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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland Rehabilitation & Nursing Cente	26 Shenipsit Lake Road Tolland, CT 06084

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 observations, clinical record review, review of facility documentation, and interviews for one of two sampled residents (Resident #68) reviewed for dignity, the facility failed to ensure that the resident's rights were honored during a meal. The findings include: Resident # 68 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, hypothermia, and congestive heart failure. The care card dated 3/16/24 identified Resident #68 was independent with feeding. The care plan dated 3/18/23 identified Resident #68 was newly admitted to the facility. Interventions included involving the resident in decision making regarding care. The admission MDS assessment dated [DATE] identified Resident # 68 had intact cognition, was occasionally incontinent of bowel, frequently incontinent of bladder, required partial assistance with toileting and bathing, and was independent with eating. Interview and observation on 3/24/24 at 8:25 AM identified Resident #68's breakfast meal tray set up at his/her bedside table by NA #2. Following the tray delivery and set up, NA #2 was observed applying a large clothing protector to Resident #68's chest area and then securing the protector in place at the back of Resident #68's neck area. During this observation, NA #2 did not speak to Resident #68 prior to applying the clothing protector. NA #2 was then observed exiting Resident #68's room. Immediately following this observation, Resident #68 identified that this was the first time a clothing protector had been applied to him/her during a meal. Resident #68 identified that he/she would have liked to have been asked and given the option to choose to use a clothing protector by NA #2. Interview with NA #2 on 3/24/24 at 8:50 AM identified she could not remember if Resident #68 had ever asked for a clothing protector, but that she should have asked Resident #68 if he/she wanted to wear the clothing protector before applying it. Interview with the DNS on 3/26/24 at 11:25 AM identified Resident #68 should have been asked if he/she needed a clothing protector by NA #2. The DNS identified Resident #68 had the right to decide if he/she wanted a clothing protector while eating. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on resident rights directed that all residents of the facility had the right to be treated with consideration, respect, and full recognition of their dignity and individuality. The policy further directed that residents of the facility had the right to make choices about aspects of their lives that were significant to them.

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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, review of facility documentation and interviews for 1 sampled resident (Resident #75) reviewed for edema, the facility failed to ensure APRN or physician were notified that weights were not obtained per physician order. The findings include: Resident #75 was admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses which included edema, congestive heart failure, and dementia. A physician's order dated 9/22/23 directed to complete a daily weight in the morning. Notify the provider for a weight gain greater than 2 lbs. in 1 day and 5 lbs. in a week. The care plan dated 9/22/23 identified congestive heart failure. Interventions directed to complete a daily weight in the morning. Notify the provider for a weight gain greater than 2 lbs. in 1 day and 5 lbs. in a week and give medications per physician order. The Admission MDS assessment dated [DATE] identified Resident #75 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. A physician's order dated 10/13/23 directed to complete a daily weight in the morning. Notify the provider for a weight gain greater than 2 lbs. in 1 day and 5 lbs. in a week. A physician's order dated 10/16/23 directed to administer Furosemide(a diuretic medication) 40 mg 2 times a day for CHF (chronic heart failure). Review of the TAR (treatment administration records) for the months of November 2023 though March 24, 2024 identified the following : 11/1/23-11/30/23 identified 6 missed opportunities out of 30 for daily weights. 12/1/23-12/31/23 identified 10 missed opportunities out of 31 for daily weights. 1/1/24-1/31/24 identified 10 missed opportunities out of 31 for daily weights. 2/1/24- 2/29/24 identified 15 missed opportunities out of 29 for daily weights 3/1/24- 3/31/24 identified 12 missed opportunities out of 24 for daily weights. Review of the TAR indicated Resident #75 had refused on 7 occasions dated 3/4, 3/13, 3/14, 3/20, 3/21, 3/22, 3/24/24. Review of the progress notes dated November 1, 2023-March 24, 2024 did not reflect any refusals and/or explanation of why the weights were not documented . Additionally,the clinical record did not reflect that the APRN or physician were notified of the weights not obtained or refused. (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 3/25/24 at 10:45 AM indicated the charge nurse was responsible for making sure the nursing assistants obtain the daily weights for Resident #75. The DNS indicated the expectation was if a resident refuses the daily weight the nurse must educate the resident and then try again. The DNS indicated if the resident still refuses the nurse must write a progress note explaining why the weight was not obtained and why the resident refused. Additionally, the DNS indicated if the weight is not obtained or refused the APRN or physician must be notified and documented in the progress notes. After clinical record review, the DNS indicated that the progress notes did not reflect that the APRN or physician had been notified of the missing weights or the refusals of weights in the last 5 months. Review of the facility Weight Management Policy identified to ensure all residents weights are routinely checked, to assess any variations, and implement appropriate interventions for significant weight loss or gain. Although requested the policy for notification of a change in condition it was not provided. Review of the facility Change of Condition Policy identified the facility shall notify the resident, his/her physician, and residnet representative of changes in the residents medical condition. The nurse will notify the physician if there was a refusal of treatment or medications. The nurse will record in the residnet's medical record information relative to changes in the residents medical condition or status.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of facility documentation, and interviews, for one sampled resident(Resident #69) reviewed for an allegation of staff to resident abuse, the facility failed to implement policies to protect the resident's from abuse. The finding includes: Resident #69 was admitted [DATE] with diagnosis which included unspecified dementia with psychotic disturbances, emphysema/COPD, and depression. Facility documentation dated 8/22/22 identified Resident #69 believed NA #1 was making a joke about the resident being moved off of the unit by singing the song Celebration. Resident #69 notified his/her spouse of the situation, stated NA #1 was rude, sang Celebration and was delighted about the move. The spouse was visibly upset and expressed concerns to management regarding the treatment. NA #1 was sent home immediately pending investigation. Interview and review of the incident with NA #1 on 03/25/24 at 11:10AM identified her recall of the incident was Resident #69 was either being discharged or moved to another floor. She identified Resident #69 had a history of being mean toward her and was combative with staff. Resident #69's spouse would often yell at staff at times, and Resident #69 was also noted to be accusatory and required an assist of 2 NAs due to behaviors. NA #1 denied singing or disrespecting Resident #69 however stated she was impolite to the spouse and walked away as the spouse was conversing with her. NA #1 stated she could have kept her job had she apologized to Resident #69's spouse however she refused to apologize and at this point was remorseful about that decision. Interview and review of the incident on 03/25/24 at 03:05 PM with then interim DNS RN #9 identified she was unable to substantiate the allegation of abuse as all of the staff supported NA #1 and there no resident heard the dialogue exchange. Review of the facility incident report identified substantiated and when asked did the abuse occur with the resident, the spouse or both, RN #9 identified it was with the spouse and could not substantiate abuse with the resident. RN #9 further stated NA #1 was placed on final warning and called back to the facility to advise her that she would be placed on final warning, however NA #1 encountered the spouse in the parking lot and told the spouse that she was untouchable and proceeded to insult the family member. RN #9 indicated she spoke to her Administrator and in the absence of HR Generalist they terminated NA#1's employment Review of NA #1 personnel file failed to identify the documentation of the incident, the final warning of 8/11/22, or a background check. Although NA #1 completed the application for fingerprinting, her personnel file failed to identify a returned fingerprint verification. Interview with HR Director on 3/25/24 at 1:20 PM identified NA #1 was hired 4/22. The HR Director was unable to locate any preliminary screening associated with NA #1's employment application. Interview with the DNS on 3/25/24 at 3:25PM identified neither he nor the Administrator were employed by the facility in 2022. It would be his expectation that employees are screened, and background checks are done prior to an offer for hire and that personnel files are complete. Although attempted a call to the Administrator of the facility in 2022 was not returned. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested a policy for hiring and screening was not provided.

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F 0623

Level of Harm - Potential for minimal harm

Residents Affected - Some

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

37293

Based on review of the clinical records, review of facility documentation and interviews for 2 of 2 residents (Resident #28 and 46), reviewed for hospitalization , the facility failed to ensure the State Long-Term Care Ombudsman was notified when the residents were transferred to the hospital. The findings include.

1. Resident #28 was admitted to the facility in September 2022 with diagnoses which included chronic obstructive pulmonary disease, morbid severe obesity, congestive heart failure, and asthma.

Review of the census list form dated 9/9/23 identified Resident #28 was transferred to the hospital.

The nurse's note dated 9/11/23 at 6:50 PM identified Resident #28 was readmitted to the facility.

Review of the Admit/Discharge Report dated 9/1/23 failed to reflect that the Office of the State Long-Term Care Ombudsman had been notified when Resident #28 was transferred to the hospital on 9/9/23.

2. Resident #46 was admitted to the facility in October 2023 with diagnoses which included diabetes, asthma, and atrial fibrillation.

Review of the census list form dated 10/3/23 identified Resident #46 was transferred to the hospital.

The nurse's note dated 10/9/23 at 11:58 PM identified Resident #46 was readmitted to the facility.

Review of the Admit/Discharge Report dated 10/1/23 failed to reflect that the Office of the State Long-Term Care Ombudsman had been notified when Resident #46 was transferred to the hospital on 10/3/23.

Interview with SW #1 on 3/25/24 at 11:30 AM identified the facility found out the Admit/Discharge Reports dated 1/1/23 - 3/1/24 that were sent to the Office of the State Long-Term Care Ombudsman were the wrong reports. SW #1 indicated she was not aware that it was the wrong reports. SW #1 indicated that was the way she was thought to retrieve the Admit/Discharge Reports. SW #1 indicated she will discuss the issue with her Regional Admission Director.

Interview with the DNS on 3/25/24 at 11:35AM indicated the social worker is responsible for ensuring the reports of hospital transfers are sent to the Office of the State Long-Term Care Ombudsman.

Interview with the Administrator on 3/25/24 at 11:40 AM identified she was aware that the Admit/Discharge Report was being sent out monthly but was not aware it was being sent incorrectly. The Administrator indicated she will discuss the issue with the Regional Admission Director and in-service will be provided to SW #1.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the facility notice of transfer or discharge form identified the regulation at 42 CFR 483.15(c)(3)(i) requires, in part, that before a facility transfer or discharges a resident, the facility must notify the resident and the resident's representatives of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must also send a copy of the notice to a representative of the Office of the State Long-Term Care ombudsman. Sending a copy of the notice to a representative of the Office of the State Long-Term Care ombudsman provided added protection to residents and ensures the Office of the State Long-Term Care ombudsman is aware of the facility practices and activities related to transfers and discharges.

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F 0625

Level of Harm - Potential for minimal harm

Residents Affected - Some

Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37293

Based on review of the clinical record, review of facility documentation, and interviews for 3 of 3 residents (Resident #24, Resident #28 and Resident #46) reviewed for hospitalization , the facility failed to provide a bed hold notice to the resident or resident representative. The findings include:

1. Resident #24 was admitted to the facility in December 2022 with diagnoses which included anxiety disorder, pneumonia, and acute respiratory failure.

A nurses note of 2/19/24 identified Resident #24 experienced altered mental status, and was sent to the hospital for evaluation on 2/19/24. Resident #24 was readmitted to the facility on [DATE] with a diagnosis of metabolic encephalopathy and pneumonia.

Review of the clinical record failed to reflect a bed hold notice had been provided to the resident or resident representative upon the resident transfer to the hospital on 2/23/24.

2. Resident #28 was admitted to the facility in September 2022 with diagnoses which included chronic obstructive pulmonary disease, morbid severe obesity, congestive heart failure, and asthma.

Review of the census list form dated 9/9/23 identified Resident #28 was transferred to the hospital.

The nurse's note dated 9/11/23 at 6:50 PM identified Resident #28 was readmitted to the facility.

Review of the clinical record failed to reflect a bed hold notice had been provided to the resident or resident representative upon the resident transfer to the hospital on 9/9/23.

3. Resident #46 was admitted to the facility in October 2023 with diagnoses which included diabetes, asthma, and atrial fibrillation.

Review of the census list form dated 10/3/23 identified Resident #46 was transferred to the hospital.

The nurse's note dated 10/9/23 at 11:58 PM identified Resident #46 was readmitted to the facility.

Review of the clinical record failed to reflect a bed hold notice had been provided to the resident or resident representative upon the resident transfer to the hospital on 10/3/23.

Interview with Social Worker #1 on 3/25/24 at 11:32 AM identified her office does not issue bed hold notices to residents or resident representatives upon transfer to the hospital.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview and clinical record review with the DNS on 3/25/24 at 11:38 AM failed to provide documentation to reflect that Resident #28 and Resident #46 or the representatives had received the notice regarding reservation of the resident bed if the resident is hospitalized (the bed hold form). The DNS indicated there were no copies of the notice regarding reservation of the resident bed if the resident is hospitalized (the bed hold form) in the clinical record of Resident #28 and Resident #46. The DNS indicated the Admission Director is responsible for ensuring the resident representative receives the bed hold notices upon a resident transfer to the hospital. The DNS indicated there should be a packet for transfer (red envelope) to the hospital that includes notice of emergency transfer to hospital and notice regarding reservation of the resident bed if the resident is hospitalized (the bed hold form). The DNS indicated the supervisor was responsible to make a copy of the notice of emergency transfer to hospital and notice regarding reservation of the resident bed if the resident is hospitalized (the bed hold form) for the resident clinical record and the original is to go with the resident to the hospital. Interview with the Admission Director on 3/25/24 at 12:00 PM identified she was not aware of Resident #28 and Resident #46 representatives did not receive the notice regarding reservation of the resident bed (the bed hold form). Although requested, a facility bed hold notice policy was not provided. Review of the notice regarding reservation of the resident bed if the resident is hospitalized for m identified the facility will reserve the bed of a private-pay resident who has been transferred to hospital as long as payment at the usual self-pay per diem rate is available to reserve the bed. In case of a Medicaid-assisted resident, the facility will reserve the bed for up to seven days as long as the facility has not received information that the resident is not expected to return to the facility at the same level of care. The facility will reserve the bed for up to an additional eight days as long as the facility has not received information that the resident is not expected to return to the facility at the same level of care. 43032

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 2 residents (Resident #75) reviewed for respiratory care, the facility failed to ensure a comprehensive care plan was developed related to the use of respiratory equipment. The findings include: Resident #75 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary edema, dementia, and obstructive sleep apnea. The admission MDS assessment dated [DATE] identified Resident #75 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Additionally, the MDS assessment did not indicate the use of a C-pap. The baseline care plan dated 10/4/23 did not identify the use of a C-pap. The comprehensive care plan dated 10/10/23 did not identify diagnosis of sleep apnea or the use of the CPAP. The physician's orders dated 1/20/24 (120 days after admission) directed the use the CPAP with medium full face mask oxygen flow rate at 2 liters per minute. On every night, off every morning and as needed when napping. Cleanse CPAP tubing with 1/2 water, 1/2 white vinegar (place tubing into a basin) remove the tubing from the basin and allow tubing to be air dry every Sunday on 11:00 PM-7:00 AM shift. (scheduled while resident is using the CPAP). Observation on 3/24/24 at 7:00 AM Resident #75 was lying in bed wearing a CPAP mask with tubing connected to a machine on a rolling cart on the left side of the bed. Interview with the DNS on 3/25/24 at 10:23 AM indicated the MDS coordinator was responsible to include the use of the CPAP in the baseline care plan and the comprehensive care plan since admission. The DNS indicated the MDS coordinator(RN #8)works remotely and completes the MDS assessments based on physician orders. The DNS indicated that he would have expected a care plan since admission regarding the CPAP. Interview with MDS coordinator (LPN #3), on 3/25/24 at 11:10 AM indicated she was responsible or MDS coordinator RN #8 to include the use of the CPAP on the care plan. LPN #3 indicates that they do the care plan based off the admission physician's orders. LPN #3 indicated that the CPAP was not in the initial admission orders, so it got missed. After surveyor inquiry, the comprehensive care plan dated 3/25/24 included alteration in respiratory status and resident uses a C-pap. Interventions included cleaning the c-pap mask daily per policy, fill humidifier with sterile water per physician order, change the mask and tubing per physician order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Care Plan Policy identified the facility will have an interdisciplinary care plan to achieve and maintain optimal status for each resident. The resident care plan will include the residents needs, realistic goals, and the care and services needed to meet these goals. The MDS coordinator is responsible for ascertaining that all MDS triggered items have been addressed.

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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, review of facility documentation, and interviews for 1 of 1 resident (Resident #47) reviewed for accidents, the facility failed to ensure the neurological assessment was completed per policy after an unwitnessed fall with injury and, and for 1 of 3 residents (Resident #84) reviewed for behaviors, the facility failed to ensure behavior observation and monitoring was provided for a resident that required 1:1 constant supervision. The findings include:

1. Resident #47 was admitted to the facility with a diagnosis which included dementia, diabetes, and difficulty in walking.

The care plan dated 8/31/23 identified multiple falls. Interventions included dycem to wheelchair, offer toileting after lunch and before end of 7:00 AM to 3:00 PM, and encourage participation in activities. Resident #47 was non ambulatory and uses a mechanical lift for transfers.

The quarterly MDS assessment dated [DATE] identified Resident #47 had moderately impaired cognition and required extensive assistance with dressing, toileting, and personal hygiene. Additionally, that Resident #47 had no falls prior to admission and no falls since prior assessment.

Review of the accident and incident report dated 11/20/23 at 5:15 PM indicated Resident #47 had an unwitnessed fall at his/her bedside. The resident was awake, alert, and forgetful. Resident #47 was last seen in bed with heel booties on prior to the fall and fell on to his/her face resulting in a laceration to the bridge of the nose and copious amounts of [NAME] red blood. Assessment identified the bridge of the nose identified it was red, painful and swollen. Resident #47 remained on the floor until EMS arrived.

The nurse's note dated 11/21/2023 at 1:49AM identified Resident #47 returned to facility at 1:40 AM from the emergency room via ambulance stretcher. Resident #47 is alert and oriented to self. Confused at baseline. Resident #47 has an abrasion, edema and hematoma noted to nose. Diagnosis with nasal fracture related to fall and a urinary tract infection. New order for antibiotic for 5 days. On call APRN notified and follow up with house APRN in the morning. Neurological checks and range of motion as tolerated. Safety measures maintained and continue to monitor.

Summary of accident and incident report dated 11/22/23 indicated that Resident #47 had sustained a nasal fracture from the unwitnessed fall. Resident returned from the emergency roiagnom on [DATE] with a diagnosis of nasal fracture, atrial fibrillation, and urinary tract infection. Intervention to offer toileting and for Resident #47 to get out of bed around dinner time. Resident #47 was started on antibiotics for the urinary tract infection. A review of the clinical record failed to provide evidence of neurological assessments following the fall on 11/20/23.

Interview with DNS on 03/25/24 at 7:00 AM indicated that his expectation was that any resident that had an unwitnessed fall would have neurological assessments including vital signs completed per facility policy. The DNS indicated if the resident goes to the emergency room and returns, he expects the neurological assessments to continue when the resident returns. The DNS indicated that Resident #47 went to the hospital but when he/she returned the nurses should have restarted the neurological assessments that include the vital signs.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER Woodlake at Tolland Rehabilitation & Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 26 Shenipsit Lake Road Tolland, CT 06084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Fall Prevention Program Policy identified that if a resident has an unwitnessed fall or suffers a head injury, a neurological assessment is to be completed and neurological signs are to be documents according to the following time line: every 15 minutes for the first 2 hours, every 30 minutes for the next 2 hours, every hour for the next 4 hours, every 4 hours for the next 16 hours, and every shift for the next 48 hours. If any point there is a change in the neurological signs, the healthcare provider will be notified. 46040 2. Resident # 84 was admitted to the facility on [DATE] with diagnoses that included dementia with agitation, post traumatic stress disorder (PTSD), and anxiety. The physician's orders dated 3/13/24 directed that Resident #84 required Quetiapine (an antipsychotic medication) 25 mg twice daily for anxiety and Trazadone (a psychotropic medication) 25 mg at bedtime for insomnia. The admission MDS assessment dated [DATE] identified Resident # 84 had severely impaired cognition, was always incontinent of bowel and bladder and required with moderate assistance with dressing, transfers, and set up for meals. The March 2024 care plan identified Resident #84 was at risk for depression due to history of PTSD. Interventions included to monitor, document and re/port any risk for harm to self, harm to others, and signs/symptoms of depression including hopelessness and negative statements. A physician's order dated 3/17/24 at 8:04 PM directed Resident #84 be placed on 1:1 monitoring until seen by psychiatry due to suicidal ideation's. The nurse's note dated 3/17/24 at 10:14 PM identified Resident #84 had reported he/she wanted to harm his/herself at 6:41 PM. The note further identified Resident #84 was placed on 1:1 monitoring until cleared by the on call psychiatric APRN. The note also identified that 1:1 monitoring was discontinued following clearance by psychiatry. The nurse's note by RN #4 dated 3/18/24 at 11:54 AM identified that Resident #84 had reported he/she wanted to harm his/herself. The note further identified Resident #84 was placed on 1:1 monitoring until seen by psychiatry and that Resident #84's significant other was at the bedside visiting. The nurse's note further identified that Resident #84's significant other was instructed to notify RN #4 prior to leaving the facility to resume 1:1 monitoring. Review of the facility visitor log for 3/18/24 identified Resident #84's significant other was at the facility from 11:40 AM to 6:35 PM. Review of the clinical record failed to identify any additional documentation related to behaviors including 1:1 monitoring for Resident #84 on 3/18/24 and 3/19/24. Review of the clinical record also identified LPN #7 cared for Resident #84 on 3/18/24 3 PM-11 PM shift and LPN #6 cared for Resident #84 on 3/18/24 11 PM-7 AM shift. A nurse's note dated 3/19/24 at 12:04 PM identified Resident # 84 was seen by PhD #1 (psychologist) and was cleared of suicidal ideation and was off 1:1 monitoring. (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 #4 on 3/26/24 at 10:05 AM identified that Resident #84 was placed on 1:1 monitoring sometime during her shift on 3/18/24 but she could not remember what time Resident #84 verbalized suicidal ideation or when 1:1 monitoring was initiated. RN #4 further identified that once Resident #84's significant other arrived to the facility, no 1:1 monitoring observations were completed by facility staff, and that she instructed Resident #84's significant other to notify someone when he/she was leaving so that 1:1 monitoring could be resumed by the facility and that Resident #84's significant other was still at the facility when she left. RN #4 identified that the facility policy was for a shift note to be documented, and that she did not document any other notes on 3/18/24 related to Resident #84's behaviors or 1:1 monitoring. Interview with LPN #6 on 3/26/24 at 10:24 AM identified that she did not provide any 1:1 monitoring for Resident #84 on 3/18/24. LPN #6 identified she received report from LPN #7 and was notified that Resident #84 had verbalized suicidal thoughts on 3/18/24 during the 7 AM-3 PM shift and had been placed on 1:1 monitoring, but that the monitoring had been discontinued prior to change of shift at 3 PM. LPN #6 identified Resident #84 was not on any type of behavior monitoring and did not have any orders related to 1:1 or behavior monitoring in place when she took over care. Interview with APRN #3 (psychiatric APRN) on 3/26/24 at 10:55 AM identified that Resident #84 should have had 1:1 monitoring by the facility staff and that that staff should have remained with Resident #84 until cleared by psychiatry. APRN #3 further identified that while Resident #84 would be able to have visitors during the monitoring, it was the responsibility of the facility staff and not Resident #84's visitors to provide 1:1 monitoring for suicidal ideation. Interview with the DNS on 3/26/24 at 11:30 AM identified Resident #84 should have had continuous 1:1 monitoring for suicidal ideation on 3/18/24 until cleared by the psychiatric provider. The DNS identified that the 1:1 monitoring did not necessarily need to be completed by nursing staff of the facility, and that any staff member with training in behavior monitoring and 1:1 observation could be assigned, it was not appropriate rely on Resident # 84 to perform any behavior monitoring as visitors to residents of the facility are not facility staff members. The DNS also identified that 1:1 monitoring would include keeping the resident within eye sight, but this would be based on a case by case basis. The DNS also identified that the facility did not have any policy related to specifics of that 1:1 monitoring should include, and that the facility only documented progress notes related to 1:1 monitoring periodically in the clinical record. Although attempted, an interview with LPN #7 was not obtained. Although attempted, an interview with PhD #1 was not obtained. The facility policy on resident suicide threats identified that residents who have threats of suicide should remain on 1:1 until deemed safe, and that staff would monitor the resident's mood and behavior accordingly. The facility policy on psychoactive medication use directed any residents receiving antipsychotic medications with a diagnosis of dementia and agitated/psychotic behaviors should have specific behaviors quantatively documented, including number of episodes and occurrences.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on facility documentation, facility policy and interview for 1 resident (Resident #12) reviewed for bowel protocols, the facility failed to follow its policy to assist a resident in maintaining bowel function. The findings include: Resident # 12 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, dysphagia, and unspecified convulsions. The annual MDS assesssment dated 2/18/24 identified Resident # 12 had moderately impaired cognition, was wheelchair dependent and incontinent of both bowel and bladder. The care plan dated 2/27/24 identified a focus on constipation with interventions that included follow facility protocol for bowel management. A physician's order dated 3/1/24 directed to administer Milk of Magnesia (laxative) 30 ml every 24 hours as needed for constipation and give Miralax 17 grams (laxative) by mouth daily as needed for no bowel movement in 3 shifts (mix with 120 ml of water, tea, juice or coffee), and Bisacodyl suppository 10mg (laxative), use if Miralax is not effective. The nurse's note dated 3/13/24 at 10:06AM identified that Resident #12 had no bowel movement in 5 days, an assessment was done, identifying abdomen soft and not tender, denies abdominal pain, APRN notified and new orders for Miralax 17 gm and Senna -S 2 tablets .daily at bedtime, responsible party notified of change. An interview and clinical record review with the DNS on 3/25/24 at 2:25PM was unable to provide documentation that Resident #12 bowels were monitored per facility policy and the Resident #12's care plan. The DNS identified the interventions should have begun on the fourth day without a bowel movement. The facility policy for bowel regime states when a resident has had no bowel movement on day number 4; the 3-11 charge nurse will administer milk of magnesia. If constipation continues, the 11-7 nurse will give the resident a suppository at 6:00AM am following the milk of magnesia dose. If constipation continues on day #5 the 7-3 charge nurse will administer a fleet enema. All of the as needed charting is to be documented in the medication administration record for the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 46040 Based on observations, clinical record review, review of facility documentation, and interviews for one of three residents (Resident #19) reviewed for choices, the facility failed to ensure that a resident's prescribed diet was followed per the physician's order. The findings include: Resident # 19 was admitted to the facility on [DATE] with diagnoses which included acute metabolic acidosis, chronic kidney disease, and ileostomy. The physician's orders dated 3/10/24 identified Resident #19 required a renal diet and Lokelma (a medication used to treat high potassium levels) 10 gram packet by mouth twice daily. The care plan dated 3/12/24 identified Resident #19 was at risk for nutritional problems due to multiple chronic diseases and the need for a therapeutic diet. Interventions included to provide and serve a renal diet as ordered. The admission MDS assessment dated [DATE] identified Resident # 19 had intact cognition, was continent of bladder and bowel with ileostomy, and required a therapeutic diet. Review of the clinical record identified Resident #19 had an elevated potassium level of 5.9 (normal range per lab result 3.5-5.1) on 3/24/24 at 1:40 AM. A nurse's note dated 3/24/24 at 3:28 AM identified stat lab result had been received and reported to APRN with new orders for 0.9% sodium chloride IV to run at 60 ml/hr for a total of 1 liter and to administer Kayexalate (a medication used to treat high potassium) 15 gm/60 ml once by mouth and repeat lab on 3/25/24. Review of the clinical record identified Resident #19 had a potassium level of 5.1 (normal range per lab result 3.3-5.1) on 3/25/24 at 12:27 PM. Observation and interview with Resident #19 on 3/25/24 at 12:40 PM identified issues with Resident #19's meal tray. Resident #19 identified he/she had issues with high potassium levels and was supposed to be served meals with low potassium foods. Resident #19 identified that the facility had repeatedly provided high potassium food items, including items with tomatoes, tomato sauce, and potatoes almost daily. Resident #19 also identified his/her lunch tray, which was observed to have a full serving size (approximately one cup) of mashed potatoes. Resident #19 identified he/she was aware that he/she must avoid high potassium foods and did not understand why his/her meal trays kept including these items. Interview with the Dietary Director on 3/25/24 at 3:00 PM identified he had been made aware by Resident #19 that his/her lunch tray did include potatoes. The Dietary Director identified that Resident #19 should not have received any high potassium food items with a renal diet order. The Dietary Director identified he would re-educate his staff regarding therapeutic diet orders. (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 Dietician and Regional Dietician on 3/26/24 at 8:30 AM identified that they were aware of Resident #19's renal diet order and elevated potassium levels. The Regional Dietician identified that the renal diet provided by the facility would restrict high potassium and high phosphorus food items, but would try to be as liberalized as possible. The Regional Dietician identified that the facility utilized instant potatoes instead of fresh potatoes when mashed, and that instant potatoes did have a lower potassium level, however she was unable to identify how that would impact a resident on a renal diet with high potassium levels. The Dietician identified that while she was aware Resident #19 had elevated potassium levels, she was not aware Resident #19 had required additional medication or IV fluids as there had not been any nutritional consults placed. The Dietician identified that going forward, Resident #19's meals would include double portions of protein and vegetable with low potassium foods and no starches. Interview with APRN #2 on 3/26/24 at 9:56 AM identified Resident #19 had orders for a renal diet and that would include avoiding any food items high in potassium. APRN #2 identified Resident #19 should not have potatoes of any kind as part of his/her diet since they are high in potassium and could increase Resident #19's already elevated potassium levels. Interview with the DNS on 3/26/24 at 10:54 AM identified he had been notified of the issue with Resident #19's renal diet order and meal trays by the Dietary Director and that going forward the dietary staff were to be re-educated on what foods residents should avoid on a renal diet, and that Resident #19 should not receive any high potassium food items. The facility policy on nutritional management directed that all residents would have their nutritional needs assessed and receive diets as prescribed by the physician. The facility policy on guidelines for a renal diet directed individuals with compromised kidney function may have trouble clearing minerals including potassium, phosphorus, and calcium. The policy further identified foods that should be avoided on renal diet included potatoes and tomatoes.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when 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 2 of 2 residents (Resident #5, #75) reviewed for respiratory care, the facility failed to ensure respiratory equipment was cleaned, changed, and stored per policy and manufacturer's recommendations (for 189 days). The findings include: 1. Resident # 5 was admitted to the facility on [DATE] with diagnoses which included COPD, centrilobular emphysema, and diabetes type 2. The admission MDS assessment dated [DATE] identified Resident # 5 had intact cognition, utilized a walker and wheelchair for mobility, and was on oxygen therapy. The care plan dated 12/22/23 identified a focus on emphysema/COPD with interventions that included oxygen settings via nasal cannula as ordered. A physician's order dated 3/10/24 directed to apply oxygen at 2-3 liters per minute via nasal cannula to keep oxygen saturation level greater than 88% ever shift for COPD, oxygen dependent. Observations on 03/24/24 08:32 AM identified no date on tubing for oxygen nasal cannula which was on the floor, no date on nasal cannula attached to a portable oxygen canister affixed to the back of the wheel chair which was in use by Resident #5, or date on a nebulizer mask which was on the bedside table. LPN #1 identified that the dating of tubing for the O2 canister, temporary/portable oxygen tank and nebulizer tubing is dated and bagged is done on the Sunday 11-7 shift. LPN#1 was not able to explain why dating of the tubing was not completed. Interview with DNS on 3/25/24 at 2:25 PM noted that the oxygen tubing should be changed and dated on the 11 PM-7AM shift on Sunday night. 2. Resident #75 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary edema, dementia, and obstructive sleep apnea. The admission MDS dated assessment dated [DATE] identified Resident #75 had moderately impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene. Additionally, did not indicate the use of a CPAP. The physician's orders dated 1/20/24 (120 days after admission) directed the use the CPAP with medium full face mask oxygen flow rate at 2 liters per minute. On every night, off every morning and as needed when napping. Cleanse CPAP tubing with 1/2 water, 1/2 white vinegar (place tubing into a basin) remove the tubing from the basin and allow tubing to be air dry every Sunday on 11:00 PM-7:00 AM shift. (scheduled while resident is using the C-pap). Observation on 3/24/24 at 7:00 AM Resident #75 was lying in bed wearing a CPAP mask with tubing connected to a machine on a rolling cart on the left side of the bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/24/24 at 7:30 AM CPAP mask was draped over the machine on a cart without the benefit of a bag and was not labeled or dated. Observation and interview with LPN #2 on 3/24/24 at 7:40 AM indicated the CPAP tubing and mask were not labeled and dated. LPN #2 indicated that the tubing should be labeled and dated each week after being cleaned. LPN #2 indicated that the CPAP full face mask probably should be in a bag when not in use. LPN #2 indicated that the tubing and mask are cleaned once a week with vinegar and water scheduled for Sundays during the 11:00 PM- 7:00 AM shift. LPN #2 indicated that he would get a bag for the full-face mask of the CPAP. LPN #2 indicated he was not aware if any of the tubing or mask get cleaned daily or how often. Interview with the DNS on 3/25/24 at 8:09 AM indicated that the C-PAP full-face mask should be bagged at the bedside when not in use. The DNS indicated he would have to check the policy for changing the mask and tubing. The DNS indicated he knows that they must be changed but not sure how often. The DNS indicated that he would get the policy and the manufacture book for that CPAP. Interview with the DNS on 3/25/24 at 9:05 AM indicated that he did not think the CPAP had a filter or a humidifier chamber. The DNS indicated that he was not sure how often if at all the full-face mask and tubing needed to be changed or cleaned. The DNS indicated that he would have to check his policy. After clinical record review, the DNS indicated there was an order to clean the tubing once a week. The DNS indicated that the filter, mask, and tubing had not been changed since admission. Observation and interview with the DNS on 3/24/24 at 9:10 AM indicated that the mask and tubing were not dated when last changed. The DNS after being shown where the filter was removed the white filter that has a layer of dust on it. After reviewing the clinical record and policy, the DNS indicated that Resident #75 had an order for the CPAP with the settings and to wash tubing weekly. The DNS indicated that Resident #75 was missing the physician orders for cleaning the tubing and the full-face mask must be cleaned daily with warm water and soap, must clean humidifier chamber every morning, disinfect humidifier chamber once a week, masks need to be disinfected weekly, change the tubing every 2 weeks, headgear for the mask should be hand washed once a month or sooner, and white disposable filter needs to be changed once a month. The DNS indicated he will need to add in the physician's orders for the care and cleaning of the CPAP per the facility policy. After surveyor inquiry, a physician's order dated 3/25/24 (189 days later), directed to change the white filter in the C-pap monthly, headgear and mask to be hand washed once monthly at bedtime, disinfect nasal and full-face mask weekly, disinfect chamber once a week in the morning, fill humidifier with sterile water to the fill line prior to the start of therapy at bedtime, nasal and full-face mask and clean humidifier chamber clean every day with warm water and soap daily and let air dry, and cleanse the humidifier chamber every morning with soap and water and let air dry then place in covering plastic bag, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility C-PAP and Bi-pap Policy identified all residents who have physician orders for a C-PAP will have equipment provided to them through designated Respiratory program or may bring in their own personal equipment. If using disposable tubing change them every 2 weeks. If using the disposable tubing clean tubing every day with warm soap and water. Full face masks need to be cleaned daily with warm water and soap. Masks also needed to be disinfected once a week. The headgear for the masks needs to be hand washed at least once a month cleaned or sooner. The ultra white disposable filter needs to be changed once a month. The humidifier chamber needs to be cleaned every morning with warm water and soap and let air dry. Fill with sterile or distilled water to the fill line prior to therapy daily and disinfect chamber once a week. Additionally, the manufacturer recommendations identified to change the full-face mask and air tubing every 3 months and the mask headgear and humidifier tubing every 6 months.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, review of facility documentation, and interviews for 1 sampled (Resident #88) reviewed for catheters, the facility failed to ensure there the nursing staff were competent to care for specialized medical equipment. The findings include: Resident #88 was admitted to the facility with diagnoses which included dementia, chronic cholecystitis, and hydronephrosis with renal and ureteral calculus obstruction. The quarterly MDS assessment dated [DATE] identified Resident #88 had severely impaired cognition and has a indwelling Foley catheter for urine and a colostomy for bowels. Resident #88 requires total assistance for dressing, toileting, showering, and personal hygiene. A physician's order dated 2/19/24 directed to apply bacitracin to JP(Jackson Pratt drain is a surgical suction drain that draws fluid from a wound following surgery) drain site in right lower quadrant and cover with a dry clean dressing daily and as needed. Document on wound bed, odor, drainage, surrounding skin, and wound outcome. With any symptoms or signs of infection contact the physician. A physician's order dated 2/26/24 directed to empty JP drain to right lower quadrant of abdomen every shift and document output. Monitor for signs and symptoms of infection every shift and make sure to squeeze bulb before capping to continue the suction every shift per policy. The care plan dated 3/14/24 identified Resident #88 has a Jackson Pratt (JP) drain related to cholecystitis. Interventions included observing JP drain output as ordered and JP drain care as ordered, observe for signs and symptoms of infection at the insertion site and update provider. A physician's order dated 3/21/24 directed to apply bacitracin to JP site 2 times a day for redness for 10 days. Observation on 3/24/24 at 10:50 AM Resident #88 was lying on his/her back flat in bed with head of bed slightly elevated. Noted on the right side of bed a clear tube stretching from Resident #88 to the floor with the bulb touching the floor. Observation and interview with LPN #4 on 3/24/24 at 10:55 AM indicated that Resident #88 had his/her gall bladder removed and has a JP drain. LPN #4 indicated that the JP drain should be lying on the bed next to the resident's leg unsecured. LPN #4 indicated that the bulb from the JP drain absolutely should not be touching the floor. LPN #4 picked the JP drain bulb and tubing up off the floor and laid it on the bed next to Resident #88's upper thigh under the sheets without the benefit of disinfecting the bulb prior to placing against resident's skin. LPN #4 indicated that she would go and educate the nursing assistants about the JP drain and placement for infection control reasons. LPN #3 did not disinfect the drainage bulb prior to placing on bed against resident's skin, did not secure the collection bulb, and did not check the placement of the tubing at the insertion site of Resident #88's abdomen. (continued on next page)

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Observation of LPN #5 on 3/26/24 at 6:43 AM she used hand sanitizer and put gloves on, flipped the cap open off top of bulb, emptied the bulb into a clear drinking 8-ounce cup then transferred the liquid into small medication cup. LPN #5 indicated it measured 25 cc. LPN #5 noted the dressing at the insertion site of the JP drain into the abdomen was not labeled or dated. LPN #5 indicated that all dressings require at the time it was changed the nurse's initials and the date it was changed.

LPN #5 indicated she has not received any education on the JP drain for at least the last 2 years and if there is any education it is just a read and sign this.

Observation and interview with NA #5 on 3/26/24 at 6:58 AM who was assisting NA #4 with care, indicated she does not know what that tube and drainage device is called but she thinks it has something to do with urine like the Foley so knows by common sense the resident should not lay on it and it lays next to the resident. NA #5 indicated she has not been educated about it but uses her common sense.

Interview with NA #4 on 3/26/24 at 7:00 AM indicated that Resident #88 had that tube for urine. NA #4 indicated that she was educated during certified nursing school about that JP tube. NA #4 indicated that the facility did not educate her on how to care for the JP drain.

Interview NA # 7 on 03/26/24 at 8:24 AM indicated that the drain goes somewhere into Resident #88's stomach. NA #7 indicated that she drains the device into a urinal and in then informs the charge nurse how much was drained. NA #7 indicated after she drains it that she squeezes the device prior to closing it. NA #7 indicated that she drains the liquid into a urinal and if less than 100 ml see with estimate how much. NA #7 indicated she does not use an alcohol pad to open or close the device to empty it. NA #7 indicates in the last year or two she has not had any education on that tube. NA #7 indicated the charge nurse LPN #2 had shown her how to empty it but there was no additional education, and it was done verbally only by LPN #2.

Interview with RN #7 on 3/26/24 at 8:34 AM indicated if the nursing assistants see a problem with a dressing, she will go look at it. RN #7 indicated that if round bulb has fluid she will empty because she has to document how many cc's. RN #7 indicated the nursing assistants when she works do not empty it. RN #7 indicated that when the dressing is changed around the JP drain insertion site the nurse must assess the area and must describe if there was any swelling or redness. RN #7 indicated the nurse must put on the new dressing including labeling it with the date, sign it with their initials and put the shift on it.

Interview with the DNS on 3/26/24 at 8:43 AM indicated the charge nurses are responsible to change the dressing and empty the drain. The DNS indicated that the nurse must empty the collection bulb using the bedpan or a urinal and then measure it. The DNS indicated he didn't know if the facility had anything to measure something as small as 20 ml's. The DNS indicated maybe the charge nurse could use a medication measurement with 3-4 med cups. The DNS indicated that the charge nurses should empty the JP drain so the nurse could assess the liquid. The DNS indicated that nursing staff education should be done if it was something new for the staff to learn about then the staff development nurse should provide education. The DNS indicated that JP drains were taught in nursing school and are part of nurse's scope of practice.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Woodlake at Tolland Rehabilitation & Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 26 Shenipsit Lake Road Tolland, CT 06084	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff Development and Wound Nurse (RN #2) on 3/26/24 at 9:21 AM indicated that education for the JP drain was done on hire for general orientation but after review of his general orientation check list it was not part of general orientation. RN #2 indicated that there was not any education or competencies done with the nurse's or nursing assistants in 2022, 2023, or 2024 regarding how to care for a resident with a JP drain, how to empty a JP drain, or dressing changes. RN #2 indicated he would only do competencies and education if we are aware of a need with a nurse. RN #2 indicated that he had just focused on the mandatory training requirements but this year he will look at adding in something about lines and drains for 2024. RN #2 indicated after review of the licensed staff general orientation for new hires that there was not a check off related to lines, drains, or JP drains. RN #2 indicated he would be responsible to do the nursing staff competencies. Although requested a policy on competent nursing staff it was not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation and facility policy, for one of six residents (Resident #12) reviewed for unnecessary medications, the pharmacy failed to identify a non-crushable medication as a do not crush. The findings include: Resident # 12 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, dysphagia, and unspecified convulsions. The annual MDS dated [DATE] identified Resident #12 had moderately impaired cognition, was wheelchair dependent and incontinent of both bowel and bladder. The care plan dated 2/27/24 identified long term use of antipsychotics related to schizoaffective disorder and the presence of drug induced tremors. Interventions included to monitor, document and report as needed adverse reactions to psychotropic medications, tardive dyskinesia, or drug induced movement disorders such as shuffling gait, rigid muscles, or shaking. A physician's order dated 3/1/24 directed to provide the following medications: Aspirin 81mg EC (enteric coated) Austedo 6 mg (film coated) (a medication used for tardive dyskinesia) Janumet 50-1000mg (film coated) (a medication used for diabetes) The medication was originally ordered 4/14/22 Review of the Medication administration records from April 2022 through 4/1/2024 identified the medication was administered 720 times crushed. According to Sanoski, Vallerand (2024) Davis's Drug Guide for Nurses 18th edition identified Austedo 6 mg can be used to reduce the severity of tardive dyskinesia and the medication should not be crushed and both the immediate release as well as the extended release must be swallowed whole. Interview with LPN #1 on 3/25/24 at 9:35AM identified Resident #12 takes their medications crushed in applesauce, and is unable to swallow medications whole. Interview and clinical record review with APRN #1 on 3/25/24 at 3:25PM identified the change was made as recommended by the pharmacy on 4/14/22. She identified she was not aware the medication was a do not crush at the time the decision was made. She further identified it is the responsibility of the APRN, physician, pharmacy, as well as nursing to identify if a medication can be crushed for a resident prior to administration, and failed to provide an explanation as to why a do not crush indicator was not included on the medication from the pharmacy nor acknowledged by the facility. Interview and clinical record review with Person #4 (pharmacist) on 3/26/24 at 7:55AM identified the medication Austedo is a do not crush, and failed to provide information as to why the medication was not identified by the pharmacy as a do not crush. He failed to provide information on the efficacy or toxicity of administering Austedo as crushed medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record with Person #5 (pharmacist supervisor) on 3/26/24 at 9:25AM identified the medication is a do not crush and will research the toxicity and efficacy and call. She further identified that medications can be coated to create a more pleasant taste for ingesting, or medications can be comprised of several clustered pellets which would impact efficacy and or toxicity if crushed. Although attempted, an interview with the medical director was not obtained. The policy for medication administration identified personnel administering drugs shall refer to the Physician's Desk Reference (PDR) or other reference material when unfamiliar with the pharmacology of the drug, its potential toxic contraindications, antidotes, etc., as well as the specific indications and uses of each drug. The PDR for Austedo identified that the medication should be taken with food, swallowed whole and do not chew, crush or break the tablets. (PDR by ConnectiveRx, March 2024, Drug Summary (pdr.net))

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation and facility policy for one resident (Resident #12) reviewed for blood sugar monitoring, the facility failed to monitor blood sugars according to professional standards of care. The findings include: Resident # 12 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease with dyskinesia, dysphagia, and diabetes type 2. The annual MDS assessment dated [DATE] identified Resident #12 had moderately impaired cognition, was wheelchair dependent and incontinent of both bowel and bladder. The care plan dated 2/27/24 identified a diagnosis of diabetes which is controlled with diet and oral meds with interventions that included oral medication as ordered, and monitor labs as ordered. The clinical record identified labs drawn on 10/20/23 identified glucose level of 51 mg/dl (normal range 74-100mg/dl) resulting in no new orders. The clinical record identified the last blood sugar documented was on 11/28/23 with a reading of 87 mg/dl with a physician's order to discontinue as blood sugar levels were within normal range of 82-133. Subsequent lab was drawn on 1/23/24 resulting in a glucose level of 41 mg (normal range 74-100mg/dl) which was defined as a critical lab resulting in a follow up call to the facility advising of the low glucose level. An HgA1C of 5.3 was also noted (normal range 4.8-5.6). The 1/23/24 labs were signed by APRN #2 as reviewed and entry into Resident #12's chart. Interview and clinical record review with APRN #2 on 3/26/24 at 9:50AM identified Resident #12's diabetes was managed. She stated the HgA1C was 5.3 on 1/23/24. An additional review of the labs identified the glucose reading of 41 mg. dl on 1/23/24 which was a critical lab resulting in immediate notification to the facility of the glucose level. APRN #2 indicated the critical lab of 1/23/24 was concerning even though the HgA1C was 5.3. APRN #2 further identified the blood sugar should have been monitored as a result of the critical glucose level of 41 mg/dl. Interview and clinical record review with the DNS on 3/26/24 at 12:40PM identified APRN #2 had reviewed the labs of 1/23/24, documented the results, and no new orders were issued. He indicated it is his expectation that diabetes is appropriately managed for residents. The DNS further identified it is his expectation that the critical glucose level of 41 mg/dl obtained on 1/23/24 warranted additional monitoring. Although attempted, an interview with the Medical Director was not successful. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy for diabetes protocol identified that the physician will follow up on any acute episodes associated with a significant change in blood sugars or deterioration of previous glucose control and document resident status as subsequent visits until the acute situation is resolved. The physician will order appropriate lab tests (for example, periodic finger sticks or A1C) and adjust treatments based on these results and other parameters such as glycosuria, weight gain or loss, hypoglycemic episodes, etc.

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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** 46040 Based on observations, clinical record review, review of facility documentation, and interviews for one of five residents (Resident #84) reviewed for unnecessary medications, the facility failed to ensure targeted behaviors were identified and monitored for a resident receiving psychotropic medications. The findings include: Resident # 84 was admitted to the facility on [DATE] with diagnoses which included dementia with agitation, post traumatic stress disorder (PTSD), and anxiety. The physician's orders dated 3/13/24 directed to administer Quetiapine (an antipsychotic medication) 25 mg twice daily for dementia with agitation; Lexapro 20 mg (an antidepressant medication) for depression, and Trazadone (an antidepressant medication) 25mg at bedtime for insomnia. Review of the clinical record failed to identify any orders or documentation related to targeted behavior monitoring for Resident #84 following admission to the facility on [DATE]. The care plan dated 3/14/24 identified Resident #84 was at risk for depression due to history of PTSD. Interventions included monitor, document, and report any risk for harm to self, harm to others, and signs/symptoms of depression including hopelessness and negative statements. A physician's order dated 3/15/24 directed to administer Trazadone 25 mg every 8 hours as needed for restlessness, anxiety and agitation for 14 days. A physician's order dated 3/16/24 directed Resident #84 required behavior monitoring every shift for 48 hours, beginning 3 PM-11 PM shift on 3/16/24. The admission MDS assessment dated [DATE] identified Resident # 84 had severely impaired cognition, was always incontinent of bowel and bladder and required with moderate assistance with dressing, transfers, and set up for meals. The MDS also identified Resident #84 had been taking antipsychotic medication on a routine basis. A physician's order dated 3/17/24 directed to administer Mirtazapine (an antidepressant medication) 15 mg at bedtime. Review of the clinical record identified Resident #84 verbalized suicidal ideation's to facility staff on 3/17/24 and 3/18/24. A physician's order dated 3/22/24 (9 days after admission) directed Resident #84 required behavior monitoring every shift for antipsychotic medication use related to behaviors that included uncontrolled agitation, physical aggression, and danger to self and others. (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 #3 (psychiatric APRN) on 3/26/24 at 10:55 AM identified she completed the initial assessment on Resident #84 following admission to the facility and had also seen him/her several times since admission. APRN #3 identified that Resident #84 should have had targeted behavior monitoring ordered upon admission to the facility based on antipsychotic medication use and that it was an oversight on her part. Interview with the DNS on 3/26/24 at 11:30 AM identified Resident #84 should have had behavior monitoring ordered upon admission the facility, and that while it was missed initially, there were orders for monitoring in place beginning 3/22/24. The facility policy on psychoactive medication use directed that residents receiving these medications would be monitored for medication effectiveness, adverse reactions, and side effects and that specific behaviors would be quantitatively documented. The policy further directed any residents receiving antipsychotic medications with a diagnosis of dementia and agitated/psychotic behaviors must have their targeted behaviors identified and monitored.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of facility documentation, and interviews, the facility failed to ensure opened refrigerator items were dated and discarded, per the facility policy, spoiled food products were discarded, frozen food items were covered, and beverage items were stored in a sanitary manner. The findings include: 1. During an initial tour of the facility kitchen on 3/24/24 at 7:10 AM with the Dietary Director, the following were identified: a. Observation of the reach-in refrigerator identified 4 opened Lactaid cartons without the benefit of an open date label and 1 carton of tomato juice, with an open date of 3/9/24. Interview during the tour with the Dietary Director identified that all opened containers should be labeled with an open date to ensure there is no guessing when the containers were opened or when they should be discarded. The Dietary Director indicated that it is the responsibility of the person who opened the container to create an open date label. The Dietary Director further indicated that the kitchen staff are expected to utilize the Date Marking Quick Reference Guide to determine when food items should be used or discarded by, and based on the reference guide the open carton of tomato juice should have been used or discarded after 7 days (3/16/24). b. Observation of the walk-in refrigerator identified a box of iceberg lettuce with a delivery date of 3/12/24 containing 6 heads of lettuce that had spoiled and further observation of the dry storage identified an undated bag of round buns that had blue-black discoloration on the bottom slices. The Dietary Director disposed of the iceberg lettuce and buns. Interview the Dietary Director identified that the box of iceberg lettuce was a recent delivery, and it should not be spoiled; it is his expectation that fresh produce and perishable food items be inspected upon delivery and daily. The Dietary Directory indicated that it is the cook's responsibility to ensure the food is fresh and to notify him of any perishable food items that were delivered spoiled. The Dietary Director further indicated that all bags of bread should be delivered from the vendor with an expiration date stamped on the bag or printed on the clip. The Dietary Director identified that he would call the vendor to notify them that some bread bags were delivered without an expiration date, and he will ensure the kitchen staff date any undated bags of bread upon delivery. c. Observation of the pantry identified an opened, unsealed bag of rice and further observation of the walk-in freezer identified the following un-wrapped items: chicken tenders, beef patties, pie shells, breaded [NAME], tortellini, and hash browns. Interview with the Dietary Director identified that it is his expectation that all food items stored in the refrigerator, freezer, and pantry must be wrapped up after opening. The Dietary Director further identified that if food is not properly sealed it will be exposed to the surrounding environment and it will not taste fresh. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. Observation of 1 of 6 refreshment carts set with fresh juices, coffee, creamers, water, and cups for breakfast service identified the bottom shelf containing the following used or soiled items: a cup partially filled with juice, 2 towels, and a coffee cup containing old coffee and a spoon. Interview with the Dietary Director identified that there should be no dirty items on the service carts, the carts are only for new drinks and snacks; there are designated carts specifically for dirty items. The Dietary Director directed the dietary aide to clean, sanitize, and restock the cart. The Date Marking Woodlake [NAME] policy ensures the proper rotation of ready-to-eat foods and potentially hazardous foods to prevent or reduce foodborne illness and directs that foods will be date marked with the name of the product, the date of the production or opening. Refer to Quick Reference List for discard date. A designated employee(s) will be assigned to monitor products within department refrigerators/freezers within their responsibility. Processes will be monitored by the food service director. The Dry Food Storage policy directs opened boxes of food shall be re-wrapped, dated, and used as soon as possible. The Cold Food Storage directs all prepared foods in the refrigerator shall be kept covered, labeled, and dated. The Sanitation Policy directs that the sanitation of the facility complies with all state, local, and federal guidelines. Kitchen surfaces and equipment will be maintained in a manner to promote clean and sanitary conditions for food preparation and service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #88) reviewed for catheters, the facility failed to ensure there the medial equipment was maintained in a sanitary manner and for one sampled resident (Resident #91) reviewed for transmission-based precautions, the facility failed to ensure transmission based precautions were maintained for a resident with a infection; and for 2 sampled residents reviewed for infection control (Resident #311 and Resident #312), the facility failed to ensure shared medical equipment was sanitized between use on residents. The findings include: Resident #88 was admitted to the facility with diagnoses which included dementia, chronic cholecystitis, and hydronephrosis with renal and ureteral calculous obstruction. The quarterly MDS assessment dated [DATE] identified Resident #88 had severely impaired cognition and has a indwelling Foley catheter for urine and a colostomy for bowels. Resident #88 requires total assistance for dressing, toileting, showering, and personal hygiene. A physician's order dated 2/19/24 directed to apply bacitracin to JP drain site in right lower quadrant and cover with a dry clean dressing daily and as needed. Document on wound bed, odor, drainage, surrounding skin, and wound outcome. With any symptoms or signs of infection contact the physician. The consultant report dated 2/20/24 identified Resident #88 had a laparascopic cholecystectomy with a JP drain. The drain was left in place and continue to monitor the output. Add Doxycycline(antibiotic) for 10 days because of redness at the drain site. Follow up will consulting physician in 2 weeks. A physician's order dated 2/26/24 directed to empty JP drain to right lower quadrant of abdomen every shift and document output. Monitor for signs and symptoms of infection every shift and make sure to squeeze bulb before capping to continue the suction every shift per policy. The consultant report dated 3/4/24 identified Resident #88 has a JP drain in place with serous drainage. Continue to monitor output. Will see Resident #88 in 2 weeks and will remove drain once drainage is about 20 ml per 24 hours for 3 days. The care plan dated 3/14/24 identified Resident #88 has a Jackson Pratt (JP) drain related to cholecystitis. Interventions included observing JP drain output as ordered and JP drain care as ordered, observe for signs and symptoms of infection at the insertion site and update provider. A physician's order dated 3/21/24 directed to apply bacitracin to JP site 2 times a day for redness for 10 days. 1. Observation on 3/24/24 at 10:50 AM Resident #88 was lying on his/her back flat in bed with head of bed slightly elevated. Noted on the right side of bed a clear tube stretching from Resident #88 right side under the sheets to the floor with the collection bulb touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LPN #4 on 3/24/24 at 10:55 AM indicated that Resident #88 had his/her gall bladder removed and has a JP drain. LPN #4 indicated that the JP drain should be lying on the bed next to the resident's leg unsecured. LPN #4 indicated that the bulb from the JP drain should not be touching the floor. LPN #4 picked the JP drain bulb and tubing up off the floor and laid it on the bed next to Resident #88's upper thigh under the sheets without the benefit of disinfecting the bulb prior to placing against resident's skin. LPN #4 indicated that she would go and educate the nursing assistants about the JP drain and placement for infection control reasons. LPN #3 did not disinfect the drainage bulb prior to placing on the resident's bed under the sheets against resident's skin and did not check the placement of the tubing at the insertion site of Resident #88's abdomen. Interview with the DNS on 3/26/24 at 8:43 AM indicated the JP drain had to be positioned with the resident and it should not be touching the floor because infection control issues. The DNS indicated the tubing from the abdomen to the collection bulb should be attached with a clip to the resident or the side rail but definitely not touching the floor. The DNS indicated if the tubing or drainage bulb touches the floor his expectation was that the charge nurse would use the disinfectant wipes on it to thoroughly clean the collection bulb before securing it to the resident or the bed or place the collection bulb into a bag like a Foley bag. Interview with Staff Development and Wound Nurse (RN #2) on 3/26/24 at 9:21 AM indicated if the JP collection bulb was on the floor the nurse should clean the collection bulb and tubing with alcohol and secure it back in bed with resident. RN #2 indicated that it was an infection control issue if the collection bulb connected to the resident's open wound had touched the dirty floor. RN #2 indicated the collection bulb should be secured with either tape on the side of the resident abdomen or clip it to resident's shirt or his/her person or could tape the tubes to the resident's abdomen on the side. 2. Observation of LPN #5 on 3/26/24 at 6:43 AM she used hand sanitizer and put gloves on, flipped cap open off top of the collection bulb, emptied the bulb into a clear drinking 8-ounce cup of off the medication cart and then transferred the liquid into a small medication cup. LPN #5 indicated it measured 25 cc. LPN #5 emptied the cup into the toilet. LPN #5 removed gloves and used hand sanitizer. LPN #5 noted the dressing at the insertion site of the JP drain into the abdomen was not labeled or dated. LPN #5 indicated that all dressings require at the time it was changed the nurse's initials and the date it was changed. LPN #5 indicated she has not received any education on the JP drain for at least the last 2 years and if there is any education it is just a read and sign this. Interview with the DNS on 3/26/24 at 8:43 AM indicated Resident #88 the charge nurses are responsible to empty the collection bulb to the JP by using the bedpan or a urinal and then measure it. The DNS indicated he didn't know if the facility had anything to measure something as small as 20 ml's. The DNS indicated maybe the charge nurse could use a medication cup and if needed to use 3-4 medication cups. The DNS indicated that the charge nurses should empty the JP drain so the nurse could assess the liquid. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Woodlake at Tolland Rehabilitation & Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 26 Shenipsit Lake Road Tolland, CT 06084	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Staff Development and Wound Nurse (RN #2) on 3/26/24 at 9:21 AM indicated only the nurses are allowed to empty the JP drains and measure the output with a disposable sterile cup and discard in the biohazard or a pill cup it is the nurse's discretion. RN #2 indicated the nurses were responsible to follow the policy for emptying the JP drain. Review of the facility policy Jackson Pratt Drain (JP) identified it is the policy of the facility to monitor the JP drainage every shift. The purpose was to ensure safe, effective drainage of serosanguinous fluid from a wound site. Empty the contents once per shift if drainage has accumulated. If excessive drainage, empty the contents more often per the physician's orders. The procedure for emptying wash hands thoroughly with soap and water and put on non-sterile gloves. Release the vacuum by removing the spout plug on the collection chamber. Empty the contents into a graduated cylinder, note the amount, appearance, and odor of the drainage. Use an alcohol swab or sponge to clean the unit's spout and plug. To establish the vacuum that creates the suction power, fully compress the vacuum unit. With one hand holding the unit compress to maintain the vacuum and replace the spout plug with your other hand. The system must be airtight to work properly. Secure the vacuum unit to the residents clothing, fasten it below the wound level to promote drainage. Observe the sutures that secure the drain the residents' skin, look for signs of pulling or tearing and for swelling or infection or surrounding skin. Cleanse the sutures per the physician's order. Flush the drainage contents down the toilet. Review of the facility Infection Control Policy identified standard precautions should be followed when dealing with bodily fluids. Apply disinfection to the area following normal disinfection procedures. 46040 2. Resident # 91 was admitted to the facility on [DATE] with diagnoses which included bladder cancer, asthma, and hyperlipidemia. The quarterly MDS assessment dated [DATE] identified Resident # 91 had intact cognition, was continent of bowel, occasionally incontinent of bladder and required moderate assistance with transfers, dressing, and set up only for meals. The care plan dated 3/7/24 identified Resident #91 was at risk for Covid 19 infection. Interventions included to follow facility protocol for Covid 19 precautions. Review of the clinical record identified Resident #91 tested positive for Covid 19 infection on 3/14/24. A physician's order dated 3/14/24 directed Resident #91 was placed on contact/droplet precautions for Covid 19. As part of the entrance to the facility on [DATE], the facility staff identified to the survey team that the facility had no active Covid 19 outbreaks. A daily nursing roster report dated 3/24/24 identified Resident #91 as Covid 19 positive. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 3/24/24 at 7:20 AM identified that he was unsure if Resident #91 was Covid + or had been cleared and would have to look into the matter. Observation on 3/24/24 at 7:30 AM identified Resident #91's room door with a sign that identified the following: Quarantine-Droplet/Contact Precautions. Everyone must-including visitors, doctors, and staff-must clean hands when entering and exiting; gown, don an N-95 respiratory, eye protection, and gloves, and keep door closed. During this observation, no PPE storage cart or equipment was observed outside or around Resident #91's room. Observation on 3/24/24 at 8:38 AM identified that Resident #91's room door no longer had any signage related to contact/droplet precautions. A line list provided by the facility on 3/24/24 at 11:03 AM identified Resident #91 had active Covid 19 infection on contact/droplet precautions through 3/24/24. Observation on 3/24/24 at 12:23 PM identified a PPE cart located outside Resident #91's room. A sign mounted to the cart identified the following: Quarantine-Droplet/Contact Precautions. Everyone must-including visitors, doctors, and staff-must clean hands when entering and exiting; gown, don an N-95 respiratory, eye protection, and gloves, and keep door closed. During this observation, Resident #91's door was observed to be completely open to the unit hallway. Interview with RN #3 (IP nurse) on 3/24/24 at 12:28 PM identified that Resident #91 was still considered to have active Covid 19 and would not be removed from precautions until 3/25/24. RN #3 identified that there was confusion with the DNS, ADNS and clinical staff regarding when Resident #91 was supposed to have Covid 19 precautions removed but that Resident #91 was still considered Covid 19 positive and in an active outbreak upon the survey team's entrance to the facility. Observation on 3/25/24 at 11:00 AM identified that all precaution signage and PPE equipment had been removed from Resident #91's doorway. Interview with RN #3 and LPN #9 (Regional IP Nurse) on 3/25/24 at 11:34 AM identified that there was confusion among the clinical staff and administration regarding when day 10 of Resident #91's outbreak was. LPN #9 identified that the ADNS had been notified by the clinical staff on Resident #91's unit that he/she was off precautions effective 3/24/24, and it was the ADNS who removed all the signage and PPE equipment from Resident #91's room. RN #3 identified that going forward she would be the one to remove precaution signage and PPE carts from resident areas to eliminate confusion for residents on transmission-based precautions. Interview with the ADNS on 3/25/24 at 11:55 AM identified that she removed the PPE cart in front of Resident #91's room on 3/24/24 shortly after 6:30 AM but did not remove the precautions sign from Resident #91's door after being notified by the RN supervisor that Resident #91 was no longer on precautions for Covid. Review of the clinical record identified the physician's order dated 3/14/24 for contact/droplet precautions for Covid 19 was discontinued on 3/26/24 at 7:39 AM. Interview with the DNS on 3/26/24 at 10:54 AM identified that he was not 100% clear on whether Resident #91 was considered Covid 19 positive on 3/24/24 and that RN #3 was new to the IP role. The DNS identified it was a bad day and that the facility was usually very detailed with tracking residents who required transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Covid 19 infection prevention directed residents with a positive Covid 19 test would be cohorted and placed on precautions per CMS guidelines as able and that a line list of residents with respiratory symptoms would be maintained. The policy further directed that full PPE should be worn per CDC guidelines for care of any resident with known or suspected Covid 19. The facility policy on droplet and contact precautions directed that droplet precautions were used to care for specific residents with documented or suspected infections from highly transmissible or epidemiologically significant pathogens. The policy directed PPE should be utilized including face mask, goggles/face shield and gloves. 3. Resident # 311 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, chronic obstructive pulmonary disease and hypertension. The baseline care plan dated 3/20/24 identified Resident #311 was at risk for altered cardiovascular status due to hypertension. Interventions included to monitor vital signs as ordered. A physician's order dated 3/20/24 directed to obtain vital signs every day shift for 5 days. 4. Resident #312 was admitted to the facility on [DATE] with diagnoses that included post surgical care, diverticulitis and peritoneal abscess. The baseline care plan dated 3/21/24 identified Resident #312 was at risk for altered gastrointestinal status due to diverticulitis. Interventions included to monitor vital signs as ordered. A physician's order dated 3/21/24 directed to obtain vital signs every day shift for 5 days. Observation on 3/24/24 at 7:45 am identified NA #3 entering the room of Resident #311 and #312, who resided in the same room. NA #3 was observed obtaining vital signs including blood pressure, oxygen saturation via pulse oximeter, and oral temperature from Resident #311. Prior to placing the pulse oximeter on Resident #311's right index finger, Resident #311 was observed rubbing his/her face and nose with his/her right hand. NA #1 then applied the same equipment to Resident #312 without sanitizing or wiping down the equipment. Interview with NA #3 on 3/24/24 at 7:50 AM identified that she only wiped down the vital sign monitoring equipment between residents based on if a resident was on any type precautions and did not routinely clean the equipment between residents who were not on any precautions. Interview with RN #3 and LPN #9 (Regional IP Nurse) on 3/25/24 at 11:34 AM identified that all medical equipment shared between resident should be sanitized after use on each resident. LPN #9 identified she was in the process of providing additional education to NA #3 regarding infection prevention including wiping down equipment between use on residents. Interview with the DNS on 3/26/24 at 10:54 AM identified that all medical equipment that is used between multiple residents should be cleaned prior to use on each resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on cleaning durable medical equipment directed the purpose of the policy was to prevent the spread of infection and provide care with clean equipment. The policy further directed that after reusable medical equipment enters a resident's room or was used, the equipment should be cleaned at minimum with alcohol or germicidal/bleach wipes.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 5 residents (Resident #74) reviewed for immunization status, the facility failed to provide the pneumococcal immunization. The findings include: Resident #74 was admitted to the facility on [DATE] with diagnoses which included hypertension and diabetes mellitus. Review of Resident #74's immunization record identified he/she received PCV (Prevnar) 13 on 9/26/13. The quarterly MDS assessment dated [DATE] identified Resident #74 had severely impaired cognition and was not up to date with the Pneumococcal vaccination. The quarterly MDS assessment failed to indicate a reason that the Pneumococcal vaccine was not received. Interview and clinical record review with the Infection Control Nurse (RN #3) on 3/25/24 at 11:52 AM failed to identify Resident #74 had received a Pneumococcal vaccination since 2013. RN #3 indicated that she had begun working as the Infection Control Nurse in November of 2023 and was unsure if Resident #74 was eligible to receive or had received a Pneumococcal vaccine while a resident at the facility. RN #3 indicated that she would further investigate Resident #74's vaccine eligibility and status. A physician's order dated 3/25/24 directed to administer Pneumococcal 20-Valent Conjugate vaccine, 0.5 ml intramuscularly one time. Interview with RN #3 and Regional Nurse (LPN #9) on 3/26/24 at 9:44 AM identified that Resident #74 should have been offered the Pneumococcal vaccine this year, but he/she had been missed by the previous Infection Control Nurse. LPN #9 further identified that on 3/25/24 Resident #74's responsible party consented to the administration of the Pneumococcal vaccination, and Resident #74 received the vaccine. Interview with the DNS on 3/26/24 at 1:00 PM identified that it was his expectation that all applicable vaccines are offered to residents on admission to the facility and whenever they are eligible to receive a vaccine. The DNS indicated that he would also expect the Infection Control Nurse to audit residents' clinical records for vaccine eligibility. The Pneumonia Vaccine Schedule directs that it is the policy of the facility to vaccinate residents for the different strains of pneumonia as recommended by the CDC. The CDC Pneumococcal vaccination guidance directs adults who received an earlier pneumococcal conjugate vaccine (PCV13 or PCV7) should talk with a vaccine provider to learn about available options to complete their pneumococcal vaccine series. Adults [AGE] years or older have the option to get PCV 20 if they have already received PCV 13, at any age.