12/21/24 through 2/19/25 identified behavior monitoring every shift for psychoactive medication use (Seroquel). The physician's order directed to monitor and document the number of behavior episodes during each shift for identified target behaviors of anxiety, sadness, insomnia, mood swings and labile mood. Physician's orders in effect from 2/20/25 through 4/8/25 identified that Resident #269 had been receiving Quetiapine (Seroquel) daily. Although the physician's orders continued to direct the administration of Quetiapine, further review of the MAR from 2/20/25 through 4/16/25 failed to identify behavior monitoring was being completed for Resident #269. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #269 was cognitively intact and required substantial/maximal assistance with transfers and was dependent with bed mobility and toileting. The MDS indicated Resident #269 was receiving an antipsychotic medication. The Resident Care Plan dated 3/13/25 identified psychotropic drug use. Interventions included to monitor for decline in mood and behavior and maintain behavior tracking sheet. A psychiatric progress note dated 4/16/25 identified Resident #269 was being assessed to evaluate mood symptoms, anxiety, psychosis and to review current medications. The progress note indicated that Resident #269 was to be monitored for anxiety, and emerging psychiatric or behavioral concerns and to continue current medications (Quetiapine) as ordered. Interview and review of the clinical record with the DNS on 4/16/25 at 11:15 AM identified that due to Resident #269 being prescribed the antipsychotic Quetiapine, the admitting nurse and physician should have identified Resident #269's target behaviors and ordered behavior monitoring. The DNS indicated that Resident #269 had behavior monitoring ordered and completed prior to 2/20/2025. The DNS identified that although Resident #269 was re-admitted to the facility on [DATE] and continued to have Quetiapine ordered and administered daily, the order for behavior monitoring had been missed and it would have been the responsibility of the charge/admitting nurse to do. The DNS indicated that Resident #269 should have had behavior monitoring completed every shift and he would need to reach out to the physician to obtain a new order. Review of the facility policy, Antipsychotic Medication Use, undated, directed that the attending physician and staff would gather and document information to clarify a resident's behavior and mood. Review of the facility policy, Behavior Monitoring, undated, directed that residents receiving antipsychotic medications will have specific target behaviors identified and monitored every shift. The policy directed that the number of episodes for each target behavior, interventions, outcomes, and side effects would be recorded each shift. The policy identified Seroquel (Quetiapine) as an antipsychotic medication.

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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** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #17) reviewed for pressure ulcers, the facility failed to ensure infection control practices were followed during a dressing change and protective personal equipment (PPE) was worn during the dressing change for a resident on Enhanced Barrier Precautions (EBP). The findings include: Resident #17's diagnoses included pressure ulcer of the sacral region, dementia with severe anxiety and mild neurocognitive disorder with behavioral disturbances. The annual Minimum Data (MDS) assessment dated [DATE] identified Resident #17 was mildly cognitively impaired and required maximum assistance for personal hygiene, assistance of 2 staff members for bed mobility, and was bedfast most of the time. The MDS further identified Resident #17 was at risk for the developing pressure ulcers, and had a Stage 1 or greater pressure ulcer over a bony prominence. The Resident Care Plan dated 2/18/25 identified skin integrity as an area of concern with an unstageable pressure ulcer on coccyx. Interventions included to follow skin care protocols, PT/OT consultation for positioning, low air loss pressure mattress, treatment as order, dietary consultation as needed, and pressure redistribution devices as ordered. A physician's order dated 4/8/25 directed to cleanse coccyx wound with normal saline or sterile water, apply collagen then Calcium Alginate followed by a dry clean dressing, change dressing daily and as needed for soiled or non-intact dressing. A progress note written by APRN #3 (wound consultant) dated 4/15/25 identified an improving Stage 3 coccyx wound, size 4.0 centimeters (cm) by 2.0 cm by 0.1 cm with a moderate amount of serosanguineous (thin, light pink in color) drainage. APRN #3 stated to optimize nutrition with consultation from the Dietitian and PT to re-evaluate support surfaces. Observation of Resident #17's treatment on 4/16/25 at 12:22 PM by LPN #2 identified that LPN #2 failed to apply PPE for Resident #17's dressing change who was on EBP. LPN #2 prepared a clean field using Resident #17's over the bed table. LPN #2 applied gloves and proceeded to remove the soiled coccyx dressing and cleanse coccyx wound with normal saline. LPN #2 then removed soiled gloves without the benefit of washing hands or using a hand sanitizer (hand hygiene). LPN #2 opened the clean dressings that were on Resident #17's bedside table. LPN #2 opened the topical dressing and wrote the date and time. LPN #2 then opened the Calcium Alginate, removed scissors from the side pocket of her scrubs without the benefit of sanitizing the scissors, cut the Calcium Alginate to size and placed the scissors back in her scrub side pocket. LPN #2 then applied clean gloves without performing hand hygiene, applied the Calcium Alginate to the wound bed and covered the wound with a topical dressing. (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	An interview with RN #1 (the Infection Preventionist) on 4/16/25 at 12:28 PM identified that LPN #2 should have had PPE on when performing the dressing change per the EBP policy. Furthermore, RN #1 stated that after LPN #2 removed the soiled coccyx dressing and cleansed the wound, hand hygiene should have been done before opening the clean dressings. RN #1 stated it was not practice of the facility to use scissors without the benefit of using the appropriate germicidal wipe before use to ensure they were clean. Lastly, LPN #2 should have performed hand hygiene and applied clean gloves prior to applying the clean dressings on Resident #17's coccyx wound per facility policy and standard infection control practices. An interview with LPN #2 on 4/16/25 at 1:10 PM identified that she should have applied PPE prior to performing the dressing change and did not know why she did not apply the PPE as she was aware that Resident #17 was on EBP and required the use of gown and gloves. LPN #2 further indicated that she should have performed hand hygiene after removing the soiled dressings and cleaning Resident #17's coccyx and before opening the clean dressing supplies. LPN #2 indicated that she should have performed hand hygiene and applied clean gloves prior to applying the clean dressings to Resident #17's coccyx. LPN #2 stated she was not aware that scissors from her scrub pocket needed to be cleaned before using them on the clean dressings. A review of Enhanced Barrier Precautions policy directed, in part, that enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact care activities. High contact resident care activities include wound care. Enhanced barrier precautions will continue until the wound has healed. A review of the policy and procedures for Clean Dressing Technique directed, in part, after establishing clean field with clean dressing supplies, wash hands/hand sanitizer and apply clean gloves. Remove old dressing and discard, remove gloves wash hands/hand sanitizer and apply clean gloves. The wound is then cleansed, then gloves are removed, wash hands/hand sanitizer and apply clean gloves. Apply any medication and dress wound. Discard any soiled materials in plastic bag. Remove soiled gloves and wash your hands.