STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075387	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #23) who required hospice care, the facility failed to honor the request for a specific hospice provider. The findings include: Resident #23 was admitted to the facility with diagnoses that included dementia, weight loss, and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #23 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance with dressing, toileting, and personal hygiene. The care plan dated 3/23/24 identified advanced directives. Interventions included providing end of life care per resident wishes and discuss with resident and resident representative. The APRN progress note dated 7/8/24 at 4:00 PM identified she spoke with Person #1 about overall generalized decline with weight loss, increased sleeping, and poor oral intake. Person #1 would like Hospice Agency #1 referral, they have used their services in the past and were happy with them. A physician's order dated 7/8/24 refers Resident #23 for hospice services if accepted (Hospice Agency #1 per Person #1 request). A nurses note written by an LPN dated 7/9/24 at 12:34 AM indicated to refer to Hospice Agency #1 per Person #1 request. The social worker noted written by SW #2 on 7/10/24 at 3:44 PM indicated that she had received a call from Person #1 who indicated he/she wanted Hospice Agency #1. SW #2 informed Person #1 that the facility did not have a contract with Hospice Agency #1 and SW #2 would email the information to Hospice Agency #2 and 3 that the facility does use. Person #1 indicated that he/she would reply to SW #2 with his/her decision. A physician's order dated 7/13/24 indicated admitted to hospice service on routine level of care. A nurses note written by an LPN dated 7/14/24 at 12:47 AM indicated that resident was admitted to Hospice Agency #2 on Friday 7/10/24. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 7/14/24 directed Resident #23 be admitted to Hospice through Hospice Agency #2 as of 7/12/24. Interview with Person #1 on 7/15/24 at 9:14 AM indicated that Hospice Agency #1 had done a great job for Resident #23 in the past and he/she knew them. Person #1 indicated that his/her first choice was Hospice Agency #1 because Resident #23 had that company for 3 years at home prior to going to the facility and they did a great job. Person #1 indicated that SW #2 had informed Person #1 the facility did not have a contract with Hospice Agency #1 and that he/she had to choose only between only 2 companies. Interview with SW #2 on 7/16/24 at 7:52 AM indicated that she has worked at this facility for 3 months but was a social worker at a facility prior. SW #2 indicated that Person #1 had called and stated he/she wanted Resident #23 to go on Hospice Agency #1. SW #2 indicated that she had asked the ADNS and was informed the facility did not have a contract with Hospice Agency #1. SW #2 indicated she informed Person #1 that he/she could not use that company because the facility did not have a contract with them and gave Person #1 names of 2 companies that the facility did have contracts with. SW #1 indicated that Person #1 had indicated that he/she preferred the other company, but SW #2 did not ask why they wanted that company. SW #2 indicated that she was not aware if the facility could do a one-time contract with the company for Resident #23 which Person #1 preferred and wanted for Resident #23. SW #2 indicated that she did not speak to or inquire regarding the hospice contracts with SW #1 or the Administrator if that was possible. Interview with SW #1 (Director of Social Services) on 7/16/24 at 7:59 AM indicated that she had been in this facility for 6 - 7 years. SW #1 indicated that there were 2 contracts with hospice agencies, Hospice Agency #2 and Hospice Agency #3. SW #1 indicated that she doesn't think the facility has a contract with the company that Person #1 wanted, Hospice Agency #1. SW #1 indicated that the facility could do a one-time contract to meet the resident or Person #1's choice. SW #1 indicated that Resident #23 and Person #1 had a right to choose who they wanted to use as a hospice agency. SW #1 indicated that we normally would inform a resident or resident representatives who we have contracts with but if they prefer any other company, we can get a one-time contract because the resident or resident representative have a right to decide who they want to use for hospice services. SW #1 indicated that she was not aware that Person #1 had wanted and preferred a different company because if she were aware the facility would have reached out to that hospice company and would have consulted with them and received an agreement with that company for Resident #23. Interview with the Administrator on 7/16/24 at 9:00 AM indicated that the facility currently has 9 contracts hospice agencies, but they primarily use 3 companies. The Administrator indicated that he was responsible for getting, updating, and reviewing all hospice contracts. The Administrator indicated that all residents have the right to choose any hospice company they want and if the facility doesn't have a contract, he would call the hospice company and get a one-time contract for that resident. The Administrator indicated that the facility does have a contract with Hospice Agency #1, (that Person #1 requested), and he was not aware that Person #1 had requested Hospice Agency #1 and had been informed the facility did not have a contract with them, and was told to pick a different agency. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospice Program Policy identified hospice services are available at the end of life. The agreement with the hospice provider will be signed by the facility representative and a representative from the hospice agency before hospice services are furnished to any resident. When a resident has a diagnosis of terminally ill, the Director of Nursing will contact the hospice agency and request that a visit/interview with the resident and/or resident representative be conducted to determine the resident's wishes relative to participation in the hospice program. Review of the Resident Rights Policy identified the resident has a right to choose their physician and participate in the decisions that affect the resident's care. The resident has the right to take part in this process.

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 1 resident (Resident #44) who had a personal funds account managed by the facility, the facility failed to ensure the resident had ready and reasonable access to those funds. The findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, insulin dependent diabetes, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident # 44 had intact cognition. The care plan dated 11/3/23 identified Resident #44 had been admitted to the facility for short term rehab. Interventions included collaboration between the interdisciplinary team and the resident to develop a discharge plan. Interview with Resident #44 on 7/14/24 at 10:25 AM identified he/she had several issues with accessing personal funds at the facility. Resident #44 identified that he/she should be receiving $75 monthly but since admission to the facility in July 2023, access to his/her money has been very restricted. Resident #44 identified that the facility had a prior social worker who would attempt to help him/her with access to his/her money, but that the social worker no longer works at the facility, and since that time it had been nearly impossible to access his/her money. Resident #44 also identified he/she has not received any quarterly statements from the facility, and that a week ago, the Administrator gave him/her $20 from his wallet because he felt bad. The resident indicated that he/she has his/her own money, and the Administrator shouldn't need to give him/her money. Interview with the Administrator on 7/15/24 at 1:05 PM identified that the Business Office Manager, who was responsible to disperse residents' funds, managed by the facility, had been out on a leave for a month and that he was covering her position while the facility worked on finding a temporary replacement. The Administrator identified that he was covering the banking hours for residents to access their funds. The Administrator identified that he made himself available in the business office on Tuesdays during my work hours from 9:00 AM - 5:00 PM for residents to access funds. The Administrator identified his work hours were Monday - Friday 9:00 AM - 5:00 PM, but that residents were aware that they could reach out to a nursing supervisor to access their funds. The Administrator also identified that any resident fund requests required clearance by either him or the DNS, and that he and the DNS did not work nights or weekends but were available by phone. The Administrator was unable to identify how staff would be allowed to disperse funds to residents outside of banking hours if he or the DNS were not available by phone. The Administrator identified that Resident #44's social security checks had been delayed due to coming via US mail instead of direct deposit and that Resident #44 was aware but could not provide any specific dates he spoke with Resident #44 regarding the issues related to his/her social security checks. The Administrator identified that he felt bad, so he gave the resident $20 because the resident was upset. But the resident did not have any money available due to the check situation. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/15/24 at 2:55 PM identified a sign posted on the business office door, which was located directly to the left of the main elevators of the facility. The sign read: RESIDENT BANKING HOURS - Routine Banking Hours are Monday - Friday 10 AM to 4 PM. If funds are needed after banking hours, residents should contact the nursing supervisor The facility policy on Resident Rights directed that the facility must ensure that residents were allowed access to their funds, bank accounts, cash, and other financial records. Although requested, the facility failed to provide a policy related to residents' personal funds access during posted banking hours.

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 1 resident (Resident #44) reviewed for personal funds, the facility failed to ensure that a resident who had funds managed by the facility was provided quarterly statements, in a clear and understandable manner and upon request, failed to ensure that facility staff utilized generally accepted accounting principles and failed to ensure the funds were in an interest bearing account. The findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, insulin dependent diabetes, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #44 had intact cognition. The care plan dated 11/3/23 identified Resident #44 had been admitted to the facility for short term rehab. Interventions included collaboration between the interdisciplinary team and the resident to develop a discharge plan. A social service note dated 4/9/24 identified she sent an email to Representative #1 (from the accounting firm used by the facility) to check Resident #44's money status. Review of a grievance, filed by Resident #44 dated 5/17/24 identified the resident verbalized concerns about the amount of money he/she receives from Social Security. The Administrator, DNS SW and HR business office spoke to the resident and provided education that income is owed to the facility, is the resident is able to keep $75.00 monthly. Interview with Resident #44 on 7/14/24 at 10:25 AM identified the resident has been responsible for his/her personal funds and property since October 2023. Resident #44 identified he/she had no idea what funds of his/hers were being provided to the facility and he/she had not received quarterly statements or an accounting of his/her money that the facility manages. Interview with the Administrator on 7/15/24 at 1:05 PM identified that the Business Office Manager, who was responsible to disperse residents' funds managed by the facility, had been out on a leave for a month and that he was covering her position while the facility worked on finding a temporary replacement. The Administrator identified while the business office manager was responsible for residents' personal fund allocations onsite, the facility utilized an outside accounting firm that was responsible for the accounting of all the residents' funds managed by the facility including the residents' quarterly statements. Review of the Funds Balance Report, which includes a list of all residents who have funds managed by the facility, provided by the Administrator on 7/15/24 at 1:30 PM identified that the list was current as of 7/10/24 and included a total of 51 residents, however, did not include Resident #44's name, (who does have funds managed by the facility). (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator following the provision of the Funds Balance Report, the Administrator could not explain why Resident #44's name was not listed despite the facility managing the resident's funds. Following review of the Funds Balance Report, a subsequent request was made on 7/15/24 to the Administrator to provide a full accounting of Resident #44's personal funds that the facility manages going back to October 2023, including documentation of all quarterly statements that have been provided to Resident #44. A review of documents provided to the surveyor on 7/22/24, related to Resident #44's personal funds, identified multiple discrepancies including two different statement types. The documents reviewed included. a. A document provided to the surveyor with a statement date of 7/16/24 identified the following. 8/1/23; patient liability/social security charge $474.00. 8/1/23; payment $474.00. 8/1/23; balance $0.00. 9/1/23; patient liability/social security charge $474.00. 9/1/23; payment $474.00. 9/1/23; balance $0.00. 10/1/23; patient liability/social security charge $474.00. 10/1/23; payment $474.00. 10/1/23; balance $0.00. 11/1/23; patient liability/social security charge $877.00. 11/1/23; payment $877.00 11/1/23; balance $0.00. 12/1/23; patient liability/social security charge $877.00. 12/1/23; payment $877.00 12/1/23; balance $0.00. Although requested, information on Resident #44's personal funds for the time period of January 2024 was not provided. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of Petty cash disbursement vouchers and the quarterly statements dated 4/1/24 - 6/30/24 with a statement date of 7/16/24 for Resident #44, identified the following. A 4/29/24 voucher for $5.00 was not documented on the quarterly statement. A 6/3/24 voucher for $15.00 was not documented on the quarterly statement. A 6/14/24 debit of $5.00 on quarterly statement without a voucher. Interview on 7/23/24 at 9:38 AM with the Administrator and Representative #1 (from the accounting firm used by the facility) regarding the management of Resident #44's personal funds, failed to identify why there were discrepancies related to the accounting documents for Resident #44. Representative #1 identified that the firm did provide the quarterly statements to the facility, but not the individual resident, as it was the responsibility of the facility to disburse the statements to the residents. The Administrator indicated it is the full responsibility of the accounting firm to disburse the quarterly statements to the residents as the facility does not touch the quarterly statements. Representative #1 also identified that she was unsure where Resident #44's quarterly statements were prior to 4/1/24 and would have to look into the matter. Representative #1 further identified she was unsure why Resident #44 was not included on the Funds Balance Report (list of all residents the outside accounting firm manages) as of 7/10/24, and identified that Resident #44 had an outstanding balance, and owed the facility money, however Representative #1 was not able to provide any documentation regarding this. Another request was made for a full accounting of Resident #44's personal funds, including funds received by the outside accounting firm, paid to the facility, funds disbursed to Resident #44, and all quarterly statements related to Resident #44's funds from October 2023 forward. Subsequent to surveyor inquiry, the Administrator provided a quarterly statement for Resident #44 on 7/23/24 at 1:11 PM dated 7/23/24 which identified the statement timeframe of 10/1/23 - 4/22/24. The quarterly statement was identified to have multiple discrepancies, including covering a 7 month time frame (multiple quarters), and also identified that as of 10/1/23, Resident #44 had an account credit of $2667.43, which directly conflicted with the Patient Liability statement provided by the facility dated 7/16/24 which identified Resident #44 had an account credit of $474 on 10/1/23 and charge on 10/1/23 of $474 by the facility, leaving a zero balance on the same date. The facility policy on Resident Rights directed that the facility must ensure that residents were allowed access to their funds, bank accounts, cash, and other financial records. The policy further directed that the facility must have a system in place that ensures a full accounting of the resident's funds and cannot combine your funds with the nursing homes funds. The facility policy on Personal Needs Allowance (PNA) identified that all residents would receive a quarterly banking statement, that PNA funds would be kept in an interest-bearing account, that outside accounting firm would conduct weekly review of the resident PNA accounts and the PNA will be kept in an interest bearing account.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 47457 Based on review of the clinical record, facility policy, and interviews for 2 of 3 residents (Resident #45 and 93) reviewed for advance directives, the facility failed to obtain, as soon as possible after admission, the resident/resident representatives wish for code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops). The findings include: 1. Resident #45 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure and dementia. The admission MDS dated [DATE] identified Resident #45 had severely impaired cognition. The care plan dated [DATE] had interventions that included discussing Resident #45's code status with the resident and resident representative and have consent signed. Review of the clinical record including the admission paperwork on [DATE], over 2 months after the resident's admission, identified the 2-page Advance Directives Level of Treatment Options forms were blank. Interview with LPN #6 (Nurse Manager) on [DATE] at 10:08 AM identified although staff had talked to the resident representative, they did not determine code status, she has not seen the resident representative and the code status and advance directives documents should have been signed within 72 hours of the resident's admission. Interview with the DNS on [DATE] at 12:50 PM identified that is her expectation that the admission information is reviewed with the resident or resident representative shortly after admission and indicated she would reach out to the resident's representative. Subsequent to Surveyor inquiry, on [DATE], Resident #45's code status was updated to include Do Not Resuscitate (DNR). Review of the Advance Directives policy identified the resident has the right to formulate an advance directive including the right to accept or refuse medical or surgical treatment, and if the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative. 2. Resident #93 was admitted to the facility on [DATE] with diagnoses that included hypertension, chronic kidney disease, and atherosclerotic heart disease. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated [DATE] identified that Resident #93 was a full code (directs the medical team to take all possible measures to save his/her life in the event of a medical emergency, including but not limited to chest compressions, breathing assistance, application of an Automated External Defibrillator, intubation, and the provision of life saving medications). Review of an Advance Directives Level of Treatment Options form included the following options for residents to choose related to advance directives and code status. a. Perform CPR (cardiopulmonary resuscitation). b. DNR (do not resuscitate). c. CMO/DNR/DNI (comfort measures only, do not resuscitate, do not intubate). d. DNT (do not transfer to the hospital). e. No artificial methods of nutrition. f. Other specific requests. The Advance Directives Level of Treatment Options form in Resident #93's clinical record, which was signed, failed to identify information for Resident #93's choice(s) for end-of-life care and treatment options. The admission MDS dated [DATE] identified Resident #93 was cognitively intact. The care plan dated [DATE] identified Resident #93 had an Advance Directive: full code. Interventions included discussing the code status with the resident, family/representative and obtaining a signed consent, and to provide CPR as needed. Interview with the Nurse Supervisor (RN #2) on [DATE] at 12:28 PM failed to identify treatment options were selected on Resident #93's signed Advance Directives Level of Treatment Options form. RN #2 indicated that Resident #93 was responsible for self, and she would expect to see the form completed with life support treatment options accompanied by the signature. RN #2 further indicated that upon admission Resident #93 verbally requested full code status, and that is how the order was obtained in the clinical record. RN #2 identified that she would have the Advance Directives Level of Treatment Options form updated to reflect Resident #93's choice regarding end-of-life care treatment options. Interview with the DNS on [DATE] at 9:00 AM identified that her expectation is that upon a resident's admission to the facility the Advance Directives Level of Treatment Options form is reviewed with resident and the document is filled out and signed. The DNS further identified that when residents, who are not alert and oriented, are admitted to the facility, and are unable to sign for him/herself there could be a delay in obtaining informed consent from the Power of Attorney. The DNS indicated that it is the joint responsibility of the charge nurse and the admitting supervisor to ensure the Advance Directives Level of Treatment Options form is completed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advance Directives policy directs each resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Prior to admission of a resident the social services director or designee inquiries about any written advance directive and the resident or resident representative is provided with written information concerning the right to refuse or accept treatment and to formulate an advance directive if he/she chooses to do so. The policy further directs if the resident or resident representative has executed one or more advance directive(s), or executes one upon admission, copies of the documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #110) reviewed for accidents, the facility failed to notify the physician when the resident returned from the hospital with a new mild anterior displacement of the right humerus with regards to the glenoid which could represent an anterior glenohumeral dislocation. The findings include: Resident #110 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, pulmonary embolism, rheumatoid arthritis, and repeated falls. The quarterly MDS dated [DATE] identified Resident #110 had intact cognition and required maximum assistance toileting and moderate assistance with dressing and personal hygiene. Additionally, was extensive assistance for transfers. The care plan dated 5/14/24 identified Resident #110 was at risk for falls related to history of falls. Interventions included to encourage out of bed daily and wear proper footwear. A physician's order dated 6/1/24 directed to administer Apixaban (blood thinner) 5mg tablet twice a day for pulmonary embolism. Additionally, transfer the resident with a mechanical lift with assistance of two. A chest x-ray dated 6/30/24 identified Resident #110 had pneumonia. The nurse's note dated 7/4/24 at 3:26 PM indicated that Resident #110 had critical labs and subsequent to the APRN notification, the resident was sent to the emergency room . The hospital discharge summary dated 7/4/24 identified Resident #110 had a chest x-ray that revealed a mild anterior displacement of the right humerus with regards to the glenoid which could represent an anterior glenohumeral dislocation. Focused clinical correlation is recommended. The nurses note dated 7/4/24 at 9:52 PM identified Resident #110 had returned to the facility at 3:10 PM and was alert and oriented with no complaints of pain. Multiple bruises and pressure injuries persist to bilateral extremities. New order for Iron tablets twice a day. The APRN progress note dated 7/9/24 at 1:49 PM identified Resident #110 went to the emergency room for a low hemoglobin. Resident #110 had received 2 units of packed red blood cells. Resident received diagnosis of anemia and was treated with intravenous fluids and right base infiltrate seen on 6/30/24. (continued on next page)

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Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #1 on 7/22/24 at 11:00 AM indicated that he was not aware that while at the hospital on 7/4/24 an x ray showed a mild anterior displacement of the right humerus with regards to the glenoid which could represent an anterior glenohumeral dislocation. MD #1 indicated that if the hospital felt it was significant that they should have had Resident #110 seen by orthopedics while at the hospital. MD #1 indicated that he was not aware of that of the x ray results that identified a mild anterior displacement of the right humerus with regards to the glenoid which could represent an anterior glenohumeral dislocation. MD #1 indicated that the mild anterior displacement of the right humerus with regards to the glenoid which could represent an anterior glenohumeral dislocation is usually from trauma like a fall or rolling out of bed or hitting the shoulder on the side rail or a nightstand. MD #1 indicated that he was not aware of any falls the resident had recently and indicated that he was aware that Resident #110 had a lot of falls just prior to coming to the facility. MD #1 indicated that Resident #110 has had chest x-rays at the facility prior to 7/4/24 and none of them had shown a right shoulder dislocation. MD #1 indicated that he would need to find out if Resident #110 had a fall or some form of trauma to that area. MD #1 indicated that he would first do a physical exam and note if the resident was having pain because a dislocation would be painful. MD #1 indicates that he would need more information to make a clinical correlation as the discharge summary indicated. MD #1 indicated that an investigation would need to be done and should have been done when Resident #110 returned from the hospital on 7/4/24. Interview with the DNS on 7/22/24 at 11:47 AM indicated that when a resident returns from a hospital visit the receiving supervisor is responsible to read and review all hospital paperwork. The DNS indicated that the unit manager and ADNS were also responsible to read and review the hospital paperwork. The DNS indicated that if Resident #110 returned with a mild anterior displacement of shoulder nursing would be responsible to notify the APRN or physician and document that in the progress notes on that day 7/4/24. After clinical record review, the DNS indicated that there was no documentation that the APRN or physician were notified of the mild dislocation of the right shoulder. Review of the Change in Condition Policy identified the facility will promptly notify the resident, resident representative, and the physician of changes in the resident's mental, or medical condition and or status. The nurse will notify the physician when there has been a discovery of injury of unknown source, or a significant change in a residents physical or emotional condition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #93) reviewed for personal property, the facility failed to ensure the resident's personal property was kept safe from loss and based on tour of the environment, the facility failed to maintain a safe, clean, comfortable, and homelike environment. The findings include: 1. Resident #93 was admitted to the facility on [DATE] with diagnoses that included hypertension, chronic kidney disease, and depression. Review of the social services notes and grievance log dated 4/25/24 through 7/22/24, three months, failed to identify that Resident #93 had reported personal items were missing. The admission MDS dated [DATE] identified Resident #93 was cognitively intact, had no active neurological diagnoses (including dementia), required set-up assistance for upper body dressing, and required a partial assist for lower body dressing. The care plan dated 5/13/24 failed to identify that Resident #93 had accusatory behaviors. Interview with Resident #93 on 7/14/24 at 10:05 AM identified that he/she had sent 2 Hawaiian shirts, 2 khaki cargo shorts, 1 black pair of shorts, 1 grey pair of capri shorts, a leather jacket, and a tee-shirt with a carnival cruise logo to the laundry, and the items were not returned. Resident #93 further identified that he/she reported the items missing and made inquiries to anyone at the facility that would listen, including calling down to the laundry room, but could not specifically recall which staff members he/she had reported to. Resident #93 indicated that some of the missing items were replaced by the facility with items that had been donated by other residents. Resident #93 further indicated that he/she appreciated the replacement items, but now there were only a few clothing items remaining that originally belonged to him/her. Resident #93 identified that 4 of the missing items had sentimental value: a. A leather winter jacket, that was labeled with his/her name and room number was reported to the facility as missing about 4 - 5 weeks ago; a (non-specified) manager had offered him/her another jacket as a replacement. b. 2 Hawaiian shirts that were labeled with his/her name were reported missing to the facility staff, about 3 - 4 weeks ago. c. A tee shirt with a [NAME] cruise logo, was reported missing to the facility over 2 weeks ago. Resident #93 identified that the missing clothing was an on-going issue, and despite complaining nothing had been done except to receive other people's donated clothes. On 7/15/24 Resident #93's Hawaiian shirts were returned. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Laundry on 7/22/24 at 10:22 AM identified that he was unaware that Resident #93 was missing clothing items, and that the facility would not be able to clean a leather jacket, it would have to be sent out for dry cleaning. Interview with Laundry Aide #1 on 7/22/24 at 10:30 AM identified that Resident #93 called down to the laundry room inquiring about missing Hawaiian shirts; she could not recall the date of the call but estimated it was the week prior. Laundry Aide #1 indicated that the Hawaiian shirts were returned to Resident #93, but she had not seen a leather jacket. Laundry Aide #1 further indicated that she was unaware of the missing [NAME] Cruise tee shirt, but she would search lost and found for it. Follow-up interview with Resident #93 on 7/22/24 at 10:53 AM identified that he/she was happy that the 2 Hawaiian shirts were returned, but the leather jacket and tee-shirt with a [NAME] Cruise logo had not been returned. Resident #93 further identified that he/she began to make inquires with the facility staff greater than 2 weeks ago when the items were not returned with all the other items that they were sent down with to the laundry. Resident #93 indicated that a report was also filed with the social worker once he/she realized the items were not coming back. Interview with SW #1 on 7/22/24 at 11:03 AM identified that she had been working at the facility for 3 months and that Resident #93 had not reported any missing items to her. Interview with the DNS on 7/23/24 at 9:02 AM identified that she was unaware that Resident #93 had reported any missing items. The DNS indicated that reports of missing items were discussed during the facility staff's morning meetings, and then an investigation of the missing item would be initiated. The DNS further indicated that if the facility is unable to locate missing items, then the resident would be reimbursed for the item. Although requested a personal property policy was not provided The facility's Quality of Life-Homelike Environment policy directs that residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. 2. Observation on 7/22/24 at 1:15 PM with the Administrator and Director of Maintenance included the following. The grand lobby had a couch with soiled upholstered fabric on the seat cushion, arm rests, and head rest area. One sofa had a towel on the seat which the Director of Maintenance and the Administrator identified belonged to a specific resident who was not currently seated in the lobby area, however the towel remained. Under the spigot water dispenser was a poorly folded, soiled blanket. The elevator room's foyer sofa had cushioning material extending below the upholstered fabric. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The elevator flooring had multiple tiles buckled and corners or tips missing, the elevator entrance flooring was missing tile pieces creating an uneven section of flooring, the grates on the lower elevator wall were not fully adhered to elevator wall. Multiple bathrooms in resident rooms on each floor had the following. The area separating the toilet base from the floor was soiled resulting in a darkened rim at the base flooring of the toilet. The sink faucet spout and handles contained either a cloudy milky residue or rusty discoloration at the base where the chrome met the sink. Multiple toilet seat risers identified with peeling paint and appeared rusted. Grey tiled floors were significantly marred with white scratches of varying degrees, the beige linoleum floors were identified with varying degrees of orange to brownish discoloration around the toilet, the area between the toilet and the wall was heavily soiled with varying degrees of brownish orange discoloration. room [ROOM NUMBER] electrical outlet poorly caulked, porcelain seating area in front of toilet marred and grey in the center area between left and right side of the toilet seat. room [ROOM NUMBER] grey flooring with spots. room [ROOM NUMBER] windowsill peeling paint. room [ROOM NUMBER] stained bathroom floor. room [ROOM NUMBER] broken electrical socket cover, 1/3 of cover missing. room [ROOM NUMBER] bathroom flooring soiled. On the 2nd floor lounge chairs in community areas at end of each hallway were torn at seams, soiled, and one sofa was identified with one of its leg 2 inches off the floor while the diagonal portion of the sofa base was against an intersecting corner of the wall. Every fabric chair observed in the dining room was heavily stained, and the wood accents on the chairs were faded and discolored. Many bureaus and nightstands were trimmed in duct tape or electrical tape. Duct tape was also used on the floors in various rooms including the dining room which had tattered and worn duct tape. The radiators and community areas at end of hall had peeling paint, area underneath radiators appeared rusted. The corridor had several areas of missing paint on drywall. The dining room sink was unclean, and the wooden microwave stand had graffiti and fading varnish. Rooms on the 2nd floor identified the following. room [ROOM NUMBER] paint peeling, curtains not hung on rod properly. room [ROOM NUMBER] diminished varnish above and below the door handles, writing on door door will not work and do not operate, and a rusted toilet seat riser. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] faucet with continuous running water, soiled drapes. room [ROOM NUMBER] door handle missing. room [ROOM NUMBER] duct tape on bedside table perimeter, worn duct tape on floor separating resident's room and bathroom. Rooms on the 3rd floor identified the following. Walls, bathroom flooring, dressers and nightstands in disrepair, many with duct tape around edges as well as furniture in alcove of corridors in disrepair. Housekeeping door spackled not painted, furniture in alcove has multiple cracks in vinyl seating. Multiple doors with peeling veneer or worn coloring, peeling paint on windowsills, and cracked paint above air conditioning unit. Multiple bathrooms with linoleum flooring with various degrees of orange coloring near toilet, faucet with running water, peeling tops of nightstands and bureaus trimmed in either electrical tape or duct tape, unclean air conditioning units (heavy dust), toilet seats in disrepair. Shower room had debris on the floor; worn glove, bottle of hygiene product, soiled wall tiles, sink containing dirty towels, hole in tile near upper door-opposite of door closer hardware, room [ROOM NUMBER] soiled flooring near toilet, varying degrees of orange stains on floor. room [ROOM NUMBER] veneer split on door unsmooth edges of veneer exposed. room [ROOM NUMBER] faucet has constant drip per maintenance requires change of faucet. room [ROOM NUMBER] red toilet seat has discoloration. room [ROOM NUMBER] dripping faucet. room [ROOM NUMBER] dripping faucet. room [ROOM NUMBER] frayed duct tape on flooring separating room from bathroom. room [ROOM NUMBER] drapes not hung properly on curtain rod. room [ROOM NUMBER] drapes with brown speckled discoloration. room [ROOM NUMBER] brown stained ceiling tiles. room [ROOM NUMBER] door veneer split unsmooth edges exposed. room [ROOM NUMBER] bathroom floor visibly soiled, toilet paper roll empty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] bathroom floor with varying degrees of orange discoloration near toilet. room [ROOM NUMBER] dripping faucet, marred walls behind beds. room [ROOM NUMBER] curtains visibly soiled. Interview with the Administrator and the Maintenance Director on 7/22/23 at 1:10 PM identified the facility is under a major renovation and all matters identified are a part of the renovation. The Maintenance Director indicated concerns regarding cleanliness would be addressed and as a recent new hire was not aware of many of the items identified during the walk through. On 7/23/24 at 12:30 PM a copy of the letter of intent for repairs was provided. The letter was dated 7/5/24 and signed by the contractor on 7/8/24. The letter addressed replacing the bathroom flooring, bathroom tile, toilet tank and toilet seat, ramp up and repair entrance as well as wall hung cabinets. The letter of intent was signed by the contractor only, the owner's name, signature and date were absent from the document, and a signed agreement by both parties was not provided. A copy of the environmental rounds was requested, however not provided. Interview with the DNS and RN #3 (Corporate Clinical Director) on 7/23/24 at 12:50 PM identified that the nursing staff is aware of the protocols to report concerns to maintenance, and the expectation is that the rooms are clean and maintained, and further identified corporate was addressing the concerns. The policy for Quality of Life-Homelike Environment states that residents are provided with a safe, clean, comfortable and homelike environment and facility staff should reflect a homelike setting with characteristics that include cleanliness and order. 47457

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #42) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to complete a PASARR rescreen after the expiration of a 30-day approval. The findings include: A Notice of PASARR Level I Screen Outcome dated [DATE] identified Resident #42 received an outcome of exempted hospital discharge 30-day approval. The outcome rationale directs that a 30-day or less stay in the nursing facility is authorized and a re-screening must occur by or before the 30th day if the individual is expected to remain in the nursing facility beyond the authorization timeframe. Resident #42 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder, schizophrenia, bipolar disorder, and depressive episodes. The admission MDS dated [DATE] identified Resident #42 had intact cognition and had not been evaluated by Level II PASARR and was determined to have a serious mental illness and/or a related condition. The care plan dated [DATE] identified Resident #42 uses psychotropic medications related to disease process. Interventions included to administer medications as ordered and to monitor, record, and report to the physician side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, and behavior symptoms not usual to the person. Subsequent to surveyor inquiry, a PASARR Level I rescreen was submitted on [DATE]. Notice of PASARR Level I Screen Outcome dated [DATE] identified that a PASARR Level II onsite evaluation must be conducted. The outcome further identified that this review was a federal compliance issue due to the untimeliness of the submission of a Level I and the continued admission at the nursing facility with an expired approval with a Level II diagnosis. The individual was given a 30-day exemption that became effective on the day of admission to the nursing facility, [DATE]. The 30-day exemption expired on [DATE]. This PASARR was submitted on [DATE]. Interview with the Director of Social Services (SW #1) on [DATE] at 11:08 AM identified that Resident #42 had a Level I PASARR completed on [DATE], with determination for a 30-day hospital exemption, which would have an end date of [DATE] and a Level I PASARR rescreen was completed on [DATE] (10 days after the 30-day exemption expired). SW #1 indicated that another Level I PASARR should have been completed a few days prior to the expiration date or on the date of expiration. The facility's Coordination-Pre-Admission Screening and Resident Review (PASARR) Program policy directs the facility to assure that all residents admitted to the facility receive a PASARR, in accordance with State and Federal Regulations.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #2 and 39) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to notify the state mental health authority of a change in mental health diagnosis. The findings include: 1. A PASARR (received from prior facility) dated 9/21/18 identified Resident #2 had a diagnosis of anxiety and bipolar disorder. The resident was approved for long term care on 9/14/18 with specialized services recommended. Resident #2 was admitted to the facility on [DATE] with diagnoses that included anxiety and bipolar disorder. A physician's order dated 9/2/21 directed to obtain a psychiatric evaluation and to treat resident as indicated. The care plan dated 9/2/21 identified Resident #2 had impaired cognition. Interventions included administering psychotropic medications per the physician's order. The admission MDS dated [DATE] identified Resident #2 had severely impaired and required extensive assistance with dressing, toileting personal hygiene and transfers. Additionally, Resident #2 was on antipsychotic medications. Review of the clinical record dated 10/1/22 identified Resident #2 was diagnosed with dementia. Interview with SW #1 on 7/16/24 at 11:15 AM identified that the PASARR dated 9/21/18 identified Resident #2 had a diagnosis of anxiety and bipolar disorder and did not identify a diagnosis of dementia. SW #1 indicated she did not know if she needed to update the PASARR with when Resident #2 received the new diagnosis of dementia. SW #1 indicated that there had not been any updates to the PASARR since 2018. Interview with SW #1 on 7/16/24 at 1:50 PM indicated that she had contacted the PASARR state mental health authority and was informed she was required to do a status change with a new diagnosis of dementia, which Resident #2 received on 10/1/22. SW #1 indicated that she had reviewed Resident #2's clinical record and determined that the psychiatric provider in a progress note added the new diagnosis of Dementia on 10/1/22. SW #1 indicated that the state mental health authority informed her that on 10/1/22 when Resident #2 received a new diagnosis they should have been updated and a representative from the state mental health authority would have come out to reevaluate Resident #2 to determine if he/she would be exempt at that time. SW #1 indicated she was not aware that she needed to update the state mental health authority when a resident with a mental illness received a new diagnosis. After surveyor inquiry, Notice of PASARR Level 1 screen dated 7/22/24 identified Resident #2 will be Level 1 exempt due to dementia and mental illness exclusion. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #39 was admitted to the facility with diagnoses that included major depressive disorder, bipolar, and post-traumatic stress disorder. The PASARR Level 2 Outcome dated 9/27/17 identified long term care approval for diagnosis of major depression, anxiety, and post-traumatic stress disorder. Further the PASARR identified Resident #39 does not have diagnosis of dementia. The quarterly MDS dated [DATE] identified Resident #39 had intact cognition. Interview with SW #1 on 7/16/24 at 11:02 AM indicated that Resident #39 was admitted to the facility with a primary diagnosis of major depressive disorder and is closely followed by the psychiatric group. SW #1 indicated that Resident #39 no longer has a diagnosis of major depression. SW #1 reviewed the clinical record and indicated that as of a psychiatric note dated 9/22/22 and again on 7/9/24 that Resident #39 no longer had the diagnosis of major depression and now has a diagnosis of only depressive episodes. SW #1 indicates that she was not sure if she needed to update state mental health authority when a resident has any change in diagnosis for mental illnesses. Interview with SW #1 on 7/16/24 at 1:55 PM indicated that after speaking on the phone with someone from the state mental health authority she will have to do a change of condition as of 1/22/22 when the clinical record shows the diagnosis of major depression was changed to situational depression episodes for Resident #39. SW #1 indicated that the state mental health authority should have been updated with the change in diagnosis on 1/22/22 when Resident #39 and indicated that it was missed. After surveyor inquiry, a PASARR Level 1 screen outcome dated 7/16/24 identified Resident #39 was approved, and no Level II was required due to no longer having a diagnosis of major depression and having a current diagnosis of situational depression.

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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** 47457 Based on review of the clinical record, facility policy, and interviews for 1 of 5 residents (Resident #49) reviewed for unnecessary medications, the facility failed to develop a comprehensive care plan for a resident with a history of dementia. The findings include: Resident #49 was admitted to the facility on [DATE] with diagnoses that included moderate dementia with other behavioral disturbances and delirium due to a known physiological condition. The quarterly MDS dated [DATE] identified Resident #49 had moderately impaired cognition, non-Alzheimer's dementia, and was receiving anti-psychotic medication on a routine basis. The care plan dated 6/19/24 failed to identify goals and interventions for the residents diagnoses dementia. Interview with the DNS on 7/23/24 at 9:54 AM identified that she would expect to see a dementia care plan, and that there is documentation that the resident had non-Alzheimer's dementia diagnosis in the baseline care plan, so she was unsure why it was not carried over to the comprehensive care plan. The DNS indicated that there is an interdisciplinary approach to the development of the comprehensive care plan, and she would have expected nursing or social services to initiate a dementia care plan. Interview with the Director of Social Services (SW #1) on 7/23/24 at 10:29 AM identified that she would expect that a resident with a dementia diagnosis would have a dementia care plan. SW #1 further identified that it has been her experience that the MDS coordinator initiates the dementia care plan, but the social worker could, as well. The MDS coordinator was unavailable for interview on 7/22/24 and 7/23/24. The Care Plan-Comprehensive policy directs the facility to develop an individualized comprehensive care plan for each resident that includes measurable objective and timetables to meet the resident's medical, nursing, mental and psychological needs. The comprehensive care plan is based on a thorough assessment that includes but is not limited to, the MDS Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The policy further directs that an interim care plan is developed upon the resident's admission and is used only until the comprehensive care plan has been developed.

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Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #44) reviewed for personal funds, the facility failed to invite the resident and resident representative to the resident care conferences and failed to ensure the resident care conferences were held timely. The findings include: Resident #44 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy, insulin dependent diabetes, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #44 had intact cognition. The care plan dated 11/3/23 identified Resident #44 had been admitted to the facility for short term rehab. Interventions included collaboration between the interdisciplinary team and the resident to develop a discharge plan. Interview with Resident #44 on 7/14/24 at 10:25 AM identified that he/she could not remember the last time he/she was invited to or participated in a care conference with facility staff. Review of the clinical record on 7/14/24 identified Resident #44 had a care conference note documented on 1/24/24 however, there was no additional documentation related to resident care conferences for 2024, over 6 months. Interview with the Social Services Director on 7/23/24 at 9:00 AM identified she was not sure why the resident had not had a resident care conference since 1/24/24. The Social Services Director identified she began her position in April 2024 and was attempting to address issues from the previous Social Services Director but could not identify why Resident #44 had not had a resident care conference in the last 6 months. Interview with the DNS and RN #3 on 7/23/24 at 10:20 AM identified that the DNS was aware there were issues related to the resident care conferences being held in a timely manner for residents of the facility. The DNS identified that the facility had issues with the social services staff at the facility, including the prior Social Services Director, and SW#1 not ensuring the resident care conferences were being held. The DNS identified that the resident care conferences are to be held at least quarterly. The facility policy on resident participation with assessments and care plans directed that each resident was encouraged to participate in the development of the resident's comprehensive assessment and care plan, and that the resident would be invited to attend and participate in the care planning conferences. The policy further directed that the Social Services Director or designee was responsible for contacting the resident related to scheduling resident care conferences. The facility policy on Resident Rights directed that residents of the facility had the right to participate in decisions that affected their care and take part in developing their plans of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 3 residents (Resident #6 and 112) reviewed for accidents, the facility failed to ensure the Registered Nurse (RN) completed an assessment after a fall and prior to moving the resident off the floor or that neurological assessments were completed after falls or the RN assessed the resident after new bruising of the skin was found. The findings include: 1. Resident #6 was admitted to the facility with diagnoses that included drug induced parkinsonism, schizophrenia, hearing loss, hypertension, and osteoporosis. The quarterly MDS dated [DATE] identified Resident #6 had severely impaired cognition and required extensive assistance with dressing, bed mobility, and transfers. Resident #6 was supervision using a walker or wheelchair for locomotion in the room and on unit. Resident #6 was not steady with walking, turning around, moving on and off toilet, and moving from a seated to standing position. The care plan dated 3/23/23 identified Resident #6 was at risk for injuries related to falls. Interventions included to encourage the resident to participate in activities. a. A physician's order dated 5/1/23 directed to provide the assistance of 1 with transfers and ambulation with a rolling walker. a reportable event form dated 5/12/23 at 11:30 AM identified Resident #6 was found lying on the floor next to the bed in his/her room. There were no witnesses. The Neurological Assessment Form for Falls dated 5/12/23 identified the neurological assessment was started at 11:10 AM until stopped at 12:55 PM and indicated Resident #6 was at the hospital. The neurological assessment was restarted at 8:55 PM. The nurse's note written by LPN #6 (Unit Manager) dated 5/12/23 at 12:13 PM indicated that she was called to Resident #6's room where Resident #6 was observed lying on the floor. Resident #6 informed LPN #6 he/she had pain. LPN #6 indicated there were no visible signs of injury. Neurological assessment was done and within normal limits. The residents blood pressure was 78/58mmHg and retaken shortly after was 97/60mmHg. The APRN was called and arrived to assess the resident at bedside and ordered an x-ray of the left shoulder and arm. The APRN progress note dated 5/12/23 at 12:22 PM indicated that staff had asked her to see Resident #6 after a fall. The APRN saw Resident #6 who was sitting on the edge of the bed. Resident #6 had complaints of left shoulder pain, Unable to get meaningful review of systems due to language barrier and hard of hearing. The Change in Condition Form completed by LPN #6 dated 5/12/23 at 12:31 PM identified the resident had complaints of pain and was seen lying on the floor. Range of motion within normal limits. Resident #6 was being transferred to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The emergency room Report dated 5/12/23 at 2:07 PM identified Resident #6 had arrived after an unwitnessed fall. Resident #6 has bruising to the left shoulder and clavicle area. Resident #6 was diagnosed with a fractured clavicle, sternum fracture, and lumbar compression fracture. The nurse's note dated 5/12/23 at 7:05 PM identified the emergency room physician had called the facility and informed her that Resident #6 had a broken clavicle and broken sternum, non-surgical. The physician informed this writer that Resident #6 would be sent back to the facility. The nurse's note dated 5/12/23 at 9:05 PM identified that Resident #6 had returned from the emergency room at 8:12 PM with a diagnosis of left clavicle fracture, fractured sternum, L1 lumbar compression fracture. Sling to left arm in place. Pain management in process. Follow up with an orthopedic visit in 1 week. Interview with LPN #6 (unit manager/supervisor) on 7/15/24 at 7:30 AM indicated that she recalls a nurse's aide called her because Resident #6 was on floor on 5/12/23, when she entered room, she saw Resident #6 on the floor at the bedside. LPN #6 indicates that she asked Resident #6 what happened, and Resident #6 repeatedly said pain but does not recall where Resident #6 had the pain. LPN #6 indicated that she did the assessment by having Resident #6 follow her finger with his/her eyes side to side, move his/her legs but when Resident #6 moved his/her arms one shoulder Resident #6 complained of pain, but LPN #6 does not recall which shoulder. After reviewing her written statement dated 5/12/23, LPN #6 indicated that when she stated the resident was assessed by the nurse, LPN #6 indicated that the nurse was her not an RN supervisor it was her. LPN #6 indicated that she did the full assessment. LPN #6 indicated that after she did the vital signs and the neurological assessment, she and the nurse may have gotten Resident #6 up off the floor and sat him/her on the side of the bed because there were no signs of a visible injury. LPN #6 indicated she did call to notify the APRN that Resident #6 had fallen and was having pain. LPN #6 indicated that the APRN initially ordered x-rays but after the APRN came to the unit and assessed Resident #6 she had decided to send Resident #6 to the emergency room . Interview with NA #5 on 7/15/24 at 1:18 PM indicated that after reviewing her statements for Resident #6's fall on 5/12/23 that she washed and dressed Resident #6 earlier in the morning. NA #5 indicated that approximately at 11:15 AM she saw Resident #6 on the floor next to the bed and immediately went up the hallway to LPN #2 and LPN #6 to inform them that Resident #6 was on the floor. NA #5 indicated that LPN #2 and LPN #6, who is the supervisor, came right away. NA #5 indicated that LPN #6 did an assessment of Resident #6 on the floor and LPN #2 and LPN #6 got Resident #6 off the floor onto the bed. NA #5 indicated she stayed with Resident #6 sitting on the bed until the APRN came later to assess Resident #6. NA #5 indicated that the APRN came after the nurses had gotten Resident #6 off the floor and into bed. Interview with APRN #2 on 7/15/24 at 2:09 PM indicated that after reviewing the clinical record for the 5/12/23 fall, Resident #6 was already sitting on the edge of bed when she came in. APRN #2 indicated the nurses (not her) do the assessments prior to getting the resident off the floor, at the time of a fall. APRN #2 indicated that if she was in the building she would go see a resident after a fall but she does not assess the residents immediately. APRN #2 indicated that she does not assess residents on the floor, or assist them up, as that was the responsibility of the facility nurses. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with ADNS on 7/23/24 at 8:56 AM indicated that Resident #6 had an unwitnessed fall on 5/12/23 at 11:30 AM. The ADNS indicated that LPN #6 did the change of condition report, fall assessment, the incident note, and the progress note. The ADNS indicated that Resident #6 was assessed by the APRN on the edge of the bed. The ADNS indicated based on the reportable event statements and documentation she could not determine who had gotten Resident #6 off the floor. The ADNS indicated after being seen by the APRN Resident #6 was sent to the emergency room and was diagnosis with a fracture of the left clavicle, shoulder, sternum and compression fracture of L1. The ADNS indicated that Resident #6 had pain in the left shoulder while on the floor that LPN #2 and LPN #6 should have not gotten Resident #6 off floor. The ADNS indicated that there should have been an RN assessment while the resident was still on the floor and Resident #6 should not have been moved until EMS arrived. Interview with the DNS on 7/23/24 at 11:12 AM indicated that if a resident falls on the floor the RN supervisor must go and assess the resident. The DNS indicated the RN must assess the resident prior to getting the resident up off the floor. The DNS indicated the RN must complete the change of condition note or an RN assessment in the progress notes in the clinical record. After review of the clinical record, the DNS indicated that LPN #6 had completed the change of condition form and there was no documentation of an RN assessment for the fall on 5/12/23. The DNS indicated that the APRN note identified she did not see Resident #6 until the resident was sitting on the edge of bed. The DNS indicated that all the fall documentation was completed by LPN #6. The DNS indicated there was no documentation of an RN assessment and Resident #6 should not have been moved off of the floor until there was an RN assessment especially since Resident #6 had multiple fractures. b. A fall assessment completed by LPN #6 on 9/26/23 at 5:00 PM identified Resident #6 had a discoloration noted to the left forehead. LPN #6 indicated Resident #6 informed staff and visitor that he/she fell in the bathroom the day prior or today causing the discoloration. Resident #6's account of the fall was inconsistent. The APRN was notified and ordered labs. The nurses note written by LPN #6 dated 9/26/23 at 5:30 PM indicated that Resident #6 was observed with discoloration on the left side of the forehead. Resident #6 claims he/she fell on [DATE] then said he/she fell on [DATE], and fall was unwitnessed. The Change of Condition form written by LPN #6 completed on 10/2/23 indicated that on 9/26/23 at 5:30 PM Resident #6 was observed with a discoloration on the left forehead. Resident #6 claims he/she fell on , d+[DATE] or 9/25/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 7/23/24 at 9:12 AM indicates that when Resident #6 claimed he/she had fallen and had the discoloration on the forehead there should have been an RN head to toe assessment done and documented with measurements for the bruise/discoloration. The ADNS indicated there was not an RN assessment or a fall accident and incident report completed. The ADNS indicates that on 9/26/23 there should have been measurements length by width for the discolored area on the forehead and an investigation going back 72 hours to figure out if any staff had seen anything. The ADNS indicated when Resident #6 indicated the discoloration was from a fall the nurses should have started a neurological assessment sheet. The ADNS indicated that LPN #6 did the fall assessment, change of condition form, and progress note. The ADNS indicated she only saw documentation in the clinical record from LPN #6. The ADNS indicated that LPN #6 did not do any measurements of the bruise and did not do a body assessment. The ADNS indicated that LPN #6 did not start the neurological assessment, but they should have been done. The ADNS indicated that she did not see that there was an RN assessment or the neurological assessments for the fall completed. The ADNS indicated that there should have been a fall reportable event and a second accident and incident report done for the bruise on the forehead. The ADNS indicated that she did not see any measurements for the bruise Interview with RN #3 (Corporate Clinical RN) on 7/23/24 at 9:15 AM indicated that an RN assessment for the bruise should have been done with measurements and there should have been a fall reportable event form because the resident reported he/she had failed. Further, a head-to-toe body assessment by an RN should have been done and documented in the clinical record. RN #3 indicated that there was only documentation from LPN #6 only and there was not an RN assessment for the bruise or the fall and there weren't any neurological assessments done for the fall that should have been done. 2. Resident #112 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease with dialysis, stroke, and anxiety. A physician's order dated 1/9/24 directed to transfer and ambulate with rolling walker to wheelchair and bathroom. The Fall Risk Evaluation dated 1/9/24 at 6:21 PM identified Resident #112 was at moderate risk for falls. Review of the clinical record from 1/9/24 to 7/16/24 identified Resident #112 had 10 falls. The care plan dated 1/10/24 identified Resident #112 was at risk for falls. Interventions included to anticipate the residents' needs. The admission MDS dated [DATE] identified Resident #112 had moderately impaired cognition, was frequently incontinent of bowel and occasionally incontinent of bladder and required minimal assistance and supervision with dressing and bathing and set up and clean up for personal hygiene. Resident #112 needs touching assistance for transfers using a walker to a wheelchair. Resident #112 had no behaviors. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A Fall Report dated 2/14/24 at 6:53 PM identified Resident #112 was found on the floor in his/her room with no witnesses. Resident #112 prior to fall was ambulatory with assistance. The nurse aide observed the resident on the floor and called LPN #2. Resident #112 stated he/she was walking to the bathroom when legs gave out. Resident #112 was assessed and could move all extremities. Resident #112 was transferred back to bed with the nurse aide assistance and was informed to call for help when needing to use the bathroom. The Fall Risk Evaluation completed by LPN #2 on 2/14/24 at 10:15 PM identified Resident #112 scored a 6 meaning at moderate risk for a fall. The nurse's note written by LPN #2 on 2/14/24 at 10:24 PM identified Resident #112 was assessed with no injuries. Resident was able to move all extremities. Resident voiced no pain or discomfort. Resident #112 was transferred back to bed and encouraged to call for help when needing to go to the bathroom. b. A Fall Report completed by LPN #6 dated 3/13/24 at 3:15 PM identified Resident #112 was observed sitting on the floor. Resident stated he/she was going to the bathroom and slipped. Resident #112 was assessed for injuries. Resident denied hitting head and was able to move all extremities. No complaints of pain. The Neurological Post Fall vital signs and neurological assessment form dated 3/13/24 started the assessments at 3:15 PM. The nurses note written by LPN #6 dated 3/13/24 at 3:28 PM identified the resident was sitting on the floor next to his/her bed. Resident stated that he/she was trying to make it to the bathroom but slipped while trying to get there. Resident was assessed with no injuries noted. Resident denied hitting his/her head and denies pain. APRN and resident representative were updated. The Change of Condition completed by LPN #6 dated 3/13/24 at 3:37 PM identified at 12:38 blood pressure was 172/93mmHg, and pulse 69bpm. LPN #6 identified Resident #112 sustained a fall while trying to self-toilet. Resident #112 did not call for assistance. The supervisor was notified on 2/5/24 at 12:20 PM. The Fall Risk Evaluation completed by LPN #6 dated 3/13/24 at 3:56 PM identified Resident #112 scored a 9 meaning at moderate risk for a fall. The nurses note written by LPN #2 dated 3/13/24 at 4:38 PM identified Resident #112 had a fall and was observed on the floor next to his/her bed by the nurse aide. Resident #112 told nurse aide he/she was trying to go to the bathroom and fell . The supervisor was called and assessed the resident with no injury noted. Intervention was to encourage resident to call when needs help. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with ADNS on 7/23/24 at 7:58 AM identified when a resident is on floor the charge nurse must call for an RN assessment before the resident is moved off floor, the RN does an assessment and then if resident is okay, then the resident is assisted off the floor. The ADNS indicated that for the 2/14/24 fall she sees the LPN #2 notes only and there was not an RN assessment as required by the facility. The ADNS indicated for the fall on 3/13/24 that the assessments were done by LPN #2 and LPN #6. The ADNS indicated there was not an RN assessment for the fall on 3/13/24. The ADNS indicated the 2 falls on 2/14/24 and 3/13/24 that did not have an RN assessment as required only had LPN #2 and LPN #6's assessments. Interview and clinical record review with RN #3 (Corporate Clinical RN) on 7/23/24 at 8:00 AM identified there must be an RN assessment when a resident has a fall and before the resident is moved off floor, the RN does an assessment and then if okay may then get resident off the floor. After review of the clinical record, RN #3 indicated that there was no RN assessment for the 2/14/24 fall. RN #3 indicated that the assessments were done by LPN #2 and LPN #6. RN #3 indicated there was not an RN assessment for the fall on 3/13/24. RN #3 indicated the 2 falls on 2/14/24 and 3/13/24 that did not have an RN assessment as required only had LPN's assessments prior to getting the resident off of the floor. Review of the facility Incident and Accident Policy identified it is the policy for staff to utilize Risk Management to report, investigate, and review any accidents and incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The nursing supervisor (RN) will be notified of the incident or accident. Any injuries will be assessed by the licensed nurse or practitioner and the affected resident will not be moved until safe to do so. In the event of an unwitnessed fall the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Review of the facility Accident and Incident Reporting Policy identified it is the responsibility of investigated in a timely manner and preventative measures initiated. The purpose of the reportable event is to ensure that all occurrences are reported and thoroughly investigated as per state and federal guidelines and to ensure residents receive immediate assessment and treatment. The staff will notify the nursing supervisor immediately when the accident occurs, or a sign of possible injury is discovered. The charge nurse will administer first aid immediately followed by an assessment by the RN supervisor. RN supervisor will document assessment of the resident's condition and the residents care plan will be initiated or updated with appropriate interventions. The Department of Public Health will be notified by phone for all class A, B, and C incidents. The date and time of notification is documented on the Accident and Incident form. A written report I to be provided within 72 hours of incident. For Class D occurrences, the report will be mailed or faxed to the Department of Public Health.

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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** 37293 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #23) reviewed for positioning, the facility failed to ensure the air mattress was set to the resident's weight as per the physician's order and for 1 resident (Resident #94), who was dependent of staff for care, the facility failed to ensure a helmet, which was recommended by a neurosurgeon to be worn while the resident was out of bed, was consistently applied. The findings include: 1. Resident #23 was admitted to the facility with diagnoses that included dementia, weight loss, and chronic obstructive pulmonary disease. A physician order dated 5/12/24 directed the use of an air mattress to be set at 160lbs. - 200 lbs., check setting and function every shift and provide the assistance of 2 out of bed. The quarterly MDS dated [DATE] identified Resident #23 had severely impaired cognition, was always incontinent of bowel and bladder and required extensive assistance with dressing, toileting, and personal hygiene. The care plan dated 6/24/24 identified potential for pressure ulcer. Interventions included air mattress to bed and check the setting and function every shift. The setting at 160lbs. - 200lbs. Review of the weight summary dated 4/1/24 - 7/16/24 identified the following Weight on 4/4/24 was 159.9lbs. Weight on 4/15/24 was 160.0lbs. Weight on 4/22/24 was 159.4lbs. Weight on 5/1/24 was 161.6lbs. Weight on 5/6/24 was 160.6lbs. Weight on 6/5/24 was 160.2lbs. Weight on 7/5/24 was 158.8lbs. Observation on 7/14/24 at 8:30 AM identified Resident #23 was lying in bed on an air mattress set at 260lbs. The air mattress had a printed piece of tape adhered on top that read setting to be set at 120lbs. - 160lbs. (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 LPN #2 on 7/14/24 at 9:00 AM identified that Resident #23 was last weighed on 7/5/24 and was 158.8lbs. Observation with LPN #2 identified Resident #23 was lying on the air mattress. LPN #2 indicated that it was set at 260lbs. and should be at 180lbs. LPN #2 changed the dial setting from 260lbs. to 180lbs. despite the residents last weight of 158.8 lbs. Physician order dated 7/14/24 at 9:37 AM directed the air mattress be set between 120lbs. - 200lbs., and to check for setting and function every shift. Interview with the DNS on 7/16/24 at 9:34 AM indicated that the charge nurses were responsible to follow the physicians order to check the placement and function of the air mattress every shift and that physician order includes the weight so the nurse can check the appropriate weight setting at that time. The DNS indicated that the unit managers were also responsible to make sure the air mattresses were at the correct weight. Interview with NA #5 on 7/16/24 at 10:35 AM identified she had just finished providing morning care to Resident #23 and was laying a sheet over the resident who was lying in bed. The air mattress was set at 120lbs. Interview with LPN #6 (unit manager) on 7/16/24 at 10:43 AM indicated the nurse aides and the charge nurses were responsible to make sure the air mattresses were set to the resident's weight. LPN #6 indicated that the air mattresses settings are written as a physician's order. LPN #6 indicated the nurses must sign off that they checked the setting and function every shift and check the setting of the weight which for Resident #23 was 120lbs. - 200lbs. LPN #6 indicated that Resident #23's last weight was done on 7/5/24 and was 158lbs. Observation on 7/16/24 at 10:50 AM with LPN indicated that the air mattress setting was to be set based on the resident's weight. LPN #6 indicated that right now Resident #23's air mattress setting was at 120lbs. and that was not correct, and LPN #6 changed the weight setting dial to 160lbs. After review of the clinical record, LPN #6 indicated that Resident #23's weight was 158.8lbs. on 7/5/24 and that the air mattress would be best set at 160lbs. Although attempted, an interview with RN #1 (Infection Control Nurse) was not obtained. Review of the Operation Manual for the air mattress identified it was for the prevention and treatment of pressure ulcers. Determine the resident's weight and set the control knob to that weight setting on the control unit. Review of the facility Support Surface Guidelines Policy identified the redistribution support surfaces are to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief or reduction. The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for all residents at risk for skin breakdown. 2. Review of the hospital discharge summary dated 8/9/22 identified Resident #94 was discharged with diagnoses of right decompressive hemicraniectomy for malignant edema on 5/8/22. Resident #94 has no bone flap on the right side. Resident #94 will need to wear a helmet when out of bed, and a follow up appointment with the neurosurgeon. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #94 was admitted to the facility on [DATE] with diagnoses that included stroke and respiratory failure. Review of the admission note dated 8/9/22 at 10:12 PM identified Resident #94 has a helmet for his/her head to be worn when not in bed. The care plan dated 8/9/22 identified Resident #94 had a history of a stroke and malignant middle cerebral artery syndrome with interventions that included the resident is to wear a helmet when out of bed. Review of the clinical record dated 8/10/22 through 11/21/22 over 3 months, failed to reflect that when Resident #94 was out of bed, he/she was wearing the recommended helmet. Further, the clinical record dated 11/23/22 to 1/4/23 also failed to reflect that when Resident #94 was out of bed, he/she was wearing the recommended helmet. The nurse's note dated 1/5/23 at 11:32 AM identified Resident #94 had lost the helmet in transition to the hospital and a new helmet was obtained and fits well. The nurse's note dated 1/6/23 - 12/31/23 failed to reflect documentation that when Resident #94 was out of bed the helmet was worn. The quarterly MDS dated [DATE] identified Resident #94 had severely impaired cognition, and utilized a wheelchair, dependent with chair to bed transfer and was non ambulatory. Interview and review of the clinical record with the DNS on 7/23/24 at 8:55 AM indicated that staff did not obtain a physician's order for the resident to wear a helmet out of bed per the discharge summary dated 8/9/22 and she was not aware that an order had not been obtained. The DNS indicated it was the responsibility of the supervisor and the licensed nurse to obtain a physician's order for the helmet when the resident was admitted . Although attempted, an interview with MD #3, MD #4, NA #6 and NA #7 was not obtained.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 47457 Based on review of the clinical record, facility policy, and interviews for 2 of 4 residents (Resident #94 and 111) reviewed for pressure ulcer/injury, the facility failed to ensure the Braden Scale (an assessment tool used to assess a resident's risk of developing pressure ulcers) and weekly skin assessments were completed per the physician's order and failed to ensure an RN assessment was documented in the clinical record upon the identification of a new pressure ulcer. The findings include: 1. Resident #94 was admitted to the facility on [DATE] with diagnoses that included a stroke, middle cerebral artery syndrome, and dysphagia. A physician's order dated 2/2/24 directed to complete a body audit on admission and daily for a total of 3 days, then every Wednesday on the evening shift. The Admit/Readmit Screener dated 2/2/24 identified Resident #94 had a surgical incision, including 61 staples to the scalp and a coccyx pressure injury, (without measurements). Although requested, a Braden Risk Assessment for Resident #94's 2/2/24 admission was not provided. The MDS dated [DATE] identified Resident #94 had severely impaired cognition, was at risk for pressure ulcers, frequently incontinent of bowel and bladder, and dependent for toileting hygiene, rolling left to right, and chair/bed to chair transfers. The care plan dated 2/16/24 identified Resident #94 had potential for pressure ulcer/injury development related to decreased mobility, incontinence of bowel and bladder, and history of sacral ulcer. Interventions included monitoring, reporting, and documenting to the physician any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length x width x depth), and stage. Further interventions included weekly skin checks on shower days and as needed. Review of the weekly skin evaluation documentation from 2/2/24 through 4/17/24 identified the following. 2/2/24 identified no new skin issues and to continue treatments to the sacral abrasion/excoriation. 2/9/24, no documented skin evaluation. 2/16/24 no documented skin evaluation. 2/21/24 skin intact. 3/1/24 no documented skin evaluation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/8/24 no documented skin evaluation. 3/15/24 no documented skin evaluation. 3/22/24 no documented skin evaluation. 3/29/24 no documented skin evaluation. 4/5/24 no documented skin evaluation. 4/12/24 no documented skin evaluation. The nurse's note dated 4/15/24 at 1:25 PM identified that RN #2 was called to the resident's room by the nurse aide and Resident #94 was noted with redness to the buttocks. The APRN was made aware and new daily treatment orders were obtained, resident on air mattress, encourage to turn and reposition every 2 hours, and the resident representative was updated. The wound physician's note dated 4/17/24 identified an initial exam of a stage 2 pressure ulcer to the bilateral sacrum measuring 7.2 x 3 x 0.2 with a small amount of purulent exudate, no odor, and a red peri-wound. a. Interview and clinical record review with the Nurse Supervisor (RN#2) on 7/22/24 at 11:50 AM failed to identify that weekly skin evaluations were completed after 2/21/24 through 5/18/24. RN #2 indicated that the charge nurse is responsible for completing weekly skin evaluations and she would expect them to be completed weekly, per the physician's order. RN #2 further indicated that she would re-educate the charge nurses in charge on her unit, about the importance of completing weekly skin assessments. Interview and clinical record review with the DNS on 7/23/24 at 9:21 AM identified that Resident #94 was admitted to the facility with pressure ulcers, but they heal and return due to the residents medical co-morbidities. The DNS further identified that Resident #94 receives weekly wound assessments and the nurse completing the wound assessment would also assess the entire body. Review of the wound assessment documentation dated 3/27/24, 4/3/24, and 4/10/24 failed to identify full body assessments. The DNS indicated that she would still expect the charge nurses to be completing the weekly skin evaluations, per the physician's order, because she wants them to be involved in the resident's skin assessments. A follow-up interview with the DNS on 7/26/24 at 11:04 AM identified that a Braden scale assessment was not completed upon the resident's admission on 2/2/24, per the facility's policy, but a skin assessment was completed. b. Interview and clinical record review with the RN Supervisor (RN #2) on 7/22/24 at 11:50 AM failed to identify documentation of a wound assessment for the pressure injury identified on 4/15/24, including measurements and description of the wound. RN #2 indicated that she thought she documented the assessment findings in a subsequent note. RN #2 further indicated that she did assess the wound, notified the APRN and resident representative, but she must have forgotten to document the assessment findings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 07/23/24 at 9:21 AM identified an incomplete nursing note dated 4/15/24, upon the identification of a new pressure injury. The DNS indicated that she would expect her to inform the APRN and resident representative, which was identified in the note, but she would also expect that the assessment findings would be part of the documentation, including measurements and a description of what the area looked like. The facility's Pressure Ulcer policy directs that when a pressure ulcer is identified, the nurse will notify the attending physician and/or APRN, responsible part; the MDS Coordinator, Wound Care Clinician, Nurse Manager/Supervisor, DNS, and the Dietitian. The policy further directs the nurse to document the assessment on the weekly skin flow sheet. The facility's Charting and Documentation policy directs all observations, medications administered, services performed, etc, must be documented in the resident's clinical record. The facility's Pressure Ulcer policy directs the licensed nurse will document skin assessments weekly on the Weekly Skin Integrity Check. This assessment sheet will be kept in the resident's medical records. The policy further directs the nursing department to complete a risk assessment (Braden/[NAME]) for all residents upon admission and initiate preventative measures. 2. Resident #111 was admitted to the facility on [DATE] with diagnoses that included history of falling, rhabdomyolysis, and failure to thrive. The physician's orders dated 11/2/23 directed to complete a Braden Scale completed upon admission and every week for 4 weeks and complete a body audit upon admission, daily for 3 days, and then weekly every Thursday for skin care. The care plan dated 11/2/23 identified Resident #111 had an unstageable pressure ulcer to the sacrum on admission. Interventions included following facility policies/protocols for prevention/treatment of skin breakdown and to complete skin checks weekly and as needed. The admission MDS dated [DATE] identified Resident #111 had moderately impaired cognition, was frequently incontinent of bowel, had an indwelling catheter in place and required moderate assistance with eating, dressing, and maximal assistance with transfers. The MDS also identified Resident #111 had an unstageable pressure ulcer present upon admission to the facility. A wound care physician note dated 12/13/23 identified Resident #111 had resolved the sacral pressure ulcer on that date. Review of the clinical record failed to identify a Braden Scale had been documented or completed following the resident's admission, per physician order. Although physician's orders directed to complete a body weekly every Thursday, review of the clinical record identified that following the resolution of the sacral pressure on 12/13/23, staff completed a body audit 4 additional times on 12/21/23, 1/11/24, 2/9/24 and 2/29/24. A body audit was not completed the weeks of 3/4/24, 3/11/24, 3/18/24 or 3/25/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 3/27/24 at 2:18 PM identified Resident #111 was noted to have pressure areas to both heels. The note further identified that the areas were unstageable and that the wounds had been referred to the wound care physician. A wound care physician's note dated 3/27/24 identified Resident #111 was seen for an initial exam of bilateral pressure ulcers to the heels. The note identified the left heel pressure ulcer measured 4.5cm x 2cm x 0.2cm and a right heel pressure ulcer measured 3cm x 5.2cm. The note further identified that the pressure ulcers were unstageable, and treatment included debridement along with calcium alginate and a dry clean dressing change daily. Review of the clinical record identified a Braden Scale was completed on 4/10/24, approximately 5 months after admission to the facility and 14 days after Resident #111 was identified as having unstageable pressure ulcers to both heels. The Braden Scale identified Resident #111 was at moderate risk of developing pressure ulcers. Interview with the ADNS on 7/23/24 at 9:25 AM identified the Braden Scale should be done on admission and per the physician's order, and skin assessments/body audits were to be done weekly, usually on a resident's shower day, and if the resident refused to shower, the skin assessment was still required to be done. Interview with the DNS and RN #3 on 7/23/24 at 10:20 AM identified that while Resident #111 had at times, refused care, and this may have been the issue related to the skin assessments not being completed, however the DNS identified that there should have been documentation in the clinical record to identify why a skin assessment was not documented for any of the missing weeks. The DNS identified she was unsure why Resident #111 did not have a Braden Scale completed upon admission or why the Braden Scale and skin assessments/body audits had not been completed per the physician's order. The Pressure Ulcers policy directed that the nurse department would complete a Braden/Norton risk assessment on all residents on admission. The policy further directed that the RN would ensure completion of the skin assessment on admission, readmission, quarterly, annually, and with a significant change of condition. The policy also directed that the licensed nurse would document skin assessments weekly and that the assessment would be kept in the resident's medical record. Although requested, the facility failed to provide a policy on following the physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation, facility policy, and interviews, for 6 residents (Residents #8, 11, 57, 64, 88, and 120) who attend the fall prevention program, the facility failed to ensure adequate supervision was maintained and for 1 resident (Resident #97) who had been found smoking at the facility and had contraband in his/her possession, the facility failed to ensure adequate supervision of the resident to ensure the resident's individual safety, as well as the safety of others in the facility and for 2 of 5 residents (Resident #111 and 94) who were reviewed for accidents and/or wandered, the facility failed to ensure interventions were revised to prevent future falls and failed to provide supervision to prevent an elopement. The findings include: 1. Residents #8, 11, 57, 64, 88, and 120 had care plans that indicated they were at risk for injuries related to falls. Interventions included allowing the resident to choose the time to participate in the fall program and to encourage community watch during the times he/she is not in the program. Review of the facility's daily nursing assignment sheets dated 7/13/24 and 7/14/24 identified NA #2 had worked 7/13/24 from 11:00 PM - 7:00AM and was assigned to work 7/14/24 from 7:00AM - 3:00PM. Observation on 7/14/24 from 9:32 AM through 9:35 AM in the third-floor dining room fall program identified NA #2 in the room with her eyes closed, sitting at a table across from Resident #88. NA #2 opened her eyes when LPN #5 entered the dining room and began speaking to Resident #88. Other residents also present in the dining were Residents #8, 11, 57, 64, and 120. Interview with the ADNS on 7/14/24 at 9:36 AM identified that the nurse aide assigned to supervise the residents in the fall program should be watching the residents, not sitting with his/her eyes closed. The ADNS removed NA #2 from the dining room and immediately replaced her with another nurse aide. The ADNS indicated that NA #2 had also worked the 11:00 PM - 7:00 AM shift, and that she would need to send her home. Interview with NA #2 on 7/14/24 at 9:38 AM identified that she had worked at the facility since 2013, and that she was assigned to watch the residents in the dining room. NA #2 indicated that she had closed her eyes for a few seconds and that she did not think that closing her eyes while supervising residents was the expectation of her role. Interview with LPN #5 on 7/14/24 at 9:42 AM identified that she did observe NA #2 sitting at a table in the dining room with her eyes closed, when she entered the dining room to see Resident #88. Interview with the DNS on 7/23/24 at 9:09 AM identified that it is her expectation that the nurse aide providing supervision of the residents participating in the fall program remains awake. The DNS further identified that the mission of the fall program is to allow residents, who are at risk for falls, the freedom to move around and socialize while ensuring their safety by having a nurse aide assigned to that room. The DNS indicated that NA #2 had been suspended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Prevention Program policy identified the purpose of the program is to reduce the incidence of falls in residents identified at high risk. Participation in the program is determined by resident's past history of falls and recommendations from the nursing staff. The program participants are encouraged by staff to attend recreation therapy programs. Residents with frequent falls are discussed with the interdisciplinary team to determine appropriate interventions. Each resident will have an individual assessment and care plan which will address their specific needs related to fall risk. The facility's Personnel Policy Handbook directs that unacceptable acts and behavior, including but not limited to sleeping during working hours, may result in immediate suspension and, pending investigation, subsequent discharge or other discipline as deemed appropriate. 2. Resident #97, with a history of smoking, was admitted to the facility on [DATE] with diagnoses that included pneumonia, cerebral infarction, and hemiplegia and hemiparesis. The admission MDS dated [DATE] identified Resident #97 had intact cognition, required a substantial/maximal assist with chair/bed-to-chair transfers, and utilized a manual wheelchair. A social service note dated 8/29/23 at 3:40 PM identified the Director of Social Services (SW #1) met with Resident #97 to educate him/her on the facility's nonsmoking policy and reviewed the nonsmoking agreement, which he/she refused to sign. Resident #97 showed understanding that smoking is not allowed inside or outside of the facility and smoking materials were not allowed in his/her room. Resident #97 stated all smoking materials were given to his/her resident representative. Resident # 97 refused to go on any medication to help with the urge to smoke because the medication had not worked in the past. Resident #97 did not want to transfer to a smoking facility. A social service note dated 9/5/23 at 3:28 PM identified that SW #1 spoke with Resident #97's representative and discussed concerns regarding smoking. SW #1 reminded the resident representative of the facility's non-smoking policy and explained that Resident #97 cannot have any smoking materials on him/her at any time. The resident representative stated he/she spoke with nursing last week about having Resident #97 start the patch. SW #1 also offered a transfer to another nursing facility that allowed smoking, but also explained a discharge back to a family member's house would be an option if Resident #97 continued to be non-compliant with smoking. The resident representative was understanding and stated he/she would talk with the family and educate them on not bringing cigarettes or smoking materials to the facility. A social service note dated 9/6/23 at 3:28 PM identified that SW #1 spoke with Resident #97, and he/she was upset that the resident representative was notified that he/she cannot smoke inside or outside of the facility. Resident #97 stated, I am not going to quit. Resident #97 also refused twice, to sign a smoking agreement. Resident #97 knows he/she is not going to quit so he/she does not want to sign the form. Resident #97 also refused to tell SW #1 how he/she gets cigarettes and other smoking materials. Resident #97 is accepting of the facility attempting to find a smoking facility for him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Activities Quarterly Note dated 9/13/23 at 8:47 AM identified that on 9/12/23 Resident #97 was smoking in the entrance way and was approached by a nurse and the Director of Recreational Therapy. Resident #97 was sitting there with a lit cigarette and the nurse took it and took a lighter. Resident #97 was very agitated; the Director of Recreational Therapy explained it is against the building's policy, could lead to a discharge, and to please stop the smoking. Review of the social service notes dated 9/14/23 through 7/15/24, 10 months, identified 3 entries addressing the non-smoking policy with Resident #97 on 3/12/24, 4/9/24, and 6/20/24. The care plan dated 9/20/23 identified Resident #97 was resistive to following the facility's non-smoking policy. Interventions included allowing the resident to make decisions about the treatment regimen, to provide sense of control, and educate the resident\ family\caregivers of the possible outcome(s) of not complying with the non-smoking policy. The care plan dated 1/30/24 identified Resident #97 was seen with a lighter and cigarettes; SW took away the lighter. Interventions included having the resident ask for guidance and to provide help to reduce smoking. Resident #97 refused to sign the Notification of Contraband documentation dated 3/12/24. The Room Audit for Smoking Paraphernalia document (completed by social services) identified a room search was conducted for smoking paraphernalia on 4/12/24 and 6/3/24, the resident agreed to both room searches, and smoking paraphernalia was found and removed on both days. Review of the nursing notes and social service notes dated 4/12/24 and 6/3/24 failed to identify documentation identifying the circumstances leading to the room search, what type of contraband was removed, and the disposition of the contraband. A Care Plan Conference Summary dated 6/20/24 identified that the resident representative suggested that Resident #97 try a nicotine patch and the resident agreed. Notification of contraband was signed by Resident #97 and the resident representative would sign, as well. Resident #97 refused to sign the Notification of Contraband documents dated 6/25/24 and 7/16/24. Facility documentation provided to the survey team on 7/14/24 identified the facility has 0 smoking patients. A nursing note dated 7/16/24 at 7:11 AM identified the nursing supervisor went into Resident #97's room and asked for all smoking materials, 3 lighters and 4 cigarettes were removed and locked in the nursing supervisor's office. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Recreational Therapy on 7/16/24 at 7:33 AM identified that the only time she observed Resident #97 smoking was during the incident on 9/12/23. The Director of Recreational Therapy indicated that she and another nurse (could not recall the nurse's last name) saw Resident #97 smoking on the far side of the entrance way, probably in the late afternoon or early evening. The Director of Recreational Therapy identified that she reminded Resident #97 that he/she was not supposed to be smoking and that the resident was resistant at first, but later indicated that his/her family member brought in the cigarettes. The Director of Recreational Therapy could not recall who she notified about this incident, but it was reported to upper management, and she shared the information during the morning report, too. The Director of Recreational Therapy denied ever seeing Resident # 97 smoking inside of the facility. Interview with Resident #97 on 7/16/24 at 7:58 AM identified that he/she does smoke at the facility sometimes, but he/she hides it. Resident #97 further identified that he/she has respect and has always gone outside and has never smoked inside. Resident #97 refused to answer where he/she had gotten a lighter and cigarettes. Resident #97 indicated that some of the nurse aides smoke on the facility grounds, so why can't he/she? Interview with the DNS on 7/16/24 at 8:56 AM identified that at least one time, Resident #97 was observed smoking by staff, and the facility staff have reeducated the resident on the non- smoking contraband policies. The DNS further identified that, one time, the facility had taken lighter and cigarette. The DNS indicated that the resident representative did not know where Resident #97 acquired cigarettes and that he/she would take the resident off the premises to smoke. The DNS further indicated that if the facility staff was aware of contraband, she would expect that a room search would be conducted, if the resident agreed, and that there would be documentation of a room search. Interview with SW #1, the DNS, and the Administrator on 7/16/24 at 9:15 AM identified that multiple discussions had occurred with Resident #97 and the resident representative about not smoking. SW #1 identified that in the last month, Resident #97 had been smoking or in possession of a lighter or cigarettes. SW #1 further identified that the facility staff have asked Resident #97 to sign a contraband form, but he/she refused to sign it; last month, Resident #97 refused to hand over his/her cigarettes. SW #1 indicated that the facility was monitoring Resident #97 by ensuring frequent checks of his/her room, which Social Services documents on paper. SW #1 indicated that Resident #97 had never refused a room check. The Administrator identified that the facility staff have spoken with Resident #97 and the family on a constant basis due to non-compliance, and even offered to have the resident moved to a smoking facility. The DNS identified that the next steps would be to pursue a 30-day discharge notice. Interview with an anonymous resident on 7/16/24 at 11:57 AM identified that around 4:00 PM, after the social worker leaves for the day, he/she has seen visitors and residents outside smoking on the front walk, and that deters the anonymous resident from having his/her family come to visit, at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #2 on 7/16/24 at 1:40PM identified that she was aware of the smoking concerns with Resident #97 but had never observed the resident smoking or in possession of contraband. APRN #2 indicated that they had explained to Resident #97 several times about the non-smoking policy, and he/she gets so upset. APRN #2 further identified that she was aware of the smoking incident almost a year ago but had not been notified of any recent smoking activity or procession of contraband. APRN #2 indicated that she would expect staff to communicate with her if Resident #97 was observed smoking or had contraband. APRN #2 further indicated that since Resident #97 had a history of smoking at the facility, she would expect supervision for smoking or having contraband, although sometimes it is hard for staff to know when residents have gained access. Interview with the DNS on 7/23/24 at 9:12 AM identified that last week Resident #97 admitted that he/she had a cigarette and a lighter, after initially refusing, and they were removed from his/her room. The DNS further identified that re-education was provided at the resident council meeting regarding the non-smoking and contraband policies to ensure a safe environment and encouraged any residents with the urge to smoke to discuss the urge and different options with the facility staff. The DNS indicated that they also sent a memo to family members discouraging anyone from bringing in smoking paraphernalia to residents, and staff members were re-educated that there is no smoking on the facility property. The DNS indicated that they were currently looking for smoking facility for Resident #97, and in case he/she refuses the transfer to a smoking facility they would involve the ombudsman, if that was not successful a 30-day discharge notice will be issued. Although requested no facility reportable event forms were provided. Although requested admission documentation signed by Resident #97 or the resident representative acknowledging the facility is non-smoking was not provided. The Contraband policy directs a list of items considered to be potentially dangerous, or items that may possess significant health risk and are therefore considered contraband and to be handled on facility premises by or under the supervision and/or the discretion of staff will be reviewed with all new admissions. On admission a list of contraband items will be reviewed with all competent residents or the responsible party of the incompetent resident. The following are considered contraband items-items that the resident may not have in their possession: any sharp items, intoxicating substances, illegal drugs, weapons, any smoking materials, lighters/matches/ignition materials, medications, any item deemed unsafe by the interdisciplinary team. In the event contraband items are suspected to be present the staff will immediately notify the supervisor at the time the determination will be made as to whether it is appropriate to utilize the facility approved room search and/or non-intrusive search procedures and protocols. If the presence of contraband has been detected by staff and the item presents a risk to the safety or health of others the staff will immediately facilitate by whatever means possible, the isolation or removal of risk to others and immediately inform the supervisor. The Notification of Contraband document directs to maintain a safe and healthy environment for all residents. This facility has developed a list of items that residents may not have in their possession (see above list). Failure to abide by the aforementioned policy may result in the need for close observation, revoking of LOA privilege and/or issuance of 30-day discharge notice. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although the facility is nonsmoking, between 9/12/23 - 7/16/24, 10 months, Resident #97 was seen smoking twice and had documentation in the clinical record that he/she had smoking paraphernalia on three occasions. The facility did not follow the Notification of Contraband document or implement measures to increase supervision of Resident #97 to ensure the resident's individual safety, as well as the safety of others in the facility. 3. Resident #111 was admitted to the facility on [DATE] with diagnoses that included history of falling, rhabdomyolysis, and failure to thrive. The admission MDS dated [DATE] identified Resident #111 had moderately impaired cognition, was frequently incontinent of bowel, had an indwelling catheter in place and required moderate assistance with eating, dressing, and maximal assistance with transfers. The MDS also identified Resident #111 had a history of falling within the month prior to admission to the facility. The care plan dated 11/15/23 identified Resident #111 was at risk for injury related to falls, deconditioning, and gait/balance issues. Interventions included to ensure the resident's call light and personal items were within reach and that Resident #111 needed prompt response to all requests for assistance. Review of clinical record and a facility accident and incident (A&I) report identified Resident #111 had a fall that resulted in a major injury on 11/17/23 at 5:00 PM. The clinical record identified Resident #111 had an unwitnessed fall in his/her room that resulted in a laceration to the forehead. The clinical record further identified that Resident #111 was sent to the hospital for evaluation and returned to the facility at approximately 10:15 PM with an additional diagnosis of a nasal fracture related to the fall. Review of the clinical record failed to identify the care plan was revised following the 11/17/23 fall with major injury. Review of the clinical record and facility A&I reports identified Resident #111 had additional unwitnessed falls on 11/28/23, 2/24/24, 3/1/24 and 4/13/24 with no major injury. The clinical record failed to identify new interventions were implemented following these falls. Review of a facility provided documented dated 7/14/24 labeled Residents in Fall Program following the survey team's entrance identified that a total of 9 residents were participants in the fall program, including Resident #111. Observation on 7/14/24 at 9:12 AM identified 5 female residents located in the 3rd floor unit dining room of the facility, including Resident #111. A female nurse aide was identified to be in the room with the residents. Interview on 7/14/24 at 9:17 AM with LPN #5 identified that the residents located within the 3rd floor dining room were residents at high risk for falls and were on the list for residents in the fall program. LPN #4 identified that the residents were placed in the dining room by the facility to be monitored in a common area by staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #111's clinical record failed to identify any documentation related to Resident #111's participation in the program, including any discussion or education with Resident #111 or Resident #111's representative related to the fall program, or when Resident #111 became a participant in the program. Interview with RN #4 (RN supervisor) on 7/23/24 at 8:15 AM identified that a current list of facility residents in the fall program was updated on 7/14/24. RN #4 identified that the facility implemented the fall program sometime at the end of 2023, but she could not remember when. RN #4 identified that any residents on the fall program were brought into the dining room on the unit daily to have direct monitoring by a facility staff member, but that the residents were able to request to go back to their rooms if they wished. RN #4 identified that she did not have any previous versions of the fall program lists and could not identify when each resident current on the list was added to the program. Interview with the ADNS on 7/23/24 at 9:25 AM identified that she started employment at the facility approximately 2/2024 and assisted with implementation of the fall program at that time. The ADNS identified that the program was a fall prevention measure which included bringing residents into the dining room of the unit to have direct monitoring by 1 - 2 facility staff, but at the program was voluntary and residents had the option to participate or opt out of the program. The ADNS identified that the monitoring was not documented in the residents' charts. The ADNS identified that she added Resident #111 to the fall program following the fall on 4/13/24 but that it was not documented in the resident's record. The ADNS identified that she could not address why Resident #111 did not have any additional interventions implemented until she added the resident to the fall program in 4/2024 and was unable to identify if any education had been provided to Resident #111 or his/her representative regarding the program. Interview with the DNS and RN #3 on 7/23/24 at 10:20 AM identified that while Resident #111 did not have any additional interventions in place related to falls until 4/2024, Resident #111's falls were reviewed during the monthly medical rounds at the facility. The DNS identified that Resident #111 was added to the fall program after his/her fall on 4/13/24 due to the number of falls that the resident had and the need for increased monitoring and had not had any falls since starting the program. The DNS identified that the facility had a policy related to fall prevention but did not have a policy specific to the fall program and did not provide any specific education to the residents or resident representatives related to participation in the program, including education regarding staff monitoring, participation in the program was voluntary, and residents could refuse to participate. The DNS identified the facility implemented the program for residents with frequent falls to keep the residents safe by providing close monitoring in a central area of the unit. Although attempted, an interview with Resident #111's representative was not obtained. Although requested, the facility failed to provide a specific policy related to the fall program and resident monitoring. The facility policy on falls directed that facility staff would attempt to define possible causes for a fall within 24 hours and would identity pertinent interventions to try to prevent subsequent falls and to address risk of serious consequences of falling. The policy further identified that if underlying causes of a fall could not be readily identified, staff would try various interventions until falling reduced or stopped. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on the fall prevention program directed that the policy was to reduce incidence of falling and that program participants would be encouraged by staff to attend recreation therapy programs. 4. The hospital physician's progress note dated 6/23/24 at 12:52 PM identified on admission to the hospital, the resident representative indicated they had noticed a change in Resident #27 memory over the past several months. The resident representative indicated Resident #27 often gets lost while driving and misplaces belongings quite frequently. A Montreal Cognitive Assessment (MoCA is a screening tool for detecting cognitive impairment) dated 6/23/24 in which Resident #27 scored 17/30 indicating impaired cognition function. Review of the hospital discharge summary dated 6/29/24 identified Resident #27 discharge diagnoses included a motor vehicle collision, dementia and altered mental status. Resident #27 was admitted to the facility in June 2024 with diagnoses that included adjustment disorder with mixed anxiety and depressed mood, other symptoms and signs involving cognitive functions and awareness, and heart failure. Review of the wandering/elopement assessment dated [DATE] identified Resident #27 was at risk to wander. The physician's order dated 7/1/24 directed to provide the assistance of 1 with transfers, and ambulation with a rolling walker. Additionally, the physician's orders failed to reflect an order for a wander guard device. The admission MDS dated [DATE] identified Resident #27 had intact cognition and required partial/moderate assistance with walking 50 feet with two turns and was dependent with walking 150 ft with the use of a walker. Additionally, Resident #27 had no wandering behavior. The care plan dated 7/9/24 identified Resident #27 is an elopement risk and wanderer as evidenced by history of attempts to leave the facility unattended. Interventions included wander alert device: apply wander guard to ankle, check placement and function every shift and as needed. The care card (undated) identified wander guard applied to ankle, monitor for placement and function every shift and as needed. Observation on 7/16/24 at 11:43 AM identified he heard Resident #46 tell the Receptionist that Resident #27 was in the parking lot at the mailbox, (which was approximately 92 feet from the front door of the facility). Observation on 7/16/24 at 11:44 AM identified Resident #27, who was wearing a wander guard, was in the parking lot of the facility walking with a rolling walker with LPN #1 heading towards the facility. Resident #27 was holding a plastic bag with old bread. Interview with Resident #27 at that time, identified the resident wanted to go for a walk after feeding the birds, so he/she started walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview at that time with LPN #1 identified Resident #27 told her he/she wanted to go for a walk and LPN #1 indicated she walked with Resident #27 because she did not want the resident to become agitated. A reportable event form dated 7/16/24 at 11:51 AM identified Resident #27, who wears a wander guard, approached the front door, the alarm sounded, and the front door locked immediately. The Receptionist turned the alarm off and let Resident #27 outside with a female companion. A written statement by the Receptionist dated 7/16/24 at 11:51 AM identified she has been employed by the facility for 4 years and works every other weekend. The Receptionist indicated she saw Resident #27 walking towards the doors with a female in close conversation who she assumed was a family member of the resident. The Receptionist indicated the doors locked, the wander guard alarm sounded, and she disarmed the alarm and unlocked the doors. The Receptionist indicated she does not recall the exact time the wander guard alarm sounded or when Resident #27 went out the door and indicated she did not verify if the female who was with Resident #27 was a family member or a friend of the resident. The Receptionist indicated a few moments later she went to check and saw Resident #27 walking towards the mailbox. The Receptionist indicated she went to a unit to find NA #3 and told NA #3 to go outside and get Resident #27. The Receptionist indicated she did not have Resident #27 in her eyesight because she assumed Resident #27 was with a family member. Interview with Resident #46 on 7/16/24 at 12:00 PM identified Resident #27 is not supposed to be outside with the ankle bracelet. Resident #46 indicated he/she has seen Resident #27 outside before without the staff. Resident #46 indicated he/she has been sitting outside for the last 3 days and has seen Resident #27 outside feeding the birds without the staff. Interview with NA #3 on 7/16/24 at 12:17 PM identified she has been employed by the facility for 5 years and she works on the 7:00 AM - 3:00 PM shift. NA #3 indicated the residents are allowed to go outside in front of the facility and she does not know how the residents with wander guards are supervised outside. NA #3 indicated she always takes Resident #27 outside to feed the birds and she leaves the resident unattended and will check on Resident #27 every 15 minutes. NA #3 indicated if she had felt Resident #27 was an elopement risk she would not have brought the resident outside and leave the resident unattended. NA #3 indicated the Receptionist came and notified her that Resident #27 was outside. NA #3 indicated by the time she arrived at the lobby she saw LPN #1 approaching Resident #27 who was walking down the parking lot area. NA #3 indicated that she did not know why Resident #27 was wearing a wander guard. Interview with the DNS and RN #5 (Corporate Regional Nurse) on 7/16/24 at 12:45 PM identified Resident #27 likes to go outside and that was the reason why the wander guard was placed on the resident. The DNS indicated the wander guard sounded the alarm which alerted the staff that the resident was attempting to go outside. The DNS and RN #5 indicated they were not aware that NA #3 brings and leaves Resident #27 outside unattended. The DNS indicated all the Receptionist will be educated on residents who wear wander guards and going outside unattended. A written statement by the Receptionist dated 7/16/24 at 1:00 PM identified she was coming around from behind the receptionist desk when Resident #46 informed her that a resident is going down the driveway. The Receptionist indicated she looked out of the lobby's window and saw Resident #27 at the mailbox. The Receptionist indicated she went to the first-floor unit and notified NA #3 that Resident #27 was outside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by LPN #1 dated 7/16/24 (no time) identified while she was in her office she overheard Resident #46 calling out the resident shouldn't be outside. LPN #1 indicated she went to the lobby and asked Resident #46 who was he/she talking about? Resident #46 replied the resident with the thing on his/her leg. LPN #1 indicated she went outside and saw Resident #27 at the mailbox. LPN #1 indicated she asked Resident #27 was he/she alright and the resident indicated he/she was feeding the birds. Resident #27 began walking towards the end of the parking lot and she walked along with the resident. LPN #1 suggested that they go inside for a drink of water because it was a bit warm outside. Review of the wandering/elopement assessment form dated 7/16/24 at 1:41 PM identified Resident #27 was at high risk to wander. Review of the facility elopement and wandering policy identified the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accidents or elopements. 46040 47457

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility policy, and interviews for 1 resident (Resident #42) reviewed for pain management, the facility failed to administer an as needed (PRN) pain medication when the resident had pain and requested the medication. The findings include: Resident #42 was admitted to the facility on [DATE] with diagnoses that included an infection following a procedure, deep incisional surgical site, infective bursitis, cellulitis, and phantom limb syndrome with pain. The physician's order dated 6/6/24 directed to administer the following. 975mg Acetaminophen, by mouth, three times daily, for pain 2mg Benztropine Mesylate, by mouth, once daily, for phantom pain 4mg Hydromorphone, by mouth, every 6 hours as needed (PRN), for severe pain (verbal report 8-10). The admission MDS dated [DATE] identified Resident #42 had intact cognition, had a surgical wound, was receiving IV (intravenous) antibiotics, and reported occasional moderate pain. The care plan dated 6/21/24 identified Resident #42 had potential for acute/chronic pain related to a hip abscess. Interventions included administering analgesia per the physician's order, document effectiveness, anticipate the resident's need for pain relief and respond immediately to any complaint of pain, monitor/record/report to nurse any complaints of pain or requests for pain medication, and to notify the physician if interventions are unsuccessful. Interview with Resident #42 on 7/14/24 at 9:10 AM identified that he/she had a fall that led to a tunneling hip infection, which was being treated with IV antibiotics and wound vacuum therapy, which was recently discontinued. Resident #42 further identified that prior to the fall and infection, he/she was working with an outpatient pain management clinic for phantom pain. Resident #42 indicated that he/she had recently had discussions with the wound doctor about breakthrough pain concerns because sometimes the Hydromorphone wears off after a few hours. Resident #42 further indicated that some of the facility nurses (could not provide specific names) don't take his/her reports of pain seriously and it depends on the nurse how long he/she waits for pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow-up interview with Resident #42 on 7/15/24 at 1:22 PM identified that during the 3:00 PM - 11:00 PM shift on 7/14/24, he/she had asked LPN #7 for the PRN dose of Hydromorphone around 8:00 PM, but LPN #7 said that he/she could not have it and that she was busy and had other medications to pass. Resident #42 further identified that he/she had approached LPN #7, 2 or 3 additional times, between the hours of 8:00 PM - 10:00 PM, requesting the PRN dose of Hydromorphone. Resident #42 identified that LPN #7 did administer the scheduled medications that evening but left out the PRN dose of Hydromorphone. Resident #42 indicated that he/she later approached the 11:00 PM - 7:00 AM nurse (could not recall her name) and requested the PRN dose of Hydromorphone and told her that he/she had not been given Hydromorphone on the prior shift. Resident #42 further indicated that the nurse ignored him/her, the resident did not ask again, and tried to go to bed. Resident #42 identified that he/she suffered during the night and was unable to sleep; when the first request was made for the PRN dose of Hydromorphone his/her pain rating was a 7.5 out of 10 and by time he/she laid down in bed on his/her left side (opposite side of hip infection site), in an effort to relieve some pain, the pain level was an 8.5 out of 10. Review of the July 2024 MAR identified 4mg Hydromorphone was administered on 7/14/24 at 12:03 AM and not again until 7/15/24 at 8:32 AM. Review of the Controlled Substance Disposition Record dated 7/4/24 identified that 4mg of Hydromorphone was last dispensed on 7/14/24 at 2:30 PM and not again until 7/15/24 at 8:00 AM. The Controlled Substance Disposition Record identified that Resident #42 was without the benefit of the PRN dose of Hydromorphone for 17.5 hours. Interview and clinical record review with LPN #7 on 7/15/24 at 3:21 PM failed to identify that Resident #42 received his/her requested PRN dose of Hydromorphone on 7/14/24. LPN #7 indicated that she thought she had medicated the resident with the PRN dose of Hydromorphone. LPN #7 further indicated that sometimes Resident #42 forgets that he/she is not due for the PRN medication but will persist with requesting it and indicated the Psychiatric APRN recommended creating a list for the resident of last administration times in an effort to remind him/her when the next dose is available. LPN #7 identified that she did not create the medication administration time list for Resident #42, the evening prior, but she did medicate him/her with all the scheduled pain relief medications; she must have gotten busy and forgotten to administer the PRN dose of Hydromorphone. Interview with RN # 2 on 7/22/24 at 11:48 AM identified that she was unaware Resident #42 was not receiving his/her PRN pain medications when requested. RN #2 further identified that it is her expectation that if a resident asks for a PRN medication within the timeframe that it can be administered, it should be given. Interview with LPN #9 on 7/23/24 at 8:17 AM identified that she had worked on 7/14/24 from 11:00 PM - 7:00 AM but she could not recall if Resident #42 had asked for the PRN dose of Hydromorphone. LPN #9 further identified that when Resident #42 asks for pain medication she will administer it, if it is due otherwise, she will tell him when it is due and then offer him/her something else, and sometimes the resident does not ask for the PRN at all. Interview with the DNS on 7/23/24 at 10:05 AM identified that she would expect the nurse to follow the physician's order for a PRN medication, and if the medication is not sufficient then she would expect the nurse to notify the APRN for further evaluation of the pain management regimen. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pain-Clinical Protocol directs that with input from the resident and/or advocate, the physician and staff will establish goals of pain treatment. The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain. The staff will evaluate and report how much and how often the individual asks for PRN pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075387	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Norwalk	34 Midrocks Drive Norwalk, CT 06851

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37293 Based on observation, review of facility documentation, facility policy, and interviews for 2 of 7 medication carts, the facility failed to ensure shift to shift controlled drugs count was consistently completed. The findings include: a. Observation on 7/22/24 at 9:47 AM of the medication carts on the first floor with the DNS identified the July 2024 controlled drugs count record (the on-coming and off-going nurses complete to ensure all controlled drugs are counted) were missing signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift on the 1B unit. The 1B unit controlled drugs count record was missing 11 signatures. Interview with the DNS on 7/22/24 at 9:50 AM identified she was not aware of the missing controlled drugs count signatures until now. The DNS indicated it was the responsibility of all the nurses to sign the controlled drugs count record at the beginning of the shift and at the end of each shift when the controlled drugs count is completed. b. Observation on 7/23/24 at 6:45 AM of the medication carts on the third floor with the DNS and the ADNS identified the July 2024 controlled drugs count record was missing signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift. The 3 AB unit controlled drugs count record was missing 8 signatures. Interview with LPN #12 on 7/23/24 at 6:48 AM indicated it was the responsibility of all nurses to sign the controlled drugs count record at the beginning of the shift and at the end of each shift when the controlled drugs count is completed. Interview with the DNS on 7/23/24 at 6:50 AM identified she became aware of the issue on 7/22/24. The DNS indicated the expectation of the facility is that the on-coming and off-going nurse count the controlled drugs during each shift change and sign the controlled drugs count record after completing the count. Interview with the ADNS on 7/23/24 at 7:00 AM identified she became aware of the missing controlled drug count record signature on 7/22/24. The ADNS indicated the expectation is that the nurses will count the controlled drugs at the change of shift and sign the controlled drugs count record after completing the count. Review of the controlled substances policy identified the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other substances. Nursing must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37293 Based on observation, review of facility policy and interviews, the facility failed to ensure food was prepared under sanitary conditions within professional standards. The findings included: Observation on 7/16/24 at 9:36 AM during BFSI tour of the kitchen with the Maintenance Assistance identified [NAME] #1 at the three compartment sinks thawing frozen chicken in a deep pot under running cold water in the third sink. The first sink was full of dirty pots and bowls soaking in a sink full of water with suds. The second sink was identified with a moderate amount of soap suds and food debris. The third sink was identified with a deep pot with chicken under running cold water with [NAME] #1 preparing the chicken without the benefit of gloves. Interview with the Dining Services Director (DSD) on 7/16/24 at 10:40 AM identified he was not aware of the issue. The DSD indicated [NAME] #1 should not have used the three compartment sinks for prepping or thawing out the chicken. The DSD indicated the kitchen has 2 preparation sinks and one of the preparation sinks is used for meat. Interview with Dietitian #2 (Director of Clinical Operations) on 7/16/24 at 10:50 AM identified she was not aware of the issue. Dietitian #2 indicated [NAME] #1 should not have been preparing the chicken in the three compartment sinks with dirty pots and a sink full of water and soap suds in one sink, and suds and food debris in the middle sink. Interview with [NAME] #1 on 7/16/24 at 11:00 AM identified she has been employed by the facility for 3 years. [NAME] #1 indicated she was not supposed to thaw the chicken in the three compartment sinks, especially when it was dirty. [NAME] #1 indicated sink #1 (on the other side of the kitchen) which is used for meat was being occupied and sink #2 (on the other side of the kitchen) is not used for meats it is only use for fruits and vegetables. [NAME] #1 indicated she had to get the chicken ready for supper. Interview with the DNS on 7/16/24 at 11:05 AM identified she was not aware of the issue. The DNS indicated she will meet and discuss with the DSD and [NAME] #1 regarding prepping in the three compartment sinks is not sanitary. Review of the facility food preparation policy identified all foods are prepared in accordance with the Food and Drug Administration (FDA) food code. Dining services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. The cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: Completely submerging the item under cold water (at temperature of 70 degrees F or below) that is running fast enough to agitate and float off loose ice particles. The FDA Guidelines for three compartment sinks identified: If food products are to be washed or thawed in the three compartment sink each sink must be emptied, washed, and sanitized before and after each use.

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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. 43032 Based on observation, review of facility policy, and interviews the facility failed to store personal protective equipment, PPE (protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission) in a sanitary manner for a resident identified on transmission-based precautions. The findings include: Observation on 7/14/24 at 8:09 AM with LPN #3 identified an isolation cart containing PPE. LPN #3 reached into the cart, into the 3rd drawer area from the side (there was no 3rd drawer), and the PPE was observed to be stored on the floor in the 3rd drawer slot. LPN #3 could not provide an explanation of the missing drawer or contents being stored on the floor. The policy for PPE storage identified that appropriate infection prevention and control equipment and supplies are obtained, stored and used in accordance with current guidelines and manufacturer instructions.