STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075395	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center for Health & Rehabilitation	642 Danbury Road Ridgefield, CT 06877

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, facility policy and interviews for four sampled residents (Resident #59, Resident #81, Resident #90 and Resident #100) reviewed for mistreatment, the facility failed to prevent resident to resident altercations between Resident #59 and Resident #81, and between Resident #90 and Resident #100. Additionally, for four of eight residents (Residents #27, #40, #62 and #99) reviewed for abuse, the facility failed to ensure the residents were free from neglect and that care was provided in a timely manner on 3/8/2025 during the 7 AM to 3 PM shift. The findings include: 1a. Resident #59 was admitted to the facility in September of 2022 with diagnoses that included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, had verbal behavioral symptoms directed towards others, had the behavior of wandering, and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #59 had a history of anxiety and depression. Interventions included observing for periods of anxiety, provide a calm, quiet environment and encourage Resident #59 to verbalize thoughts and feelings related to anxiety. A nursing note written by the Nursing Supervisor (the current Director of Nursing (DNS)) dated 5/13/24 at 12:45 PM identified she assessed Resident #59 who had been punched in the face by another resident (Resident #81). The nursing note identified Resident #59 was seated in the dining room with other residents when Resident #81 approached Resident #59 and asked some questions, Resident #59 responded saying, I don't understand you., and Resident #81 then punched Resident #59 in the face. The nursing note identified Resident #59 was taken to his/her room for further assessment and neuro checks, Resident #59 denied pain, and had intact skin with no redness or scratches to the face. The nursing note further identified the responsible party and attending APRN had been notified, and the attending APRN came to the facility to evaluate Resident #59. The progress note failed to identify Resident #59 had been punched in the face the previous evening on 5/12/24 (when the actual event occurred). (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note written by Licensed Practical Nurse (LPN) #2 on 5/13/24 at 5:45 PM (1 day after the resident to resident altercation occurred) identified Resident #59 was in the dining room waiting for dinner when another resident (Resident #81) approached him/her asking questions and Resident #59 responded, I don't understand you, after which Resident #81 punched Resident #59 in the face. The nursing note identified that LPN #2 assessed Resident #59, performed neuros, and did not identify bleeding, pain or discomfort. The nursing note further identified LPN #2 redirected Resident #81 to his/her room, and the APRN and responsible party were notified. b. Resident #81 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's disease, anxiety disorder, and delusional disorders. The Resident Care Plan (RCP) dated 2/27/24 identified Resident #81 had potential for agitation manifested by hitting other residents and Resident #81 was physical and combative at times as evidenced by hitting and aggression on 10/20/23 and aggression/altercation on 4/29/24. Interventions included offering fluids and snacks and have Resident #81 stay next to the nursing station sitting on the bench, ensure Resident #81 was the first resident to get ready for bed after dinner, and provide one on one with Resident #81 to manage agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, had several days mood symptoms of being short-tempered and easily annoyed, had verbal behavioral symptoms directed towards others, had the behavior of wandering, required supervision or touching assistance with eating, and was independent with transfers and walking. A nursing note by LPN #2 dated 5/12/24 at 10:18 PM identified Resident #81 was anxious, crying and aggressive with another resident (Resident #59), and Resident #81 was redirected to his/her room, was offered crackers and apple juice without positive results, and was given Lorazepam (an antianxiety medication) 0.25 milligrams (mg) with positive results. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM Resident #81 walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. A nursing progress note written by the Nursing Supervisor (the current Director of Nursing (DNS)) dated 5/13/24 at 7:44 PM identified Resident #81 had been evaluated by the APRN who issued a Physician's Emergency Certificate (PEC) (authorization for temporary involuntary psychiatric treatment) sending Resident #81 to the Emergency Department (ED) for crisis intervention. Interview with LPN #2 on 4/8/25 at 11:00 AM identified she had been outside the dining room when she heard yelling and she went into the dining room to see what was happening. Upon entering the dining room LPN #2 identified she had observed Resident #81 standing next to Resident #59 and a visitor sitting near them told her Resident #81 had hit Resident #59. LPN #2 identified she had removed Resident #81 from the dining room and brought him/her to his/her room to sit with a Nurse Aide. LPN #2 identified she had evaluated Resident #81 but that she cannot recall what she had done after that. Review of the Clinical Services Abuse Policy and Procedure directed, in part, the facility will provide individualized care plans that identify risk factors of residents as well as plans for protecting their rights and when any allegations of abuse or mistreatment are observed by any employee the facility will immediately protect the resident from alleged abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Resident #90's diagnoses included Alzheimer's disease, delusional disorder, and psychosis. The Resident Care Plan (RCP) dated 2/28/25 identified Resident #90 had the potential for negative behaviors with interventions to approach and speak to Resident #90 in a calm manner. Also, for the staff to anticipate/meet Resident #90's needs, and to explain all procedures to the resident before starting care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 was severely cognitively impaired, required substantial/maximal assistance for toileting, showering, dressing and personal hygiene. Also, identified that Resident #90 was independent with ambulation/transfers, and required set up for eating. b. Resident #100's diagnoses included dementia, anorexia, and chronic heart disease. The quarterly MDS assessment dated [DATE] identified Resident #100 was severely cognitively impaired, requiring substantial assistance for dressing, and personal hygiene. Also, identified Resident #100 required assistance for eating, and oral hygiene, was totally dependent on showering, and toileting. Further, identified that Resident #100 required supervision assistance with transfers, and ambulation. The Resident Care Plan dated 1/27/25 identified Resident #100 had a deficit in functional mobility with interventions to encourage Resident #100 to engage in physical activities such as walking along with supervise/touching assist for transfers. Resident #100 was also at risk for falls with interventions for Resident #100 to ask for assistance prior to transfers or ambulation as needed, and to orient Resident #100 to his/her surroundings. A facility Reportable Event form dated 3/26/25 identified at 10:26 AM Nurse Aide (NA) #6 was trying to provide morning care to Resident #90 but he/she was visibly agitated even though an attempt was made by NA #6 to redirect Resident #90. Resident #90 pushed NA #6 away and then proceeded to push Resident #100 who fell to the ground. The Psychiatric Evaluation and Consultation dated 3/26/25 noted Resident #90 was evaluated after increased behavioral disturbances. Resident #90 was identified with becoming more impulsive/combatively recently and has been more difficult to redirect. Resident #90 was anxious and pacing throughout the interview. Resident #90 had become combative with care with increased impulsive behavior and tended to be intrusive and wander throughout the facility. An interview on 4/3/25 at 12:05 PM with Licensed Practical Nurse (LPN) #2 identified that Resident #90 was resistive to care on 3/26/25 while NA #6 was with him/her. Further, identifying that Resident #100 was walking the hallway by Resident #90's room that morning when the incident occurred but her vision was obstructed, and she did not see the pushing. An interview on 4/7/25 at 10:16 AM with NA #6 identified that she was attempting to provide morning care for Resident #90, but the resident was agitated, angry and pacing in his/her room. NA #6 further identified that she attempted to redirect Resident #90 to go in the opposite direction in the hallway. Further, identifying Resident #90 then tried to push her and then as Resident #100 was walking by, Resident #90 pushed Resident #100 onto the floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Resident Abuse policy dated 1/23 identified that each resident has the right to be free from abuse, neglect, and misappropriation of resident's property and exploitation. Also, identified was the facility to encourage an environment that recognizes the special qualities of the residents and provides them with a safe environment. Further, identified was Resident to Resident altercation is defined as physical or verbal act between two residents with or without resulting an injury. 3a. Resident #27 had a diagnosis of obstructive and reflux uropathy (impaired urine flow). The admission MDS dated [DATE] identified Resident #27 had a BIMS of 14 indicating an intact cognition and was always incontinent of bladder and bowel. The RCP dated 1/6/2025 identified a self-care deficit, and incontinent of bladder and bowel. Interventions directed to assist with ADLs and provide incontinent care. b. Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. c. Resident #62 had a diagnosis of cerebral infarction (stroke) with hemiplegia affecting the left side, and a cognitive communication deficit. The annual MDS dated [DATE] identified Resident #1 had a BIMS of 14 indicating intact cognition and was frequently incontinent of bladder, and always incontinent of bowel. The RCP dated 2/3/2025 identified incontinent of bowel and bladder, and a self-care deficit. Interventions directed to assist with ADLs and to provide incontinent care approximately every 2 hours and as needed. d. Resident #99 had a diagnosis of dementia. The quarterly MDS assessment dated [DATE] identified Resident #99 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition, was dependent for ADLs, and was always incontinent of bladder and bowel. The RCP dated 1/23/2025 identified an ADL deficit and incontinent of bowel and bladder. Interventions directed to assist with ADLs, and to provide incontinent care every two (2) hours and as needed. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments he identified Resident #40 was in need of incontinent care. LPN #1 and a NA provided the care. Further, LPN #1 identified Residents #27, #62 and #99 were in need of incontinent care, and care was provided. Facility summary dated 3/14/2025 identified although morning care was provided for Residents #27, #40, #62 (Resident #99 refused morning care), incontinent care was not provided until 2 PM for Residents #27, 40, #62 and #90 when it was provided by LPN #1. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of NA care card on 3/8/2025 identified Resident #27 received or provided incontinent care at 4:08 AM and did not receive incontinent care again until 2:31 PM (10 hours and 23 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #40 received incontinent care at 6:47 AM on 3/8/2025 and did not receive incontinent care again until 1:44 PM on 3/8/2025 (6 hours and 57 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #62 received incontinent care at 3:49 AM and did not receive incontinent care again until 2:34 PM (10 hours and 45 minutes after last received). Record review of NA care card on 3/8/2025 identified Resident #99 received incontinent care at 4:40 AM and did not receive incontinent care again until 11:53 AM (7 hours and 13 minutes after last received). Facility written statement from LPN #1 on 3/9/2025 identified he took a NA with him to perform resident treatments and when performing treatments on Resident #40, LPN #1 identified the resident's brief was fully soiled with a bowel movement and urine. The statement further identified that all the residents he provided treatments for, required incontinent care. RN #1 (day shift supervisor) was notified the residents had not received care. Facility undated written statement from RN #1 identified on 3/8/2025 LPN #1 notified her that NA #1 did not change the residents she was assigned to during the afternoon. RN #1 questioned NA #1 about her assigned residents that were not changed and indicated all assigned residents need to be toileted and changed in the afternoon after lunch. Although attempted, interviews with LPN #1 and RN #1 were not obtained during the survey. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 3/28/2025 at 1:26 PM identified NA #1 gave incontinent care to Resident #27 at 8:30 AM and then did not check on Resident #27 again until 1:30 PM (5 hours later), and she gave no additional incontinent care after 8:30 AM because Resident #27 said he/she did not need it. NA #1 stated Resident #40 required assist of two (2) staff, and on 3/8/2025 about 9:30 AM she tried asking other NAs to wash and change Resident #40, but they never came to help her. NA #1 stated she tried to change Resident #40 but he/she said no, and then when she checked, Resident #40 was not incontinent. The next care provided was about 2:30 PM by LPN #1 and another NA; NA #1 stated she gave no care to Resident #40 during the shift because she did not have a second staff to assist. For Resident #62, NA #1 stated she saw Resident #62 at 9:30 AM and washed only his/her upper body. NA #1 did not change Resident #62's brief or wash the lower body, and stated Resident #62 was not incontinent at 9:30 AM. NA #1 indicated she wanted to change Resident #62 but no other staff would help her. NA #1 stated she then checked on Resident #62 at 2:30 PM (5 hours later) and another NA saw Resident #62 was incontinent and she said she was going to report NA #1. NA #1 stated she told the other NA that she had asked for help during the shift, but the other NA did not help her. NA #1 stated she washed Resident #99's upper body at 9:30 AM and Resident #99 was not incontinent at that time. NA #1 gave no care to the lower body because Resident #99 required two (2) staff for care and no other staff would help her. NA #1 did not check on Resident #99 again until 2:30 PM (5 hours later) and then provided care to the resident at that time. NA #1 stated she only must check on residents two (2) times a shift - once in the morning and then again right before her shift ends. NA #1 further stated that she did not ask the charge nurse or RN supervisor for help but stated that she should have asked them and she should have checked on her residents more often. Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified the 4 residents that did not receive care on 3/8/2025 were Resident #27, #40, #62 and #99. The DNS stated she did not know why the residents did not receive care. The DNS indicated NA #1 had asked other staff for assistance, but did not notify LPN #1/charge nurse or RN #1/supervisor that she required assistance. The DNS stated the facility investigation identified the last time incontinent care was provided was a follows: Resident #27 at 8:30 AM, next provided at 1:30 PM (care was next provided 5 hours later). Resident #40 at 4:16 AM, next provided at 2:30 PM (care was next provided 10 hours and 14 minutes without care). Resident #62 at 3:49 AM and then next provided at 2:36 PM (care was next provided 10 hours and 47 minutes without care). Resident #99 at 4:41 AM and then next received care at 2:30 PM (care was next provided 9 hours and 49 minutes without care). The DNS stated residents are supposed to be checked every two (2) hours to see if they need incontinent care and as needed. The DNS stated based on her investigation, NA #1 failed to check on her residents every two (2) hours to see if care needed to be provided. The DNS concluded based upon the investigation that was conducted the allegation of neglect was substantiated. Review of facility Abuse Policy dated 12/2023 directed in part, neglect means the failure of the facility/employees to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for 1 of 1 residents (Resident #9) reviewed for an injury of unknown origin, for 2 of 4 residents involved in resident to resident altercations (Resident #59 and Resident #81), and for four of eight residents (Resident #27, #40, #62 and #99) reviewed for abuse, the facility failed to report the injury of unknown origin (Resident #9) and the resident to resident altercations to the Stage Agency. Additionally, for Resident #27, #40, #62 and #99, the facility failed to ensure staff reported an allegation of abuse immediately. The findings include: 1. Resident #9 was admitted to the facility in October of 2024 with diagnoses that included hemiplegia (one sided muscle paralysis) affecting the right dominant side, hypertension, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was cognitively intact, was dependent on staff for toileting and required maximum assistance for personal hygiene and bed mobility and transfers. The MDS further identified Resident #9 had an impairment on one side of his/her upper extremity and lower extremities and used a walker and wheelchair for ambulation. The Resident Care Plan (RCP) dated 10/24/24, identified Resident #9 required extensive assistance of 1 staff member for self-care tasks due to weakness, impaired sitting balance and strength. Interventions included assisting Resident #9 with self-care tasks and referral to occupational therapy when applicable. A facility Reportable Event (RE) form dated 11/29/24 at 12:00 PM written by LPN #3 identified Resident #9 with a discoloration to the left eye with no complaints of pain or discomfort. The RE further identified Resident #9 was alert and oriented, the responsible party was notified of the injury on 11/29/24 at 3:00 PM and APRN #2 was notified of the left eye discoloration on 11/29/24 at 3:05 PM. A nursing note dated 11/29/24 at 3:17 PM written by LPN #3 identified that she was notified by NA #7 of Resident #9's discoloration to the left eye. LPN #3 notified APRN #2 who directed a complete blood count with differential test (group of blood cells that measure the number and size of the different cells in blood), cold compresses every 15 to 20 minutes for 24 hours and neuro assessments according to the facility's protocol. The nursing note further directed staff to notify the APRN with worsening symptoms such as swelling to the left eye, blurred or double vision, headache, nausea or vomiting. LPN #3 indicated that Resident #9's responsible party was also notified. Interview with LPN #3 on 4/3/24 at 2:40 PM identified that she was notified of Resident #9's discoloration to left eye on 11/29/24 by NA #7. LPN #3 identified that she assessed Resident #9 and noted a bluish color/discoloration around the entire left eye. LPN #3 further identified that she notified the Nursing Supervisor (RN#2) and the provider APRN #2 of the injury through a phone call. LPN #3 identified that APRN #2 directed a blood test and cold compress to the left eye. LPN #3 identified that the RN Supervisor was responsible for assessing and ensuring that accidents and incidents were reported to the appropriate state agencies according to the facility's policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with RN #2 on 4/3/25 at 3:00 PM, identified that she was the Nursing Supervisor for the 7:00 AM to 3:00 PM shift on 11/29/24 when Resident #9's injury was identified. RN #2 identified that notification of Resident#9's injury to the state agency was not done since she did not complete an assessment of Resident #9's left eye. RN #2 identified that such an injury would be classified as an injury of unknown origin and should have been reported to the overseeing state agency after the injury was identified. (Please cross reference F 658) Interview with the DNS on 4/5/25 at 12:00 PM identified that Resident #9's injury was not reported to the overseeing state agency. The DNS identified that an injury of unknown origin should have been investigated and reported to the overseeing state agency. Subsequent to document request, the facility provided a statement completed by LPN #3 dated 4/11/24 that identified that the discoloration to Resident#9's left eye was approximately pea size even though she had identified in an interview with the surveyor that she noted a bluish color/discoloration around Resident #9's entire left eye. Review of facility policy titled, Accident/Incident Reporting Policies and Procedures, identified in part, that all incident all occurrences are reported and thoroughly investigated as per state and federal regulations. 2a. Resident #59 was admitted to the facility in September of 2022 with diagnoses that included dementia, anxiety, and dysphagia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, had verbal behavioral symptoms directed towards others, had the behavior of wandering, and was independent with eating, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/24 identified Resident #59 had a history of anxiety and depression. Interventions included observing periods of anxiety, provide a calm, quiet environment and encourage Resident #59 to verbalize thoughts and feelings related to anxiety. A nursing note written by Licensed Practical Nurse (LPN) #2 on 5/13/24 at 5:45 PM (referring to an event that occurred on 5/12/24 per the facility Reportable Event form) identified Resident #59 was in the dining room waiting for dinner when another resident (Resident #81) approached him/her asking questions and Resident #59 responded, I don't understand you., after which Resident #81 punched Resident #59 in the face. The nursing note identified that LPN #2 assessed Resident #59, performed neuros, and did not identify bleeding, pain or discomfort. The nursing note further identified LPN #2 redirected Resident #81 to his/her room, and the APRN and responsible party were notified. b. Resident #81 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's disease, anxiety disorder, and delusional disorders. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan (RCP) dated 2/27/24 identified Resident #81 had potential for agitation manifested by hitting other residents and Resident #81 was physical and combative at times as evidenced by hitting and aggression on 10/20/23 and aggression/altercation on 4/29/24. Interventions included offering fluids/snacks and have Resident #81 stay next to the nursing station sitting on the bench, ensure Resident #81 was the first resident to get ready for bed after dinner, and provide one on one with Resident #81 to manage agitation. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired, had several days of the mood symptom of being short-tempered and easily annoyed, had verbal behavioral symptoms directed towards others, had the behavior of wandering, required supervision or touching assistance with eating, and was independent with transfers and walking. A nursing note written by LPN #2 dated 5/12/24 at 10:18 PM identified Resident #81 was anxious, crying and aggressive with another resident (Resident #59), and Resident #81 was redirected to his/her room, was offered crackers and apple juice without positive results, and was given Lorazepam (antianxiety medication) 0.25 milligrams (mg) with positive results. A facility Reportable Event form dated 5/13/24 identified on 5/12/24 at 4:30 PM Resident #81 walked up to Resident #59 and punched Resident #59 in the face. The event was witnessed by a visitor who reported it to Licensed Practical Nurse (LPN) #2. Review of the State Agency reportable event website identified the facility didn't report the resident to resident altercation until 5/13/24 at 10:00 AM (17 hours and 30 minutes after the event). Interview with Director of Nursing Services (DNS) on 4/8/2025 at 9:50 AM identified she had not reported the resident to resident altercation to the State Agency timely due to she was not aware of the incident until the following day. On 5/13/25 when she became aware of the incident she immediately reported it to the State Agency. Review of the Clinical Services Abuse Policy and Procedure directed, in part, when any allegations of abuse or mistreatment are observed by any employee the following steps will be implemented: immediately protect the resident from alleged abuse; immediately notify the nursing supervisor; the nursing supervisor/charge nurse will immediately report abuse allegations to the Administrator and DNS; and the facility will notify the Department of Public Health immediately but no later than 2 hours after the allegation is made if the event involves abuse. 3a. Resident #27 had a diagnosis of obstructive and reflux uropathy (impaired urine flow). The admission MDS dated [DATE] identified Resident #27 had a BIMS of 14 indicating an intact cognition and was always incontinent of bladder and bowel. The RCP dated 1/6/2025 identified a self-care deficit, and incontinent of bladder and bowel. Interventions directed to assist with ADLs and provide incontinent care. b. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 had a diagnosis of hemiplegia/ hemiparesis (weakness/paralysis) of the right dominant side, and aphasia. The annual MDS dated [DATE] identified severely impaired cognitive skills, required assistance with ADLs, and was always incontinent of bladder and bowel. The Resident Care Plan (RCP) dated 2/3/2025 identified alteration in ADLs, and incontinence. Interviews directed to assist with ADLs and provide incontinent care. c. Resident #62 had a diagnosis of cerebral infarction (stroke) with hemiplegia affecting the left side, and a cognitive communication deficit. The annual MDS dated [DATE] identified Resident #1 had a BIMS of 14 indicating intact cognition and was frequently incontinent of bladder, and always incontinent of bowel. The RCP dated 2/3/2025 identified incontinent of bowel and bladder, and a self-care deficit. Interventions directed to assist with ADLs and to provide incontinent care approximately every 2 hours and as needed. d. Resident #99 had a diagnosis of dementia. The quarterly MDS assessment dated [DATE] identified Resident #99 had a Brief Interview of Mental Status (BIMS) score of 8 indicating moderately impaired cognition, was dependent for ADLs, and was always incontinent of bladder and bowel. The RCP dated 1/23/2025 identified an ADL deficit and incontinent of bowel and bladder. Interventions directed to assist with ADLs, and to provide incontinent care every two (2) hours and as needed. A facility incident report dated 3/10/2025 at 12 noon identified on 3/8/2025 at approximately 1:30 PM, LPN #1 identified when LPN #1 was providing treatments he identified Resident #40 was in need of incontinent care. LPN #1 and a NA provided the care. Further, LPN #1 identified Residents #27, #62 and #99 were in need of incontinent care, and care was provided. Facility summary dated 3/14/2025 identified although morning care was provided for Residents #27, # 40, #62 (Resident #99 refused morning care), incontinent care was not provided until 2 PM for Residents #27, 40, #62 and #90 when it was provided by LPN #1. Please cross reference F 600. Review of the State Agency reportable event website identified the State Agency was notified of the allegation of neglect on 3/10/2025 at 12 PM. Review of the reportable event identified the incident occurred on 3/8/2025 at 1:30 PM; the State Agency was notified (1 day, 22 hours and 30 minutes after the facility was aware). Facility undated written statement from RN #1 identified on 3/8/2025 LPN #1 notified her that NA #1 did not change the residents she was assigned to during the afternoon. Although attempted, an interview with RN #1 was not obtained during the survey. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with the DNS on 3/28/2025 at 9:32 AM identified Residents #27, 40, 62 and 99 did not receive care on 3/8/2025. The DNS stated although RN #1 (supervisor working 7 AM to 3 PM) was aware of the allegation, RN #1 did not notify her until the end of RN #1's shift (shift ended at 3 PM). The DNS stated RN #1 should have notified her immediately when the neglect was identified, and the State Agency should have been notified within two (2) hours. Interview failed to identify why the State Agency was not notified until 3/10/2025. Review of facility Abuse Policy directed in part, abuse allegations require immediate action, report immediately to the supervisor and a two (2) hour requirement to report to the State Agency. Facility documentation review identified staff education was initiated on 2/28/2025 and included directing staff to report allegations immediately, and allegations are required to be reported to the State Agency within two (2) hours. A QAPI meeting was held on 3/10/2025, and audits were initiated on 3/14/2025. Based on review of facility documentation, past non-compliance was identified.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #9) reviewed for accidents, the facility failed to conduct a complete investigation for a resident with an injury of unknown origin. The findings include: Resident #9 was admitted to the facility in October of 2024 with diagnoses that included hemiplegia (one sided muscle paralysis) affecting the right dominant side, hypertension, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was cognitively intact, was dependent on staff for toileting and required maximum assistance for personal hygiene and bed mobility and transfers. The MDS further identified Resident #9 with an impairment on one side of his/her upper extremity and lower extremities and used a walker and wheelchair for ambulation. The Resident Care Plan (RCP) dated 10/24/24, identified Resident #9 required extensive assistance of 1 staff member for self-care tasks due to weakness, impaired sitting balance and strength. Interventions included assisting Resident #9 with self-care tasks and referral to occupational therapy when applicable. A facility Reportable Event (RE) form dated 11/29/24 at 12:00 PM written by LPN #3 identified Resident #9 with a discoloration to the left eye with no complaints of pain or discomfort. The RE further identified Resident #9 was alert/oriented, the responsible party was notified of the injury on 11/29/24 at 3: 00 PM and APRN #2 was notified on 11/29/24 at 3:05 PM. A nursing note dated 11/29/24 at 3:17 PM written by LPN #3 identified that she was notified by NA #7 of Resident #9's discoloration to the left eye. LPN #3 notified APRN #2 who directed a complete blood count with differential test (group of blood cells that measure the number and size of the different cells in blood), cold compresses every 15 to 20 minutes for 24 hours and neuro assessments according to the facility's protocol. The nursing note further directed staff to notify the APRN with worsening symptoms such as swelling to the left eye, blurred or double vision, headache, nausea or vomiting. LPN#3 indicated that Resident #9's responsible party was also notified. Interview with LPN #3 on 4/3/24 at 2:40 PM identified that she was notified by NA #7 of the discoloration to Resident #9's left eye on 11/29/24. LPN#3 identified that she assessed Resident #9 and noted a bluish color/discoloration around the entire eye. LPN #3 further identified that she notified the Nursing Supervisor (RN #2) and the APRN #2 of the injury through a phone call. LPN #3 identified that APRN #2 directed a blood test and cold compress to the left eye. LPN #3 identified that the RN Supervisor was responsible for ensuring that investigative statements were obtained from all staff members who worked on the unit for the last 72 hours to try and determine the cause of injury, but review of the clinical record and facility RE form failed to identify an investigation was completed for an injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with RN #2 on 4/3/25 at 3:00 PM, identified she was the Nursing Supervisor for the 7:00 AM to 3:00 PM shift on 11/29/24 when Resident #9's injury of unknown origin to the left eye was identified. RN #2 identified that investigative statements were not obtained from staff members who worked on the unit for the previous 72 hours due to her failure to assess Resident #9. RN #2 indicated that had she assessed Resident #9, she would have obtained statement from Resident #9 and staff members to try and determine the cause of injury. (Please cross reference F 658). Interview with the DNS on 4/5/25 at 12:00 PM identified that investigative statements should have been obtained from all staff who worked on the unit for the previous 72 hours of Resident #9 developing a left eye discoloration and from Resident #9 him/herself to identify the cause of the injury so that preventive measures could be initiated. The DNS was unable to give a reason an investigation was not done. Subsequent to document request, the facility provided a statement completed by LPN #3 dated 4/11/24 that identified that the discoloration to Resident#9's left eye was approximately pea size even though she had identified in an interview with the surveyor that she noted a bluish color/discoloration around Resident #9's entire left eye. Review of facility policy titled, Accident/Incident Reporting Policies and Procedures, identified in part, that occurrences will be investigated in a timely manner and preventive measures initiated. If the occurrence is an injury of unknown origin, i.e., skin tear or a bruise, statements from staff members on the unit will be taken to try and determine the cause of injury. Statements may need to continue for the previous 24-72 hours or more if needed and cease once cause is identified.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #83) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to refer Resident #83 for a Level II PASRR evaluation after identifying a new mental disorder. The findings include: Resident #83 was admitted to the facility in January 2023 with diagnoses that included a cerebral infarction affecting right dominant side and Parkinson's disease. Upon admission to the facility, there was no mental disorder diagnoses identified. A PASRR Level I screen dated 1/11/23 identified that a Level II PASRR screening was not required because there was no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavior health condition. Additionally, it identified if changes were to occur or new information refuted those findings, a new screening must be submitted. An Advanced Practice Registered Nurse (APRN) note dated 5/26/23 identified Resident #83 with a new diagnosis of psychotic disorder with delusions due to known physiological condition. On 4/7/25 at 12:53 PM, an interview and record review with the Director of Social Services #1 (SW), identified that Resident #83 had a Level I PASRR completed on 1/11/23 and that a Level II PASRR screening was not required at that time because there was no evidence of a an intellectual/developmental disability or a serious behavior health condition. SW #1 indicated a Level II PASRR should have been completed when the APRN diagnosed the resident with a new mental disorder on 5/26/23 and it was Social Services who was responsible to ensure it was done. Additionally, the interview identified that the process for identifying residents with new mental disorders was that after the psychiatry provider assesses the residents' and assigns a new diagnosis, they will report the findings to Social Services, who would then notify the proper agency to conduct a Level II PASRR screening. SW #1 also stated that this was missed due to the new diagnosis not coming from the psychiatry provider but from the medical APRN. Although a policy for PASRR was requested, one was not provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #104) reviewed for recreational activities, the facility failed to develop a comprehensive care plan regarding Resident #104's activity needs and preferences. The findings include: Resident #104 was admitted to the facility in October 2024 with diagnoses that included chronic kidney disease, diabetes, combined forms of age-related bilateral cataracts, and hypertension. An activities admission assessment dated [DATE] indicated Resident #104's past interests included drawing/painting, fishing, traveling, sports, movies, concerts, cooking, and listening to music. The Resident Care Plan dated 11/24/24 identified Resident #104 had impaired visual function related to visual loss in left eye from previous stroke and bilateral cataracts. Interventions included one-on-one visits from staff. An admission Minimum Data Set assessment dated [DATE] identified Resident #104 with a severe cognitive impairment, highly impaired vision, adequate hearing and supervision or touching assistance with activities of daily living. The MDS (daily preferences) further identified that Resident #104 indicated that it was very important for him/her to choose clothes to wear, have snacks available between meals and have family or close friends involved in discussion about his/her care. Additionally, activity preferences identified that it was very important to listen to music that he/she liked, go outside and to get fresh air when the weather permitted and be around animals such as pets. Interview and observation with Resident#104 on 3/31/25 at 11:46 AM identified Resident #104 was lying in bed with the head of the bed elevated with the television on. Observations of the room identified a recreation calendar but failed to identify a radio/CD player was in the room to provide music as was identified as being very important to him/her. Interview with Resident #104 at that time indicated that he/she was unaware about recreational activities that were offered at the facility. Resident #104 further identified he/she was blind and was not involved in activities or taken out for fresh air. Interview and care plan review on 4/8/25 at 10:30 AM with the Assistant Director of Recreation failed to identify a care plan was initiated related to activities therefore there were no interventions to provide activities to Resident #104. Subsequent to the surveyor inquiry, the RCP was updated identifying Resident #104 would benefit from 1 to 1 visitation from staff since he/she was not interested in group activities but accepted 1 to 1 visits. Interventions included providing 1 to 1 visitation, offering refreshment cart treats and offering independent activity material such as music and pet therapy visits. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Baseline/Comprehensive Person-Centered Care Plan (CPCP), identified in part, that the CPCP will be periodically reviewed and revised by a team of qualified persons after each assessment or re-assessment. The CPCP will be reviewed and revised quarterly following MDS completion. The CPCP will be kept by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan when there is a new problem that requires that discipline to intervene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #104) reviewed for recreational activities, the facility failed to provide activities that met Resident #104's interests and preferences. The findings include: Resident #104 was admitted to the facility in October 2024 with diagnoses that included chronic kidney disease, diabetes, combined forms of age-related bilateral cataracts, and hypertension. An activities admission assessment dated [DATE] indicated Resident #104's past interests included drawing/painting, fishing, traveling, sports, movies, concerts, cooking, and listening to music. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #104 had a severe cognitive impairment, highly impaired vision, adequate hearing, and supervision or touching assistance with activities of daily living. The MDS (daily preferences) further identified that Resident #104 indicated that it was very important for him/her to choose clothes to wear, have snacks available between meals and have family or close friend involved in discussion about his/her care. Activity preferences identified that it was very important for him/her to listen to music that he/she liked, go outside and to get fresh air when the weather permitted and be around animals such as pets. The Resident Care Plan dated 11/24/24 identified Resident #104 had impaired visual function related to visual loss in left eye from previous stroke and bilateral cataracts. Interventions included one-on-one visits from staff. (The RCP failed to include a recreational activities care plan. Please cross reference F 656). Review of the activities calendar for the month of March and April 2025 identified that pet therapy was provided 3 times per week by the facility. Interview and observation with Resident #104 on 3/31/25 at 11:46 AM identified Resident #104 was lying in bed with the head of the bed elevated with the television on. Observations of the room identified a recreation calendar on the bathroom door but failed to identify any means for Resident #104 to listen to music as was identified an the preference assessment. Interview with Resident #104 at that time indicated that he/she was unaware about recreational activities that were offered at the facility. Resident #104 further identified he/she was blind, was not involved in activities or taken out for fresh air. Interview with the Assistant Director of Recreation (ADR) on 4/7/25 at 2:30 PM indicated that he provided 1:1 activity for Resident #104 in the resident's room twice a week which entail; socializing, listening to TV, and passing snacks. The ADR further indicated that socializing entails about 1 minute of 1:1 interaction with Resident #104 whereby he asks the resident how he/she was doing and nothing else in specific while for the television therapy he would pass by/peek inside the room and if the television was on, without necessarily entering the room, he would chart/document that television therapy was administered. The ADR identified that Resident #104 liked music and hockey sports but had not looked into that or engaged him/her in those activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Re-interview with the ADR on 4/8/25 at 10:30 AM identified that even though Resident #104 liked music, pets and fresh air, he/she had not been out of his/her room for fresh air breaks since he was admitted to the facility due to bad weather, does not have a radio/cd player in his/her room for music therapy and pet therapy had not been attempted (despite pet therapy occurring in resident rooms). The ADR further indicated Resident #104 had visual impairment and did not seem like he/she wanted to go to groups. The ADR further identified that he would start Resident #104 on daily therapy to include dog therapy, fresh air breaks and start music therapy. The ADR indicated that engaging Resident #104 in activities of his/her interests was his responsibility and indicated that it was an oversight on his part for not having done it. Interview with the Recreational Director (RD) on 4/8/25 at 11:01 AM, identified that Resident #104 had vision impairment, refused to come out of his/her room, and was not inclined to engaging in group activities. The RD indicated that Resident #104 received 1:1 activity in his/her room which were provided by the ADR. The RD identified that since the initial admission recreational activity assessment was done in November of 2024, no further assessments had been done. The RD indicated that she would reassess Resident #104 and engage him/her in activities of his/her interests to include music therapy, fresh air breaks and dog therapy. Review of facility policy titled, Therapeutic Recreation, identified in part, that therapeutic recreation will provide recreational activities that will contribute to resident's level of function and well-being by stimulating increased physical, emotional and social interactions. The therapeutic recreation department will provide activities centered around individual interest, needs as well as expressed requests. Activities are resident centered based on residents' age, physical and cognitive limitations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #40) reviewed for pressure ulcers, for 1 of 2 residents (Resident #45) reviewed for positioning and for 1 of 3 residents (Resident #102) reviewed for nutrition, the facility failed to ensure an air mattress was set at the appropriate setting. Additionally, for 1 of 1 resident (Resident #65) reviewed for a non-pressure skin condition, the facility failed to initiate timely treatments. The findings include: 1. Resident #40's diagnosis included cerebrovascular disease, pressure ulcer, and epilepsy. The annual Minimum Date Set (MDS) assessment dated [DATE] identified Resident #40 was severely cognitively impaired, was dependent on bathing, dressings, personal hygiene, and transfer. Also, identified that Resident #40 was a set up for eating and had an unhealed stage 3 pressure ulcer. The Resident Care Plan dated 2/3/25 identified Resident #40 had a facility acquired stage 3 pressure ulcer with interventions that included to monitor for signs and symptoms of infection, update the physician with any changes as needed, and provide treatments as ordered. Review of weights summary dated 2/4/25 identified that Resident #40 weight was 202 pounds (lbs). A physician order dated 3/7/25 directed air mattress monitoring function of mattress/setting must be adjusted to resident's weight every shift for preventative care. Observation on 4/7/25 at 10:50 AM noted Resident #40 lying in bed on an air mattress with the setting of the air mattress on light 7. Additionally, an instruction card was attached to the mattress indicating the light level for Resident #40 with a weight of 212 should be set at level 4 (not level 7). Interview and observation on 4/8/25 at 10:00 AM with Licensed Practical Nurse (LPN)# 6 who was the Infection Preventionist, identified that she was unsure about the setting of Resident #40's air mattress because it was a turn and reposition mattress, but it was set on light 7. Also, identified was the resident had it about a month (2/20/25) and LPN #6 did not think it was set by the resident's weight of 214 pounds, LPN#6 did not think it was set correctly, was attempting to adjust the setting but did not know how. Further, identifying that she needed to refer to the manufacturer's instructions. Interview with Vendor #2 from the Air Mattress company on 4/9/25 at 4:35 PM identified that the type of air mattress that Resident #40 utilizes was the turn and repositioning mattress and should be set by the resident's weight, that every mattress comes with a card attached identifying what light level it should be set at according to weight and width of bed. (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 Vendor #2 Air Mattress on 4/10/25 at 8:30 AM identified that light #7 was for a heavier individual. Also, identifying that Resident #40 was in a size 36-inch-wide mattress, and one should follow what the attached card indicated for the level the air mattress should be set at. Further, identifying that a good starting point was to go with each resident weight, but the air mattress could be adjusted somewhat for comfort. Also, identified that if it was set too high/firm it could take longer for a pressure ulcer to heal. Review of the Manufactures education identified the pump had a turn/lock dial which can be adjusted to the individual resident's weight to ensure comfort and to aid caregivers. The facility policy for use of support surfaces identified for the correct setting to be set by the nurse based on the resident's current weight. 2. Resident #45 was admitted to the facility in January of 2020 with diagnoses that included dementia, dysphagia, and abnormal weight loss. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #45 was severely cognitively impaired and was dependent for eating, bed mobility, and transfers. Additionally, the MDS identified Resident #45 was at risk for developing pressure ulcers, had 2 venous/arterial ulcers, had a pressure reducing device for the chair, and had a pressure reducing device for the bed. The MDS further noted that Resident #45 was receiving hospice services. The Resident Care Plan dated 2/25/25 identified Resident #45 had the potential for skin breakdown due to decreased level of consciousness, impaired circulation, and sensory impairment. Interventions included to perform weekly skin evaluations, turn and reposition Resident #45 every 2 to 3 hours and/or as tolerated by Resident #45, and placement of a special mattress (alternating pressure air mattress) set to current weight and check for function and placement every shift. .A physician order dated 3/3/25 directed use of a specialty air mattress and to check setting and function every shift. A Wound Care Specialists Physician (MD) #2 progress note dated 3/31/25 identified Resident #45 was seen for evaluation of his/her wounds. The note identified Resident #45 had a pressure ulcer to the coccyx which was first evaluated on 6/10/24 and an arterial wound to the left foot. Observation on 3/31/25 at 11:35 AM identified Resident #45 was lying supine in bed on top of an air mattress set on alternating pressure with a 15 minute cycle time and with all 5 lights lit up indicating a setting of firm (Resident #45 weighed 114.0 pounds (lbs.)). .Review of the Treatment Administration Record (TAR) dated 3/1/25 through 4/3/25 identified a specialty air mattress was ordered, check setting and function every shift was signed off by the licensed nurse(s) on all 3 shifts (11:00 PM to 7:00 AM, 7:00 AM to 3:00 PM, and 3:00 PM to 11:00 PM). Observation on 4/1/25 at 11:10 AM, 4/2/25 at 11:08 AM, and 4/3/25 at 1:39 PM identified Resident #45 was lying supine in bed on top of an air mattress set on alternating pressure with a 15 minute cycle time and with all 5 lights lit up indicating a setting of firm (Resident #45 weighed 114.0 pounds (lbs.)). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation of Resident #45's air mattress pump settings with Licensed Practical Nurse (LPN) #2 on 4/3/25 at 1:45 PM identified when following the physician order for an air mattress, LPN #2 would verify that the air mattress was set at the correct weight for the resident, LPN #2 would then check the inflation of the mattress by pushing down on it to make sure that the mattress wasn't flat allowing her to feel the metal frame beneath it. LPN #2 identified that none of the residents on the unit should have an air mattress at a firm setting. When the settings of the air mattress pump were observed with LPN #2 she was unable to identify the reason the setting was on firm with all 5 lights lit up or what the correlating firmness setting on the pump should be for Resident #45's weight of 114 lbs. LPN #2 identified that she would call Maintenance to come check the pump and to determine the correct setting because that air mattress pump was different than what she was used to and she didn't know what the settings should be. Interview and observation of Resident #45's air mattress pump settings with Registered Nurse (RN) #5 on 4/3/25 at 3:30 PM identified that the air mattress settings should be included within the physician orders. When the settings of the air mattress pump were observed with RN #5 she was unable to identify the reason the setting was on firm with all 5 lights lit up or what the correlating firmness setting on the pump should be for Resident #45's weight of 114 lbs. RN #5 further identified a clear see through plastic sleeve on the front of the pump containing a settings card for the air mattress pump that did not have settings filled out (all setting bubbles on the card were blank) and no writing was noted on the plastic sleeve. RN #5 indicated that she would call the company and find out the correct setting, she would then adjust the settings on the air mattress pump and update the provider order for the air mattress with the correct settings. Subsequent to surveyor inquiry, a physician order dated 4/3/25 directed use of a specialty air mattress with settings of alternate pressure, cycle 15 with medium pressure, and to check setting and function every shift. Observation on 4/7/25 at 11:44 AM identified Resident #45 lying supine in bed with the HOB elevated approximately 75 degrees. Resident #45 was lying on top of an air mattress set on alternating pressure with a 15 minute cycle time and on medium pressure with 3 lights lit. The settings card inside the clear plastic sleeve was filled out for medium pressure and cycle of 15. Interview with the DNS on 4/8/25 at 9:50 AM identified the air mattress settings were set according to the resident(s) weight, and the resident's weight would be identified by a sticker on top of the air mattress pump. The DNS identified the settings were verified and checked by nursing every day on all 3 shifts. The DNS identified settings for Resident #45's pump would have needed to be obtained from the company for the air mattress pump, and she was unable to identify what the correlating setting would be for Resident #45's weight. Interview with Customer Service Representative for Resident #45's air mattress on 4/8/25 at 11:32 AM identified Resident #45's air mattress and pump were supplied by his company at the request of hospice and his technicians set up Resident #45's air mattress on the bed for the facility. He identified for Resident #45's height and weight in his records the air mattress pump should be set medium pressure. He further identified that the clear plastic sleeve on the front of the pump should have markings on it superimposed over the card inside to indicate the correct pump pressure and cycle settings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 on 4/8/25 at 11:38 AM identified that Resident #45's air mattress was provided through his hospice agency. RN #4 identified that it was his understanding that it was the facility nurse's responsibility to manage the air mattress and pump and it's settings, and if there was a problem with the air mattress or pump they were to call hospice so that the vendor could be sent to evaluate it. RN #4 identified that the air mattress settings were not included within the hospice care plan because the facility nurses managed the air mattress, but that going forward he would ask about having those settings added to the hospice care plan so the hospice nurse could help to monitor and alert the facility nurse if the settings were incorrect. Review of the Guidelines for Use of Support Services policy identified the support surface would be placed on the bed by housekeeping/maintenance and/or the vendor, the correct settings would be set by the nurse based on the resident's current weight and comfort level, and monitoring of the support surface inflation would be done by the nurse every shift and then documented on the TAR. 3. Resident #65 was admitted to the facility in January of 2025 with diagnoses that included metabolic encephalopathy, sepsis, and chronic kidney disease. The Resident Care Plan (RCP) dated 1/27/25 identified Resident #65 had potential for skin breakdown due to fragile skin and Prednisone taper. Interventions included skin checks with care, supplements and/or vitamins as ordered and update provider with changes as needed. The RCP further identified on 2/12/25 Resident #65 had an actual alteration in skin integrity (non-pressure) related to a ruptured blister to the left dorsal foot and blood blister to the left shin. Interventions included treatment as ordered, weekly wound evaluation until resolved, and observe extremities for signs/symptoms of poor tissue perfusion, document changes and report significant findings to the provider. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was severely cognitively impaired, used a walker and wheelchair, was setup or clean-up assistance for eating, and partial/moderate assistance for bed mobility and transfers. Additionally, the MDS identified Resident #65 was at risk for developing pressure ulcers, did not have a pressure ulcer at the time of the assessment and utilized a pressure reducing device to the bed and chair. The Clinical Summary/W10 discharge paperwork dated 2/5/25 (from the hospital) identified Resident #65 was admitted to the hospital on [DATE] and discharged back to the facility on 2/5/25. Further identified was Resident #65 had an abrasion to the anterior left leg which measured 2.0 centimeters (cm) long by 2.0 cm wide by 0.0 cm deep and had a dressing of Xeroform covered by a foam dressing. Also identified was Resident #65 had a ruptured blister to the anterior upper left foot with moderate serous drainage and had a dressing of Xeroform (topical wound dressing) followed by a pad wrapped with a gauze bandage roll. A nursing note written by RN #2 and dated 2/5/25 at 11:19 PM identified Resident #65 had a skin check completed (upon re-admission) and discoloration was observed to the right and left hands, discoloration was observed to the right hip, pitting edema was observed to both feet, a popped blister was observed to the left dorsal foot, and discoloration was observed to the left shin (a discrepancy with the hospital W10 that indicated a left leg abrasion). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, RN #2's nursing note dated 2/5/25 failed to identify measurements, description, assessment of the surrounding skin for the popped blister and did not identify the discrepancy of an abrasion to the left shin versus (hospital W10 documentation) RN #2's documentation of discoloration. A Non-Pressure Wound Evaluation completed by the ADNS on 2/10/25 at 4:39 PM identified a ruptured blister to the left dorsal foot with date of origin of 2/5/25 which measured 6.5 centimeters (cm) long by 5.0 cm wide, with a small amount of drainage, no odor, a wound base of 100% pink or red tissue, and with the periwound intact (there were no previous wound measurements, descriptions documented from re-admission on [DATE] until 2/10/25 to ascertain if the popped blister worsened or was at baseline). A physician's order dated 2/10/25 directed to cleanse the left dorsal foot with Normal Saline and apply Emulsion oil then cover with a dry dressing daily for 14 days (treatment order obtained 5 days after re-admission). A physician's order dated 2/12/25 (treatment order obtained 7 days after re-admission) directed to cleanse the left shin with wound cleanser followed by Medihoney (topical wound treatment) then cover with a dry clean dressing daily and as needed. A Non-Pressure Wound Evaluation completed by the ADNS on 2/10/25 at 4:39 PM identified a ruptured blister to the left dorsal foot with date of origin of 2/5/25 which measured 6.5 centimeters (cm) long by 5.0 cm wide, with a small amount of drainage, no odor, a wound base of 100% pink or red tissue, and with the periwound intact (there were no previous wound measurements, descriptions documented from re-admission on [DATE] until 2/10/25 to ascertain if the popped blister worsened or was at baseline). A Wound Care Specialist progress note by Medical Doctor (MD) #2 on 2/24/25 identified she was requested for a consult to evaluate a wound to the left foot. The note identified Resident #65 was admitted with a large blister on the left foot, and since admission the blister ruptured and was slow to heal. MD #2 identified the wound measured 5.0 cm long by 5.0 cm wide by 0.1 cm deep, with a moderate amount of seropurulent drainage, no odor, wound base of 75-99% granulation, and with scarring to the periwound. MD #2 further identified a treatment to the wound of cleanse the wound followed by apply Mupirocin (antibiotic) ointment, followed by oil emulsion dressing to the wound base followed by secure with a dry clean dressing and change daily. Interview with RN #2 on 4/3/25 at 2:40 PM identified she had completed the nursing assessment for Resident #65 on readmission on [DATE] and had obtained all the physician orders for that readmission. RN #2 could not identify the reason her documentation of the ruptured blister on Resident #65's left dorsal foot in the nursing assessment did not include measurements or a description of the wound indicating that she had probably missed entering the description. RN #2 identified that she verified treatments and skin issues she observed during her skin check with the documentation of skin issues and treatments included in the hospital paperwork (W10), and she would then verify with the MD and put treatment orders in place. RN #2 did not know the reason she had not put treatment or monitoring orders in place for Resident #65's left dorsal foot or left shin but further identified that Resident #65 had arrived from the hospital with both the left dorsal foot and left shin open to air with no dressings in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #2 on 4/7/25 at 12:30 PM identified that she had documented on the 2 pages of skin check diagrams on 2/5/25. RN #2 identified she had not obtained physician orders for treatments or monitoring to Resident #65's left dorsal foot and left shin because those areas were uncovered upon arrival from the hospital and both wounds appeared dry. RN #2 further identified that the charge nurses' monitor and chart on all new admission residents for 72 hours after admission, and further identified that the wound nurse followed up on all new admissions during Monday wound rounds even without specific treatment orders in place for monitoring. Interview with the DNS on 4/8/25 at 9:50 AM identified she had instructed the nursing staff to use treatment orders included in the hospital paperwork first and after those orders were in place they could be adjusted as needed. The DNS identified that even though Resident #65 may have arrived to the facility without dressings in place it was her expectation that the treatments in the hospital paperwork would have been put in place. The DNS further identified that the 11:00 PM to 7:00 AM shift audit the new admissions, and she had told the nurses when doing the audits to fix orders that are incorrect or missing. The DNS could not identify the reason treatment orders had not been put in place for Resident #65 on readmission. Review of the Order Review History Report dated 4/8/25 for 2/1/25 through 2/28/25 failed to identify treatment orders initiated for Resident #65's left dorsal foot wound and left shin wound on readmission to the facility on 2/5/25. Review of skin check diagrams in the clinical record identified by RN #2 as completed on 2/5/25 identified bruising to the right hip, bruising above the peri area, bilateral bruising to both arms, bruising to the left shin, an open blister to the left dorsal foot, and pitting edema to both feet. Review of the Admission, Discharge Policy identified the licensed nurse would complete the re-admission Evaluation which encompasses a systematic review of the resident's condition, and orders are reviewed and discrepancies resolved with the attending healthcare provider when validating re-admission orders. 4. Resident #102's diagnoses included unspecified protein calorie malnutrition, primary generalized osteoarthritis, depression and panic disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #102 had intact cognition, required set up assistance for eating and maximum assistance for personal hygiene, bed mobility and transfers. The MDS further identified that Resident #102 experienced pain almost constantly over the last 5 days of the assessment which affected his/her sleep and day to day activities constantly. Additionally, the MDS identified Resident #102 was at risk for the development of pressure ulcers, did not have a pressure ulcer at the time of the assessment and had a pressure reducing device to the bed. The assessment further identified Resident #102 weighed 87 pounds (lbs). Physician's order dated 2/16/25 directed a specialty air mattress to be set at resident's current weight and check setting and function every shift. The Resident Care Plan in effect for the month of March and April 2025 identified Resident #102 was at risk for skin breakdown due to decreased mobility, and incontinence. Interventions included a low air loss mattress, nutrition/hydration assessment, offloading heels, offering turning and repositioning approximately every two hours and as needed, and providing treatments as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #102 and Person #1 on 3/31/25 at 12:30 PM identified Resident #102 lying in bed with Person #1 in attendance. The alternating pressure mattress (APM) was set at 250 pounds (lbs), and Resident #102 weighed 87 lbs. Interview with Resident#102 identified that the APM felt hard, and Person #1 identified that it felt like a rock. Observation on 4/1/25 at 9:52 AM and 4/1/25 at 3:05 PM identified Resident #102 was lying in bed and the APM was set at 250 pounds. Review of Resident #102's clinical record identified a current weight of 87 pounds. Further review of the clinical record identified that staff signed off the Treatment Administration Record (TAR), that APM was set at Resident #102's current weight (87 Lbs) and were checking APM setting and function every shift even though the APM was set at 250 lbs. Observation and interview with Licensed Practical Nurse (LPN) #4 on 4/1/25 at 3:10 PM identified that the APM was set at 250 pounds instead of 87 pounds, that Resident #102 was on comfort measures and the APM had been placed by hospice for comfort. LPN #4 identified that Resident #102 had not complained that the APM felt hard throughout the 7:00 AM to 3:00 PM shift. LPN #4 identified that she was responsible for checking the APM setting function/placement and had not checked for placement and function on her shift even though she had signed off that she did on the TAR. LPN #4 indicated that Resident #102 or Person #2 may have adjusted the setting since the APM was set at the correct setting when it was initially placed by hospice staff. Subsequent to surveyor inquiry, the APM setting was adjusted by LPN #4 to reflect Resident #102's current weight of 87 pounds. Interview with the Infection Preventionist (LPN #6) on 4/2/25 identified Resident #102's APM was for comfort and assigned nurse was responsible for checking the setting and function of the APM each shift and as needed. Interview with Resident #102 on 4/2/25 at 12:45 PM identified that neither her/him or Person #1 interfered with or reset the APM setting. Interview with the DNS on 4/7/25 at 10:30 AM identified that nurses were responsible for checking APM placement and function and following physician's orders. The DNS identified that LPN #4 would be re-educated regarding APMs. Review of facilities Guidelines for Use of Support Surfaces, identified, in part, that the correct setting will be set by the nurse based on the residents correct weight and comfort level. Monitoring the support surface inflation will be done by the nurse every shift and documented on TAR.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on staff interview and review of Payroll Based Journal (PBJ) the facility failed provide appropriate number of staff for Quarter 2 (January 1, 2024 through March 31, 2024). The findings include: PBJ submissions for Quarter 2, 2024 (January 1, 2024 to March 31, 2024) indicated excessively low weekend staffing. An interview on 4/8/25 at 11:41 AM with the Administrator identified for Quarter 2 in 2024 (January 1, 2024 to March 31, 2024), the previous owner would not allow the facility to use agency staff or to have licensed staff work as Nursing Assistants, which would assist with having adequate nursing staff. Further identifying that the facility did have low weekend staffing during Quarter 2 of 2024. Review of the Mandatory submission of staffing information based on payroll data in a uniform format. The facility must electronically submit to CMS complete and accurate direct care staffing information.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, facility documentation, facility policy and interviews, the facility failed to ensure food temperatures were palatable. The findings include: A Resident council meeting was completed on 4/2/25 at 1:44 PM and residents verbalized concerns regarding food palatability, specifically cold food. The residents identified that they had raised the issue with the Food Service Director (FSD) during Monthly Food Committee meetings but food continued to be cold. Review of Food Committee Meeting minutes from 4/10/24 through 3/12/25 identified residents' concerns about cold food. On 4/10/24 residents expressed concerns about cold coffee, cold soup and cold dinner. On 8/14/24 a resident raised concern about cold soup. On 2/12/25 the FSD informed residents that if they get cold food, they could call the kitchen or ask the Nurse Aides (NA's) to warm the food since thermometers were available at the nursing stations to measure food temperatures. On 3/13/25 the issue about cold soup and cold meals was mentioned once again and the FSD encouraged residents to ask staff for food to be reheated or ask for the meal to be replaced. Observation of the tray line on 4/3/25 at 11:45 AM identified meal plates being placed on trays then covered by clear plastic lids. Each plastic lid contained a large hole/opening at the top/upper section. The trays were placed in enclosed/insulated meal delivery carts and delivered on the first-floor unit (dementia unit). No hot plates or insulated lids were used on the first-floor meal delivery cart. Interview with the FSD identified that residents who reside on first floor were served meals using plates that were covered by plastic lids. The FSD further identified that hot plates and insulated lids were not used for residents who reside on first floor due to risk of burns related to dementia but indicated that insulated lids and hot plates were used for residents who reside on second floor and third floor. The FSD further indicated that first floor residents were always served before all other residents to avoid issues with food temperatures. FSD was not able to give a reason the clear lids had holes/openings on top or explain if the hole/opening would affect food temperature. Observation of tray line on 4/3/25 identified second floor food carts were served at 12:00 PM and third floor food carts were served at 12:25 PM. Even though FSD had indicated that insulated lids and hot plates were used for second and third floor residents, about half of the meals loaded in the delivery carts had plates that were covered by plastic lids that had openings/holes at the top. Interview with the FSD identified that they did not have enough hot plates and insulated lids for residents on second and third floor. The FSD indicated that sometimes not all dishes were collected from previous meals. The FSD further indicated that she had placed an order for more insulated lids and hot plates to be supplied. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A test tray was conducted on the third-floor meal delivery cart at 12:38 PM on 4/3/25 with the FSD and the cart was brought through the elevator to the third-floor nursing unit. All meal trays were delivered to the residents by nursing staff on the unit. The test tray was the last tray served on the nursing unit, was brought to the nursing unit kitchenette at 12:45 PM and the following temperatures were obtained: Cheezy potatoes: surveyor obtained a temperature of 136 degrees Fahrenheit, the FSD obtained a temperature of 140 degrees Fahrenheit. The pork lion: surveyor obtained a temperature of 127 degrees Fahrenheit and the FSD obtained a temperature of 130 degrees Fahrenheit. The brussel sprout: surveyor obtained a temperature of 124 degrees Fahrenheit and the FSD obtained a temperature of 124 degrees Fahrenheit. Interview with the FSD on 4/6/25 at 12:16 PM identified the food temperatures were low for the pork lion and sprout. The FSD further indicated that food temperature should be maintained above 140 degrees Fahrenheit with use of insulated covers and hot plates. Review of the Food Temperatures policy identified that hot foods would be maintained at 140 degrees Fahrenheit or more.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, initial tours and review of the facility policy, the facility failed to ensure snacks were passed out after dinner/before bed. The findings include: 1. Resident #14 's diagnosis included cerebral palsy, chronic kidney disease, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact, and dependent assist for showering, dressing, personal hygiene, and repositioning. The MDS further identified Resident #14 required a set up for eating. The Resident Care Plan (RCP) dated 1/6/25 identified Resident #14 had an activities of daily living risk related to paralysis and cerebral palsy with intervention that included to provide a mechanical lift for transfers with assistance of 2, Resident #14 was non ambulatory and was to be provided set up assistance for meals. On 4/1/25 at 10:22 AM during initial tour Resident #14 identified that she/he was not always offered a snack and at times Resident #14 would want a snack. On 4/1/25 at 11:00 AM an observation during the initial tour of the facility identified signage for snacks was posted for 10:00 AM, 3:00 PM and 8:00 PM, containing a large list of snacks that was available. 2. On 4/2/25 at 1:44 PM a Resident Council meeting was conducted with numerous residents who were in attendance that identified that residents were not offered snacks from staff, but had to request a snack. On 4/2/25 at 3:00 PM an interview with the Dietary Director identified that snacks were provided at 10:00 AM, 3:00 PM, and 8:00 PM. Also, identified that the dietary staff delivered the snacks to the residents in the facility and a list was provided by the Dietician and/or nursing for the residents that were provided with a snack. Resident #14 was not on the list provided. Further identifying, that if a resident was bedbound the resident needed to ask for a snack. On 4/3/25 at 1:53 PM an interview with Nurse Aide (NA) #4 identified that the Dietary staff brings the snacks to the unit and the NAs were responsible for passing the snacks, that there was a list provided for Residents wanting a snack and that a resident was care planned for snacks with this information being found in the Electronic Health Record. Further, identifying that a resident needs to request a snack and that NA #4 was not sure of the policy regarding snacks. On 4/3/25 at 1:58 PM an interview with Registered Nurse (RN) #2 identified that NAs were responsible for asking residents if they would like a snack between 10:00 AM, 3:00 PM and 8:00 PM. On 4/ 3/25 at 2:04 PM an interview with NA #5 identified that she does not go to each room and offer residents snacks and that if a resident requested a snack she would check with the nurse to see if the snack was acceptable for the individual resident before providing one. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075395	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center for Health & Rehabilitation	642 Danbury Road Ridgefield, CT 06877

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 2:32 PM an interview with the Administrator identified that the staff was responsible for offering snacks and that a resident needed to ask for one. Further, identified that the signage regarding snacks posted by the nurse's station was new and that she had never seen it before. Also, she identified that snacks were not provided at 10:00 AM, 3:00 PM, and 8:00 PM, the NAs were responsible for passing out snacks to residents on all shifts when a resident requested a snack, and education would be provided to the staff regarding the signage posted on all the units regarding snacks. Review of the policy for Meal Frequency identified that the meal service schedule was planned such that there are no more than 14 hours between the evening meal and breakfast the following day. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a nourishing snack was provided for all residents. Also, identified snacks are offered to residents at bedtime and per their request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on staff interview and review of Payroll Based Journal (PBJ) submissions for Quarter 1, 2025 (October 1, 2024 through December 31, 2024) the facility failed to ensure the PBJ data was submitted accurately. Also, it was identified through the PBJ report that the facility failed provide appropriate number of staff for Quarter 2 (January 1, 2024 through March 31, 2024). The findings include: PBJ submissions for Quarter 1 of 2025 identified the facility was had 1-star rating, Registered Nurse (RN) Hours and Licensed Nursing Coverage for 24 hours/day for 10/1/24, 10/2/24, 10/3/24, 10/4/24, 10/5/24, 10/6/24, 10/7/24, 10/8/24, and 10/9/24 identified no RN hours and failed to have licensed nursing coverage 24 hours/day. Also, identified on the PBJ report for Quarter 2, 2024 (January 1, 2024 to March 31, 2024) indicated excessively low weekend staffing. An interview on 4/8/25 at 11:41 AM with the Administrator identified that the No Registered Nurse hours along and a licensed nursing coverage for 24 hours in a day was triggered (coded) incorrectly by the previous owner of the facility. Also, identified was that Quarter 2 in 2024, the previous owner would not allow the facility to use agency staff or to have licensed staff work as Nursing Assistants, which would assist with having adequate nursing staff. Further identifying that the facility did have low weekend staffing during Quarter 2 of 2024. Review of the Mandatory submission of staffing information based on payroll data in a uniform format. The facility must electronically submit to CMS complete and accurate direct care staffing information.