STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075374	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monsignor Bojnowski Manor	50 Pulaski Street New Britain, CT 06053

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one of two sampled residents (Resident #34) reviewed for hospitalization , the facility failed to ensure the Ombudsman's office was provided with the required notification of the transfer. The findings included: Resident #34's diagnoses included osteomyelitis, anemia, and osteoarthritis of the knee. The quarterly assessment dated [DATE] identified Resident #34 had moderate cognitive impairment, required maximal assistance with personal hygiene, toileting hygiene and was non-ambulatory. LPN #6's progress note dated 11/29/24 at 2:44 PM identified the nurse aide reported Resident #34 was unresponsive and LPN #6 and the Nursing Supervisor entered the Resident #34's room and found the resident slumped over in the wheelchair and was unresponsive to the administration of sternal rub. The APRN was notified and ordered Resident #34 be sent to the emergency room for evaluation. The DNS's note dated 11/29/24 at 2:44 PM identified Resident #34 was admitted to the hospital with osteomyelitis and syncope. A request for the monthly Ombudsman's report for transfers and discharges for the last 4 months was made on 2/3/25 at 9:00 AM. A copy of the report was not provided. Review of the facility's admission/discharge reports for the past six months identified the following: For the month of September, there were sixteen residents discharged and/or transferred from the facility. For the month of October 2024, there were twenty-one residents discharged and/or transferred from the facility. For the month of November 2024, there were seventeen residents discharged and/or transferred from the facility. (continued on next page)

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

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	For the month of December 2024, there were twelve residents discharged and/or transferred from the facility. For the month of January 2025, there were fifteen residents discharged and/or transferred from the facility. Interview with the Administrator on 2/3/25 at 1:04 PM identified the Social Worker is responsible for sending the monthly report of transfers and discharges to the Ombudsman's office. The Administrator further identified that the Social Worker was out on leave, and he did not have access to the Ombudsman's reporting portal. Interview with the Social Worker (SW #1) on 2/4/25 at 10:25 AM identified she was responsible for completing the monthly transfer and discharge report; however, it was not completed. SW #1 identified she started working at the facility in September of 2024 and was unaware that she was responsible for completing the report. She further identified the report should include all discharges and/or transfers to the hospital, home, deaths in the facility, and admission. On 2/4/25 (after surveyor inquiry) the facility updated the Ombudsman's office of all discharges and transfers that occurred during the period of September/2024 through January/2025. Review of the Transfer and Discharge (including AMA-against medical advice) policy identified the facility would maintain evidence that the notices were sent to the Ombudsman. The policy further identified the Social Services Director would provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirements for content of such notice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for five of five sampled residents (Residents #12, #31, #43, #46, and #49) reviewed for immunizations, the facility failed to ensure the MDS assessments were accurately encoded. The findings include: 1. Resident #12's diagnoses included hypertension, osteoarthritis, and hypercholesterolemia. The quarterly MDS assessment dated [DATE] identified Resident #12 was cognitively intact, and noted the influenza vaccine was received on 11/15/24 and the pneumococcal vaccination was up to date. Review of the clinical record with LPN #4 (MDS Coordinator) identified a hospital discharge summary dated 7/7/24 that identified Resident #12 received PPSV23(PPSV23 stands for pneumococcal polysaccharide vaccine 23. It is a vaccine that helps protect against pneumococcal disease, which is caused by bacteria called Streptococcus Pneumoniae) on 8/14/2014. Further review of the clinical record failed to identify that the resident was offered and/or received an up-to-date pneumococcal vaccine (administered within the past five years). There was also no documentation to support the resident being administered the influenza vaccine. Interview with Resident #12 on 2/14/25 at 2:08 PM identified he/she did not recall receiving the influenza vaccine in the fall of 2024. Interview with LPN #4 (MDS Coordinator) on 2/3/25 at 12:23 PM identified Resident #12's pneumococcal vaccine was not up to date and the resident had not been administered the influenza vaccine. 2. Resident #31's diagnoses included dementia, depressive disorder, and gastrointestinal hemorrhage. The quarterly MDS assessment dated [DATE] identified Resident #31 had severe cognitive impairment, had an up-to-date pneumococcal vaccine, and noted the influenza vaccine was not administered in the facility Review of the clinical record with LPN #4 (MDS Coordinator) on 2/3/25 at 12:23 PM identified Resident #31 had not been administered the pneumococcal vaccine within the past five years, and there was also no documentation to support the resident being administered the influenza vaccine. Interview with LPN #4 (MDS Coordinator) on 2/3/25 at 12:23 PM identified Resident #31's pneumococcal vaccine was not up to date and the resident had not been administered the influenza vaccine. 3. Resident #43's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and spinal stenosis. The quarterly MDS assessment dated [DATE] identified Resident #43 was cognitively intact and had an up-to-date pneumococcal vaccine. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the clinical record with the MDS coordinator (LPN #4) on 2/3/25 at 12:23 PM failed to identify Resident #43 had been administered the pneumococcal vaccine within the past five years. Interview with LPN #4 on 2/3/25 at 12:23 PM identified Resident #43 had not been administered the pneumococcal vaccine within the past five years. 4. Resident #46's diagnoses included sepsis, sleep apnea, chronic obstructive pyelonephritis and gout. The quarterly MDS assessment dated [DATE] identified Resident #46 had moderately impaired cognition and was up to date with the pneumococcal vaccine. Review of the clinical record with LPN #4 on 2/3/25 at 12:23 PM failed to identify Resident #46 had received the pneumococcal vaccine within the past five years. Interview with LPN #4 on 2/3/25 at 12:23 PM identified Resident #46 had not been administered the pneumococcal vaccine within the past five years. 5. Resident # 49's diagnoses included dementia, hypercholesterolemia and psychotic disorder. The quarterly MDS assessment dated [DATE] identified Resident #49 had severely impaired cognition and was up to date with the pneumococcal vaccine. Review of the clinical record with LPN #4 on 2/3/25 at 12:23 PM identified Resident #49 had received the Prevnar 13 (PCV13/a type of pneumococcal vaccine) on 9/22/2019. Further review of the record failed to identify any other pneumococcal vaccines administered or offered within the past five `years. Interview with LPN #4 on 2/3/25 at 12:23 PM identified Resident #49 had not been administered the pneumococcal vaccine within the past five years. According to the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine timing for adults identified that adults 65years or older have the option to receive the pneumococcal vaccine 20 (PVC 20) if they have already received both Prevnar 13 (PCV 13) at any age and/ pneumococcal vaccine (PPSV23) at or after age [AGE] years old and are eligible to receive after 5 years the PCV20 or another dose of the PPSV23. The CDC also identified that an adult over the age of [AGE] years and have no prior vaccination of the pneumococcal vaccine are eligible for receiving the PCV20 vaccine or the PCV15 then after one year the PPSV23 vaccine. Interview with LPN #4 on 2/3/25 at 12:23 PM identified that when completing the immunization section of the MDS, he reviews the resident's hospital discharge documentation, and immunization consent forms. LPN #4 further identified that he is responsibility for the accurate coding of the MDS assessments and noted that he had not coded the assessments for Resident's #12, #31, #43, #46 and #49 accurately. In addition, he did not explain why the MDS assessments had been inaccurately coded when the clinical records did not contain the information necessary for what was indicated in the MDS assessments. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the DNS on 2/3/25 at 2:15 PM identified she was responsible for signing off on the resident assessments. The DNS identified she signs the MDS assessments to indicate the completion of the assessment, but noted it is the MDS Coordinator's responsibility to ensure the assessments accurately reflect the resident's status. Review of the MDS 3.0 Completion policy identified the facility conducts an initial and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity using the RAI specified by the state. The policy further identified that persons completing part of the assessment must attest to the accuracy of the section they complete by signature and indication of the relevant sections. The R.N. Coordinator signs, dates and attests to the timely completion of the RAI once all other disciplines have completed their sections.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #52) reviewed for hospice care and had the behavior of refusing care and medications, the facility failed to ensure the resident's care plan addressed the refusals of care and medication. The findings include: Resident #52 was admitted to the facility in October of 2024. Diagnoses included vascular dementia with agitation, anxiety disorder due to known physiological condition, open wound of unspecified front wall of thorax without penetration into thoracic cavity, disorientation and insomnia. The admission MDS assessment dated [DATE] identified the resident had intact cognition, required supervision or touching assistance with toileting, showering, and personal hygiene, independent with position changes and required supervision/touching assistance with transfers and walking. The assessment further indicated Resident #52 exhibited delusions, but did not exhibit physical or verbal behavioral symptoms directed toward others and did not exhibit rejection of care or wandering. The significant change MDS assessment dated [DATE] identified Resident #52 had intact cognition, was experiencing delusions, and did not exhibit rejection of care or wandering. The care plan dated 1/3/25 identified the problem of end-of-life requiring Hospice services, pain, and the risk for potential adverse effects of psychotropic medication. Physician's orders dated 1/12/25 directed an assist of one for transfers and ambulation with a rolling walker, monitor for side effects of medication and monitor target behaviors. The orders further identified the following medication orders: 1. Administer Lorazepam 0.5 mg 1 tab by mouth every six hours for anxiety 2. Administer Morphine Concentrate 20mg sublingually every three hours as needed for pain or shortness of breath 3. Administer Prochlorperazine Maleate 10mg by mouth every six hours as needed for nausea and/or vomiting. 4. Administer Seroquel 12.5mg by mouth twice per day 5. Administer Trazadone 25mg by mouth twice per day for anxiety, insomnia, and delusions. Review of nursing notes from 11/1/24 through 2/3/25 identified Refusals of care as listed below with no indication of re-approach or redirection: 11/17/24: Refused Trazodone this evening 11/18/24: Continues to refuse scheduled Trazodone (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/19/24: Continues to refuse scheduled Trazodone 11/23/24: Continued to refuse scheduled Trazodone 12/9/24: Refused scheduled Trazodone stating there was no need for sleeping aid 12/15/24: Refused HS Trazodone 12/16/24: Refused HS Trazodone 12/17/24: Refused HS Trazodone 12/23/24: Refused HS Trazodone 12/24/24: refused HS Trazodone 12/25/24: Refused HS Trazodone 12/28/24: Refused HS Trazodone 12/30/24: Refused Trazodone 12/31/25: Refused scheduled Trazodone 1/1/25: Refused Trazodone 1/15/25: Refused body check so post fall assessment not completed. 1/15/25: Refused vitals and remains combative 1/16/25: Refused medications and treatment to chest 1/22/25: Refused scheduled Trazodone 1/24/25: Refused Hospice assessment and was not cooperative. 1/25/25: Refused am medications, refused dressing change 1/28/25: Confused and non-cooperative with care. The medication administration record (MAR) for December 2024 identified Resident #52 refused Trazodone at bedtime 26 times out of 31 attempted administrations. The MAR for January 2025 identified Resident #52 refused 23 out of 31 attempted administrations at bedtime. The nurse's progress note dated 1/23/25 identified Resident #52 opted to discontinue radiation treatments for cancer and was placed on Hospice. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's progress note dated 1/28/25 at 10:32 PM identified Resident #52 refused care by the hospice and identified he/she was able to manage. Interview on 2/4/25 at 10:50 AM with LPN#6 identified Resident #52 is redirectable but often refuses care and medications depending on the staff and the resident's mood. LPN#6 indicated that he reapproaches the resident with a good outcome usually. Interview on 2/4/25 at 11:07 AM with the DNS identified that when a resident has consistent refusals of care or medications, the supervisor and the provider should be notified. The DNS further identified the facility did not have a policy regarding refusals of care or refusals of medications, but she would expect refusals to be addressed in the resident's care plan. Interview on 2/4/25 at 11:29 AM with RN#2 regarding resident refusals identified that the RN Supervisor and the APRN should be notified, and the type and frequency of refusals should be identified. She further noted that when Resident #52 refuses, the staff should reapproach and if the resident still does not allow the treatment/care/medication, then the APRN should be notified. Additionally, RN #2 identified the care plan should have been updated to include interventions such as reapproach, etc. and indicated the MDS coordinator is responsible for making care plan changes. Further review of the care plan dated 1/3/25 failed to address Resident #52's behavior of refusing care, treatments and medications. Interview on 2/4/25 at 11:48 AM with LPN#4 (MDS Coordinator) identified he looks at the morning report/24-hour report and run reports back to the last time he reviewed the chart. When asked about refusals being reflected in the care plan LPN #4 indicated that the change in condition was reflected in the transition to Hospice Care. Additionally, LPN #4 indicated that there was a care plan that addressed refusal of showers and directed staff to redirect and honor resident's right to refuse. The care planning policy identified that the facility ensures residents have a comprehensive and individualized plan of care that will guide caregivers to assist residents to achieve or maintain their highest practical level of wellbeing. The policy indicated that the care plan is reviewed and updated at least quarterly and as necessary to reflect changes in the resident's status.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on observations, clinical record review, facility documentation review, facility policy review, and interviews for one of three sampled residents (Resident #16) reviewed for accidents, the facility failed to ensure the resident was provided accurate supervision to prevent an elopement and failed to ensure staff responded to the door alarm when the resident exited the building. The findings include: Resident # 16 's diagnoses included dementia, poly-osteoarthritis, restlessness and agitation. The elopement evaluation dated 6/24/24 identified Resident #16 was at risk for elopement. A physician's order dated 6/24/24 identified Resident #16 wander guard on right wrist and check bracelet application every shift, check function once a shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #16 had severe cognitive impairment, required supervision with transfers and ambulation and had a wander guard (monitoring device that triggers an alarm) in place. The care plan dated 9/13/24 identified Resident #16 frequently wandered and was at risk for elopement from the building. The care plan interventions directed to offer and engage resident in an activity, apply wander guard and check function when resident is seen heading toward or lingering near an exit door, and offer to escort to another area of the building. The nurse's note dated 11/17/24 at 7:34 PM identified Resident #16 had eloped to the courtyard patio outside of the facility at approximately 5:50 PM and Resident #16 returned into the facility at 6:00 PM. Resident #16 was independent with ambulation and the wander guard was noted to the right wrist. Resident #16 was in the dining room which ended approximately at 5:30PM and he/she was noted ambulating back and forth in the St. [NAME] hallway. A body audit was completed with no noted injuries. The physician, responsible party and DNS were notified of the elopement. Review of facility Accident and Incident (A & I) report dated 11/17/24 identified Resident #16 had eloped outside to the courtyard patio, and he/she was seen knocking on the window outside the building at the end of the St [NAME] hallway. Further review of facility (A &I) report identified the timeline of events based on the facility cameras identified the following: 5:14 PM: Resident #16 was sitting in the dining room on the St. [NAME] unit. 5:35 PM: Resident #16 finished dinner and left the dining room. 5:39 PM: Resident #16 was noted sitting on a chair in the St [NAME] hallway near the nurses' station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5:50 PM: The dining room was cleared from all residents, tables were cleaned, and lights were turned off and the door to the recreation room was closed but not locked. 5:55 PM: Resident #16 walked toward the dining room located on St [NAME] and there was no staff present in the St [NAME] hallway. Resident #16 opened the door that led to the dining room and closed the door behind him/her. The nursing supervisor was on the phone with a family member sitting at the nurses' station and was facing the St, [NAME] hallway. 5:56 PM: Resident #16 opened the door and walked out to the courtyard patio. 6:00 PM: LPN #2 walked out of a resident's room and walked toward the medication cart located near the St [NAME] lounge door, LPN #2 heard a knock on the window and saw Resident #16 knocking on the windows from outside in the courtyard. LPN #2 opened the door and brought Resident #16 back inside the building from the courtyard. 6:05 PM: Resident #16 was inside the facility and the St [NAME] rear door and St [NAME] lounge door were both alarming when resident brought into the facility. Observation on 1/29/25 at 10:30 AM identified Resident #16 was pacing back and forth without assistive device in the St. [NAME] hallway. A tour of the building with the DNS on 2/3/25 at 9:40 AM identified all doors that could lead to outside the facility are equipped with an alarm. The St [NAME] rear door where Resident #16 went out to the courtyard patio was equipped with a door alarm when opened and also the St [NAME] lounge area door was also equipped with a door alarm where Resident #16 was seen knocking on the window. The DNS identified that when a door is opened, there is an audible alarm and blinking red light at the alarm panel near the nurses' station. The alarm panel is labelled and will identify the door that has been opened. The tour further identified that the patio is enclosed but is not secure (a resident can exit the patio area through a gate). Interview and review of the facility timeline of events with the DNS on 2/3/25 at 9:30 AM identified Resident #16 was a high risk for elopement because of his/her independent ambulation and frequently wandering throughout the facility hallway. She identified that she received a call from her nursing staff because Resident #16 went out to the courtyard on 11/17/24. She also identified that she reviewed the facility camera the next day to review how Resident #16 accessed the courtyard without staff's knowledge. She identified that Resident #16 was seen walking in St [NAME] hallway and there was no staff at St [NAME] because they were taking care of other resident. Furthe, the recreation room leading to the St [NAME] dining room was closed but it was not locked. Resident #16 was able to open and exit the recreation door. She identified that all facility doors that lead to the outside are equipped with an alarm, and it will show an alert at the alarm panel near the nurses' station when a door is opened. She also identified that after this incident, the recreation door is now locked after dinner time. She identified that the courtyard patio was for resident use; however, any resident in the courtyard patio would need staff supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2 on 2/3/25 at 3:20 PM identified that she was not the assigned nursing aide for Resident #16. She identified that she did not observe Resident #16 elope to the courtyard patio. She noted that she heard the door alarm at the alarm panel at the nurses' station, but she did not stop to investigate which door alarm was activated and noted that when the facility investigated the facility camera, she was seen walking by the alarm panel approximately three times without stopping to investigate which door alarm was activated. NA #2 further identified that she was given a verbal warning and education was provided regarding responding to the alarm. Interview with LPN #2 on 2/4/25 at 12:30 PM identified she saw Resident #16 knocking on the window in the courtyard patio at St [NAME] lounge door when she came out from a resident room, and she had not heard the alarm. She further identified that the St [NAME] rear door and St [NAME] lounge door were both active at the alarm panel when she brought Resident #16 back inside the facility. The Elopement and Wandering Resident's policy identified that the facility would ensure that residents who exhibit wandering behavior and/or at risk of elopement will receive adequate supervision to prevent accidents. The policy also indicated that the alarms are not a replacement for necessary supervision and staffs will be vigilant in responding to the alarms in a timely manner.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47489 Based on observations, review of facility policy/procedures and interviews, the facility failed to ensure medications designated for destruction and/or return to pharmacy were secured. The findings include: Observation on 1/30/25 at 10:28 AM identified the DNS office door opened and unoccupied with a yellow basket located on top of the medication safe that contained several blister packs containing medications. The office is located on a nursing unit and opens to the resident corridor. There was one resident seated in a chair located next to the nurses' station approximately 20 feet from the opened door/office. Observation on 1/31/25 at 1:18 PM identified the DNS office door open with medications in sight. The office was unoccupied, and four residents were seated in wheelchairs outside of the unoccupied office. There was no facility staff present in the area. Observation on 2/3/25 at 12:07 PM noted the office door opened with medications in sight and unsecured. Interview on 2/3/25 at 12:39 PM with RN#2 identified discontinued and expired medications are stored in a cabinet in the medication storage room. RN#2 indicated that the medications are kept there until taken by the DNS for destruction or return to pharmacy. Interview on 2/3/25 at 1:00 PM with the DNS identified that on a biweekly basis, medications that belonged to discharged or expired residents are removed from circulation and kept in a locked box in the DNS office. Some medications that need to be returned to pharmacy or destroyed are kept in the medication room. The DNS further identified that the medications in the DNS office are supposed to be destroyed; however, they had not yet been destroyed. Observation of the open office on 2/3/25 from 2:00 PM to 2:20 PM identified several ambulatory residents, and visitors in the corridor near the opened office. Interview on 2/3/25 at 2:22 PM with the DNS identified she did not secure the office door because she did not feel residents and visitors would enter the office. Medications present and unsecured in the yellow basket included: 1. Eliquis 2.5 mg tablet 5 tablets 2. Eliquis 2.5 mg tablet (6 pills) 3. Eliquis 2.5 mg tablet (22 pills left) 4. Amox-Clav 500-125mg (7 pills) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monsignor Bojnowski Manor	50 Pulaski Street New Britain, CT 06053

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Cephalexin 500 mg capsule (14 pills) 6. Cephalexin 500mg capsule (30 pills) 7. Ciprofloxacin HCL (1 pill) 8. Cephalexin 500mg capsule (2 pills) 9. Ciprofloxacin HCL 250 mg (2pills) 10. Ciprofloxacin HCL 250 mg (1 pill) 11. Eliquis 2.5 mg tablet (22 pills) 12. Smz/TMP DS DS 800-160 mg (3 pills) 13. Cephalexin 500 mg (2 pills) 14. Prednisone 5mg (30 pills) 15. Minocycline HCL 100mg (4 pills) 16. Prednisone 5mg (22 pills) 17. Levofloxacin 500 mg tablet (1 pill) 18. Ciprofloxacin HCL f/c 250 mg (1 pill) 19. Midodrine HCL 10 mg (11 pills) 20. Eliquis 5 mg (22 pills) 21. Levofloxacin f/c 750 mg (2 pills) 22. Smz/TMP DS 800-160 mg tab (2 pills) 23. Cephalexin 500 mg (4 pills) 24. Cefuroxime f/c 500 mg (5 pills) 25. Levofloxacin 500 mg (2 Pills) 26. Levofloxacin 500 mg (1 pill) 27. Baclofen 5mg tab (30 pills) 28. Cefuroxime 500mg (3 pills) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for medication storage identified that all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security and indicated that the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective or deteriorated medications.

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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 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47402 Based on observations, facility policy and interviews, the facility failed to label/cover food in the refrigerator, freezer, and dry storage as well as wear proper hair/beard coverings while preparing food in the kitchen. Observation on 1/29/25 at 10:30 AM with [NAME] Supervisor #1 during the initial brief tour identified bologna wrapped in plastic wrap in the reach in fridge with no label of date opened or discard date. Interview on 1/29/25 at 10:30 AM with [NAME] Supervisor #1 identified the bologna should have been labeled when it was opened and he was unsure when it was opened and will discard. Observation on 1/29/25 at 10:42 AM with [NAME] Supervisor #2 identified a tray of pasta with meat sauce in a metal tray covered with foil with the lower right corner of the tray opened exposing the food to open air in the walk-in freezer. Interview on 1/29/25 at 10:42 AM with [NAME] Supervisor #2 identified the food should not have been opened to air in the freezer and it should have been properly covered. Observation on 1/29/25 at 10:45 AM with [NAME] Supervisor #2 identified 2 bags of fish squares opened and tied at the top of the bag in the walk-in freezer with no open label date and no date of expiration. Interview on 1/29/25 at 10:45 AM with [NAME] Supervisor #2 identified that food should be labeled with an open date and a date of expiration while stored in the freezer. Observation on 1/29/25 at 10:50 AM with [NAME] Supervisor #2 identified two bags opened and tied at the top of yellow cake mix with no open date and no expiration date. Interview on 1/29/25 at 10:50 AM with [NAME] Supervisor #2 identified the cake mix should have been labeled with an open date and a expiration date. Observation on 1/29/25 at 10:52 AM with [NAME] Supervisor #1 identified Dietary Aide #1 preparing pears into individual servings from a can. Dietary Aide #1 was not wearing a beard guard and had a full beard that was approximately 1 inch in length. Interview on 1/29/25 at 10:52 with Dietary Aide #1 identified he does not typically wear a beard covering and did not believe it was required. Observation on 1/31/25 at 11:20 AM identified [NAME] Supervisor #2 was not wearing a head covering and was placing food into the steam table. After seeing the surveyor, [NAME] Supervisor #2 walked over to the far side of the kitchen to place his hat on. (continued on next page)

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F 0812 Level of Harm - Potential for minimal harm Residents Affected - Many	Interview on 1/31/25 at 11:22 AM with [NAME] Supervisor #2 identified he should have been wearing a hair guard. Interview on 1/31/25 at 11:30 AM with the Dietary Manager identified food should be labeled with date prepared or when opened in the refrigerator/freezer and food should also be labeled with an expiration date on it. The facility policy directs the staff to wear hair guards and beard guards while preparing food in the kitchen. Review of facility Food Storage Policy directed the facility to utilize a date marking system. Dry storage items will be required to have a date (including month/date/year) in which product was delivered or a manufacturer printed Best By/use by date. A product still within its delivered box with a visible food distributor shipping label with date is acceptable. Review of the facility policy Hair Restraint directed anyone within the kitchen, who will have close contact with the preparation or service of food, food storage areas, equipment will keep hair effectively/appropriately restrained to include a facial hair.

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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. 47489 Based on observations, review of facility policy/procedures and interviews, the facility failed to ensure the hand hygiene procedures were followed by staff involved in direct resident contact. The findings include: Continuous observations of medication administration on 1/30/25 at 9:21 AM identified LPN#5 took Resident #34's blood pressure and then exited the room without performing hand hygiene. LPN #5 then preceded to the medication cart, prepared Resident #34's medications, and re-entered the resident's room and administered the medications. LPN#5 spoon fed the resident a few medications at a time and assisted the resident with drinking the water. LPN#5 then returned to the med cart and prepared an additional medication that Resident #34 had requested. It was noted that Resident #34 had a new complaint of rash to bilateral arms. At 9:45 AM, LPN#5 exited Resident #34's room, retrieved the blood pressure machine (which had been wiped down by the NA) and entered Resident 50's room and obtained a blood pressure. LPN#5 exited the room without performing hand hygiene, and did not sanitize the blood pressure machine. LPN#5 prepared Resident #50's medications. A NA took Resident #50 to the bathroom to wash up. LPN#5 was then asked by another NA to obtain supplies for another resident. LPN#5 labelled and taped up Resident #50's medications and placed them in the top drawer of the medication cart and went down the hallway. At 9:58 AM, LPN #5 walked away from the medication cart and entered Resident #46's room, donned gloves, provided care to Resident #46 then exited the room and discarded the gloves. LPN #5 did not perform hand hygiene after discarding the gloves. He then obtained foley bags from a hall closet and brought them into Resident #46's room. LPN#5 exited Resident #46's room and returned to the medication cart. At 10:11 AM LPN#5 poured juice for Resident #50 and entered Resident #50's room to administer medications. While in Resident #50's room LPN#5 handed the medication cup to Resident #50, grabbed a paper towel from the bathroom and picked something up off of the floor. He discarded whatever he picked up into the trash, poured more juice for the resident continued observing the resident take medication and then performed hand hygiene as he exited the room. Interview on 1/30/25 at 10:20 AM with LPN #5 identified he is from the agency but has worked at the facility regularly for the past two months. LPN#5 identified he was unfamiliar with the facility's hand hygiene policy and indicated that when performing medication administration, he should perform hand hygiene every couple of rooms by using the hand sanitizer or washing his hands. Interview on 1/30/25 at 10:24 AM with RN#2 identified that hand hygiene should be completed by sanitizing after every care, or in between each patient and before and after glove use. Additionally, staff should wash hands with soap and water if visibly soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for hand hygiene identified hand hygiene as a general term for cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub, and indicated alcohol-based hand rub with 60 - 95% alcohol is the preferred method for cleaning hands in most clinical situations. Additionally, the policy identified to wash hands with soap and water whenever they are visibly dirty, before eating and after using the restroom. Additionally, the policy identified the use of gloves does not replace hand hygiene and indicated to perform hand hygiene prior to donning gloves, and immediately after removing gloves. The policy identified hand hygiene is indicated and will be performed under the conditions listed in the attached hand hygiene table which indicated alcohol-based hand rub should be used: between resident contacts, before applying and after removing personal protective equipment, including gloves, before preparing or handling medications, and before providing resident care procedures

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for five of five sampled residents (Resident #12, Resident #31, Resident #43, Resident #46, and Resident #49) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was assessed/and administered and failed to offer the influenza vaccine to residents (Resident #12 and Resident #31). The findings include: Resident #12's diagnoses included hypertension, osteoarthritis, and hypercholesterolemia. Review of the Resident Vaccine Consent form which consists of the pneumococcal vaccine consent identified Resident #12 gave the facility permission to administer the pneumococcal vaccine on 4/21/24 and on 7/7/24. Review of Resident #12's vaccination report failed a history of receiving the pneumococcal vaccine(s) or that he/she had been administered the vaccine while at the facility. Interview with the DNS (who is an Infection Preventionist (IP) and is covering for the IP) on 2/3/25 at 2:15 PM identified Resident #12 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. Resident #31's diagnoses included dementia, depressive disorder, and gastrointestinal hemorrhage. Review of the Resident Vaccine Consent form which consists of the Pneumococcal vaccine consent dated 4/21/24 identified Resident #31 indicated that he/she had received the PCV 13 vaccine in the past in the month of October of 2023. Review of Resident #31's clinical records failed to identify that he/she had received any of the pneumococcal vaccines while at the facility or documentation of having received them prior to being admitted to the facility. It also did not contain documentation that the resident had refused the vaccine. Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 2/3/25 at 2:15 PM identified Resident #31 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. Resident #43's diagnoses included type 2 diabetes mellitus, peripheral vascular disease, and spinal stenosis. Review of the Resident Vaccine Consent form which consist for Pneumococcal vaccine consent identified Resident #43 gave the facility permission to administer the pneumococcal vaccine on 7/25/24. Review of Resident #43 vaccination report failed to identify any history obtained or inoculation of pneumococcal vaccine for the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's clinical records failed to identify that he/she had received any of the pneumococcal vaccines at the facility. Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 2/3/25 at 2:15 PM identified Resident #43 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. Resident #46's diagnoses included sepsis, sleep apnea, chronic obstructive pyelonephritis and gout. Review of the Resident Vaccine Consent form which consist for Pneumococcal vaccine consent identified Resident #46 gave the facility permission to administer the pneumococcal vaccine on 10/30/24. Review of Resident #46 vaccination report failed to identify any history obtained or inoculation of pneumococcal vaccine for the resident. Review of Resident #46 clinical records failed to identify that he/she had received any of the pneumococcal vaccine at the facility. Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 2/3/25 at 2:15 PM identified Resident #46 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. Resident # 49's diagnoses included dementia, hypercholesterolemia and psychotic disorder. The quarterly MDS assessment dated [DATE] identified Resident #49 had severely impaired cognition, and resident pneumococcal vaccine was up to date. Review of the Resident Vaccine Consent form which consist for Pneumococcal vaccine consent identified Resident #46 gave the facility permission to administer the pneumococcal vaccine on 9/27/24. Review of Resident #49's vaccination report failed to identify any history obtained or inoculation of pneumococcal vaccine for the resident. Review of Resident #49's clinical records failed to identify that he/she had received any of the pneumococcal vaccines at the facility. Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 2/3/25 at 2:15 PM identified Resident #49 should have been offered and given the PCV 20 vaccine based on the resident's pneumococcal history. According to the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine timing for adults identified that adults 65years or older have an option to receive the pneumococcal vaccine 20 (PVC 20) if they had already received both Prevnar 13 (PCV 13) at any age and/ pneumococcal vaccine (PPSV23) at or after age [AGE] years old and are eligible to receive after 5 years the PCV20 or another dose of the PPSV23 after shared decision with the provider and the patient. CDC also identify that an adult over the age of [AGE] years and had no prior vaccination of the pneumococcal vaccine are eligible for receiving the PCV20 vaccine or the PCV15 then after one year the PPSV23 vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 2/3/25 at 2:15 PM identified it is the responsibility of the infection control nurse on admission to review and assess vaccination status and obtain consents from residents. The DNS further identified the IP nurse is also responsible for obtaining the physician's order for the appropriate vaccine and input the order for the nurses on the unit or the IP nurse to administer the vaccine. The DNS identified she expects residents to receive the pneumococcal vaccine within 30 days of giving consents and for historically vaccine information to be documented in the preventative care section of the electronic medical record system. Review of the Pneumococcal Vaccination policy identified each resident would be assessed for pneumococcal immunization upon admission, self-reporting of immunization will be accepted. Any additional efforts to obtain information will be documented, including efforts to determine fate of immunization or type of vaccine received. Resident #12's diagnoses included hypertension, osteoarthritis, and hypercholesterolemia. Review of the Resident Vaccine Consent form which consist of the Influenza vaccine consent identified Resident #12 had signed the consent on 7/7/24 without selecting an option to receive, refuse, or provided vaccination history of receiving the vaccine. Review of Resident #12 vaccination report identified on 11/15/24 that the influenza consent was not obtained and was not on record for the resident to receive the annual flu vaccine. Review of Resident #12 clinical records failed to identify that he/she had received the influenza vaccination at the facility or had refused in the fall when the facility hosted the influenza vaccination clinic for the residents. Interview with Resident #12 on 2/14/25 at 2:08 PM identified he/she could not recall the facility offering or administering the influenza vaccine to him/her in the fall of 2024. Resident #12 identified if it was offered, he/she would have accepted as the providers encourage him/her to receive the influenza vaccine. Resident #31's diagnoses included dementia, depressive disorder, and gastrointestinal hemorrhage. Review of the Resident Vaccine Consent form which consist of the Influenza vaccine consent identified Resident #31 had signed the consent on 4/20/24 indicating that he/she had already received the influenza vaccine in October of 2023. Review of Resident #31 vaccination report identified on 11/15/24 that the influenza consent was not obtained and was not on record for the resident to receive the annual flu vaccine. Review of Resident #31 clinical records failed to identify that he/she had received the influenza vaccination at the facility or had refused in the fall when the facility hosted the influenza vaccination clinic for the residents. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Person #3 identified he/she could not recall the facility offering or signing any consent for Resident #31 to receive the influenza vaccine. Person #3 identified the only vaccine offered he/she recalled was the COVID -19 which consent was signed, and Resident #31 received the COVID-19 vaccine. Interview with the DNS (who is also an Infection Preventionist (IP) covering for the IP in her absence) on 1/31/25 at 1:30 PM identified Resident #12 and Resident #31 should have been offered and given the influenza vaccine as the resident was in the facility during the time the vaccine was being administered to all residents. The DNS indicated the IP nurse was out on leave at the moment who would be better able to answer why the resident did not receive the vaccine as she was only aware of this when she host the COVID-19 clinic on 1/21/25 that some residents who were in the building did not receive the vaccine. Review of the Influenza Vaccination Program policy identified to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza.