STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075377	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at West River	245 Orange Avenue Milford, CT 06460

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #60) reviewed for accidents, the facility failed to provide feeding assistance according to the physician's order to ensure a dignified dining experience. The findings include: Resident #60 was admitted to the facility on [DATE] with diagnoses that included dementia, cognitive communication deficit, and diabetes. A physician's order dated 1/18/24 directed Resident #60 to receive hospice services. The quarterly MDS dated [DATE] identified Resident #60 had severely impaired cognition, was always incontinent of bowel and bladder and required set up for meals and substantial assistance from staff with dressing, bathing and toileting. The care plan dated 10/29/24 identified Resident #60 had the potential for alteration in nutritional status related to dementia. Interventions included advanced meal set up, assistance with feeding, and offering individual parts of a meal at once (i.e. yogurt, then sandwich, etc.). A physician's order dated 11/1/24 directed a regular diet. A physician's order dated 12/18/24 directed Resident #60 have 1:1 feeding with all meals. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/27/25 at 8:50 AM identified NA #3 assisted Resident #60 to a seat at a table in the dining room. NA #3 retrieved a meal tray from the food truck, placed the tray directly in front of Resident #60, which included yogurt. NA #3 opened the yogurt, placed a spoon in it, and offered it to Resident #60, and all other food items on the tray, including a main entree, remained covered. NA #3 walked away from Resident #60 and assisted with delivering a meal to another resident at a different table, approximately 6 - 7 feet away from Resident #60, with her back turned 180 degrees from Resident #60. During this time, Resident #60 was observed making multiple attempts to self-feed, first by attempting to partially insert his/her lower face and mouth into the yogurt and attempting to lick the yogurt from the container. At 8:52 AM, Resident #60 inserted his/her right index and middle fingers into the yogurt and attempted to scoop the yogurt into his/her mouth. At 8:53 AM, Resident #60 was observed attempting to use the spoon, which had remained in the yogurt container during these attempts and began to self-feed with the spoon. NA #3 turned to look at Resident #60 and left the dining room. From 8:53 AM - 8:55 AM, Resident #60 remained unsupervised in the dining room with the meal tray position directly in front of him/her self-feeding the yogurt. At 8:55 AM, LPN #3 entered the dining room, removed Resident #60's yogurt from his/her hand, placed the yogurt on the meal tray, and removed the meal tray from the dining room and brought it to the unit pantry. During this time, NA #3 was observed entering the dining room and assisting another resident at the same table as Resident #60 and setting up the resident's meal tray, while Resident #60 remained seated at the table. Resident #60 was observed without a meal tray, with 2 other residents seated and eating in the dining room, from 8:55 AM - 8:58 AM. Interview with LPN #3 immediately following this observation identified she removed Resident #60's meal tray because the resident required 1:1 feeding assistance. LPN #3 identified that she was unsure why NA #3 would have left the tray with Resident #60. Observation on 1/27/25 at 8:59 AM identified a male staff member bringing Resident #60's meal tray back to his/her table, setting the tray up including removal of the entree lid, drink lids, and then sat directly next to Resident #60 and provided feeding prompts and assistance by offering food items. The male staff member remained with Resident #60 for the duration of his/her meal. Interview with NA #3 on 1/27/25 at 9:55 AM identified she was aware that Resident #60 had an order for 1:1 feeding with meals, however this was not a strict rule if Resident #60 was given one item at a time. NA #3 identified she believed that Resident #60 was okay to eat some items independently, while other items required 1:1 feeding, and yogurt was an item Resident #60 was fine to eat independently but other items on his/her tray required feeding assistance. Interview with the Dietitian on 1/27/25 at 10:00 AM identified Resident #60 had an order for 1:1 feeding with all meals due to his/her continued cognitive decline and need for supervision and prompts with meals. The Dietitian identified Resident #60 was on hospice services due to advanced dementia, and due to the advanced stage of cognitive decline, Resident #60 would often forget how to eat, including how self-feed and use utensils. The Dietitian identified due to the decline, Resident #60 required 1:1 assistance to have a staff member remind him/her how to use a fork, for example, and that staff should also be setting Resident #60's meal tray, including removing the lids and covers from food and drink items. The Dietitian identified that Resident #60 did not have any selective 1:1 food item list, and while Resident #60 can self-feed, he/she required a staff member to sit with him/her for the entire meal and to provide multiple prompts and reminders through the duration of the meal. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS and ADNS on 1/27/25 at 10:05 AM identified Resident #60 required 1:1 feeding assistance due to cognitive deficits with self-feeding and not due to risk of aspiration. The DNS identified that Resident #60 can self-feed with each meal, but a staff member must sit with him/her for the duration of the meal. The ADNS identified that someone should have been sitting with Resident #60 during his/her meal, and that she and the DNS would speak with the staff on Resident #60's unit to determine the issue. The facility policy on resident rights directed that residents of the facility had the right to a dignified existence and to be treated with respect, kindness, and dignity. The facility policy on assistance with meals directed that residents should receive assistance with meals in a manner that meets the individual needs of the residents. The policy further directed that facility staff would serve resident trays and help residents who required assistance with eating and residents who required feeding assistance would be treated with attention to safety, comfort and dignity. The facility policy on dignity, respect and neglect of care directed that facility staff could provide dignified care of residents by always checking on residents to assist with their needs during the shift and providing care in a dignified manner.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #48) reviewed for advance directives, the facility failed to ensure the physician's orders were consistent with the resident's wishes for code status. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, diabetes, and muscle weakness. The Resident/Patient Health Care Instructions for signed and dated by Resident #48's representative at admission on 5/2/24 identified Resident #48's advance directive choice was do not resuscitate (DNR). Physician's order dated 5/2/24 directed Resident #48 was a full code. Review of the clinical record identified Resident #48 was hospitalized from 11/18/24 - 11/21/24 for pneumonia. The Resident/Patient Health Care instructions form identified Resident #48 requested do not resuscitate (DNR). The form was signed and dated by Resident #48's representative on 11/21/24. The form further indicated it was not a physician's order and should be reviewed and a physician's order written. A physician's order dated 11/21/24 directed Resident #48 was a full code. Review of Resident #48's face sheet identified Resident #48's advance directive choice as DNR/DNI. The 5-day MDS dated [DATE] identified Resident #48 had severely impaired cognition. Review of the clinical record failed to identify a care plan related to Resident #48's advance directive choice. A resident care conference note dated 12/10/24 identified Resident #48's code status as DNR. Review of Resident #48's face sheet dated 1/27/25 identified Resident #48's advance directive choice as DNR/DNI. Interview with LPN #5 (Regional Nurse) on 1/27/25 at 10:39 AM identified that the admitting nurse is responsible to reconcile the resident's signed advance directive choices outlined on the health care instruction form and reconcile the choices against the physician's orders in the clinical record. LPN #5 identified she was unsure why the physician's order did not match Resident #48's choice of DNR but that it should have. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 1/27/25 at 10:55 AM identified that she was the admitting nurse for Resident #48 on 11/21/24. LPN #1 identified she was unsure why the physician's order directed full code when the resident's choice was DNR. LPN #1 identified that Resident #48's order did not match Resident #48's advance choices indicated on the health care instructions form. Although requested, the facility failed to provide a policy related to a clear and accurate clinical record. The policy on Advance Directives directed that information about whether or not a resident had executed an advance directive would be displayed prominently in the clinical record, and the plan of care for the resident would be consistent with the resident's documented treatment preferences and/or advance directives.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #56 and 84) reviewed for a specialty medical treatment and/or nutrition, for Resident #56 the facility failed to notify the physician and/or and the specialized treatment center when the resident was over the fluid restriction and for Resident #84 the facility failed to ensure the physician and resident representative were notified when the resident had a weight loss. The findings include: 1. Resident #56 was admitted to the facility in May 2024 with diagnoses that included end stage renal disease requiring peritoneal dialysis and a stroke affecting the right dominant side. A monthly physician's order dated 11/8/24 directed a fluid restriction of 1000 ml per day. The quarterly MDS dated [DATE] identified Resident #56 had intact cognition and required moderate assistance with toileting and personal hygiene. The care plan dated 11/29/24 identified Resident #56 receives peritoneal dialysis for end stage renal disease. Interventions included to monitor fluid intake, 1000 ml within 24 hours. Review of the Fluid Intake Report dated 12/1/24 to 12/31/24 identified Resident #56 had gone over the fluid restriction 28 out of 31 days. Review of the Fluid Intake Report dated 1/1/25 to 1/28/25 identified Resident #56 had gone over the fluid restriction 26 out of 28 days. Review of the nursing and physician progress notes dated 12/1/24 to 1/28/25 failed to reflect that the physician had been notified that Resident #56 had gone over fluid restriction 54 days out of 59 days. Interview with LPN #4 on 1/29/25 at 9:40 AM indicated Resident #56 was on a 1000 ml fluid restriction per physician order. LPN #4 indicated that the charge nurse is responsible to document the fluid intake into the EMR every shift. LPN #4 indicated that the 11:00 PM to 7:00 AM supervisor was responsible for adding up the 24-hour totals of fluid intake to see if a resident goes over their fluid restriction and notify the physician and dialysis center. Interview with RN #4 (7:00 AM to 3:00 PM day supervisor) on 1/29/25 at 10:17 AM indicated that the 11:00 PM to 7:00 AM RN supervisor was responsible to add the 24-hour intakes for residents on a fluid restriction. RN #4 indicated that if Resident #56 went over the fluid restriction, the supervisor is responsible to notify the dialysis center and the physician and document it in the medical record. (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 DNS on 1/29/25 at 10:22 AM indicated that if a resident on a fluid restriction goes over the fluid restriction more than 5 - 10 ml's the APRN or physician must be notified and the nurse must write a progress note indicating such. The DNS indicated that the 11:00 PM to 7:00 AM RN supervisor was responsible to add up each day's fluid totals for residents on fluid restrictions. The DNS indicated that if the resident went over the fluid restriction the night supervisor would inform the day supervisor to call or inform the APRN that day. After review of the progress notes the DNS indicated the notes failed to reflect the dialysis center or the APRN had been notified that Resident #56 had gone over the fluid restriction. Interview with MD #1 on 1/29/25 at 10:53 AM indicated that if a peritoneal dialysis resident is on a 1000 ml fluid restriction every day nursing was responsible to calculate the 24-hour totals. MD #1 indicated that if Resident #56 went over the fluid restriction he should be notified that day and documented in the clinical record. Review of the Change in a Resident's Condition or Status identified the facility will promptly notify the resident, physician, and the resident's representative of changes in the residents medical/mental condition and/or status. The nurse will notify the residents physician if there has been a significant change in the resident's physical, emotional, or mental condition or need to alter the resident's medical treatment. Notifications will be made within 24 hours of a change occurring in the resident's medical condition or status, except in medical emergencies. The nurse will record in the medical record information related to changes. Although requested, a facility policy for dialysis residents on fluid restrictions was not provided. 2. Resident #84 was admitted to the facility in July 2024 with diagnoses that included stroke, dysphasia, and dementia. Review of the weight record dated 7/24/24 identified Resident #84 weighed 156 lbs. A physician's order dated 8/13/24 directed to weigh the resident daily and if weight loss is greater than 2 lbs. in a day or 5 lbs. in 7 days notify the physician/APRN. A physician's order dated 8/14/24 directed to provide a dysphasia puree diet but allow ground meats and soft sandwiches and thin liquids. Additionally, provide house supplement 237 ml twice a day. The quarterly MDS dated [DATE] identified Resident #84 had severely impaired cognition, was independent to eat, did not have a weight loss of 5% in the last month or loss of 10% in the last 6 months. The care plan dated 9/24/24 identified Resident #84 has the potential for alteration in nutritional status related to dementia. Interventions included evaluating the nutritional status on admission, per the MDS schedule and as needed and report any concerns or changes to the physician and resident representative. Review of the weight record dated 10/4/24 identified the resident weighed 150 lbs., (a 6 lbs. weight loss in 3 months). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weight record dated 11/10/24 identified Resident #84 weighed 138 lbs., (a 12 lbs. weight loss in 1 month, 18 lbs. in 4 months). Review of the nurse's progress notes, APRN, and physician notes dated 11/10/24 - 12/11/24 failed to reflect that the APRN, physician, or resident representative were notified of the resident's weight loss. Further, review of the clinical record dated 11/10/24 to 12/11/24 failed to reflect that Resident #84 was seen by the dietitian subsequent to the weight loss. Review of the weight record dated 12/2/24 identified Resident #84 weighed 133 lbs., (a 5 lbs. weight loss in 1 month). Review of the nurse's progress notes, APRN, and physician notes dated 12/2/24 - 12/12/24 failed to reflect that the APRN, physician, or resident representative were notified of the continued weight loss. Review of the clinical record dated 12/2/24 to 12/11/24 failed to reflect that Resident #84 was seen by the dietitian for a weight loss. The dietitian progress note dated 12/12/24 at 11:19 AM identified a significant weight loss trend. Recommendations included orders for house supplement 237 ml twice daily, and liquid protein 30 ml daily remain appropriate to maximize protein and caloric intake. The APRN progress note dated 12/13/24 at 9:44 PM identified Resident #84 was seen for a significant weight loss of 11 lbs. over the past month. Resident #84 is tolerating diet order without difficulty. Resident #84 has variable oral intakes of 50-100% of meals. Assessment and plan resident has poor oral intake decreased, poor appetite, will have speech therapy evaluate resident for a diet upgrade, dietitian evaluated resident, food preferences upgraded, monitor intakes and weights. Interview with the Dietitian on 1/27/25 at 10:30 AM indicated that she had seen Resident #84 in August 2024, and not again until the quarterly MDS assessment on 12/12/24. The Dietitian indicated that it was nursing's responsibility to notify her when a resident had a weight loss right away so she could evaluate the resident. The Dietitian indicated she was not aware of the significant unplanned weight losses on 11/10/24 and 12/2/24 until she reviewed the clinical record on 12/12/24. Interview with MD #1 on 1/27/25 at 10:48 AM indicated when Resident #84 had a significant weight loss the APRN or physician, and the resident representative, and dietitian should have been notified. Further, the notification should be documented in the clinical record. Interview with the DNS on 1/27/25 at 11:07 AM indicated that when a resident has a weight loss the nurse is responsible to notify the dietitian, physician, and residents' representative. After clinical record review, the DNS indicated that Resident #84's weight loss the physician, dietitian, and resident representative should have been notified. The DNS indicated that she did not see a progress note of anyone being updated. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Change in a Resident's Condition or Status identified the facility will promptly notify the resident, physician, and the resident's representative of changes in the residents medical/mental condition and/or status. The nurse will notify the residents physician if there has been a significant change in the resident's physical, emotional, or mental condition or need to alter the resident's medical treatment. A significant change of condition is a major decline or improvement in the resident's status requires interdisciplinary review and/or revision to the care plan. Notifications will be made within 24 hours of a change occurring in the resident's medical condition or status, except in medical emergencies. The nurse will record in the medical record information related to changes. Review of the Weight Monitoring Policy identified nursing was responsible for notifying the dietitian of any significant weight changes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #70) reviewed for pre-admission screening and resident review (PASARR), the facility failed to ensure the State-designated authority was notified when the resident was diagnoses with a new mental health diagnosis (10/20/21) and again when the physician discontinued the mental health diagnosis on 10/13/23. The findings include: Review of a PASARR Level 1 screen dated 8/5/21 identified no level 2 required. Resident #70 has anxiety and depression and was receiving Klonopin (anxiety medication), Lexapro (antidepressant medication), and Wellbutrin (antidepressant). If changes occur or new information refutes these findings, a new screen must be submitted. Resident #70 was admitted to the facility on [DATE] with diagnoses that included anxiety, depression, and dysthymic disorder (mild but long-term depression). The admission MDS dated [DATE] identified Resident #70 had intact cognition, no delusional or hallucinating thoughts and no physical or verbal behaviors. A physician's order dated 8/26/21 directed to administer Abilify 5 mg (anti psychotropic medication) once daily at bedtime. A PASARR Level 1 screen dated 9/22/21, conducted because the resident came off insurance on 9/4/21 identified Resident #70 has diagnosis of depressive disorder, unspecific mood disorder, anxiety, and dysthymic disorder. Approved for long-term care based on information provided. If medical conditions improve to the point that the resident can safely return to the community, the facility should assist with discharge planning with appropriate support services. The effective date is 9/4/21. The psychiatric evaluation and consultation, written by MD #3, dated 10/20/21 at 1:23 PM identified given history of symptoms it would be appropriate to add the diagnosis of schizoaffective disorder to the diagnosis list. Tapering of psychotropic medication will lead to worsening of symptoms. The Psychiatric Evaluation and Consultation, written by MD #3, dated 10/13/23 (2 years later) identified based upon symptoms, etiology of current disease, and response to recent medication trials, it would be prudent to discontinue the diagnosis of schizoaffective disorder. Will recommend a gradual dose reduction trial of antipsychotics as tolerated and if indicated. Interview with the SW #1 (Director of Social Services) on 1/27/25 at 7:20 AM indicated she was responsible to oversee all PASARRs starting with admission. Further, she was also responsible to track Level 2 PASARRs, update as needed and ensure all Level 2 recommendations are followed and care planned. SW #1 indicated that when the psychiatric provide adds or discontinues a diagnosis it is their responsibility to notify her so she can update State-designated authority. SW #1 indicated that if she was notified of the new diagnosis or discontinuation of the diagnosis of schizoaffective disorder for Resident #70, she would have notified State-designated authority. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Coordination with PASARR Program Policy identified the facility coordinates assessments with the pre-admission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental health disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. PASARR Level 1 is the initial pre-screening that is completed prior to admission. Negative Level 1 Screen permits admission to proceed and ends the PASARR process. Positive Level 1 Screen necessitates a PASARR Level 2 evaluation prior to admission. PASARR Level 2, a comprehensive evaluation by the appropriate state-designated authority, (cannot be completed by the facility) that determines the appropriate setting for the individual and recommends any specialized services and/or rehabilitation services the individual needs. The facility will only admit individuals with a mental disorder or intellectual disability who the State-designated authority has determined as appropriate for admission. Recommendations, such as any specialized services, from a PASARR Level 2 determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transition of care. Any Level 2 resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. Any resident who exhibits a newly evident or possible serios mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual authority for a level 2 resident review.

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Resident #24, 81 and 312) reviewed for nutrition and/or choices, for Resident #24 the facility failed to ensure the air mattress was set per the physician's order, for Resident #81 the facility failed to ensure the resident had close supervision during meals and for Resident #312 the facility failed to ensure that weights were obtained per the physician's order The findings include: 1. Resident #24 was readmitted to the facility in September 2024 with diagnoses that included stroke and a stage 4 pressure ulcer. The annual MDS dated [DATE] identified Resident #24 had severely impaired cognition and was dependent requiring total assistance for dressing, toileting, and personal hygiene. Resident #24 was always incontinent of bladder and frequently incontinent of bowel and at risk for developing a pressure ulcer. A physician's order dated 12/3/24 directed to utilize a specialty mattress with the setting at 210 lbs. Check function and settings every shift from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM The care plan dated 12/12/24 identified Resident #24 was at risk for a pressure ulcer due to impaired mobility and incontinence. Interventions included having a pressure-reducing mattress, a cushion to bed and wheelchair as ordered. Review of the weight report dated 12/5/24 identified Resident #24's weighed 210 lbs. Review of the weight report dated 1/8/25 identified Resident #24's weighed 208 lbs. Observation on 1/26/25 at 8:43 AM and 2:00 PM identified Resident #24 was lying in bed on an air mattress in a semi upright position. The air mattress was set to 270 lbs. Observation on 1/27/25 at 8:00 AM and 8:30 AM identified Resident #24 was lying in bed on air mattress in a semi upright position. The air mattress was set to 270 lbs. Interview with LPN #2 on 1/27/25 at 8:45 AM indicated that according to the physician's order, the air mattress was to be set at 210 lbs., and the nurse on each shift must check the setting and then sign off that it had been checked in the EMR that the setting was accurate. LPN #2 indicated that the air mattress is to be set according to the resident's weights to be therapeutic to prevent skin breakdown. LPN #2 indicated that Resident #24 would not be able to state if the air mattress was too soft or too hard. Observation with LPN #2 on 1/27/25 at 8:47 AM indicated that Resident #24 was lying in bed on the air mattress that was set at 270 lbs. LPN #2 indicated that the setting of 270 lbs., was not correct, and she would re-set it to the 210 lbs. as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/28/25 12:34 PM indicated that the air mattress is set based on the resident's weight and the physician's order. The DNS indicated that the nurses are to check the setting every shift and make sure it is set according to the physician order. The DNS indicated there is a sticker with the resident's weight and what the setting should be located on the face of the machine. The DNS indicated that the charge nurse was responsible to check the air mattress every shift to make sure the setting was the same as the physician's order and resident's weight and then sign off in the EMR. Review of the manufacturer manual for air mattress identified the pump and mattress system is indicated for the prevention and treatment of all pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. Turn the machine on and determine the resident's weight and set the control knob to that weight setting on the control unit. Although requested, a facility policy for use of air mattress was not provided. 2. Resident #81 was admitted to the facility in December 2021 with diagnoses that included dementia and a stroke affecting the right dominant side. The annual MDS dated [DATE] identified Resident #81 had severely impaired cognition and was totally dependent on staff for toileting, dressing, and personal hygiene. Additionally, Resident #81 needed partial assistance with eating. A physician's order dated 12/5/24 directed a dysphagia puree diet with ground meats and soft sandwiches with close supervision during meals. The care plan dated 12/12/24 identified Resident #81 was at risk for weight loss. Interventions included to use a sippy cup with meals, diet mechanical soft with thin liquids. Aspiration precautions and monitor eating closely. Encourage to use feeding skills as much as he/she could and assist times 1 as needed. Observation on 1/26/25 at 9:00 AM identified Resident #81, who was in a semiprivate room, by the window with the curtain pulled from the head to the foot of the bed, (not able to be seen from the door) was lying in bed in upright position with breakfast tray in front of him/her with closed eyes. The breakfast tray was untouched and contained a scoop of puree eggs and scoop of puree bread. There was a built-up spoon on the side of the tray not used, the coffee was in a brown cup (not a sippy cup) and a carton of milk was opened. The orange juice cup had the metal cover peeled back halfway. NA #1 had dropped off the tray and continued passing trays. Interview with NA #1 on 1/26/25 at 9:10 AM indicated that she had given Resident #81 his/her breakfast meal this morning and indicated Resident #81 eats breakfast in his/her room daily with the privacy curtain pulled all the way and is not visible from the doorway. NA #1 indicated that Resident #81 was responsible for feeding him/herself and did not require supervision. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 1/26/25 at 9:17 AM indicated that Resident #81 feeds him/herself to start and just needs cueing during the meal. RN #3 indicated that the nurse aides were to provide supervision and after the resident has a chance to feed him/herself then provide assist with eating to finish meal. RN #3 identified Resident #81 was behind the pulled privacy curtain and not visible from the doorway while left with the breakfast tray. RN #3 indicated that the nurse aide will come back and assist Resident #81 with eating after resident has had time to eat independently. Observation on 1/27/25 at 8:20 AM identified NA #2 entered the room with the breakfast tray. Resident #81 was sitting upright in bed with eyes closed. The breakfast tray had a flat plate with a scoop of puree eggs and a scoop of puree bread per the meal ticket. NA #2 removed the cover from the main meal and placed the weighted spoon in it. NA #2 did not uncover the hot liquid cup, did not open the 8oz milk cartoon, and did not open the disposable container of orange juice. NA #2 left the room. Resident #81's privacy curtain was pulled completely between the beds so Resident #81 was not visible from doorway. Interview with NA #2 on 1/27/25 at 8:45 AM identified she had delivered Resident #81's breakfast tray. NA #2 indicated Resident #81 could eat by him/herself and just needed to be set up. NA #2 indicated that she does not know why she did not open the drinks and set up the meal tray. NA #2 indicated that she was planning on going back after passing the rest of the breakfast trays and a resident wanted his/her coffee heated in the microwave. NA #2 indicated that Resident #81 was to have supervision during meals and eats breakfast in bed and lunch in the dining room. NA #2 indicated that the privacy curtain was pulled and Resident #81 was not visible from the hallway, but she was planning on going back to assist Resident #81 with breakfast. Interview with LPN #2 on 1/27/25 at 8:50 AM indicated that Resident #81 needed to be set up for meals. LPN #2 indicated that Resident #81 will start to feed him/herself but then staff need to assist. LPN #2 indicated that Resident #81 needed to be supervised for all meals, but staff can do that from the hallway when they pass by the room. LPN #2 identified the privacy curtain was pulled and Resident #81 was not visible from the hallway and the curtain would need to be pulled back. Interview with the Rehab Director on 1/28/25 at 10:53 AM indicated that Resident #81 required self-feeding with supervision and or cueing with meals which means the resident must be visually seen by a staff person during the meal. Interview with OTA #1 on 1/28/25 at 11:55 AM indicated that Resident #81 was last seen for therapy related to eating in December 2021, but she had worked with Resident #81 in September of 2024. OTA #1 indicated that Resident #81 must have close supervision will all meals because he/she needs cueing to eat due to dementia. OTA #1 indicated that supervision means the nurse aide must be able to visually observe the resident for entire meal. OTA#1 indicated that Resident #81 cannot be in bed with the curtain pulled for meals unless the nurse aide stays in the room behind the curtain with the resident throughout the whole meal. Interview with the DNS on 1/28/25 at 12:26 PM indicated her definition of supervision with meals means the resident would have to eat in the dining room so the nurse aides can visually see the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Meal Pass Policy purpose is to provide appropriate assistance for residents who choose to receive meals in their rooms. Review the residents care plan and provide the special needs of the resident. Check the meal tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. Ensure that the necessary non-food items are on the tray. Report or replace missing items such as silverware, napkins, special devices, etc. 3. Resident #312 was admitted to the facility in January 2025 with diagnoses that included hemiplegia following stroke, urinary tract infection, and chronic kidney disease. The physician's order dated 1/16/25 directed to obtain weights on admission and consecutively for 2 days and then to obtain monthly weights on the 3rd Monday of every month. Review of the clinical record identified Resident #312 had an admission weight of 94.6 lbs. on 1/16/25. A physician admission note dated 1/17/25 identified Resident #312 had a developmental disability, was nonverbal at baseline and admitted from the hospital due to urinary tract infection requiring daily antibiotics via a PICC line. Resident #312 had a history of diabetes requiring Insulin, and had a low grade hypernatremia with concern for malnutrition thought to be related to oral intake. The care plan dated 1/17/25 identified Resident #312 required mechanically altered diet due to dysphagia and stroke. Interventions included providing diet and supplements as ordered. The January 2025 TAR identified licensed staff signed that weights had been obtained on 1/17, 1/18 and 1/20/25 however, the clinical record failed to identify the weights for 1/17, 1/18 and 1/20/25. The admission MDS dated [DATE] identified Resident #312 had severely impaired cognition, was dependent on staff to assist with eating, bathing, and toileting. A physician's order dated 1/23/25 directed to obtain weekly weights x 4 weeks every Monday at 9:00 AM. Interview with Person #2 on 1/26/25 at 12:47 PM identified that he/she notified facility staff that Resident #312 was very picky regarding food choices. Review of the January TAR on 1/27/25 at 2:00 PM identified the weekly weight ordered to be obtained on 1/27/25 at 9:00 AM was signed off as obtained, however, no weight could be found. Review of the clinical record identified LPN #3 as the nurse who signed off that the weights on 1/16, 1/17, 1/20, and 1/27/25 had been obtained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with LPN #3 on 1/27/25 at 2:21 PM identified she initially could not recall signing off the TAR for Resident #312's weights on 1/17 and 1/20/25. LPN #3 identified that while she had signed off Resident #312's weight for 1/27/25 at 9:00 AM as obtained, she had not obtained the resident's weight and identified that since Resident #312 required a hoyer lift for transfers to a motorized wheelchair, she was waiting until Resident #312 was going to be transferred back to bed to obtain the weight. LPN #3 identified she worked the 7:00 AM - 3:00 PM shift and indicated Resident #312 probably would not be transferred back to bed prior to the end of her shift. LPN #3 identified that she typically signed off the weight orders in the TAR and then made a note to herself to obtain the weight at a later time during the shift and document the weight in the clinical record. Subsequent to surveyor inquiry, Resident #312 was weighed 1/27/25 at 2:29 PM and had a weight of 98 lbs. Interview with the DNS on 1/29/25 at 12:05 PM identified it was her expectation that when a physician's order was in place related to obtaining weights, that the nurse who signs off in the MAR or TAR that the weight had been obtained, had actually obtained the weight and documented it in the clinical record. The facility policy on weight assessment and intervention directed that the nursing staff would measure and obtain weights on admission, the next 2 days, weekly for 4 weeks and then monthly if no concerns. The policy further directed that the weights would be recorded in the resident's medical record. 46040

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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** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #37) reviewed for pressure ulcers, the facility failed to complete the Braden Scale (a tool used to assess a resident's risk of developing a pressure ulcer) weekly after admission per the physician's order, failed to ensure that a wound care physician's recommendation was implemented, and failed to ensure that a thorough RN assessment of the residents pressure ulcers was completed following re-admission. The findings include: Resident #37 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia, muscle weakness, and anemia. A physician's order dated 11/14/22 directed to complete a Braden Scale weekly for 4 weeks. A Braden Scale dated 11/14/22 identified Resident #37 had a score of 20, indicating the resident was not at risk for the development of pressure ulcers. a. Review of the clinical record failed to identify any additional weekly Braden scale documentation following Resident #37's initial assessment on 11/14/22. A nurse's note dated 11/14/22 at 1:44 PM identified the admission skin audit indicated Resident #37 had a scar on the coccyx and discoloration on the buttocks. The care plan dated 11/16/22 identified Resident #37 was at risk for skin breakdown related to bowel and bladder incontinence. Interventions included keeping the skin as clean and dry as possible and minimizing skin exposure to moisture. The admission MDS dated [DATE] identified Resident #37 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and required moderate staff assistance with bathing, toileting, and dressing. The MDS further identified Resident #37 was at risk to develop pressure ulcers. A wound care note, written by MD #4, the Wound Care Physician, dated 11/21/22 identified Resident #37 was seen for wound evaluation of coccyx and buttocks related to moisture. The note identified a wound to the coccyx had resolved and recommendations included to apply Dermaseptin (a zinc oxide-based barrier cream) daily and as needed. The plan of care was discussed with LPN #1 (Wound Care Nurse). b. Review of the clinical record failed to identify the Dermaseptin, or any other zinc-based barrier cream, according to MD #4's recommendation, had been implemented. Review of clinical record identified Resident #37 was sent to the hospital on 1/18/23 related to a possible gastrointestinal bleed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weekly skin assessment dated [DATE] by LPN #1, completed while Resident #37 was hospitalized and outside of the facility, identified Resident #37 had clean, dry and intact skin with no alterations observed. The hospital discharge paperwork identified Resident #37 was discharged from the hospital on 1/21/23 following a gastrointestinal hemorrhage. The hospital discharge paperwork identified Resident #37 was found to have a stage IV pressure ulcer to the coccyx and deep tissue injury to the left buttock with recommendations including multiple treatments and to continue cleansing the wound with normal saline, daily dressing changes and with soiling, Silvadene ointment to the coccygeal wound bed, 40 % zinc oxide paste to the peri wound and left buttock, and to cover the coccyx/buttocks with bordered foam. A physician's order dated 1/21/23, following readmission to the facility, directed to complete a Braden Scale weekly for 4 weeks. A Braden Scale dated 1/21/23 identified Resident #37 had a score of 20, indicating the resident was not at risk for development of pressure ulcers. A nursing admission assessment, completed by LPN #2, on 1/21/23 at 1:55 PM, identified Resident #37 was always continent of urine and bowel and was observed to have an open area to the coccyx that measured 1. 0 cm x 0.3 cm with no depth. The note further identified no wound care observation was performed and failed to identify documentation or an assessment of the left buttock DTI identified in the hospital discharge documentation. A nurse's note dated 1/21/23 at 3:08 PM by RN #7 identified Resident #37 was readmitted to the facility at 11:30 AM following hospitalization for GI bleed. The note further identified Resident #37 was observed to have an open area to the coccyx with treatment in place. c. Review of the clinical record failed to identify an RN assessment of Resident #37's left buttock deep tissue injury and stage IV pressure ulcer to the coccyx, including wound measurements and appearance, which had been noted in the hospital discharge paperwork had been completed on admission. Interview and clinical record review with LPN #1 on 1/28/25 at 11:24 AM identified that she completed weekly wound rounds with MD #4 after she became the wound care nurse in September 2022. LPN #1 identified that she was present when MD #4 evaluated Resident #37 on 11/21/22 and he ordered Dermaseptin to be started. LPN #1 identified it was her responsibility to place the order in the clinical record as a telephone order to ensure that the treatment was started. Review of the clinical record with LPN #1 identified the treatment was not in place following the 11/21/22 wound rounds. LPN #1 identified she also worked as a unit manager and that the new additional role of wound care nurse at that time was very overwhelming, which may have been why the order was not placed, but she should have taken care of it. LPN #1 identified she did not know why she documented a skin assessment on 1/20/23 while the resident was out of the facility and in the hospital and identified the volume of her workload in multiple roles at the facility as a possible cause. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #7 (RN Supervisor) on 1/28/25 at 2:14 PM identified that she documented her RN admission assessments under the nurse's notes in the clinical record. RN #7 identified she usually reviewed the hospital discharge paperwork for all residents who are admitted or re admitted to the facility and ensured all orders are in place including reviewing medications. RN #7 identified that she did not remember Resident #37 having any wound treatments following the re admission, but due to the amount of time that had passed, she was not sure. RN #7 identified that she would have placed wound measurements in the note if she had assessed and measured the wounds when Resident #37 was readmitted to the facility on [DATE]. RN #7 identified that she should have reviewed Resident #37's hospital discharge paperwork from 1/21/23 and noted any pressure ulcers and treatments identified in the documentation present upon readmission and if that she did not document the details in her nurse's note, she did not complete a full assessment of the wounds. Interview with LPN #5 (Regional Nurse) on 1/29/25 at 8:15 AM identified that the facility utilized non medicated barrier creams that did not require a physician's order. LPN #5 identified that any barrier cream that was medicated, including zinc oxide-based barrier creams, required a physician's order and were to only be administered by a licensed nurse. LPN #5 identified that the order would populate on the TAR and the nurse would sign off the cream as administered based on the order in place. Interview with MD #4 on 1/29/25 at 9:48 AM identified that he had been treating Resident #37 for several years related to recurrent pressure ulcers of the coccyx and that when he saw and evaluated Resident #37 on 11/21/22, Resident #37 had a healed closed area on the coccyx from a previous pressure injury. MD #4 identified that he specifically ordered Dermaseptin daily and as needed for Resident #37 related to his/her history of being very incontinent and identified that a zinc oxide based barrier cream was needed to protect Resident #37's skin from moisture and breakdown to prevent further pressure injuries. MD #4 identified he was not aware the treatment had not been implemented. Interview with the DNS on 1/29/25 at 12:05 PM identified that it was the responsibility of the RN supervisor to review the hospital discharge paperwork and complete the initial physical exam of any resident newly admitted or readmitted to the facility. The DNS identified that the LPN assigned to care for the resident would also document following admission and readmission. The DNS identified that a resident who was admitted with a pressure ulcer or wound should have a wound assessment completed on admission under the wound observation assessment in the electronic record which would include the measurements and wound appearance at the time of admission. The DNS identified the Braden Scale assessments were ordered weekly for 4 weeks on admission by the physician and she would expect the nursing staff to ensure that the assessments were completed per the order and identified any resident with a pressure ulcer present on admission should have a risk of pressure ulcers per the Braden Scale if entered correctly. The DNS also identified it was the responsibility of LPN #1 to ensure that any treatment orders added to the resident's wound were entered into the physician's orders in the electronic record to ensure treatment was initiated. The facility policy on pressure ulcers/skin breakdown directed that incidence of new pressure ulcers would be minimized and healing of existing pressure ulcers would be optimized to the extent possible. The policy also directed that nursing staff would assess and document an individual's risk factors for developing pressure ulcers and examine the skin of newly admitted residents for evidence of existing pressure ulcers and other skin conditions. The policy further directed that the physician would help identify contributing factors to skin breakdown, including macerated or friable skin, and would order pertinent treatment for treating a wound including the application of topical agents. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on resident examination and assessment directed the purpose of the policy was to examine and assess the resident for any abnormalities in health status. The policy further directed that the skin assessment should include assessment findings related to intactness, color, texture and the presence of any pressure ulcers and all assessment data should be recorded in the resident's medical record. The facility policy on physicians' orders directed that verbal orders must be recorded immediately in the resident's chart by the person receiving the order, and must include the name and strength of the drug, the dosage, route and frequency of administration.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 (Resident #84) reviewed for nutrition, the facility failed to address a weight loss according to professional standards and facility policy. The findings include: Resident #84 was admitted to the facility in July 2024 with diagnoses that included stroke, dysphasia, and dementia. Review of the weight record dated 7/24/24 identified Resident #84 weighed 156 lbs. A physician's order dated 8/13/24 directed to weigh the resident daily and if weight loss is greater than 2 lbs. in a day or 5 lbs. in 7 days notify the physician/APRN. A physician's order dated 8/14/24 directed to provide a dysphasia puree diet but allow ground meats and soft sandwiches and thin liquids. Additionally, provide house supplement 237 ml twice a day. The quarterly MDS dated [DATE] identified Resident #84 had severely impaired cognition, was independent to eat, did not have a weight loss of 5% in the last month or loss of 10% in the last 6 months. The care plan dated 9/24/24 identified Resident #84 has the potential for alteration in nutritional status related to dementia. Interventions included evaluating the nutritional status on admission, per the MDS schedule and as needed and report any concerns or changes to the physician and resident representative. Review of the weight record dated 10/4/24 identified the resident weighed 150 lbs., (a 6 lbs. weight loss in 3 months). Review of the weight record dated 11/10/24 identified Resident #84 weighed 138 lbs., (a 12 lbs. weight loss in 1 month, 18 lbs. in 4 months). Review of the nurse's progress notes, APRN, and physician notes dated 11/10/24 - 12/11/24 failed to reflect that the physician was notified of the resident's weight loss. Further, review of the clinical record dated 11/10/24 to 12/11/24 failed to reflect that Resident #84 was seen by the dietitian subsequent to the weight loss. Review of the weight record dated 12/2/24 identified Resident #84 weighed 133 lbs., (a 5 lbs. weight loss in 1 month). Review of the nurse's progress notes, APRN, and physician notes dated 12/2/24 - 12/12/24 failed to reflect that the APRN, physician, or resident representative were notified of the continued weight loss. Review of the clinical record dated 12/2/24 to 12/11/24 failed to reflect that Resident #84 was seen by the dietitian for a weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dietitian progress note dated 12/12/24 at 11:19 AM identified a significant weight loss trend. Recommendations included orders for house supplement 237 ml twice daily, and liquid protein 30 ml daily remain appropriate to maximize protein and caloric intake. The APRN progress note dated 12/13/24 at 9:44 PM identified Resident #84 was seen for a significant weight loss of 11 lbs. over the past month. Resident #84 is tolerating diet order without difficulty and has variable oral intakes of 50 - 100% of meals. Will have speech therapy evaluate for a diet upgrade, dietitian evaluated resident, food preferences upgraded, monitor intakes and weights. The dietitian progress note dated 12/12/24 identified significant weight loss trend for 30 days and 90 days for 11 lbs. noted over past month. Resident status post antibiotic for urinary tract infection. Suspected weight loss due to acute illness. History of recent stroke and variable oral intakes at times. Tolerating dysphasia puree diet order without difficulty swallowing. Appropriate for speech therapy referral. Staff set up and give encouragement with meals in room or small dining room. Orders for house supplement 237 ml twice daily and liquid protein 30 ml daily remain appropriate to maximize protein and caloric intake the physician, APRN, and A physician's order dated 12/16/24 directed to obtain bloodwork (CBC, CMP, lipid panel, A1C, TSH with reflex, Free T4, Vitamin D 250H, B12). Interview with the Dietitian on 1/27/25 at 10:30 AM indicated that she had seen Resident #84 in July 2024 after admission and again in August 2024 after readmission. The Dietitian indicated that in August Resident #84 had gone to the hospital for a few days because of another stroke and she noted a weight loss. The Dietitian indicated on readmission 8/14/24 she started Resident #84 on the supplement and therapy had downgraded the diet to puree. The Dietitian indicated she had not been notified of the weight loss at the beginning of November or beginning of December and indicated had she been notified she would have seen Resident #84 right away because she is in the facility 4 days a week. The Dietitian indicated that for the 11/10/24 weight loss and the weight loss on 12/2/24 she would have done a complete evaluation and looked at the whole picture to determine what interventions were in place and to determine if it was dietary or medical issue causing the weight loss. The Dietitian indicated that the nurses should have communicated the weight loss. The Dietitian indicated that she did not see or evaluate resident's weights until she went to see Resident #84 to do the quarterly MDS assessment on 12/12/24 and noted the undesired weight loss. Interview with MD #1 on 1/27/25 at 10:48 AM indicated that when a resident has a weight loss of 5% in a month, he would expect the provider and dietitian to be notified that day. MD #1 indicated that he would expect the nurse to document in the progress notes who was notified. After clinical record review, MD #1 indicated that Resident #84 had a 10 lbs. weight loss or over 5% based on the weight 11/10/24, and a 17 lbs. weight loss on 12/2/24. MD #1 indicated that on 11/10/24 and 12/2/24 he should have been notified so he/she could do an evaluation to determine if this unplanned weight loss was a dietary or medical issue. MD #1 indicated that the provider was only notified based on documentation of Resident #84 weight loss on 12/13/24 and seen by APRN for the weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/27/25 at 11:07 AM indicated that when a nurse takes a weight and there is a discrepancy by 2, 3, or 5 lbs. based on the physician's order they are responsible to notify the physician. The DNS indicated if a reweight is needed it should be done the same day but no later than the next day to verify the weight loss then notify the dietitian, physician, and residents' representative. After clinical record review, the DNS indicated that Resident #84's weight loss on 11/10/24 and 12/2/24 were verified and the physician and dietitian should have been notified however, there was no documentation to reflect notification had taken place. Interview with LPN #2 on 1/27/25 at 12:14 PM indicated that she had taken Resident #84's weight on 12/3/24 and 12/4/24 and she was not aware that it was a weight loss because the computer did not trigger it as it only shows the last 3 daily weights. LPN #2 indicated that she would have had to go to the vital sign section to pull up the last months weights to identify a weight loss and she does not do that. LPN #2 indicated that if she was aware of the weight loss she would have notified the APRN, resident representative, and the dietitian. Interview with Dietitian on 1/28/25 at 8:10 AM indicated that she sees all new admission, readmissions, quarterly, and if nursing notifies her of weight loss, or if the physician puts in for a consult. The Dietitian indicated that she had not been notified prior to seeing Resident #84 to do the quarterly assessment on 12/12/24 of a weight loss. Review of the Weight Assessment and Intervention Policy identified the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our resident's. The nursing staff will measure resident's weights on admission, and next 2 days, and weekly for 4 weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. Weights will be recorded in the resident's medical record. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Verbal notification must be confirmed in writing. The Dietitian will evaluate resident after notification of identified weight discrepancy. The Dietitian will review the unit's weight record by the 15th of the month to follow individuals weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change have been met. The threshold for significant unplanned and undesirable weight loss will be based on the following criteria a 5% weight loss in 1 month is significant, if greater than 5% is severe, 7.5% weight loss in 3 months is significant, if greater than 7.5% is severe, 10% weight loss in 6 months is significant, if greater than 10% is severe. The physician and interdisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss, for example cognitive or functional decline, chewing or swallowing abnormalities, pain, medications, environmental factors like noise or distractions, etc. Review of Nutritional Assessment Policy identified as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change of condition that places the resident at risk for impaired nutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weight Monitoring Policy identified staff should obtain timely and accurate weights to maintain acceptable nutritional parameters. Weights will be documented in the EMR by the unit manager or unit assistant. If there is a 3 or more-pound difference a reweight is to be performed immediately. Nursing is responsible for notifying the dietitian of any significant weight changes. The dietitian may change resident back to weekly weights if oral intake has been noted to be a concern, change in medical status, weight loss or potential for weight loss is suspected.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #56) reviewed for a specialized medical treatment and who had orders for a 1000 ml fluid restriction, the facility failed to consistently monitor fluid intake to ensure the resident was within the fluid restriction and implement measures according to professional standards. The findings include: Resident #56 was admitted to the facility in May 2024 with diagnoses that included end stage renal disease requiring peritoneal dialysis. The quarterly MDS dated [DATE] identified Resident #56 had intact cognition and required moderate assistance with toileting and personal hygiene. The care plan dated 11/29/24 identified Resident #56 receives peritoneal dialysis for end stage renal disease. Interventions included monitoring fluid intake and a fluid restriction of 1000 ml per 24 hours. Review of the December 2024 monthly physician's order directed a fluid restriction of 1000 ml per day and to provide a 2-gram sodium renal diet. Review of the fluid intake record dated 12/1/24 to 12/31/24 identified Resident #56 had gone over the fluid restriction 28 out of 31 days. Review of the fluid intake record dated 1/1/25 to 1/28/25 identified Resident #56 had gone over the fluid restriction 26 out of 28 days. Review of the nursing and physician progress notes dated 12/1/24 to 1/28/25 failed to reflect that the physician, APRN, or resident was notified that Resident #56 had gone over the physician's order for the 1000 ml fluid restriction. Interview with LPN #4 on 1/29/25 at 9:40 AM indicated Resident #56 was on a 1000 ml fluid restriction per physician order. LPN #4 indicated that the charge nurses every shift document the fluid intake into the EMR. LPN #4 indicated that the 11:00 PM to 7:00 AM supervisor was responsible for adding up the 24-hour totals and if the resident goes over the fluid restriction, she would notify the RN supervisor. Interview with RN #4 (7:00 AM to 3:00 PM day supervisor) on 1/29/25 at 10:17 AM indicated that the 11:00 PM to 7:00 AM RN supervisor was responsible to add the 24-hour intakes for residents on a fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/29/25 at 10:22 AM indicated that if a resident on a fluid restriction goes over the fluid restriction more than 5 - 10 ml's the APRN or physician must be notified, and the nurse must write a progress note to indicate such. The DNS indicated that the 11:00 PM to 7:00 AM the RN supervisor was responsible for adding up each day's fluid totals for residents on fluid restrictions. The DNS indicated that if the resident went over the fluid restriction the night supervisor would inform the day supervisor to call or inform the APRN that day. The DNS indicated that the resident would be educated about going over the fluid restriction and it would be documented by the nurse in the progress notes. After review of the clinical record the DNS was not able to identify that the dialysis center or the APRN were notified that Resident #56 had gone over the fluid restriction or that the resident had been educated on the fluid restriction. Interview with MD #1 on 1/29/25 at 10:53 AM indicated that if a peritoneal dialysis resident is on a 1000 ml fluid restriction, nursing was responsible to calculate the 24-hour totals. MD #1 indicated that if Resident #56 went over the fluid restriction he should be notified that day and that notification be documented in the clinical record. MD #1 indicated that if the resident was about 1000 ml over the fluid restriction that was more serious and the APRN would do an assessment and the dialysis center should be notified that day, because they would have to take more fluid off through the next dialysis cycle. MD #1 indicated that if Resident #56 continuously goes over the fluid restriction he/she may need to have an extra exchange of the peritoneal dialysis during the day not just at night. Review of the Encouraging and Restricting Fluids Policy identified the purpose of this procedure is to provide the resident with the number of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Verify there is a physician's order. Be accurate when recording fluid intake. Record fluid intake in ml's. When a resident has been placed on a restricted fluid, remove the water pitcher and cup from the room. Review of the Intake, Measuring, and Recording Policy identified the purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period. Verify the physician's order. Inform the resident and his/her representatives and visitors that the resident is on intake and output. Record the fluid intake as soon as possible after the resident has consumed the fluids. At the end of your shift, total the amounts of all liquids the resident has consumed. Post an intake and output record form in the resident's room. Although requested, a facility policy for dialysis residents on fluid restrictions was not provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #70) reviewed for unnecessary medications, the facility failed to attempt continued gradual dose reductions (GDR) according to professional standards, after the diagnosis of schizoaffective disorder had been discontinued and failed to ensure a comprehensive care plan had been developed for the use of an antipsychotic medication. The findings include: Resident #70 was admitted to the facility on [DATE] with diagnoses that included anxiety, depression, and dysthymic disorder. The admission MDS dated [DATE] identified Resident #70 had intact cognition, no delusional or hallucinating thoughts and no physical or verbal behaviors. A physician's order dated 8/26/21 directed to administer Abilify (antipsychotic medication) 5mg daily at bedtime. The psychiatric evaluation and consultation dated 10/20/21 at 1:23 PM identified given history of symptoms it would be appropriate to add schizoaffective disorder diagnosis to the diagnosis list. Tapering of psychotropic medications will lead to worsening of symptoms. The Psychiatric Evaluation and Consultation dated 10/13/23 (2 years later) identified based upon symptoms, etiology of current disease, and response to recent medication trials, it would be prudent to discontinue the diagnosis of schizoaffective disorder. Will recommend a gradual dose reduction trial of antipsychotics as tolerated and if indicated. Review of the psychiatric note written by APRN #1 dated 11/10/23 recommended per diagnosis of schizoaffective disorder, stop Abilify 5mg and start Abilify 2mg. A physician's order dated 11/10/23 directed to decrease Abilify to 2mg daily at bedtime. Review of psychiatric notes written by APRN #1 dated 11/21/23, 12/21/23, 3/21/24, 4/23/24, 5/23/24, 6/25/24, 7/25/24, 8/27/24, 9/26/24, 10/25/24, and 11/26/24 identified that Resident #70 was receiving Abilify for schizoaffective disorder. Interview with SW #1 on 1/27/25 at 8:57 AM identified there was no care plan for the diagnosis of schizoaffective disorder because she thought the diagnosis had been discontinued in October 2023. SW #1 indicated that she does see in the psychiatric visits during 2024 that the schizoaffective diagnosis and Abilify were still in place, but in October 2023 she had asked for the psychiatric group to see Resident #70 and maybe discontinue that diagnosis. SW #1 indicated that she did not follow up on it in October 2023, she just assumed it was discontinued. After surveyor inquiry, the diagnosis of schizoaffective disorder was discontinued on 1/27/25. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 1/28/25 at 10:03 AM identified she had been contacted yesterday by her company's head of management CEO notifying her that the state agency was looking into Resident #70's diagnosis of schizoaffective disorder and that her documentation should not reflect that diagnosis. APRN #1 identified she reviewed Resident #70's clinical record and noted that MD #3 had diagnosed Resident #70 with the diagnosis of schizoaffective disorder on 10/20/21. APRN #1 indicated that she was not aware until yesterday that the diagnosis had been discontinued by MD #3 on 10/13/23. APRN #1 indicated she started seeing Resident #70 on 9/7/23 and the Abilify was already in place for the diagnosis of schizoaffective disorder. APRN #1 indicated that she was not verbally informed by MD #3 or staff that the diagnosis of schizoaffective disorder had been discontinued. APRN #1 indicated that on 11/21/23 she had decreased the Abilify to 2mg and indicated that if she were aware that the diagnosis had been discontinued, she would have weaned Resident #70 completely off the Abilify. APRN #1 indicated since November 2023 she should have stopped the Abilify because Resident #70 no longer had the diagnosis. Although attempted, an interview with MD #3 was not obtained. Review of the Antipsychotic Medication Use policy identified antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period and are subject to gradual dose reduction and re-review. Antipsychotics medications shall generally be used only for the following conditions/diagnosis as documented in the record, consistent with the definition in the Diagnostic and Statistical Manual of [NAME] Disorders for schizophrenia, schizoaffective disorder, delusional disorder, mood disorder (bipolar disorder, depression with psychotic features, and treatment refractory major depression). Diagnosis alone does not warrant the use of antipsychotic medications. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: the behavioral symptoms present a danger to the resident or others and the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations, delusions, paranoia, or grandiosity). : or behavioral interventions have been attempted and included in the plan of care, except in an emergency. All antipsychotic medications will be used within the dosage guidelines, or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours. The physician shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting based on assessing why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #81) reviewed for nutrition, the facility failed to provide adaptative equipment with meals according to physician's orders and the plan of care. The findings include: Resident #81 was admitted to the facility in December 2021 with diagnoses that included dementia and a stroke affecting the right dominant side. A Therapy Communication to Nursing form dated 12/24/21 identified Resident #81 needed to be given a scoop plate, built up utensils, and a 2 handled sippy cup with every meal. The monthly physician's order dated 7/1/24 to 7/31/24 directed a dysphasia mechanical diet and can have soft bread. Sippy cup with breakfast, lunch and dinner. Additionally, close supervision during meals. Review of the Electronic Health Records (EMR) identified that in August 2024, the facility transitioned to a new EMR. Review of monthly physician's orders (in the new EMR) dated 9/1/24 to 12/31/24 failed to reflect the order for the sippy cup with breakfast, lunch and dinner. The annual MDS dated [DATE] identified Resident #81 had severely impaired cognition and needed partial assistance with eating. The care plan dated 12/12/24 identified Resident #81 was at risk for weight loss. Interventions included using a sippy cup with meals, providing a mechanical soft diet with thin liquids, aspiration precautions and monitor eating closely. Encourage the resident to use feeding skills as much as he/she could and assist as needed. Observation on 1/26/25 at 9:00 AM identified Resident #81's breakfast tray was in front of the resident without the benefit of a scoop dish and a 2 handled sippy cup. The entree was on a flat plate, orange juice cup had the metal cover peeled back halfway, coffee was in a brown cup, and milk in the carton. The meal ticket dated 1/26/25 identified Resident #81 needed a sippy cup. Interview with NA #1 on 1/26/25 at 9:10 AM indicated that she had given Resident #81 the breakfast meal this morning and indicated she does not read the meal tickets because it was the kitchens responsibility to make sure the meal trays are correct. NA #1 indicated that she did not read Resident #81's meal ticket when providing breakfast today. After reading the meal ticket, NA #1 indicated that she was not aware that Resident #81 needed the sippy cup. NA #1 indicated that the kitchen was responsible for making sure the sippy cup and scoop plates were on the tray. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 on 1/26/25 at 9:17 AM indicated that the nurse aides were responsible to read every resident meal ticket when delivering the meal tray and making sure the meal is correct based on the meal ticket. RN #3 indicated she can see Resident #81 did not have the scoop dish or sippy cup and indicated that NA #1 should have called the kitchen to make sure Resident #81 had the sippy cup to be able to drink his/her liquids. Observation during the lunch meal on 1/26/25 at 1:00 PM identified Resident #81 was sitting in his/her wheelchair in the small dining room without the benefit of the scoop dish or a 2 handled sippy cup. Observation on 1/27/25 at 8:20 AM identified NA #2 entered room with Resident #81's breakfast tray. Resident #81 was sitting upright in bed with eyes closed. The breakfast tray had a flat plate with a scoop of puree eggs and a scoop of puree bread per the meal ticket. NA #2 removed the cover from the main meal and placed the weighted spoon in it and walked away. NA #2 did not uncover the hot liquid cup, did not open the 8oz milk cartoon, and did not open the disposable container of orange juice. There was no sippy cup or scoop dish on the tray. Meal ticket dated 1/27/25 breakfast identified Resident #81 needed weighted silverware and a sippy cup. Interview with NA #2 on 1/27/25 at 8:45 AM identified she had delivered Resident #81's breakfast tray. NA #2 indicated Resident #81 could eat by him/herself just needed to be set up. NA #2 indicated that she does not know why she did not open the drinks and set up the meal tray for Resident #81. NA #2 indicated that she was planning on going back after passing the rest of the breakfast trays including heating another resident's coffee heated in the microwave. NA #2 indicated that she did not read Resident #81's meal ticket when she delivered the tray. NA #2 indicated that she was not aware the meal ticket stated Resident #81 needed built up utensils and a sippy cup. NA #2 indicated that the kitchen was responsible for making sure all adaptive equipment is on the meal trays if they are needed. Interview with LPN #2 on 1/27/25 at 8:50 AM indicated that Resident #81 needed to be set up for meals. LPN #2 indicated that the kitchen staff and the NA #2 were responsible for making sure Resident #81 had the right meal consistency and the adaptive equipment needed. LPN #2 indicated that Resident #81 will start to feed him/herself but then staff will need to cue and provide assistance. Interview with Director of Dietary on 1/27/25 at 9:30 AM indicated that the dietary aide at the end of the tray line was responsible to make sure the meal tray was accurate matching the meal ticket. Director of Dietary indicated that he has plenty of sippy cups and Resident #81 should have had the sippy cup on the meal tray every meal. Director of Dietary indicated that he did not know why Resident #81 did not have the sippy cup for the last 2 days, but he will make sure for lunch today that Resident #81 gets a sippy cup. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dietitian on 1/27/25 at 10:20 AM indicated that the dietary staff in the kitchen were responsible to make sure trays are accurate prior to leaving the kitchen and then the nurse aides are responsible on the unit as they pull the tray off the carts to verify the meal ticket and the tray match prior to bringing the tray to the resident. The Dietitian indicated that the dietary aides on the tray line were responsible to make sure the adaptive equipment was on the meal tray, but the nurse aides are the last check before bring the tray to the resident. The Dietitian indicated that if a piece of adaptive equipment was not on a tray the nursing staff can call the kitchen, and the kitchen staff will bring it right up to the unit. Interview with Rehab Director on 1/28/25 at 10:53 AM indicated that Resident #81 was seen 9/16/24 in discharge summary from occupational therapy indicated resident was self-feeding with supervision and or cueing with assistive device. Interview with OTA #1 on 1/28/25 at 11:55 AM indicated that Resident #81 was last seen for therapy related to eating was in December 2021, but she had worked with Resident #81 in September of 2024 for his/her wheelchair. OTA #1 indicated that at that time she did not change the orders for Resident #81 to have a scoop dish, weighted utensils, and a 2 handled sippy cup because she felt Resident #81 would benefit from continuing to use the adaptive equipment to maintain as much independence as possible. OTA #1 indicated that the 2 handled cup is needed to prevent spillage onto the resident. Interview with the DNS on 1/28/25 at 12:26 PM indicated that the kitchen staff were responsible to make sure that every meal tray based on the meal ticket was correct before leaving the kitchen, and nursing was responsible to make sure the resident was getting the correct diet and adaptive equipment on the tray. The DNS indicated that if anything was wrong or missing the nurse's aide or nurse were to call the kitchen staff right away. Interview with OTA #1 on 1/29/25 at 11:16 AM indicated that Resident #81 should currently have the order for the adaptive equipment including the 2 handled sippy cup and scoop dish because therapy had not discontinued that order. Interview with the Chief Nursing Officer on 1/29/25 at 12:18 PM indicated that on 8/9/24 the facility started a new computer program for the meal tracker. The Chief Nursing Officer indicated that was when the EMR would talk to the meal ticket tracking system. The Chief Nursing Officer indicated that prior to that date, the adaptive equipment was in the same order as the diet but with the new system the diet order went under dietary, and the adaptive equipment order would go under the general physician orders. The Chief Nursing Officer, after review of Resident #81's clinical record, indicated that when the system changed over it only took the diet order but not the adaptive equipment order for Resident #81. The Chief Nursing Officer indicated that someone would have had to separately enter the order for the adaptive equipment under general physician orders. The Chief Nursing Officer indicated that it was an importing glitch when the system changed over. The Chief Executive Officer indicated that they would have to do a house wide audit to make sure this did not happen to any other residents. Interview with the DNS on 1/29/25 at 12:40 PM indicated that moving forward Resident #81 would be out of bed for all meals and in the dining room to be supervised for meals. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at West River	245 Orange Avenue Milford, CT 06460

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Corporate Manager on 1/29/25 at 1:00 PM indicated that they would have to do a house audit to see if any other residents with orders for adaptive equipment and supervision had dropped off and were not in place subsequent to the change to the meal tracker program. Review of the Resident Meal Pass Policy identified the purpose was to provide appropriate assistance for residents who choose to receive meals in their rooms. Review the residents care plan and provide the special needs of the residents. Check the meal tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. Ensure that the necessary non-food items are on the tray. Report or replace missing items such as silverware, napkins, special devices, etc. Although requested, a facility policy for adaptive equipment was not provided.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47457 Based on review of the facility documentation, facility policy, and interviews the facility failed to ensure the Infection Preventionist completed specialized training in infection prevention. The findings include: The Infection Preventionist (RN #1) was hired on 11/30/2015. During entrance conference on 1/26/24 at 7:45 AM the facility failed to provide documentation that RN #1 had been awarded the certification for Nursing Home Infection Preventionist with contact hours. Upon review of facility documentation, it was identified that RN #1 had completed the Nursing Home Infection Preventionist Training Course on 4/23/24 but had not completed the final test to obtain the Infection Preventionist certificate. The facility provided documentation that the ADNS had been awarded the certification for Nursing Home Infection Preventionist on 9/4/2020. Interview with RN #1 on 1/28/25 at 8:20 AM identified that she had served as the facility's Infection Preventionist (IP) for 10 months, and that she had completed the Nursing Home Infection Preventionist Training Course and obtained a certification of training course completion on 4/23/24, which she thought fulfilled all the IP requirements. RN #1 indicated that it was subsequent to surveyor inquiry on 1/26/25 that she learned that she also had to take a final test after completing the modules in order to be certified as an IP; RN #1 attempted to take the test, but she did not pass. RN #1 indicated that her last day as the facility's full time IP was 1/27/25, but she would remain at the facility, part-time and assist with training a new IP once one was hired; the ADNS would oversee the day-to-day infection control duties, in the interim. Interview with the DNS on 1/28/25 at 1:20 PM identified that RN #1's certificate reads that RN #1 had successfully completed the Nursing Home Infection Preventionist Training Course on 4/23/2024, and she thought that certificate indicated that the IP requirements had been met. The Infection Preventionist Job Description document directs the minimum qualifications of the IP was to have any combination of education and experience that would likely provide the required knowledge, skills, and abilities; as well as any required licenses or certifications. Education: primary professional training in nursing, medical technology, microbiology, epidemiology, or related field; and have completed specialized training in infection prevention and control.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical records, facility documentation, facility policies, and interviews for 6 of 10 residents (Resident #2, 18, 79, 87, 88, and 100) reviewed for immunizations, the facility failed to ensure consented residents received the ,d+[DATE] Covid vaccination, in a timely manner. The findings include: Resident #2 was admitted to the facility on [DATE]. Review of Resident #2's clinical record identified a signed Annual Vaccinations form dated [DATE] which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE] (a vaccine that helps prevent the Covid-19 virus); 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] identified Resident #2 received the Covid-19 vaccination on [DATE], subsequent to surveyor inquiry. Resident #18 was admitted to the facility on [DATE]. Review of Resident #18's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] identified Resident #18 received the Covid-19 vaccination on [DATE], subsequent to surveyor inquiry. Resident #50 was admitted to the facility on [DATE]. Review of Resident #50's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had declined to the Covid-19 vaccine. Resident #58 was admitted to the facility on [DATE]. Review of Resident #58's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had declined to the Covid-19 vaccine. Resident #60 was admitted to the facility on [DATE]. Review of Resident #60's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directing the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] identified Resident #60's resident representative declined the Covid-19 vaccination on [DATE] because Resident #60 was on hospice care. Resident #79 was admitted to the facility on [DATE]. Review of Resident #79's clinical record identified a signed Annual Vaccinations form dated [DATE] which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] failed to identify Resident #79 had received the Covid-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #87 was admitted to the facility on [DATE]. Review of Resident #87's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] identified Resident #87 received the Covid-19 vaccination on [DATE], subsequent to surveyor inquiry. Resident #88 was admitted to the facility on [DATE]. Review of Resident #88's clinical record identified a signed Covid Vaccine Consent form dated [DATE], which identified he/she or the responsible party had consented the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] identified Resident #88 received the Covid-19 vaccination on [DATE], subsequent to surveyor inquiry. Resident #100 was admitted to the facility on [DATE]. Review of Resident #100's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had consented to the Covid-19 vaccine, and a physician's order dated [DATE] directed the administration of Comirnaty ,d+[DATE]; 30 mcg/0.3ml; intramuscular, one time. Review of the facility's Preventative Health Care Report dated [DATE] failed to identify Resident #100 received the Covid-19 vaccination. Resident #109 was admitted to the facility on [DATE]. Review of Resident #109's clinical record identified a signed Annual Vaccinations form dated [DATE], which identified he/she or the responsible party had declined to the Covid-19 vaccine. Interview and clinical record review with the Infection Preventionist (RN #1) on [DATE] at 8:20 AM failed to provide surveillance data on resident Covid-19 vaccinations but indicated that she pulls her reports from the electronic health record system when needed. RN #1 indicated that 2 of the 5 residents (Resident #60 and #87) initially reviewed for immunizations had consented for the Covid-19 vaccination but had not yet received the Comirnaty ,d+[DATE] vaccine. RN #1 indicated that Resident #60 and Resident #87 were scheduled to receive their Covid-19 vaccination on the upcoming Monday. RN #1 further indicated that the pharmacy dispenses Covid-19 vaccines in quantities of 10 at a time, and the next order of 10 vaccines was expected to be delivered by Monday. RN #1 was unable to provide a policy indicating that there was a limit to how many Covid-19 vaccines could be received from the pharmacy; RN #1 indicated that was the directive she was told by the pharmacy. RN #1 identified that the following residents were scheduled to receive the Covid-19 vaccine on Monday: Residents #2, 18, 50, 58, 60, 79, 87, 88, 100, and 109. RN #1 further identified that she had been the facility's Infection Preventionist (IP) for 10 months, and her last day as the facility's full time IP was [DATE], but she would remain at the facility in a part time capacity until a new IP was hired and trained. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the pharmacy manager (Person #1) on [DATE] at 11:49 AM indicated that, last year during a medication review, it was identified that the facility had multiple expired Covid-19 vaccinations in the medication refrigerator. Person #1 indicated that Covid-19 vaccines have a shorter shelf life than other vaccines, and once defrosted it must be administered within 30 days. Person #1 identified that representatives from the pharmacy had a conversation with facility management and it was determined that 10 vaccines would be supplied at a time to devoid waste. Person #1 further identified that the pharmacy was not rationing Covid-19 vaccines and there was no policy in place to limit quantities supplied to the facility; if the facility had a need for more than 10 vaccines, the pharmacy would provide a larger quantity. Observation with the DNS of the medication refrigerator on [DATE] at 10:37 AM identified 5 Covid-19 vaccinations in a bag dated [DATE] and 10 Covid-19 vaccinations in a bag dated [DATE]. Interview with the Administrator on [DATE] at 10:57 AM identified that he never learned that there was a limit on ordering Covid-19 vaccinations. Interview with the DNS on [DATE] at 11:51 AM identified that she was aware that Covid-19 vaccines were routinely being supplied 10 at a time; while she was unable to recall where that directive came from, the DNS indicated that more could have been ordered if there was a need. The DNS further indicated that she was unaware that there were multiple residents that were consented to receive the Covid-19 vaccine but had not yet received it, and she was also unaware that there 15 Covid-19 vaccines in the refrigerator that were available to be given to consented residents. The DNS identified that it was her expectation that a Covid-19 vaccination would be administered right away, once you receive the vaccinations. Interview and clinical record review with the ADNS on [DATE] at 12:22 PM identified that the expectation is that once consent is obtained, if the vaccine is available then it would be administered, unless there was an issue or the resident was sick. The ADNS further identified that she had been unaware that there were Covid-19 vaccinations available at the facility while there were consented residents that had not yet received the vaccine. The ADNS indicated that Residents # 50, 58, and 109 declined the Covid-19 vaccination, and she was unsure why RN #1 had identified them as receiving the vaccination on Monday, Resident #60's resident representative declined the Covid-19 vaccination on [DATE] because he/she was on hospice care, Resident # 79's vaccine was on hold because he/she was not feeling well, Resident #100 was out of the facility on an LOA and would receive the vaccine upon his/her return, and Residents #2, 18, 87, and 88 received the Covid-19 vaccine on [DATE]. The Preventative Health Care Report dated [DATE] identified 9 residents received the Covid-19 vaccine on [DATE], subsequent to surveyor inquiry. Although attempted a second interview was not obtained with RN #1, and RN #1 was unavailable for majority of the survey process. The facility's Covid-19 Vaccination policy directs that all residents will be offered the Covid-19 vaccination. The IP will maintain surveillance data on all Covid-19 vaccinations among staff and residents. Administration of the Covid-19 vaccine will be made in accordance with current CDC recommendations. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Infection Preventionist policy directs that the IP shall coordinate the development and monitoring of the facility's established infection prevention and control policies and practices. The IP will collect, analyze and provide infection and antibiotic usage data and trends to nursing staff and health care practitioners; consult on infection risk assessment and prevention control strategies; provide education and training, and implement evidence-based infection prevention and control practices.