STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **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 4 residents (Resident #14) reviewed for nutrition and who required aspiration precautions and supervision with meals, the facility failed to provide a chopped diet as ordered by the physician, failed to provide supervision with eating on 3 days (3 breakfast meals) of the survey, and failed to ensure required safe swallowing strategies were implemented to prevent the resident from choking. These failures resulted in Immediate Jeopardy. The findings include: Resident #14 was admitted to the facility in May 2021 with diagnoses that included dementia, dysphasia, and anxiety. The care plan dated 5/1/25 identified Resident #14 was at risk for aspiration with interventions that included a mechanically altered chopped diet with aspiration precautions and assist with meal intake. The annual MDS assessment dated [DATE] identified Resident #14 had severely impaired cognition and required supervision or touching assistance with staff providing verbal cues and/or touching and/or contact guard assistance for eating and was on a mechanically altered diet. The speech therapy Discharge summary dated [DATE] identified Resident #14 was seen for dysphasia and required the following swallow techniques; alternate solids with liquids to increase pharyngeal clearance, facilitate small bites and sips 1/2 to 1/3 teaspoon, facilitate body positioning to increase safety with intake and facilitate alternating bites with sips of liquids with distant supervision. Resident #14 is to receive a mechanically soft chopped diet using swallow strategies to facilitate safety and efficiency. Recommendations include using the following strategies or maneuverers during oral intake, lingual sweep and swallow, alternating solids and liquids with rate modification, upright posture during meals and upright posture for at least 30 minutes after meals. Resident and primary caregivers were trained in compensatory strategies and safe swallowing techniques to enable resident to safely consume highest level of intake. A physician's order dated 6/23/25 directed to provide a chopped diet with thin liquids. The APRN note dated 7/30/25 at 3:59 PM identified Resident #14 had intermittent generalized weakness and poor oral intake. Staff are to encourage nutritional supplements and assist with feeding. APRN reinforced with staff to assist Resident #14 with feeding and follow up with dietitian. The dietitian note dated 8/12/25 at 4:24 PM identified Resident #14 required a chopped diet and total feed. The dietitian noted on 7/10/25 Resident #14 triggered for a significant undesirable weight loss of 5.7% in a month. Resident #14 has a history of trending weight loss in the last 6 months. Boost supplements were increased to twice a day. Dietitian noted Resident #14 was at risk for malnutrition related to dementia, mechanically altered diet, and total feed. The physician's order dated 8/18/25 directed for a low sodium chopped diet with less than 6 ounces of animal protein per day.^ Observation on 8/24/25 at 9:06 AM identified Resident #14 was sitting upright in bed with a half-eaten breakfast tray in front of him/her on the overbed table. Resident #14 was holding a piece of a non-toasted whole bagel that had been cut in half and had some of the bagel in his/her mouth. There was a half-eaten hardboiled egg with bites out of it on the plate not cut up into pieces, and the other half of the bagel was in 1 piece on the plate. There were no staff in the room or supervising Resident #14 at the time. Resident #14's breakfast meal ticket dated 8/24/25 identified Resident #14 had (continued on next page)

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

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

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	aspiration precautions and was to receive 3 ounces of scrambled eggs and 2 slices of chopped French toast.ˆ Interview with the charge nurse on the unit, LPN #1, on 8/24/25 at 9:07 AM indicated Resident #14 was on a chopped diet and should not have been given the whole hard-boiled egg or the whole bagel that had been cut in half. LPN #1 indicated that Resident #14 was at risk for aspiration and was on aspiration precautions. LPN #1 indicated Resident #14 received the wrong consistency meal (a regular diet) and should have received a chopped diet. LPN #1 informed Resident #14 she would be removing the meal and indicated she would notify the director of the kitchen and have the correct meal sent.ˆ ˆ Interview with the Dietary Director (Interim) on 8/24/25 at 9:10 AM indicated that all residents should receive what is on their meal ticket. Dietary Director (Interim) reviewed Resident #14's meal ticket and compared what was delivered to Resident #14 and indicated that Resident #14 had received the wrong meal and that the meal ticket and the plate of food did not match. Dietary Director (Interim) indicated that the last person on the tray line in the kitchen was responsible to make sure the meal ticket and the meal matched on every tray before placing on the cart prior to delivery to the nursing unit. Dietary Director (Interim) indicated the nurse aide was responsible for reading the meal ticket and making sure it matched the items on the tray before bringing the tray to the resident. ˆ ˆ Interview with NA #1 on 8/24/25 at 2:05 PM indicated that she had given Resident #14 his/her breakfast tray this morning, a hard-boiled egg it its shell and a bagel.ˆ NA #1 indicated she had peeled the egg and cut it in half for Resident #14.ˆNA #1 indicated she did not read the meal ticket or compare the meal ticket to the food on the plate to make sure it was the correct diet. NA #1 indicated she did not realize that Resident #14ˆwas on a chopped diet or aspiration precautions and should not have received a regular diet for breakfast. NA #1 indicated that the kitchen was responsible to make sure the food on the tray was correct before sending it up to the nursing units. NA #1 indicated she has worked at the facility for more than 5 years and does not recall being educated on reading the meal tickets to ensure the diet consistency was correct. NA #1 indicated that her understanding of aspiration precautions was that staff were to ensure the residents sit upright for meals. NA #1 indicated that she was not aware if Resident #14 had to be supervised for meals. NA #1 indicated that Resident #14 always ate breakfast in bed and did not need supervision with eating before today. ˆ Interview with the DNS on 8/24/25 at 3:10 PM indicated the nurse aide was responsible to read the resident's care card to verify what diet the resident was on before distributing the meal tray so the resident receives the correct diet. Additionally, the DNS indicated the nurse aide was responsible to make sure the meal ticket and the items on the tray match before giving the tray to the resident. After reviewing the breakfast meal ticket for Resident #14, the DNS indicated Resident #14 was on a chopped diet with aspiration precautions. The DNS indicated Resident #14 should not have received a whole hard-boiled egg or a whole bagel sliced in half. The DNS indicated that aspiration precautions mean a resident must be upright 45 to 90 degrees when eating and chew slowly, and the food must be chopped up. The DNS indicated if the resident receives the wrong diet, he/she would be at risk of aspiration and choking where food goes into the lungs instead of going into the stomach. ˆ Interview with Dietary Director (Interim) on 8/24/2025 at 3:41 PM indicated the dietary aide on the tray line was responsible to make sure the meal ticket and the food items on the tray matched before the meal tray's leave the kitchen. Dietary Director (Interim) indicated he started education with the kitchen staff regarding making sure the meal tickets and the food items on the tray match. ˆ Observation on 8/25/25 at 8:50 AM identified Resident #14 was sitting upright in bed with his/her breakfast tray directly in front of him/her on the overbed table. Resident #14 was eating the cut-up pieces of pancake with syrup and off the plate with his/her fingers. There were no staff present for supervision or to assist Resident #14 with eating. Resident #14's breakfast meal ticket dated 8/25/25 identified aspiration precautions in capital letters at the top of the ticket, and the meal included 2 individual chopped pancakes and 1 chopped sausage patty. After surveyor inquiry, the speech evaluation dated 8/25/25 was completed and identified Resident #14 is currently on a chopped soft texture diet with thin liquids. Resident #14 has dysphasia with incomplete bolus (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	formation, inadequate mastication and rotary chew pattern, lack of mastication, effortful mastication, excessive mastication time, oral residue, piecemeal chewing, poor attention to task and residue on tongue base. Resident #14's behavior was impacting safety with impulsive rate, poor safety monitoring skills, decreased safety awareness, uncontrolled talking while eating and reduced attention to task. To facilitate safety and efficiency it is recommended the resident use the following strategies and maneuvers during oral intake: lingual sweep and re-swallow, alternating liquids and solids, rate modification, and general swallowing techniques and upright during meals and upright at least 30 minutes after meals. Resident #14 chugged liquids and was unable to take small single sips with verbal and visual cues. Based on today's evaluation, continuation of a chopped texture diet is recommended. Encourage Resident #14 to have a slow rate of intake, upright posture during meals. Observation on 8/26/25 at 8:55 AM identified Resident #14 was lying in bed in the upright position eating the scrambled eggs with his/her fingers without staff present or supervision. The breakfast meal ticket for Resident #14 dated 8/26/25 identified 3 ounces scrambled eggs and 1 chopped up muffin. Interview with Dietitian #1 on 8/26/25 at 10:08 AM indicated that Resident #14 is on a chopped diet and should never have received a whole hard-boiled egg or a bagel. Interview with SLP #1 on 8/26/25 at 11:00 AM indicated when Resident #14 returned from the hospital she was asked to see the resident to do an evaluation for the diet. SLP #1 indicated she had Resident #14 on case load from 4/15/25 to 6/13/25 for dysphasia and to assess for the least restrictive diet. SLP #1 indicated Resident #14 is impulsive and eats too fast with food and requires cues to not eat fast and alternate a bite of food then a sip of liquid. SLP #1 indicated Resident #14 has mild to moderate residue diffuse food left after a bite of food in his/her mouth and pockets food in his/her cheeks. SLP #1 indicated Resident #14 needs the liquid sips to clear the food from the mouth before taking another bite. SLP #1 indicated Resident #14 needs cueing to stop talking while eating to prevent choking, the liquid to clear the food, and cueing to slow the rate he/she is eating. SLP #1 indicated after Resident #14 had ended therapy his/her chewing had improved but the resident still was eating too fast, was impulsive and needed cueing throughout the meal. SLP #1 explained that with a chopped diet, the food is chopped into pieces approximately a third to a half inch in size for all meats, vegetables, fruits, etc. SLP #1 indicated the kitchen is responsible to make sure that all food for a chopped diet is chopped prior to being sent to the unit. SLP #1 indicated Resident #14 puts food in his/her mouth quickly, has impaired cognition, and impaired reasoning which was why SLP #1 placed Resident #14 on aspiration precautions. SLP #1 indicated that when she recommends a mechanically altered diet, she verbally informs the nurse aides and charge nurses of the diet and safety strategies. SLP #1 indicated that she had informed the nursing staff that Resident #14 needed distant supervision for meals and to make sure Resident #14 is using strategies for aspiration precautions during the meal. SLP #1 indicated that staff need to make sure implement these measures when Resident #14 eats. SLP #1 indicated she was asked on 8/25/25 after surveyor inquiry to reevaluate Resident #14's aspiration precautions. SLP #1 indicated after evaluation there were no changes for Resident #14's diet or behaviors, he/she still needed a chopped diet, was still at risk for aspiration and needs to continue with the same aspiration precaution strategies. SLP #1 indicated when she recommends swallowing strategies and aspiration precautions, she verbally informs the nursing supervisor, and it would be the nursing supervisors responsibility to call the physician and get the orders to put the recommendations into place. SLP #1 indicated that Resident #14 should not have received a hard-boiled egg cut in half or a whole bagel cut in half. SLP #1 indicated that Resident #14 was at increased risk for aspiration with the bagel because a bagel is hard to chew and sticky and the resident eats at a fast rate and the bagel can adhere to the pharyngeal wall (inner lining of the throat) and could cause it to get stuck there. SLP #1 indicated that Resident #14 is on a chopped diet because the resident would take huge bites. SLP #1 indicated Resident #14 is at increased risk for aspiration with the hard-boiled egg due to impaired cognition and eating to fast. Interview with NA #14 on 8/27/25 at 2:22 PM indicated that the speech therapist verbally educates her when a resident needs aspiration precautions. NA #14 (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated that if a resident was on aspiration precautions that meant the resident should eat all meals in the dining room so staff cand keep an eye on the resident while eating. NA #14 indicated that the nurse aide goes back and forth from the hallway to the dining room to observe the residents while eating. NA #14 indicated she was not aware Resident #14 needed distant supervision or was on aspiration precautions. NA #14 indicated the care card only stated mechanically altered diet. NA #14 indicated that she does not know what mechanically altered means. NA #14 indicated that if Resident #14 was on aspiration precautions due to his/her confusion and was eating in his/her room she would have sat in the room to observe the resident eating or brought resident to the dining room. A physician order dated 8/27/25 at 6:25 PM identified Resident #14 to receive a chopped diet with less than 6 ounces of animal protein per day and a direct 1:1 feed. The nurses note dated 8/27/25 at 8:01 PM identified that Resident #14's lungs were assessed by an RN and noted to be clear to auscultation and without any distress. Oxygen saturation was 98% on room air. Resident #14 was able to talk and in no respiratory distress. Review of the Meal Type Policy and Procedure, undated, identified the purpose was to ensure accurate identification and delivery of prescribed and preferred meal types to all residents, thereby promoting safe, dignity, and compliance with physician's orders and resident choice. It is the policy that all meals served to residents must be clearly identified according to the physician orders, dietary restrictions, and resident preferences. Staff must utilize standardized labeling and cross-checks to prevent errors in meal service. The registered dietitian or dietary manager will update meal tickets accordingly. The meal tray identification for each meal ticket must include resident name, room number, diet type (regular, mechanically soft, cardiac, etc), allergen and texture alerts, beverages and for any special diet it must be clearly noted on the meal ticket. Texture-modified diets such as pureed, chopped, regular meal tickets must be checked by both dietary and nursing staff. Meal service and cross-checks the dietary staff prepares and verifies trays before leaving the kitchen, nursing staff receives tray and cross checks against the resident ticket before serving, direct care staff will confirm correct tray delivered to the resident at bedside or dining area. Staff training - all food service and nursing staff will receive annual training on therapeutic diets, meal identification (meal tickets and label), therapeutic and modified diets, resident rights to meal choice, and procedures for resolving discrepances. Random audits will be conducted by the dietary manager at least weekly to ensure accuracy of meal identification. Review of the Aspiration Precaution Policy dated 1/19/18 identified it was the policy to implement evidence-based aspiration precautions for all residents identified at risk for dysphasia or aspiration. This includes a multidisciplinary approach to ensure safe oral intake, appropriate supervision, and immediate intervention to mitigate risk and promote resident safety. To establish a consistent protocol to prevent aspiration events among at-risk residents, ensuring proper dietary modifications, positioning, and feeding techniques are incorporated into individualized care plans and implemented by staff. The nurse aide is responsible to follow positioning and feeding guidelines, observing signs of distress, and report promptly. The licensed nurse is responsible to implement and documenting in the care plan, notifying the provider of changes, and oversee feeding compliance. The SLP is responsible to assess swallowing function and providing written recommendations. Dietary is responsible to prepare and label meals in accordance with the diet order. Aspiration precautions procedures include verify the residents consistency on the meal ticket, ensure resident is sitting at 75 - 90 degree angle, clean residents mouth, feed slowly and do not rush resident, encourage small bites and sips of liquid, alternating solids with liquids, monitor for signs of distress (coughing, throat clearing, wet voice, etc.), avoid talking while chewing or swallowing, remain present and attentive during feeding, maintain upright position for at least 30 - 60 minutes after meal, inspect oral cavity for pocketing of food. During the survey it was determined that Immediate Jeopardy existed under S483.60(c)(3) Menus and nutritional adequacy. Menus must be followed.The Immediate Jeopardy began when observations on 8/24/25 at 9:06 AM identified Resident #14 alone in his/her room without supervision and had been provided and was eating a hardboiled egg and bagel, both cut in half. Subsequently, the (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	investigation identified that the resident required aspiration precautions, swallowing strategies and a chopped diet. Further observations on 8/25/25 at 8:50 AM and 8/26/25 at 8:55 AM identified that although Resident #14 was provided the correct diet (chopped), the resident was observed alone in his/her room eating breakfast without supervision. On 8/27/25 at 5:55 PM the Administrator was notified that the failure to provide the correct diet (chopped) and supervision to Resident #14 on 8/24/25 at 9:06 AM with the ongoing failures to supervise the resident's meal intake on 8/25/25 at 8:50 AM and 8/26/25 at 8:55 AM constituted Immediate Jeopardy to the health and safety of the resident. The IJ Template was provided to the Administrator on 8/27/25 at 5:55 PM. The facility provided an Immediate Jeopardy removal plan on 8/27/25 at 8:00 PM that was accepted by the state agency. The IJ removal plan included the following. Immediate Actions Taken.Resident #14: Immediately removed all non-compliant food items from the tray and provided the correct physician-ordered diet (NAS chopped diet, thin liquids). Resident was placed under 1:1 supervision during all meals. RN assessed the resident. Physician and family were notified. No signs of aspiration were noted post-incident.Other residents on aspiration precautions: A rapid review was conducted on 8/27/25 of all residents with swallowing impairments or special diet orders. All diet orders were verified against current tray tickets and care plans. Corrections were made immediately for any discrepancies.Staff Re-Education: Nursing assistants, dietary aides, licensed nurses, Registered Dietitian, and speech therapy staff were immediately re-educated beginning 8/27/25 on: Reading and verifying meal tickets before tray delivery. Following physician orders and speech therapy recommendations for diet texture and supervision needs. Direct supervision protocols for residents on aspiration precautions.Systemic Changes Implemented.Tray Line Checks: Dietary Manager or designee will implement a checking system on the tray line to ensure meals match physician orders and diet tickets before trays leave the kitchen.Nursing Verification: Nursing staff will be required to confirm that trays match resident diet orders before serving.Communication Protocol: A formal handoff process is now required between Speech Therapy, Registered Dietitian, Nursing, and Dietary when aspiration precautions or swallowing and/or altered diet recommendations are made. All changes will be entered immediately into physician orders. Changes will be communicated electronically via email to SLP, RD, Nursing and Dietary. A paper communication form will be sent to the kitchen by the nurse with the confirmed changes. This communication form will be brought to the IDT for review to ensure accuracy and filed for reference and validation.Mandatory Education: All staff who deliver or assist with meals will undergo mandatory training on diet consistencies and aspiration precautions. Attendance logs will be maintained.Monitoring and Quality Assurance.Daily Meal Observation Audits: For the next 14 days, the DON or designee will conduct daily audits of meal service for all residents with aspiration precautions. Any non-compliance will result in immediate correction and staff re-education.Weekly IDT Review: The Interdisciplinary Team (IDT) will review all residents on aspiration precautions weekly to ensure orders are accurate, interventions are being followed, and supervision levels are consistent.Quarterly QA Reporting: Results of audits will be reported to the facility Quality Assurance & Performance Improvement (QAPI) Committee quarterly for ongoing monitoring and further corrective action as needed.Responsible party.The Director of Nursing (DON) will be the responsible party.Date of Compliance.The facility asserts that the immediate jeopardy was removed on 8/27/25, when all residents on aspiration precautions were verified for correct diet orders, supervision was implemented, and staff education initiated. The facility will remain in compliance ongoing.Based on observations and interviews by the survey team, the IJ was removed on 8/29/25.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility documentation, facility policy and interviews, the facility failed to ensure consistent response and follow-up to Resident Council concerns according to facility policy. The findings include: Review of Resident Council minutes from 1/29/25 to 7/30/25 identified repeated concerns raised by residents regarding the following.Nurse aides using personal phones during work hours.Food quality issues, including cold meals, greasy or undercooked items, and meals served with reported allergens.Unmet food requests (e.g., butter, fruit, salt, and pepper).Incorrect meal tickets.The review identified there was no documented response from facility staff to concerns raised during the 2/26/25, 6/25/25, and 7/30/25 meetings, despite similar issues being previously reported. Additionally, the Food Service Director was not in attendance at the Resident Council meetings on 3/31/25, 5/28/25, 6/25/25, and 7/30/25, where food-related concerns were discussed. Interview with Resident #123 on 8/24/25 at 1:27 PM identified facility administration did not consistently follow up on Resident Council concerns. Interview with Resident #71 on 8/24/25 at 1:27 PM indicated facility administration did not consistently follow up on food-related concerns, there was no dedicated food committee, and the Food Service Director did not attend Resident Council meetings. Interview with the Director of Recreation on 8/25/25 at 10:02 AM identified she was responsible for facilitating Resident Council meetings and coordinating follow-up. Resident concerns were referred to appropriate departments using a ?Response Form' for review at the next meeting. The Director of Recreation indicated interdisciplinary follow-up was inconsistent, making it difficult to address concerns, and that the Administrator was aware. The Director of Recreation also noted the Food Service Director declined repeated invitations to attend the meetings. Interview with the Administrator on 8/26/25 at 10:25 AM identified he was aware Resident Council concerns were not being responded to consistently and that the Food Service Director was not attending monthly meetings. The Administrator further identified he would expect the Food Service Director to be in attendance monthly to address concerns related to food. Regardless, it was his responsibility to ensure monthly follow-up was unable to explain the ongoing breakdown to ensure consistent responses.Review of the facility's Resident Council policy directs accurate documentation of meetings, including concerns and recommendations, forwarding of concerns to the Administrator and department heads, written responses or updates to be provided at the next scheduled meeting.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 7 residents (Resident 12, 14, 23, 28, 51, 105, 137) the facility failed to provide adequate supervision to prevent accidents and failed to ensure the resident environment remained as free of accident hazards as is possible. For 2 of 7 residents (Resident #12 and 14) reviewed for nutrition and who required aspiration precautions, the facility failed to ensure adequate supervision during meals.For 2 of 12 residents (Resident #23 and 28), reviewed for accidents, the facility failed to ensure adequate supervision and follow smoking policies for residents with smoking violations. For 1 of 12 residents (Resident #51) reviewed for accidents, the facility failed to complete and document leave of absence (LOA) risk assessments prior to allowing the resident to go on an independent LOA, failed to ensure staff reviewed, and the resident understood and abided by the LOA protocols, failed to develop and implement interventions to keep the resident safe during LOA after the resident had several accidents, including sustaining a significant injury after falling out of the motorized wheelchair while intoxicated, and tested positive for substance use after being on an independent LOA, and exhibited ongoing unsafe behaviors of smoking in the street in front of the facility in the wheelchair.For 2 of 12 residents (Resident #51 and 105) reviewed for accidents, the facility failed to ensure smoking assessments were completed timely and when indicated, failed to ensure residents were not smoking unsupervised in unauthorized areas, failed to provide education related to smoking in areas adjacent to the facility property, failed to ensure that residents were free from contraband, and failed to address smoking violations and contraband violations per facility policy.For 1 resident (Resident #137) reviewed for closed record, the facility failed to develop appropriate strategies and ensure adequate supervision for a resident with a swallowing disorder who was known to access potentially unsafe food, who was found with whole nuts in their mouth, failed to examine root causes of how food was accessed and establish measures to prevent recurrence.Further, the facility failed to ensure an oxygen tank was stored securely away from residents, failed to ensure that the designated smoking area was free of hazards, and failed to ensure the smoking cart was supervised by facility staff when unlocked with smoking materials on the top and in the presence of residents. The findings include: 1. Resident #12 was admitted to the facility in November 2013 (readmission in January 2024) with diagnoses that included dementia, stroke affecting the left side, dysphasia, and abnormal weight loss. The Speech Therapy Discharge summary dated [DATE] identified Resident #12 was seen for skilled dysphasia therapy. Resident #12 needed to facilitate liquid delivery using small and controlled sips, facilitate small bites of 1/2 to 1/3 of a teaspoon for modification to bolus presentation, instruction in alternating a sip of liquid with a bite of food to increase pharyngeal clearance, and facilitate rate control during oral intake of food and liquids. Additionally, training was provided in the need for upright posture during meals and instruction in the use of upright posture for at least 30 minutes after meals. Resident #12 and care giver training in compensatory strategies, positioning maneuvers, safe swallow techniques and safety precautions to preserve current level of function and enable resident to safely consume highest level of intake with least amount of supervision. The Speech Evaluation and Plan of Treatment dated 11/27/23 identified Resident #12 had a recent decrease in oral intake and concerns for weight loss. Speech recommendations include close supervision for meals and continue with safe swallowing techniques and precautions. The speech therapy note dated 11/27/23 at 1:10 PM identified Resident #12 would benefit from being a total feed at this time. Resident #12 will continue a regular diet with thin liquids. A physician's order dated 4/7/25 directed to provide a regular diet, aspiration precautions, and total assistance with feeding. The care plan dated 6/23/25 identified Resident #12 was at increased risk for alterations in nutritional status due to diagnosis. Interventions included to provide a regular diet and monitor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident for difficulties with chewing, swallowing, and a need for a modified consistency requiring a speech evaluation. The dietitian note dated 7/8/25 at 1:16 PM identified Resident #12 was on a regular diet and required aspiration precautions and total feed. The annual MDS dated [DATE] identified Resident #12 had moderately impaired cognition, needs set-up and clean-up assistance for meals and has a therapeutic diet. The dietitian note dated 8/14/25 at 4:15 PM identified Resident #12 was on a regular diet and required total feed for meals.The dietitian note dated 8/21/25 at 3:40 PM identified he had met with the nurse aide because Resident #12 was requesting his/her food to be cut up because the resident is unable to independently cut up the food. The special instruction for chopped food is solely for residents' ease of eating, not convenience. Observation on 8/24/25 at 8:45 AM to 9:10 AM identified Resident #12 was in the dining room eating breakfast independently. A nurse aide was standing in the doorway with her back to Resident #12 looking into the hallway approximately 15 feet from the resident. There was one other resident in the dining room with his/her back towards Resident #12 at another table. At 8:46 AM the nurse aide exited the dining room and went down the hallway out of sight. Resident #12 continued feeding him/herself half a bagel with cream cheese. Resident #12 at 9:05 AM had completed eating most of the bagel but did not touch the bowl of hot cereal. At 9:08 AM the nurse aide entered the dining room and asked Resident #12 if he/she was done eating breakfast and removed the meal tray. Interview with NA #1 on 8/24/25 at 10:00 AM indicated Resident #12 eats independently and does not need supervision for meals. NA #1 indicated that sometimes Resident #12 will eat in the dining room and on other days will eat in bed for breakfast. Observation on 8/26/25 at 9:10 AM to 9:30 AM identified Resident #12 was lying in bed sitting in the upright position with the overbed table in front of him/her. On the table were 2 bowls of hot cereal, a cup of juice, and a cup of a hot beverage in front of the resident and within reach. Resident #12 had one bite missing from one bowl of hot cereal and no staff were present in the room. Interview with the DNS on 8/27/25 at 1:51 PM indicated that Resident #12 was on aspiration precautions and required a total feed per the physician's orders. The DNS indicated that the nurse aide should sit next to Resident #12 and assist the resident with every meal. The DNS indicated food should not be left in front of Resident #12 without someone present. After surveyor inquiry, the care plan dated 8/27/25 identified Resident #14 was at increased risk for alteration in nutritional status. Interventions included aspiration precautions in capital letters, regular diet and thin liquids, and a 1 to 1 feed.Interview with the DNS on 8/29/25 at 8:15 AM indicated that the physician's diet order, the care plan, and the nurse aid care card for the resident should all match. The DNS indicated the diet order, the assistance needed, if someone needed aspirations precautions, or any other special instructions would be a part of the physician's order. After reviewing the clinical record, the DNS identified there were 2 dietary physician orders for Resident #12. The DNS indicated there was one listed as a regular diet with aspiration precautions and a total feed, and a second order for self-feeding with set up. The DNS indicated the most recent physician order should be followed. The DNS indicated the order for aspiration precautions, and total feed was the most recent and the physician order for a setup should have been discontinued. After review of the nurse aide flow sheets, the DNS identified the day shift nurse aides were documenting Resident #12 was independent with meals, but Resident #12 should be fed. The DNS indicated she does not know why the nurse aides are documenting Resident #12 is independent eating meals.Interview with SLP #1 on 8/28/25 at 10:00 AM indicated Resident #12 was discharged from speech therapy on 11/27/23 and was made a total feed at that time with aspiration precautions. SLP #1 indicated she uses the term safety strategies interchangeable with aspiration precautions. Interview with OT #1 (Director of Rehab) on 8/28/25 at 10:05 AM indicated Resident #12 has required a total feed for a long time with the physician order as a 1 to 1 feed. OT #1 indicated Resident #12 became a 1 to 1 feed because of weight loss. OT #1 indicated there were 2 physician orders for diet but the OT order for diet for a set up for meals should have been discontinued when the total feed order was put into place. OT #1 indicated the physician order was fixed this morning after surveyor inquiry. Review of the Meal Type Policy and Procedure, (continued on next page)

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New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	undated, identified the purpose was to ensure accurate identification and delivery of prescribed and preferred meal types to all residents, thereby promoting safety, dignity, and compliance with physician's orders and resident choice. It is the policy that all meals served to residents must be clearly identified according to the physician orders, dietary restrictions, and resident preferences. Staff must utilize standardized labeling and cross-checks to prevent errors in meal service. The registered dietitian or dietary manager will update meal tickets accordingly. The meal tray identification for each meal ticket must include resident name, room number, diet type (regular, mechanically soft, cardiac, etc), allergen and texture alerts, beverages and for any special diet it must be clearly noted on the meal ticket. Texture-modified diets such as pureed, chopped, regular meal tickets must be checked by both dietary and nursing staff. Meal service and cross-checks the dietary staff prepares and verifies trays before leaving the kitchen, nursing staff receives tray and cross checks against the resident ticket before serving, direct care staff will confirm correct tray delivered to the resident at bedside or dining area. Staff training - all food service and nursing staff will receive annual training on therapeutic diets, meal identification (meal tickets and label), therapeutic and modified diets, resident rights to meal choice, and procedures for resolving discrepancies. Random audits will be conducted by the dietary manager at least weekly to ensure accuracy of meal identification. Review of the Aspiration Precaution Policy dated 1/19/18 identified it was the policy to implement evidence-based aspiration precautions for all residents identified at risk for dysphasia or aspiration. This includes a multidisciplinary approach to ensure safe oral intake, appropriate supervision, and immediate intervention to mitigate risk and promote resident safety. To establish a consistent protocol to prevent aspiration events among at-risk residents, ensuring proper dietary modifications, positioning, and feeding techniques are incorporated into individualized care plans and implemented by staff. The nurse aide was responsible to follow positioning and feeding guidelines, observing signs of distress, and report promptly. The licensed nurse was responsible to implement and documenting in the care plan, notifying the provider of changes, and oversee feeding compliance. The SLP was responsible to assess swallowing function and providing written recommendations. Dietary was responsible to prepare and labelling meals in accordance with the diet order. Aspiration precautions procedures include verify the residents consistency on the meal ticket, ensure resident is sitting at 75 - 90 degree angle, clean residents mouth, feed slowly and do not rush resident, encourage small bites and sips of liquid, alternating solids with liquids, monitor for signs of distress (coughing, throat clearing, wet voice, etc.), avoid talking while chewing or swallowing, remain present and attentive during feeding, maintain upright position for at least 30 - 60 minutes after meal, inspect oral cavity for pocketing of food. 2. Resident #14 was admitted to the facility in May 2021 with diagnoses that included dementia, dysphasia, and anxiety. The care plan dated 5/1/25 identified Resident #14 was at risk for aspiration with interventions that included a mechanically altered chopped diet with aspiration precautions and assist with meal intake. The annual MDS assessment dated [DATE] identified Resident #14 had severely impaired cognition and required supervision or touching assistance with staff providing verbal cues and/or touching and/or contact guard assistance for eating and was on a mechanically altered diet. The speech therapy Discharge summary dated [DATE] identified Resident #14 was seen for dysphasia and required the following swallow techniques; alternate solids with liquids to increase pharyngeal clearance, facilitate small bites and sips 1/2 to 1/3 teaspoon, facilitate body positioning to increase safety with intake and facilitate alternating bites with sips of liquids with distant supervision. Resident #14 is to receive a mechanically soft chopped diet using swallow strategies to facilitate safety and efficiency. Recommendations include using the following strategies or maneuverers during oral intake, lingual sweep and swallow, alternating solids and liquids with rate modification, upright posture during meals and upright posture for at least 30 minutes after meals. Resident and primary caregivers were trained in compensatory strategies and safe swallowing techniques to enable resident to safely consume highest level of intake. The APRN note dated 7/30/25 at 3:59 PM identified Resident #14 had intermittent generalized weakness and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	poor oral intake. Staff are to encourage nutritional supplements and assist with feeding. APRN reinforced with staff to assist Resident #14 with feeding and follow up with dietitian. The dietitian note dated 8/12/25 at 4:24 PM identified Resident #14 required a chopped diet and total feed. The physician's order dated 8/18/25 directed a low sodium chopped diet with less than 6 ounces of animal protein per day.ˆ Observation on 8/24/25 at 9:06 AM identified Resident #14 was sitting upright in bed with a half-eaten breakfast tray in front of him/her on the overbed table. Resident #14 was holding a piece of a non-toasted whole bagel that had been cut in half and had some of the bagel in his/her mouth. There was a half-eaten hardboiled egg with bites out of it on the plate not cut up into pieces, and the other half of the bagel was in 1 piece on the plate. There were no staff in the room or supervising Resident #14 at the time. Interview with the charge nurse on the unit, LPN #1, on 8/24/25 at 9:07 AM indicated Resident #14 was on a chopped diet and should not have been given the whole hard-boiled egg or the whole bagel that had been cut in half. LPN #1 indicated that Resident #14 was at risk for aspiration and was on aspiration precautions. LPN #1 indicated Resident #14 received the wrong consistency meal (a regular diet) and should have received a chopped diet. LPN #1 informed Resident #14 she would be removing the meal and indicated she would notify the director of the kitchen and have the correct meal sent.ˆ ˆˆ Interview with NA #1 on 8/24/25 at 2:05 PM indicated that she had given Resident #14 his/her breakfast tray this morning, a hard-boiled egg it its shell and a bagel. NA #1 indicated she did not realize that Resident #14ˆwas on a chopped diet or aspiration precautions and should not have received a regular diet for breakfast. NA #1 indicated that her understanding of aspiration precautions was that staff were to ensure the residents sit upright for meals. NA #1 indicated that she was not aware if Resident #14 had to be supervised for meals. NA #1 indicated that Resident #14 always ate breakfast in bed and did not need supervision with eating before today. ˆ Interview with the DNS on 8/24/25 at 3:10 PM indicated the nurse aide was responsible to read the resident's care card to verify what diet the resident was on before distributing the meal tray so the resident receives the correct diet. Additionally, the DNS indicated the nurse aide was responsible to make sure the meal ticket and the items on the tray match before giving the tray to the resident. After reviewing the breakfast meal ticket for Resident #14, the DNS indicated Resident #14 was on a chopped diet with aspiration precautions. The DNS indicated Resident #14 should not have received a whole hard-boiled egg or a whole bagel sliced in half. The DNS indicated that aspiration precautions mean a resident must be upright 45 to 90 degrees when eating and chew slowly, and the food must be chopped up. The DNS indicated if the resident receives the wrong diet, he/she would be at risk of aspiration and choking where food goes into the lungs instead of going into the stomach. ˆ Observation on 8/25/25 at 8:50 AM identified Resident #14 was sitting upright in bed with his/her breakfast tray directly in front of him/her on the overbed table. Resident #14 was eating the cut-up pieces of pancake with syrup and off the plate with his/her fingers. There were no staff present for supervision or to assist Resident #14 with eating. Resident #14's breakfast meal ticket dated 8/25/25 identified aspiration precautions in capital letters at the top of the ticket. After surveyor inquiry, the speech evaluation dated 8/25/25 was completed and identified Resident #14 is currently on a chopped soft texture diet with thin liquids. Resident #14 has dysphasia with incomplete bolus formation, inadequate mastication and rotary chew pattern, lack of mastication, effortful mastication, excessive mastication time, oral residue, piecemeal chewing, poor attention to task and residue on tongue base. Resident #14's behavior was impacting safety with impulsive rate, poor safety monitoring skills, decreased safety awareness, uncontrolled talking while eating and reduced attention to task. To facilitate safety and efficiency it is recommended the resident use the following strategies and maneuvers during oral intake: lingual sweep and re-swallow, alternating liquids and solids, rate modification, and general swallowing techniques and upright during meals and upright at least 30 minutes after meals. Resident #14 chugged liquids and was unable to take small single sips with verbal and visual cues. Based on today's evaluation, continuation of a chopped texture diet is recommended. Encourage Resident #14 to have a slow rate of intake, upright posture during meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 8/26/25 at 8:55 AM identified Resident #14 was lying in bed in the upright position eating the scrambled eggs with his/her fingers without staff present or supervision. Interview with SLP #1 on 8/26/25 at 11:00 AM indicated Resident #14 is impulsive and eats too fast with food and requires cues to not eat fast and alternate a bite of food then a sip of liquid. SLP #1 indicated Resident #14 has mild to moderate residue diffuse food left after a bite of food in his/her mouth and pockets food in his/her cheeks. SLP #1 indicated Resident #14 needs the liquid sips to clear the food from the mouth before taking another bite. SLP #1 indicated Resident #14 needs cueing to stop talking while eating to prevent choking, the liquid to clear the food, and cueing to slow the rate he/she is eating. SLP #1 indicated after Resident #14 had ended therapy his/her chewing had improved but the resident still was eating too fast, was impulsive and needed cueing throughout the meal. SLP #1 indicated Resident #14 puts food in his/her mouth quickly, has impaired cognition, and impaired reasoning which was why SLP #1 placed Resident #14 on aspiration precautions. SLP #1 indicated that when she recommends a mechanically altered diet, she verbally informs the nurse aides and charge nurses of the diet and safety strategies. SLP #1 indicated that she had informed the nursing staff that Resident #14 needed distant supervision for meals and to make sure Resident #14 is using strategies for aspiration precautions during the meal. SLP #1 indicated that staff need to make sure implement these measures when Resident #14 eats. SLP #1 indicated she was asked on 8/25/25 after surveyor inquiry to reevaluate Resident #14's aspiration precautions. SLP #1 indicated after evaluation there were no changes for Resident #14's diet or behaviors, he/she still needed a chopped diet, was still at risk for aspiration and needs to continue with the same aspiration precaution strategies. SLP #1 indicated when she recommends swallowing strategies and aspiration precautions, she verbally informs the nursing supervisor, and it would be the nursing supervisors responsibility to call the physician and get the orders to put the recommendations into place. SLP #1 indicated that Resident #14 was at increased risk for aspiration with the bagel because a bagel is hard to chew and sticky and the resident eats at a fast rate and the bagel can adhere to the pharyngeal wall (inner lining of the throat) and could cause it to get stuck there. SLP #1 indicated that Resident #14 is on a chopped diet because the resident would take huge bites. SLP #1 indicated Resident #14 is at increased risk for aspiration with the hard-boiled egg due to impaired cognition and eating to fast. Interview with NA #14 on 8/27/25 at 2:22 PM indicated that the speech therapist verbally educates her when a resident needs aspiration precautions. NA #14 indicated that if a resident was on aspiration precautions that meant the resident should eat all meals in the dining room so staff cand keep an eye on the resident while eating. NA #14 indicated that the nurse aide goes back and forth from the hallway to the dining room to observe the residents while eating. NA #14 indicated she was not aware Resident #14 needed distant supervision or was on aspiration precautions. NA #14 indicated the care card only stated mechanically altered diet. NA #14 indicated that she does not know what mechanically altered means. NA #14 indicated that if Resident #14 was on aspiration precautions due to his/her confusion and was eating in his/her room she would have sat in the room to observe the resident eating or brought resident to the dining room. A physician order dated 8/27/25 at 6:25 PM identified Resident #14 to receive a chopped diet with less than 6 ounces of animal protein per day and a direct 1:1 feed. Review of the Aspiration Precaution Policy dated 1/19/18 identified it was the policy to implement evidence-based aspiration precautions for all residents identified at risk for dysphasia or aspiration. This includes a multidisciplinary approach to ensure safe oral intake, appropriate supervision, and immediate intervention to mitigate risk and promote resident safety. To establish a consistent protocol to prevent aspiration events among at-risk residents, ensuring proper dietary modifications, positioning, and feeding techniques are incorporated into individualized care plans and implemented by staff. The nurse aide is responsible to follow positioning and feeding guidelines, observing signs of distress, and report promptly. The licensed nurse is responsible to implement and documenting in the care plan, notifying the provider of changes, and oversee feeding compliance. The SLP is responsible to assess swallowing function and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	providing written recommendations. Dietary is responsible to prepare and label meals in accordance with the diet order. Aspiration precautions procedures include verify the residents consistency on the meal ticket, ensure resident is sitting at 75 - 90 degree angle, clean residents mouth, feed slowly and do not rush resident, encourage small bites and sips of liquid, alternating solids with liquids, monitor for signs of distress (coughing, throat clearing, wet voice, etc.), avoid talking while chewing or swallowing, remain present and attentive during feeding, maintain upright position for at least 30 - 60 minutes after meal, inspect oral cavity for pocketing of food. 3. Resident #23 was re-admitted to the facility in April 2025 with diagnoses that included chronic obstructive pulmonary disease, and history of opioid use.A copy of the smoking policy dated 4/1/25, signed by Resident #23, identified smoking was only allowed outside in designated smoking areas. All residents must be supervised while smoking and smoking materials were to be secured by staff. Violations would be subject to a noninvasive room/person search and counseling.A Smoking Observation assessment dated [DATE] identified Resident #23 was safe to smoke on independent leave of absence (LOA).The MDS dated [DATE] identified Resident #23 had moderately impaired cognition and was independent with locomotion using a wheelchair/walker.The care plan dated 6/24/25 identified Resident #23 was a smoker and approved for independent LOA. Interventions included providing education on contraband and smoking policies.A physician's order dated 7/15/25 directed Resident #23 could be independent while on LOA with rollator.a. A Nurse's note dated 8/21/25 identified at 9:56 PM Resident #23 was found with an unknown substance in a box in his/her room. The APRN was notified, and a urine sample was requested.Subsequently, the corresponding care plan was revised noting contraband had been found in Resident #23's room with interventions that the resident submit to random room/person/container searches and may have restricted LOA.b. Observation on 8/26/25 at 2:45 PM identified Resident #23 was in a wheelchair in the front parking lot, actively smoking, with a cigarette pack visible in the shirt pocket. The area was without designated smoking signage, fire-safe disposal containers or appropriate fire control materials. Resident #23 declined to comment when asked about the smoking activity. The Administrator was immediately notified.A Resident Room Worksheet dated 8/26/25 identified Resident #23 was present during a room search with no documented findings of contraband.A Contraband Policy Violation Investigation dated 8/26/25 identified Resident #23 denied smoking but was on the premises with cigarettes, which was against facility policy. Interdisciplinary recommendations included no smoking materials while out on LOA and obtain consent for noninvasive searches.Interview with the Administrator on 8/27/25 at 11:32 AM identified Resident #23 had prior smoking violations and transfer to a sister facility was in progress.Review of the smoking policy directs smoking is allowed outside in designated smoking areas and at designated times. All residents must be supervised while smoking and at no time are residents allowed to have cigarettes and other smoking materials in their possession.Review of the Contraband policy directs violations of the contraband agreement may result in involuntary discharge including possession of controlled substances, cigarettes, cigars, pipes, e-cigarettes, vapes or other fire sources. 4. Resident #28 was admitted to the facility in August 2025 with diagnoses that included aftercare following surgery of the nervous system and chronic obstructive pulmonary disease (COPD).A Smoking Observation dated 8/1/25 identified Resident #28 was safe to smoke independently on leave of absence (LOA).A copy of the smoking policy dated 8/1/25, signed by Resident #28 identified smoking was only allowed outside in designated smoking areas and at designated times. All residents must be supervised while smoking and at no time are residents allowed to have cigarettes and other smoking materials in their possession.The care plan dated 8/1/25 identified Resident #28 was a smoker with interventions that included that Resident #28 would abide by the smoking policy and not possess any smoking materials in their room/on their person.The admission MDS dated [DATE] identified Resident #28 had moderately impaired cognition required supervision with ambulation using a walker.A physician's order dated 8/15/25 directed Resident #28 was independent while on LOA with rollator.A LOA Notification Form dated 8/27/25 identified Resident #28 was leaving the facility at 9:30 AM for a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doctor's appointment.Observation on 8/27/25 at 10:07 AM identified Resident #28 was outside, on the premises, near the front entrance, smoking unsupervised. The area was without designated smoking signage, fire-safe disposal containers and appropriate fire control materials. When questioned Resident #28 responded that he/she was aggravated. The Administrator was immediately notified.Interview with the Administrator on 8/27/25 at 11:32 AM identified he met with Resident #28 and reminded the resident of the smoking policy. Resident #28 agreed to a room search upon return. The Administrator further identified that although smoking violations were subject to an emergency discharge notice for any violation, he indicated a notice had not been provided.A Notice of discharge date d 8/27/25 identified Resident #128 was to be discharged on 9/27/25 with a right to appeal. The notice was signed by the Administrator. It was noted Resident #28 refused to sign the notice at 10:16 AM, 1 hour and 16 minutes earlier.The Contraband Policy Violation Investigation dated 8/27/25 identified Resident #28 left the faciity on approved LOA, refused to sign the contraband policy, denied smoking and having contraband, stated he/she did not need to follow policies. Resident #28 did, however, agree to a room search which identified cigarettes that were removed.Review of the smoking policy directs smoking is allowed outside in designated smoking areas and at designated times. All residents must be supervised while smoking and at no time are residents allowed to have cigarettes and other smoking materials in their possession.Review of the Contraband policy directs violations of the contraband agreement may result in involuntary discharge including possession of controlled substances, cigarettes, cigars, pipes, e-cigarettes, vapes or other fire sources. 5. Resident #51 was admitted to the facility in May 2021 with diagnoses that included traumatic brain injury, alcoholic hepatitis, malignant neoplasm of the colon and left kidney, mild neurocognitive disorder with behavioral disturbance, hemiplegia and hemiparesis following a stroke affecting the right dominant side, and bipolar disorder. A Physician's order dated 8/21/24 identified Resident #51 may go out on pass independently (end date of 8/21/25). Review of the clinical record failed to reflect that a LOA risk assessment had been completed prior to the physician's order dated 8/21/24 that allowed the resident to go out on pass independently. The annual MDS dated [DATE] identified Resident #51 had moderately impaired cognition, was taking an anticoagulant and antiplatelet medication, and used a manual wheelchair with the ability to independently wheel at least 50 feet and make two turns and wheel at least 150 feet in a corridor or similar space. The care plan dated 5/21/25 identified Resident #51 was at risk for falls related to weakness and history of falls. Interventions included checking the wheelchair brakes and instructing the resident on proper use, toileting at regular intervals, and monitoring and reporting changes in mood, anxiety, sleep patterns, and behavior. The care plan further identified Resident #51 exhibited behaviors as evidenced by verbally/physically abusive, wandering, refusals of care, delusions, hallucinations, aggression, psychiatric conditions, and a history of risk of injury to self or others. Interventions included monitoring any changes in mood or behavior and reporting to the physician, providing the resident with the opportunity to express feelings through 1 to 1 and group visits, and using the resident's name and explaining the purpose upon approach. The care plan further identified Resident #51 had been approved for a LOA with responsible party. Interventions included completing an interdisciplinary team review for LOA, obtaining a physician's order for LOA, educating the resident on LOA and contraband policies and obtaining signatures. a. The[TRUNCATED]

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, policy, and interviews for 5 of 5 nurse aides (NA #1, NA #6, NA #16, NA #17, and NA #18), the facility failed to ensure performance evaluations were completed, at least every 12 months. The findings include:Review of NA #1's personnel file identified that she was hired on 6/25/09 and failed to identify documentation that an annual performance evaluation was completed in the year of 2024 or to date, in 2025.Review of NA 18's personnel file identified that she was hired on 1/28/10 and failed to identify documentation that an annual performance evaluation was completed in the year of 2024 or to date, in 2025.Review of NA #17's personnel file identified that she was hired on 9/26/18 and failed to identify documentation that an annual performance evaluation was completed in the year of 2024 or to date, in 2025.Review of NA #6's personnel file identified that she was hired on 4/12/22 and failed to identify documentation that an annual performance evaluation was completed in the year of 2024 or to date, in 2025.Review of NA #16's personnel file identified that she was hired on 1/10/24 and failed to identify documentation that an annual performance evaluation was completed in the year of 2024 or to date, in 2025.Interview with the interim-DNS on 8/28/25 at 4:53 PM identified that she was unaware that the nurse aide annual performance evaluaitons were not completed in 2024 or to date in 2025, but she would expect them to have been completed annually.Interview with the Administrator on 8/29/25 at 10:00 AM identified that it was just brought to his attention that the 2024 performance evaluations were not completed for the nurse aide staff, and that no 2025 annual performance evaluations had been completed, yet. The Administrator indicated that he remembered a prior DNS completing the annual evaluations back in 2024, but he was unable to locate the documentation that they were completed. The Administrator further identified that he began conversations with the former DNS, back in March 2025, to start working on the annual performance evaluations, and the former DNS indicated that they were being completed; during the survey process he learned that they had not been completed. The Administrator identified that he would expect performance evaluations to be completed at 30, 60, and 90 days for new hires and annually thereafter.The Annual Staff Evaluation policy directs that formal performance evaluations for all staff members are conducted at least annually, and more frequently as needed. Evaluations will be used to assess job performance, recognize strengths, identify areas for improvement, and establish goals for the upcoming year. Performance evaluations are to be conducted annually, generally in the month of the employees hire date anniversary. Additional evaluations may be completed at the end of the probationary period, following a significant change in job duties, or when performance concerns arise. Direct supervisors or department heads are responsible for conducting evaluations of staff under their supervision, and evaluations must be reviewed and signed by the Administrator or designee to ensure consistency and fairness.

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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. Based on observation, review of facility policy, and interviews, the facility failed to ensure food items were labeled and dated in the kitchen and nourishment rooms and failed to ensure the walk-in freezer was defrosted. The findings include: 1. Tour of the kitchen with [NAME] #1 on 8/24/25 at 7:15 AM identified the following.Main walk-in refrigerator identified a 1/2 cut up cucumber without being covered, labeled, or dated, 1/2 an onion not covered, labeled, or dated, 3 heads of lettuce not covered labeled or dated with dripping liquid and wilted leaves and brown spots, 9 stalks of celery uncovered sitting on a metal tray not covered, labeled, or dated. The walk-in freezer identified 7 brown meat patties in a blue bag not closed with frost on them not labeled or dated. [NAME] #1 indicated they were Salisbury steaks. They were not in their original container. A blue bag not closed with visible frost on the chopped-up onions not labeled or dated, a clear bag with grey colored meat that was not labeled or dated. [NAME] #1 indicated they were pork chops. A blue bag not closed with breaded items inside not labeled or dated. [NAME] #1 indicated they were fish cakes. Twenty hamburgers in a clear plastic bag with frost covering them not labeled or dated, 18 chicken patties in a clear untied bag with freezer burn not labeled or dated. [NAME] #1 and the Dietary Director (Interim) on 8/24/25 at 7:20 AM discarded all the unlabeled and undated food items into the garbage. Interview with the Dietary Director (Interim) on 8/24/25 at 7:40 AM indicated the refrigerator items should have been covered, labeled, and dated. The Dietary Director (Interim) indicated the items that were prepared, used, or opened were to be discarded after 3 days. The Dietary Director (Interim) indicated the cooks, and dietary aides were responsible to check dates on all food items daily and discard outdated items after 3 days. The Dietary Director (Interim) indicated that the freezer items when removed from the original package were expected to be labeled and dated. 2. Tour of the walk-in freezer with the Dietary Director (Interim) on 8/24/25 at 7:35 AM identified large drips of ice from the fan in the back at the top wall to the top shelf with a half basketball size frozen block of ice. The fan on the right side had an ice drip frozen from the corner of the fan covering the corner of a box on the top shelf. There was a large frozen strip of ice on the right side in the middle of the wall from the top shelf going down to the bottom shelf. Interview with the Dietary Director (Interim) on 8/24/25 at 7:40 AM indicated he would defrost the freezer today.Observation on 8/25/25 at 1:00 PM identified the freezer had large forms of ice present inside the freezer.Observation on 8/26/25 at 10:00 AM identified the freezer continues to have the large forms of ice present in the freezer. Interview with Dietary Director (Interim) on 8/29/25 at 9:20 AM indicated on 8/27/25 he had cleaned the freezer. The Dietary Director (Interim) indicated that he did not have time before that to get the freezer defrosted and clean the freezer. 3. interview with the Dietary Director (Interim) on 8/25/25 at 11:00 AM indicated the dietary staff were responsible to check the nourishment refrigerators daily for expired foods, food or drinks not labeled with resident's name and items were dated. The Dietary Director (Interim) indicated any item not labeled or dated or past the 3 days from dated were to be discarded. The Dietary Director (Interim) indicated nursing was responsible to label and dating all items for residents prior to placing them in the nourishment refrigerator or freezer. 4. Observation and tour of 1 out of 3 nourishment refrigerators on 8/25/25 at 11:00 AM with the Dietary Director (Interim) in the nourishment room on second floor identified the following.The freezer had a 1/2 full 12-ounce water bottle not labeled or dated, 6 juice cups not labeled or dated and 5 individual ice pops not labeled or dated. The refrigerator had a half-used container of horseradish dip was not labeled but was dated as opened on 3/16/25 with an expiration date of 3/25/25. Dumpling bites expired 7/31/25, open box of sugar 16 ounces not labeled or dated. 7 cups of grape juice not labeled or dated, a kit kat chocolate bar with a manufacturer expiration date of 8/9/25, a chocolate bar 2/3's eaten not covered, labeled, or dated, 2 containers of food dated 8/14/25, a 1/2 eaten sandwich in a paper towel not labeled or dated. Further, the refrigerator contained Chinese yellow soup not labeled but dated 8/11/25, 2 containers of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	yogurt with expiration dates of 4/3/25, 1/2 pound of sliced ham use expired 8/21/25, 4- eight-ounce orange juice boxes with manufacturer expiration date of 8/9/25, 1 plastic container with a solid substance and the liquid had separated not labeled or dated, bacon horseradish dip manufacturer expiration date of 6/11/25, an open container of sliced ham not labeled but dated 8/16/25, deli sliced ham not labeled but dated 8/13/25, deli sliced ham not labeled but dated 8/18/25, 1/2 pound deli sliced cheese not labeled dated 8/12/25. The Dietary Director (Interim) discarded all the expired food items. Review of the Freezer and dry food Storage Policy identified to ensure all frozen and dry food items are stored in a safe, sanitary, and organized manner to prevent contamination, foodborne illness, and compliance with federal, state, and local regulations. Freezer storage all items must be labeled with product name, date received, date opened, and a use by or expiration date. Cover and seal all food items in freezer-safe containers or packaging. Discard any food with signs of freezer burn, torn packages, or exceeding safe storage time. Although requested a policy for labeling and dating refrigerated items and nourishment refrigerators were not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to ensure that monitoring and tracking related to a GI outbreak was documented, failed to ensure ongoing infection surveillance tracking, and for 1 of 5 residents (Resident #86) reviewed for infection control, the facility failed to administer medications according to infection control standards and facility policy, and for 1 of 2 residents (Resident #90) reviewed for indwelling catheter, the facility failed to ensure the outlet valve of a supra pubic catheter collection bag was stored in a sanitary manner. The findings include: 1. A review of the state agency reportable event portal identified the facility reported 2 outbreaks since January 2024, one of which included a gastrointestinal outbreak (GI) in January 2025 that involved a total of 10 residents. Review of the documentation, provided by the former DNS, identified initially one resident developed nausea and vomiting on 1/4/25, with 5 additional residents experiencing the same symptoms along with diarrhea on 1/7/25, and 4 additional residents on 1/10/25. Further review of the documentation identified the residents were treated with an antiemetic, placed on isolation precautions until recovered, and that the outbreak was closed by the facility on 1/24/25.During a review of the facility infection prevention program as part of the recertification survey on 8/26/25 at 8:07 AM, a request was made to RN #1 (Infection Preventionist) to provide documentation related to all outbreaks for 2024 and 2025.Review of the outbreak documentation failed to include the GI outbreak that started on 1/4/25. Subsequent to surveyor inquiry on 8/27/25 at 7:30 AM, the DNS and RN #1 provided a line list which identified a total of 10 residents involved in a GI outbreak on the 1st floor unit beginning on 1/4/25 and ending 1/12/25. Review of the line list failed to reflect that the residents were placed on precautions or that testing was done to determine the cause. Interview with the DNS on 8/27/25 at 8:00 AM identified the line list provided was from the former DNS, but it was a basic list to try to keep track of the residents. The DNS identified since the facility did not have an IP nurse during that time, the staff did the best they could to track the outbreak. The DNS identified the residents were placed on contact precautions, but she could not identify when the precautions were placed. The DNS identified she remembered that the residents were all off precautions on 1/13/25 per the direction of the former DNS. Interview with RN #1 on 8/27/25 at 8:10 AM identified she vaguely remembered the outbreak after surveyor inquiry but was not the IP nurse at that time. RN #1 identified she was unsure who documented on the line list for the outbreak as it was in a shared drive for the facility but she believed the prior DNS completed it since the facility did not have an IP nurse during that time. 2. During a review of the facility infection prevention program as part of the recertification survey on 8/26/25 at 8:07 AM, a request was made to RN #1 (Infection Preventionist) to provide documentation including infection surveillance tracking for the last 12 months (8/2024 - 8/2025).Although requested, RN #1 was unable to provide any documentation related to infection surveillance tracking.Interview with RN #1 on 8/27/25 at 8:10 AM identified that she had taken on the role of the IP nurse in February 2025 and since that time she had not completed any infection tracking for residents of the facility. RN #1 identified that other than the facility list of MDROs, she did not track any infections, antibiotics, or statistical information related to infections and antibiotic use for facility residents. RN #1 identified she was the facility wound nurse, the staff development nurse, and infection prevention (IP) nurse, and had very minimal training for all the roles, and was basically learning on the job. RN #1 identified that prior to her becoming the IP nurse, there was no IP nurse for several months so there was no tracking done for that timeframe as well. RN #1 identified that there was no staff available to help her and she was doing the best she could. Interview on 8/27/25 at 8:00 AM with the DNS identified that she had been covering as the DNS for the last five weeks and had worked as the ADNS prior to that. The DNS identified that the facility did not have an IP nurse for several months prior to RN #1 taking over the role as there were issues filling the position. The DNS identified she had taken an infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preventionist certification at one point shortly after she started working at the facility in August 2024 but never covered the infection prevention program. Interview with the Administrator on 8/28/25 at 11:10 AM identified that the facility did not have a designated IP nurse from August of 2024 until RN #1 began in the position in February 2025. The Administrator identified the facility had several issues with finding a qualified nurse to fill the role. The facility policy on surveillance for infections directed that the infection preventionist would conduct ongoing surveillance of healthcare associated infections (HAIs) and other endemically significant infections that have had substantial impacts on potential resident outcomes and that may require transmission-based precautions or other preventative interventions. The policy further directed that surveillance of infections was used to identify both individual cases and trends of epidemiologically significant organisms and HAIs to guide the appropriate interventions and to prevent further infections. The policy further directed that infections to be included with routine surveillance included those with evidence of transmissibility and healthcare environment, clinically significant morbidity or mortality associated with the infection, and pathogens associated with serious outbreaks. The policy further directed that the charge nurse would notify the attending physician and the Infection Preventionist of a suspected infection. The policy also directed that the infection preventionist was responsible for gathering and interpreting surveillance data on infections. 3. Resident #86 was admitted to the facility in July 2024 with diagnoses that included anxiety and chronic pain. The care plan dated 6/12/25 identified Resident #86 has anxiety and chronic pain, with interventions that included to administer medications as ordered. The annual MDS dated [DATE] identified Resident #86 had intact cognition. Resident #86 is on a scheduled pain and as needed pain medication regime. Review of the August 2025 monthly physician's orders directed to administer the following medications.Alprazolam (antianxiety)1mg tablet at 6:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 9:00 PM.Tramadol (pain relief) 100 mg at 6:00 AM, 2:00 PM, and 10:00 PM.Sertraline 100mg (2 tablets) daily for major depressive disorder.Fluphenazine 10mg (antipsychotic) (2 tablets) three times daily. Observation on 8/28/25 at 1:26 PM identified LPN #14 was at the medication cart. LPN #14 picked up a medication cup and dropped the cup, which contained 2 pills, onto the floor. LPN #14 was observed to pick up the cup and the 2 pills off the floor and place them back into the medication cup and onto the top of the medication cart. Without the benefit of handwashing, LPN #14 removed a blister pack from the medication cart and popped 2 tablets into the medication cup containing the pills from the floor. LPN #14 opened the narcotic lock box, removed a blister pack, and popped 2 tablets into the medication cup containing the pills from the floor. Further, LPN #14 was also noted to intermittently use the laptop computer. Without the benefit of handwashing, LPN #14 proceeded to lock the medication cart and went down the hallway to Resident #86's room. LPN #14 offered the medications to Resident #86 and as LPN #14 was handing the medication cup to Resident #86, surveyor intervened and asked LPN #14 to step out of the room. The medications were not administered at that time. Interview with LPN #14 on 8/28/25 at 1:30 PM indicated that she was not going to throw any of the pills away and was going to administer all the pills to Resident #86. LPN #14 indicated repeatedly that she was not going to discard the medications that were on the floor because Resident #86 would not want her to discard any of his/her medications.Observation on 8/28/25 at 1:32 PM identified LPN #14 re-entered Resident #86's room and attempted to administer the pills in the medication cup that included the pills that had been on the floor. As LPN #14 extended her arm with the medication cup toward Resident #86, the resident extended his/her arm to take the pills. As the resident reached to take the medication cup, LPN #14 observed this surveyor standing in the doorway and she pulled the medication cup back and exited the room. Interview with LPN #14 on 8/28/25 at 1:33 PM indicated to this surveyor, (since you want me to discard the medication I will). Interview with the DNS on 8/28/25 at 1:45 PM indicated that if a nurse drops medication on the floor, the nurse is to discard the medication and get new medication. Interview with the DNS on 8/28/25 at 2:30 PM indicated that she had spoken with LPN #14 and who indicated she was going to give Resident #86 the medications she had dropped on the floor. The DNS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated that LPN #14 should have discarded the medications immediately and obtained new medication. Review of the Infection Control for Dropped Medications Policy dated 1/19/18 identified medications that come in contact with the floor, unclean surfaces, or otherwise become contaminated are not considered appropriate for administration and must not be given to residents. The purpose is to prevent infection, cross-contamination, and ensure resident safety by establishing procedures for handling medications that are dropped on the floor or otherwise contaminated. 4. Resident #90 was admitted to the facility in January 2023 with diagnoses that included artificial openings of urinary tract status, neuromuscular dysfunction of the bladder, and urinary retention. A physician's order dated 6/1/25 directed for Resident #90's foley bag to be changed every month, special instructions: nurse must write date on the bag. The quarterly MDS dated [DATE] identified Resident #90 had severely impaired cognition, was dependent for personal and toileting hygiene, and had an indwelling catheter. The care plan dated 8/8/25 identified Resident #90 had a foley catheter related to impaired bladder functioning, urinary retention, and acute illness, with interventions that included irrigation or foley change as ordered/as needed and keep foley-bag below bladder level. The care plan identified Resident #90 required the application of Enhanced Barrier Precautions (EBP) during high contact resident care activities due to an indwelling medical device, with interventions that included gown and gloves to be worn with high contact with the affected source-urinary catheter. Observation on 8/24/25 at 7:20 AM with NA #2 identified the unsecured outlet valve to Resident #90's catheter collection bag was in contact with the floor. Interview with NA #2 on 8/24/25 at 7:20 AM identified that she had just begun her shift and had not yet rounded on Resident #90, but the external part of the catheter should not be touching the floor due to infection control, and that she would notify the nurse. Interview with LPN #4 on 8/24/25 at 7:40 AM identified that he had worked the night shift; when he last rounded on Resident #90 around 5:30 AM the drainage valve to the catheter collection bag was not touching the floor, and that the valve should not be in contact with the floor due to infection control problems. LPN #4 indicated that he would notify the nursing supervisor and ensure the collection bag was changed. Interview with LPN #2 on 8/24/25 at 10:35 AM identified that education was provided to the night shift nurse aide that no part of the catheter collection bag should be touching the ground and, and that LPN #4 had replaced the bag prior to the end of his shift. Observation of Resident #90's catheter collection bag on 8/24/25 at 10:40 AM identified a change date of 8/24/25 had been written on the bag. Interview with the interim DNS on 8/27/25 at 7:28 AM identified that the outlet valve of the catheter collection bag should not be in contact with the floor because it would be an infection control violation and that the nurse followed the procedure by changing the bag immediately. The interim DNS indicated that she would educate staff to ensure no part of a catheter collection bag should be in contact with the floor.The Urinary Catheterization policy directs a sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems, if there are breaks in aseptic technique, disconnection of tubing, or leakage from the bag the drainage system should be replaced. Urine in drainage bags should be emptied at least once every shift using a container designated for that resident only, and care must be taken to keep the outlet valve from becoming contaminated. Catheter change indications may include mechanical dysfunction or blockage of the urinary catheter system and contamination of the closed system.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on observation, review of the clinical record, facility documentation, facility policy, and interviews, the facility failed to ensure ongoing review of antibiotic stewardship including tracking and monitoring of use for residents who required antibiotic treatment for infection. The findings include:During a review of the facility infection prevention program on 8/26/25 at 8:07 AM, a request was made to RN #1 (Infection Preventionist) to provide documentation including antibiotic use including criteria, tracking and monitoring for all residents who required antibiotic treatments in the last 12 months (8/2024 - 8/2025). Although requested, RN #1 was unable to provide documentation related to antibiotic surveillance or tracking. Interview with RN #1 on 8/27/25 at 8:10 AM identified that she had taken on the role of the IP nurse in February 2025 and since that time she had not completed any infection tracking, antibiotic use, or statistical information. RN #1 identified since she began in the IP role, she had attended 2 medical staff meetings but had not prepared or provided any statistical tracking or information related to infection rates or antibiotic use. RN #1 identified was the facility wound nurse, the staff development nurse, and infection prevention nurse, and had very minimal training for all the roles, and was basically learning on the job. RN #1 identified that prior to her becoming the IP nurse, there was no IP nurse for several months so there was no tracking done for that timeframe as well. RN #1 identified that there was no staff available to help her and she was doing the best she could. Interview on 8/27/25 at 8:00 AM with the DNS identified that she had been covering as the DNS for the last five weeks and had worked as the ADNS prior to that. The DNS identified that the facility did not have an IP nurse for several months prior to RN #1 taking over the role as there were issues filling the position. The DNS identified she had taken an infection preventionist certification at one point shortly after she started working at the facility in 8/2024 but never covered the infection prevention program.Interview with the Administrator on 8/28/25 at 11:10 AM identified that the facility did not have a designated IP nurse from August of 2024 until RN #1 began in the position in February 2025. The Administrator identified the facility had several issues with finding a qualified nurse to fill the role. The facility policy on the infection prevention and control program directed that the infection prevention and control program was coordinated and overseen by an Infection preventionist. The policy also directed the IP program included antibiotic stewardship which included culture reports, sensitivity data, and antibiotic usage reviews which would be included in surveillance activities and that antibiotic usage would be evaluated and practitioners. The policy further directed that the Infection Preventionist would gather data from nursing units and categorized each infection by body site and provide a uniform basis for comparison of infection rates then monthly rates would be plotted graphically or otherwise to compare trend comparisons.The facility policy on antibiotic stewardship directed that the facility would work to ensure safe and effective use of antibiotics and would actively seek to minimize the inappropriate use of antibiotics through ongoing assessment, education, and leadership activities as part of the facility infection prevention and control program. The policy further directed the facility medical director in conjunction with the infection preventionist, DNS, and pharmacy consultant, would assume the leadership roles in antibiotic stewardship. The facility would utilize the services of clinicians with specialized expertise in antibiotic prescribing as deemed clinically necessary. The policy further directed antibiotic stewardship activities would be coordinated through the pharmacy committee and infection control committee. The policy also directed antibiotic stewardship activities would include regular review of antibiotic utilization patterns and sensitivity patterns at committee meetings, use of antibiotics over time including quarterly, yearly, and past years, distribution of educational materials to staff on improving safe and effective use of antibiotics as well as materials on prevention of overprescribing on a regular basis in conjunction and coordination with annual in service training of nursing staff and other clinicians with clinical privileges.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of the clinical record, facility documentation, facility policy, and interviews for 4 of 5 residents (Resident #15, 18, 22, and 38) reviewed for covid vaccinations, the facility failed to offer and/or provide education on covid vaccinations. The findings include: During a review of the facility infection prevention program on 8/26/25 at 8:07 AM, a request was made to RN #1 (Infection Preventionist) to provide documentation for covid vaccinations or signed refusals with education for a list of 5 sampled residents (Resident #15, 18, 22, 38, and 60) for the last 12 months (8/2024 - 8/2025). Although requested, the facility failed to provide any documentation related to covid vaccinations or declinations for Resident #15, 18, 22, and 38. Interview with RN #1 on 8/27/25 at 8:10 AM identified that she did not have any mechanism for tracking vaccinations for residents of the facility. RN #1 identified she could not locate any tracking information in the IP that was provided to her when she took the position, and the only way she knew to track vaccinations to look up each individual resident in the electronic medical record to determine if they had been vaccinated. RN #1 identified she did not track any of the consents, declinations, or vaccines for any of the facility residents and was unaware of who needed vaccinations or who had refused them. The facility policy on COVID-19 vaccinations for residents directed that upon admission and readmission to the facility, residents would be assessed for eligibility to receive the most current recommended COVID-19 vaccination, and when indicated would be offered the vaccine within 14 days of admission to the facility, unless medically contraindicated or if the resident had already received the CDC's recommended dose. The policy further directed that residents who refused COVID-19 vaccinations would be reoffered the vaccine at each care plan meeting if applicable. The policy further directed that the facility would track consents, declinations, and vaccinations of all residents.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and interviews for 1 of 5 residents (Resident #63) reviewed for dining, the facility failed to provide the resident a breakfast tray in a timely manner, resulting in the resident trying to obtain items from other resident's leftover trays. The findings include:Resident #63 was admitted to the facility in July 2025 with diagnoses that included anxiety disorder, specified depressive episodes, and orthopedic aftercare. The admission MDS dated [DATE] identified Resident #63 had intact cognition, was independent with eating, and required supervision or touch assist with ambulating 50 feet.The care plan dated 7/15/25 identified Resident #63 was at increased risk for alterations in nutritional status secondary to alcohol use, major depressive disorder, emphysema, prediabetes, hypocalcemia, and obstructive sleep apnea. Interventions included encouraging oral intake at meals and providing current diet: regular texture, thin liquids.Observation on 8/24/25 at 9:42 AM identified Resident #63 opened the door to the food truck containing dirty trays from the breakfast pass and rummaged through the breakfast trays. NA #3 told Resident #63 not to go through the old trays on the food truck and redirected him/her back to his/her room. NA #3 closed the food truck door.Observation on 8/24/24 at 9:46 AM identified Resident #63 re-entered the food truck containing dirty breakfast trays and removed a carton of milk and sugar; NA #3 told Resident #63 to return to his room and not to go through the truck. Resident #63 began yelling that his/her breakfast tray never came and he/she wanted sugar for his/her coffee.Interview with NA #3 at 8/24/25 at 9:46 AM identified that she observed Resident #63 remove milk and sugar from an old tray in the breakfast truck, and that she had told Resident #63 not to go through the old trays on the breakfast cart, but the resident didn't listen. NA #3 indicated that she had called the kitchen and notified them that Resident #63 had not received a breakfast tray yet.Interview with NA #4 on 8/24/25 at 9:47 AM identified that she had just delivered Resident #63's breakfast tray to his/her room at 9:40 AM; the kitchen had forgotten to send the residents breakfast tray.Interview with Resident #63 on 8/24/25 at 9:49 AM identified that he/she did not receive a breakfast tray and wanted a cup of coffee. Resident #63 indicated that he/she was tired of waiting, so he/she went into the dining room and poured a cup of coffee and then looked through the dirty cart to find milk and sugar on the leftover trays. Resident #63 further indicated that he/she was frustrated because when he/she did finally receive a breakfast tray it only contained one egg (2 eggs were ordered), a bagel with cream cheese, oatmeal, and grape juice. (There was no meal ticket on Resident #63's breakfast tray to confirm the order).Interview with the Administrator on 8/28/25 at 7:11 AM identified that it would be his expectation that the issue with Resident 63's food tray not being delivered in a timely manner would have been identified earlier by the nursing staff and that the kitchen would have been notified sooner. The Administrator indicated that the nurse aide that observed Resident #63 open the food truck with old breakfast trays should have asked him/her what he/she was looking for and gotten the milk and sugar the first time he/she began looking through the old breakfast trays.The Resident Rights policy directs that the facility will provide care and services in accordance with the Resident [NAME] of Rights; residents have the right to be treated with consideration, respect, and full recognition of their dignity and individuality.

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New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **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 7 residents (Resident #130) reviewed for nutrition, the facility failed to ensure the resident received double portions per his/her request to receive double portions and per the physician order. The findings include:Resident #130 was admitted to the facility in June 2014 with diagnoses that included diabetes and malignant neoplasm of breasts. A physician's order dated 6/20/24 directed for a regular diet with double portions.The dietician note dated 3/18/25 at 1:50 PM identified Resident #130 requested to see the dietitian. Resident #130 complained he/she was still hungry after meals and requested increased portions. Resident #130 already receives double portions for meals and would recommend alternate foods on the meal tray. Resident #130 was agreeable to receive an egg salad sandwich at lunch and dinner. Kitchen updated.The dietitian quarterly assessment dated [DATE] identified Resident #130 is currently on a regular diet with double portions. Resident #130 is at risk for malnutrition related to breast cancer. Resident #130's weight 6 months ago was 295 lbs. on 10/2/24 and one month ago on 3/1/25 the resident weighed 206.4 lbs. Resident #130 is currently on double portions and the dietician will continue to monitor. The dietitian quarterly assessment dated [DATE] identified Resident #130 is currently on a regular diet with double portions. Resident #130 is at risk for malnutrition related to breast cancer. Resident #130 weight was 207 lbs. on 4/2/25 and 204 lbs. on 6/4/25. Weight is stable with no significant changes. The quarterly MDS dated [DATE] identified Resident #130 had intact cognition and was independent with eating. The care plan dated 7/31/25 identified Resident #130 was at risk for alterations in nutrition due to breast cancer, with interventions that included set up for meals, offer alternates, and provide diet per physician order. Interview with Resident #130 on 8/24/25 at 7:55 AM indicated that the portions of food at every meal are small. Resident #130 indicated that he/she was not trying to lose weight. Resident #130 indicated that no one offers snacks between meals or at bedtime and if you ask you won't get anything. Resident #130 indicated that he/she is still hungry after meals but does not get anything extra. Resident #130 indicated that he/she does not receive any sandwiches in addition to his/her meals. Resident #130 indicated that he/she had informed the nursing staff, dietary person, and the administrator that he/she was still hungry after eating a meal, but nothing changed.Observation on 8/24/25 at 8:55 AM identified Resident #130's meal included one hardboiled egg and 1 dry bagel cut in half.Resident #130's breakfast meal ticket dated 8/24/25 identified Resident #130 was to receive 2 hardboiled eggs and 2 bagels with cream cheese.Interview with NA #1 on 8/24/25 at 9:30 AM indicated that she had delivered Resident #130's breakfast tray. NA #1 indicated that there was one egg and 1 bagel on the tray. NA #1 indicated that she did not read the meal ticket and did not realize Resident #130 was supposed to receive 2 of each item per the meal ticket on the tray. NA #1 indicated that she did not inform the charge nurse or call the kitchen for the additional hard-boiled egg and bagel. Interview with the Director of Dietary (Interim) on 8/24/25 at 2:00 PM indicated that Resident #130 was only supposed to receive one egg and one bagel for a regular diet. The Director of Dietary (Interim) indicated he did not know why Resident #130's meal ticket said 2 eggs and 2 bagels. The Director of Dietary (Interim) indicated Resident #130 was not on double portions because the meal ticket did not identify double portions for Resident #130.Observation on 8/25/25 at 9:00 AM identified Resident #130 had his/her breakfast tray and received 2 pancakes and corn beef hash but did not receive double portions.Resident #130's breakfast meal ticket dated 8/25/25 identified Resident #130 was on a regular diet and received 4 pancakes with syrup and 4 ounces corn beef hash.Observation on 8/26/25 at 9:05 AM identified Resident #130 received a regular tray with scrambled eggs and 1 slice of toast cut in half and did not receive double portions.Resident #130's breakfast meal ticket dated 8/26/25 identified Resident #130 was on a regular diet and was to (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receive 1 cup cream of rice, 4 ounces scrambled eggs, and 2 individual muffins.Interview with the Director of Dietary (Interim) on 8/26/25 at 9:10 AM identified Resident #130 had received a regular portion and did not receive double portions. The Director of Dietary (Interim) indicated that he would investigate why Resident #130 had not received double portions for breakfast.Observation on 8/27/25 at 9:00 AM identified the meal tray had 2 slices of French toast cut in half and a sausage patty but did not receive double portions.Resident #130's breakfast meal ticket dated 8/27/25 identified Resident #130 was on a regular diet and was to have 4 slices of French toast and two sausage patties. Observation and interview with Resident #130 on 8/27/25 at 9:20 AM indicated that he/she still is not getting enough food on his/her tray for meals. Resident #130 indicated when dietary sends him/her a sandwich they cut it in half and count it as 2 sandwiches. Resident #130 indicates that when he/she should receive 2 slices of toast the dietary staff give one slice of toast cut in half and count it as 2 slices of toast.Interview with Dietitian #2 with Dietitian #1 present on 8/28/25 at 8:12 AM identified Resident #130 was supposed to be getting double portions for over a year, but Resident #130 has not received double portions per the physician's order. Dietitian #2 indicated that Resident #130 was on double portions per his/her request. Dietitian #2 indicated for example if Resident #130 was supposed to get 2 sandwiches the kitchen would take 1 sandwich and cut it in half and count it as 2 sandwiches even though it was only one. Dietitian #2 indicated that Resident #130 also wants a salad with Italian dressing for lunch and dinner every day. Dietitian #2 indicated he had informed the Director of Dietary (Interim) on 8/27/25 via email that Resident #130 should have been receiving double portions and the new request for salads.Dietitian #1 indicated there was a note in the electronic email system on 5/7/24 from the dietitian to the Director of Dietary that Resident #130 was to receive double portions for meals. Dietitian #1 indicated in the past there were paper slips that the dietitian would fill out to give to the Director of Dietary but now it is done via emails. Observation on 8/28/25 at 8:35 AM identified Resident #130 was sitting in the dining room at a table. SW # 1 brought Resident #130 his/her breakfast tray. Resident #130 received scrambled eggs and 1 slice of toast cut in half. Resident #130's breakfast meal ticket dated 8/28/25 indicated Resident #130 was to receive 4 ounces eggs and 2 slices of toast but did not identify double portions.Interview with the Director of Dietary (Interim) on 8/28/25 at 8:37 AM indicated that Resident #130 had received a regular portion of eggs and only 1 slice of toast not 2 as the meal ticket directed. The Director of Dietary (Interim) indicated that he would get Resident #130 another slice of toast. The Director of Dietary (Interim) indicated that Resident #130 was to receive a regular diet and did not know why his/her meal ticket said 2 slices when everyone else on a regular diet only received one slice of toast. The Director of Dietary (Interim) indicated that he did not receive any changes for Resident #130's meal from the dietitian yesterday or today regarding double portions. Interview with DA #1 with the Director of Dietary (Interim) present on 8/28/25 at 8:55 AM indicated that he was responsible for making sure the meal ticket matched the meal tray for the resident's breakfast trays this morning. Review of Resident #130's breakfast meal ticket with DA #1, he indicated he did not read the meal ticket this morning. DA #1 indicated Resident #130 had received a regular portion of scrambled eggs and one slice of toast instead of the double portions. DA #1 indicates that double portions are not on Resident #130's meal ticket, but he knows that is Resident #130 request when he speaks with him/her on the unit. Additionally, DA #1 indicated the Administrator has come to the kitchen and told the dietary staff to give Resident #130 double portions. Interview with DA #2 with the Director of Dietary (Interim) present on 8/28/25 at 9:57 AM indicated that he was aware that Resident #130 wants double portion because the Administrator came into the kitchen about 3 weeks ago and had informed the dietary staff to give Resident #130 double portions moving forward. DA #2 indicated the double portions were not on the meal ticket but the Administrator told them verbally to give Resident #130 double portions for meals. Interview with the Director of Dietary (Interim) on 8/28/25 at 9:00 AM indicated that the dietary staff were to follow what was on the meal tickets and it was DA #1's responsibility to read the meal ticket to make sure the tray was accurate before placing it on the cart to go upstairs. The (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Dietary (Interim) indicated that the dietary staff nor the dietitian had informed him that Resident #130 was to receive double portions. The Director of Dietary (Interim) indicated he had reviewed the meal tracker and noted Resident #130 was to receive a regular diet not double portion. The Director of Dietary (Interim) indicated the prior director of dietary would receive the emails for changes that would need to be made to a resident meal ticket and would not update the meal tickets. The Director of Dietary (Interim) indicated he had found emails for resident preferences, aspiration precautions, double portions, and allergies that were not updated on the resident's meal tickets in the tracker system when he recently conducted an audit.Interview with the Administrator on 8/28/25 at 9:10 AM indicated Resident #130 has many times informed him that he/she was still hungry after eating a meal. The Administrator indicated he would go to the kitchen staff and the prior director of dietary and had requested Resident #130 receive double portions. The Administrator indicated the last time he had gone to the kitchen to request double portions for Resident #130 was about a month ago. The Administrator indicated that he had not informed the dietitian or nurses regarding Resident #130 requesting double portions.Review of the Resident Food Preferences Policy identified individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The dietitian or designee will identify a residents food preference. Dietitians or nursing staff will document the residents' food and potential eating preferences in the care plan. The food service department will offer a variety of foods at each scheduled meal with alternatives available, as well as snacks throughout the day and night.Review of the Resident Rights Policy dated 4/4/18 identified the resident has the right to be treated with consideration, respect and full recognition of your dignity and individuality. The residents have the right to receive quality care and services with reasonable accommodation of your individual needs and preferences.

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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** Based on review of facility documentation, facility policies, and interviews for the only sampled resident (Resident #45) reviewed for personal funds, the facility failed to provide quarterly financial statements to the resident. The findings include:Resident #45 was admitted to the facility in June 2021 with diagnoses that included major depressive disorder, moderate protein-calorie malnutrition, and chronic pain.The annual MDS dated [DATE] identified Resident #45 had intact cognition.Interview with Resident #45 on 8/24/25 at 7:58 AM identified that the facility oversees his/her personal funds and he/she had not received a written financial statement in 2025.Interview with the Business Office Manager on 8/26/25 at 9:50 AM identified that she worked at the facility twice a week but was always accessible for staff and residents via telephone. The Business Office Manager indicated that Resident #45 was responsible for self and was most recently given a quarterly statement at the end of March/beginning of April 2025, but she did not have documentation to support that the quarterly statement had been provided to the resident. The Business Office Manager indicated that her process was to put the completed quarterly financial statements in the mailboxes of the residents that were responsible for self and someone from the recreation department would deliver the statements. The Business Office Manager identified that the facility changed fund management systems recently, and that due to that change, the quarterly statements for 4/1/25 through 6/30/25 were delayed and would be going out later that day (8/26/25). The Business Office Manager further identified that residents that were responsible for self were verbally notified of the system change and the potential delay in the delivery of their quarterly statements, however, no documentation of that notification was provided. A letter dated 5/1/25 was sent to families and conservators notifying them of the change in systems.Interview with the Administrator on 8/28/25 at 7:40 AM identified that residents should be receiving quarterly financial statements and first quarter statements should have gone out by the end of April. Additionally, residents would be welcome to obtain an account balance at any time. The Administrator indicated that he was aware that there was a fund management system change, and it went live a few weeks prior, which could have affected the second quarter statements, but he was not aware that the quarterly statements were going out late. The Administrator further indicated that the best practice would have been to provide a statement to each resident before the old system started to migrate to the new system of the final accounting information, and then a statement should have been provided again when the new system was up and running. The facility's Quarterly Resident Statement policy directs that the resident and/or their resident representative will be provided with written statements of all financial transactions related to the resident's account, at least once per quarter. These statements will detail charges, payments, credits, and the current account balance. Statement generation will be prepared at least quarterly (January, April, July, and October). Distribution of statements will be delivered to the resident, if the resident can understand financial documents, or the resident's responsible party, Power of Attorney, or other legal representative as designated in the admission agreement. Statements may be distributed via mailed hard copy, hand delivery during care plan meetings or upon request, or secured electronic transmission if consent has been obtained. The policy further directs that residents and/or their representatives have the right to request clarification of charges at any time.The Resident Rights policy directs that residents have the right to have the facility manage their personal funds, if it is authorized in writing, have the right to a quarterly accounting of funds, and be provided a separate statement about how the facility manages resident funds.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 1 resident (Resident #76) reviewed for pressure ulcer, the facility failed to ensure the resident representative was notified of a new wound. The findings include:Resident #76 was admitted to the facility in July 2023 with diagnoses that included polyneuropathy, bipolar, and diabetes. The care plan dated 4/28/25 identified Resident #76 was at risk for skin impairment related to decreased mobility, with interventions that included applying zinc oxide to coccyx area, encourage resident not to sit in the wheelchair for extended periods of time, perform weekly skin checks, and notify physician or APRN of any changes. The annual MDS dated [DATE] identified Resident #76 had moderately impaired cognition, was always incontinent of bowel and bladder and required maximum assistance with toileting, dressing, personal hygiene, turning side to side in bed, and transfers. Additionally, Resident #76 had a significant weight loss not prescribed by a physician of 5% or more in the last month or 10% or more in the last 6 months. Resident #76 was at risk for developing a pressure ulcer or injury. Resident #76 had a pressure-reducing device for the bed, nutrition or hydration intervention, and application of ointment other than the feet. The nurse's note written by LPN #7 dated 7/27/25 at 11:01 PM identified Resident #76 had a reddened area noted to the coccyx, resident was added to the skin rounding report, and the supervisor was notified. The nurse's note written by LPN #6 dated 8/10/25 at 2:15 PM identified that Resident #76 upon assessment was observed with a 0.5 cm by 1.0 cm open area at the top of the coccyx. Resident #76 expressed pain to the area. The nursing supervisor was made aware. The nurse's note written by RN #2 dated 8/10/25 at 6:47 PM identified earlier this morning she was notified Resident #76 had an open area on the sacrum. The area was measured, and a dry protective dressing was applied. The APRN was notified, and Resident #76 was placed in the skin rounding report for 8/11/25. A physician's order dated 8/11/25 directed to cleanse the coccyx with normal saline, pat dry, apply triad paste to peri wound, apply silver alginate to wound bed, and cover with dry clean protective dressing daily and as needed. The nurse's note written by RN #1 dated 8/13/25 at 7:59 PM identified Resident #76 had a stage 3 sacral wound measuring 0.4 cm by 0.3 cm by 0.2 cm with 100% granulated tissue with moderate serosanguineous drainage. Treatment is silver alginate to wound bed and zinc to peri wound with dry clean dressing daily and as needed. The APRN was updated. The wound physician note dated 8/13/25 identified he was asked to see Resident #76 for a sacral wound. The wound was classified as a stage 3 pressure ulcer measuring 0.4cm by 0.3 cm by 0.2 cm with moderate serosanguinous drainage. The nurse's note written by RN #1 dated 8/20/25 at 6:11 PM identified Resident #76 had a stage 3 sacral wound measuring 0.5 cm by 0.7 cm by 0.2 cm with 100% granulated tissue with moderate serosanguineous drainage. Treatment is silver alginate to wound bed and zinc to peri wound with dry clean dressing daily and as needed. The wound physician note dated 8/27/25 identified the sacral wound had been debrided of slough tissue with a curette on 8/20/25 and 8/27/25. Post debridement measurement is 0.6 cm by 0.6 cm by 0.4 cm. Debridement will be performed weekly as needed to remove devitalized tissue, decrease risk of infection, and expose viable tissue to promote wound healing. Resident #76 is still awaiting a low air loss mattress. Interview with RN #1 on 8/29/25 at 12:10 PM indicated when a nurse aide identifies a change in the resident's skin he or she must inform the charge nurse, and the charge nurse would inform the RN supervisor. RN #1 indicated the RN supervisor must perform an RN assessment on the new pressure ulcer or skin condition. RN #1 indicated the RN must notify the physician or APRN to receive a new treatment order for the new area on the skin that day. RN #1 indicated the RN must update the resident representative. RN #1 indicated that Resident #76 on 7/27/25 had a new open area to the coccyx and the resident representative (COP) was not notified. RN #1 indicated that she learned about the wound on Monday 8/11/25 and she evaluated the wound on 8/13/25. RN #1 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated she assumed the resident representative had already been updated by the nurse either on 7/27/25 when area was first noted or on 8/10/25 when the RN assessment was done, and new treatment orders for the wound were obtained. After clinical record review, RN #1 indicated the resident representative (COP) was not updated on 7/27, 8/10, or 8/13/25 of the new ulcer he/she should have been updated.Interview with the DNS on 8/29/25 at 12:35 PM identified when Resident #76 developed an open area on the sacrum and a treatment was ordered; the charge nurse or RN supervisor was responsible to notify Resident #76' representative (COP). After clinical record review, the DNS indicated the resident representative (COP) had not been notified of the new pressure area or new treatment until 8/20/25, 11 days after its discovery. Review of the Change of Condition Policy identified it was to ensure that changes in residents' conditions are reported to the providers and families. The purpose is to ensure that all residents' change of condition is assessed and documented properly and is reported to the physician and family. All residents with the potential change of condition are identified in a timely manner. Any alteration in a resident's baseline indicates a potential change of condition. Any resident with a change of condition will receive timely and appropriate treatment. The RN will assess and determine if a change of condition has occurred. The RN will make the APRN or physician aware of a resident's current condition by in person notification or telephone call. Documentation will be noted in the residents' medical record and on the 24-hour report to ensure shift-to-shift communication. Repeated attempts will be made to reach the physician or the medical director and family until successful. The nurse will document the attempts noting the date and time. Review of the Skin and Wound Management Policy identified the nursing staff will assess and document an individual's risk factors for developing pressure ulcers. The nurse shall describe and document and report the following: a full assessment of a pressure sore including location, stage, length, width, depth, presence of exudate or necrotic tissue, a pain assessment, resident's mobility status, and current treatments including support surfaces. The physician will order pertinent treatments wound cleaning, dressings, and application of topical agents. Residents with pressure ulcers or other skin conditions will be seen and followed by the facility's wound physician.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews for the only sampled resident (Resident #45) reviewed for personal funds, the facility failed to protect the resident from misappropriate of resident funds. The findings include:Resident #45 was admitted to the facility in June 2021 with diagnoses that included major depressive disorder, paranoid personality disorder, and chronic pain.The quarterly MDS dated [DATE] identified Resident #45 had intact cognition and based on a brief interview for mental status and review of the medical record the resident had no acute change in mental status from baseline, no signs of inattention, disorganized thinking, or altered level of consciousness, had no hallucinations or delusions, and no physical, verbal, or wandering behaviors.The annual MDS dated [DATE] identified Resident #45 had intact cognition, was currently considered by the state level II PASRR process to have serious mental illness and based on a brief interview for mental status and review of the medical record he/she had no acute change in mental status from baseline, no signs of inattention, disorganized thinking, or altered level of consciousness, had no hallucinations or delusions, and no physical, verbal, or wandering behaviors.The care plan dated 6/9/25 identified Resident #45 preferred privacy and chose to remain in his/her room, with interventions that included therapeutic recreation (TR) staff providing the resident with a personal activity calendar and offering 1 to 1 visits from the activity cart. The care plan further identified Resident #45 exhibited behaviors as evidenced by pocketing medications in mouth, verbally/physically abusive, wandering, refusals of care, delusions, hallucinations, aggression, psychiatric conditions, and risk of injury to self or others. Interventions included reapproaching the resident at another time, providing the resident with the opportunity to express feelings through 1 to 1 and group visits, and using the resident's name and explaining the purpose upon approach.Interview with Resident #45 on 8/24/25 at 7:58 AM identified that the facility oversees his/her personal funds and he/she had not received a written financial statement in 2025.Interview with Resident #45 and the Director of Social Services (SW #1) on 8/26/25 at 1:25 PM identified that he/she just received his/her quarterly financial statement after not seeing his/her statements this year, and there were discrepancies identified. There were 3 withdrawals (2 withdrawals for $20 and 1 withdrawal for $10) that the resident indicated he/she did not recall authorizing. Resident #45 indicated that the last withdrawal he/she made from the account was in December 2024 or January 2025. Resident #45 further indicated that he/she notified the Business Office Manager of the discrepancies, and it was being worked on.Interview with the Business Office Manager on 8/26/25 at 2:00 PM identified that Resident #45 had notified her of the discrepancies in the quarterly financial statement and that the charges were not unauthorized by the resident. The Business Office Manager identified that she would pull the sign-out documentation for the withdrawals, as they had been filed away. The Business Office Manager indicated that residents would come to her or call her if they would like to make a withdrawal from their personal account, but she only works in the facility two days per week. In her absence residents could go to the Administrator, and the Recreation Director assisted. The Business Office Manager further indicated that she could not recall Resident #45 coming to her directly for a withdrawal from the personal funds, but that the Recreation Director sometimes assists residents with ordering food from outside the facility. Interview with the Recreation Director on 8/26/25 at 2:10 PM identified that Resident #45 preferred to stay in his/her room and chose not to participate in group activities. Resident #45 was very astute, and she would often engage the resident in different ways to ensure he/she felt part of things. The Recreation Director indicated that Resident #45 did not always like the food at the facility so there were a few times the resident asked about getting a pizza. The Recreation Director further indicated that she could not recall the last time she assisted Resident #45 with ordering a pizza or the details surrounding the pizza order, because she has a lot of residents that she deals with, but she would have gotten the money for the pizza from the Business (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Office Manager and could not recall who signed for the withdrawal.Review of the Resident Petty Cash document dated 4/18/25 with the Recreation Director on 8/27/25 at 9:25 AM identified that $10 was withdrawn from Resident #45's account for a bake sale.Review of the Resident Reimbursements document dated 5/2/25 with the Recreation Director on 8/27/25 at 9:25 AM identified that $20 was withdrawn from Resident #45's account.Review of the Resident Reimbursements document dated 5/5/25 with the Recreation Director on 8/27/25 at 9:25 AM identified that $20 was withdrawn from Resident #45's account.Interview with the Recreation Director on 8/27/25 at 9:25 AM identified that the withdrawal on 4/18/25 from Resident #45's personal account was for bake-sale items and that the withdrawals on 5/2/25 and 5/5/25 were for a pizza for Resident #45. Interview with Resident #45 on 8/27/25 at 9:35 AM identified that the Recreation Director worked very hard to please everyone at the facility and often times used her own money to treat the residents. Resident #45 indicated that he/she was under the impression that any baked good items that he/she had received were covered by the house or purchased with the Recreation Director's personal money, which was causing confusion because he/she was not aware that money had been withdrawn from his/her personal account for baked goods. Resident #45 identified that he/she did not know how to best answer this writer's questions but to read between the lines. Resident #45 received a piece of paper, yesterday, indicating that he/she had withdrawn $20 from his/her personal account on 5/2/25 and 5/5/25, but he/she had never authorized those withdrawals nor was he/she aware of those withdrawals. Resident #45 indicated he/she had authorized only 1 withdrawal, at the end of December 2024 or beginning of January 2025, which was sent directly to a family member. Resident #45 identified that he/she had ordered pizza twice; the first time he/she paid $20 for pizza and the second time he/she paid $22 for pizza using money from his/her own bank account at which point Resident #45 held up a small plastic bag containing cash that he/she kept on his/her person.The Administrator was notified on 8/27/25 at 9:47 AM of Resident #45's allegation of misappropriation and a facility investigation was initiated.Interview with the Administrator on 8/29/25 at 9:00 AM identified that he completed the investigation and was unable to substantiate the allegation of misappropriation as it was not willful misappropriation. The Administrator indicated the Recreation Director was not clear in her communication to Resident #45 that when pizza and bake sale items were purchased, the items were not provided by the facility and that money was going to be taken out of the resident's account. Interview with the Recreation Director on 8/29/25 at 9:15 AM identified that she prides herself on being honest, and that she tried very hard to create meaningful connections with all the residents at the facility, in unique ways. The Recreation Director indicated that she could not recall the conversation she had with Resident #45 regarding the purchase of bake sale items, but that she always tried to include the resident and would always try to ensure the resident felt included in activities and often times paid for resident items with her own money. The Recreation Director identified that on the day's pizza was purchased for Resident #45, NA #19 had approached her that Resident #45 wanted pizza. The Recreation Director indicated that NA #19 and the resident made a deal that if he/she would allow NA #19 to give him/her a shower and a shave they would buy pizza. The Recreation Director indicated that she then went to the Business Office Manager to get money for the pizza. The Recreation Director indicated she did not ask Resident #45 if he/she was aware that the money would be coming from his/her personal account; she was happy that he was included and participating in something. The Recreation Director further indicated that once she got the money from the Business Office Manager, she gave it to NA #19 to pay for the pizza upon delivery. The Recreation Director indicated she placed the order, herself, before leaving for the day to ensure it would be delivered for supper.Interview with Resident #45 on 8/29/25 at 9:30 AM identified that he/she still had some confusion about the bake-sale withdrawal because the details were a little foggy. Resident #45 further identified that a few months back he/she was talking about pizza with NA #19, and she told him/her that she would order it if he/she would like pizza for dinner. Resident #45 indicated that the pizza was not offered as an incentive for getting bathed or a shave and that he/she (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paid for the pizza with cash from the bag he/she kept with him/her. Resident #45 further indicated that he/she had only ordered pizza twice. The first time he/she gave $20 to NA #19 and the second time he/she gave $22 to NA #19. Resident #45 indicated that it was only two times he/she ordered pizza at the facility, this year, and both times he/she gave NA #19 cash, and neither time was it disclosed to him/her that money would be withdrawn from his/her facility account, and both times he/she gave cash directly to NA #19.Interview with the Business Office Manager on 8/29/25 at 9:51 AM identified that she was not aware that NA #19 had taken cash from Resident #45, nor did she provide Resident #45 with a receipt for the 5/2/25 and 5/5/25 withdrawals. The Business Office Manager indicated that subsequent to this incident she had already begun developing new procedures for cash withdrawals that included witnessed signatures and better documentation. The Business Office Manager further indicated that the facility would reimburse Resident #45 for withdrawals dated 4/18/25, 5/2/25, and 5/5/25.Interview with the Administrator on 8/29/25 at 10:05 AM identified that during his investigation of the alleged misappropriation it had not been disclosed to him that Resident #45 had given NA #19 cash for the pizza orders on 5/2/25 and 5/5/25. The Administrator indicated that a new investigation would be initiated. Review of the Daily Staffing Breakdown dated 5/2/25 identified NA #19 worked on Resident #45's unit from 3:00 PM - 11:00 PM.Review of the Daily Staffing Breakdown dated 5/5/25 identified NA #19 worked on Resident #45's unit from 3:00 PM - 11:00 PM.Although attempted, an interview with NA #19 was not obtained.The facility's Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property, and Retaliation policy directs that residents are free from abuse, mistreatment, neglect exploitation, misappropriation of property, and retaliation. Misappropriation of resident property means intentional misplacement, exploitation or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent.The facility's Quarterly Resident Statement policy directs that residents and/or their representatives have the right to request clarification of charges at any time.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #59) reviewed for abuse, the facility failed to report an allegation of staff to resident verbal abuse to the state agency per established timeframes. The findings include:Resident #59 was admitted to the facility in 12/2023 with diagnoses that included allergies, unspecified asthma and diabetes mellitus.The quarterly MDS dated [DATE] identified Resident #59 was cognitively intact, independent with eating and independently mobile with the use of a wheelchair.The care plan dated 3/10/25 identified Resident #59 had the potential for alteration in nutrition with interventions that included accommodating resident's food preferences, observe allergies to pork, lactose intolerance and avoid serving pork, dairy, eggs, tomatoes and breaded foods.Interview with Resident #59 on 8/24/25 at 9:02 AM identified that [NAME] #2 had threatened him/her by saying (I am going to get you) after the resident had reported to the Administration repeated issues with receiving the wrong food items. The concern had been reported to the Administrator and Ombudsman without any follow-up.Interview with the Administrator on 8/25/25 at 7:15 AM identified there were past performance concerns related to food not being prepared according to preference denied that Resident #59 reported that [NAME] #2 had threatened him/her.Subsequent interview with Resident #59 on 8/25/25 at 8:40 AM identified the resident was in a meeting 6/24/25 at 1:07 PM which included the Administrator and the Ombudsman. Resident #59 raised concerns about receiving incorrect food items and reported during the meeting that [NAME] #2 had said to him/her (I am going to get you). Resident #59 further identified the Administrator said he would look into the issue but never got back to him/her.Subsequent interview with the Administrator on 8/25/25 at 10:30 AM identified that he could not recall Resident #59 reporting that [NAME] #2 had threatened him/her. The Administrator further identified any allegation of mistreatment or abuse should be reported immediately to the state agency.A review of the facility policy for Resident Abuse directed all residents are to be free from abuse, including verbally defined as any oral, written or gestured language used as a threat to harm. All allegations of abuse are to be reported to the Department of Public health within two hours of the allegation.

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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 3 residents (Resident #59) reviewed for abuse, the facility failed to remove an employee and initiate an investigation following a reported allegation of verbal abuse. The findings include:Resident #59 was admitted to the facility in 12/2023 with diagnoses that included allergies, unspecified asthma and diabetes mellitus.The quarterly MDS dated [DATE] identified Resident #59 was cognitively intact, independent with eating and independently mobile with the use of a wheelchair.The care plan dated 3/10/25 identified Resident #59 had the potential for alteration in nutrition with interventions accommodating resident's food preferences, observe allergies to pork, lactose intolerance and avoid serving pork, dairy, eggs, tomatoes and breaded foods.Interview with Resident #59 on 8/24/25 at 9:02 AM identified that [NAME] #2 had threatened him/her that I am going to get you after the resident had reported to the administration repeated issues with receiving the wrong food items. The concern had been reported to the Administrator and Ombudsman without any follow up.Interview with the Administrator on 8/25/25 at 7:15 AM identified there were past performance concerns related to food not being prepared according to preference but denied Resident #59 reported that [NAME] #2 had threatened him/her.Subsequent interview with Resident #59 on 8/25/25 at 8:40 AM identified the resident was in a meeting 6/24/25 at 1:07 PM which included the Administrator and the Ombudsman. Resident #59 raised concerns about receiving incorrect food items and reported during the meeting that [NAME] #2 had said to him/her (I am going to get you). Resident #59 further identified the Administrator said he would look into the issue but never got back to him/her.Subsequent interview with the Administrator on 8/25/25 at 10:30 AM identified that he could not recall Resident #59 reporting that [NAME] #2 had threatened him/her. The Administrator further identified any allegation of mistreatment or abuse should be reported immediately to the state agency.Review of the facility policy for Resident Abuse identified directed all residents are to be free from abuse including verbally defined as any oral, written or gestured language used as a threat to harm. An investigation will be immediately conducted following any allegation of abuse with any staff member named in the allegation be removed pending completion of the investigation.Attempts to interview Ombudsman #1 were unsuccessful.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 2 residents (Resident #4 and 17) reviewed for dementia and respiratory care, for Resident #4, the facility failed to develop and implement a comprehensive individualized care plan when the resident was newly diagnoses with dementia, and for Resident #17 the facility failed to develop and implement a comprehensive person-centered care plan for a resident with a tracheostomy. The findings include: 1. Resident #4 was admitted to the facility in April 2018 (readmission in July 2025) with diagnoses that included schizoaffective disorder and anxiety. The quarterly MDS dated [DATE] identified Resident #4 had moderately impaired cognition. Resident #4 did not have an identified diagnosis of dementia on the MDS. A Census form identified Resident #4 was admitted to the hospital on [DATE] and returned to the facility on 7/27/25. The hospital Discharge summary dated [DATE] identified the discharge diagnosis was urinary tract infection treated with antibiotics, agitation with diagnosis of schizoaffective disorder, anxiety, and dementia. Resident #4 diagnosis list identified the diagnosis of dementia was added to the EMR on 7/29/25. The APRN note dated 8/3/25 at 10:11 PM identified Resident #4 as recently hospitalized for behavioral disturbances and agitation. Resident #4 was treated with antibiotics for a urinary tract infection, and medications were adjusted by psychiatry. The assessment and plan of care for the diagnosis of schizoaffective disorder was to continue medications from the hospital. Additionally, Resident #4 has a diagnosis of dementia, unspecified severity with agitation. Resident #4's cognitive status is at baseline per hospital discharge summary and continue with current medication regimen and supportive care. The quarterly MDS dated [DATE] identified Resident #4 had moderately impaired cognition. Resident #4 has an active diagnosis of dementia. Review of the care plan dated 8/+3.002598/25 failed to reflect a diagnosis of dementia or interventions to address such.Interview with the DNS on 8/29/25 at 10:52 AM indicated that everyone in nursing and the interdisciplinary team were responsible for updating the care plans, but indicated she does not know exactly who was responsible for updating the care plan when a resident receives a new diagnosis of dementia. After reviewing the clinical record, the DNS indicated that there is nothing in the care plan regarding Resident #4 having dementia or interventions to address the diagnoses of dementia. The DNS indicated the nurses and the MDS coordinator were responsible for updating the care plan when Resident #4 was readmitted . The DNS indicated there was no one person responsible, it was the teams responsibility. The DNS indicated the comprehensive care plan is to provide care based on the resident's individual needs and diagnosis. The DNS indicated that the care plan is a guideline for the IDT to meet the needs of the resident's based on diagnosis and a communication tool to provide resident centered care. The DNS indicated she does not know why Resident #4's care plan was not updated with the diagnosis of dementia by nursing or the MDS coordinator RN #4. Interview with RN #4 (MDS Coordinator) on 8/29/25 at 11:02 AM indicated that she did not know who was responsible to make sure the care plans were updated and accurate for a resident after readmission. RN #4 indicated she had started as the MDS coordinator in March 2025, and this position was all new for her. RN #4 indicated that the charge nurses were responsible to update the care plan when a resident receives a new diagnosis and the care needed for that resident. RN #4 indicated her responsibility was to update the care plan when the MDS's (in section V) triggers for a specific care plan. RN #4 indicated she will check only those areas that triggered to make sure they are in place. RN #4 indicated that there are templets for all care plans in her computer, and she will add a specific care plan and individualize it for a resident when needed. After clinical record review, RN #4 indicated that Resident #4 had received the diagnosis of dementia with the last hospitalization. RN #4 reviewed the care plan and identified Resident #4 does not have a care plan for dementia, and she could not find the word dementia within the current care plan. RN #4 indicated she does not know when Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#4's MDS after hospitalization was due. RN #4 indicated Resident #4 was scheduled for a care conference on 8/21/25 but she had postponed it because she couldn't be present and represent nursing. RN #4 indicated during the care conferences she would have reviewed and updated the care plan. RN #4 indicated there were 2 specific care plans for residents with dementia and provided copies of blank templets. RN #4 indicate that there was not a baseline care plan completed for Resident #4's readmission that included the diagnosis of dementia. RN #4 indicated there was not a baseline care plan or updates from readmission on [DATE] in the current care plan dated 8/8/25. RN #4 could not identify when a baseline care plan or a comprehensive care plan should be completed on readmission.Interview with the DNS on 8/29/25 at 11:23 AM indicated after discussion with the corporate nurse; when residents are readmitted , the nurses are responsible to update the care plan within 24 hours. Updates should include any new diagnosis or any changes as the part of the baseline care plan on the resident's prior comprehensive care plan adding the new dates and information. The DNS indicated that she did not know how many days until the comprehensive care plan must be completed after readmission.Interview with RN #4 on 8/29/25 at 11:25 AM indicated that she had asked the corporate nurse and was informed that it should have been done within 14 days of re-admission for the comprehensive care plan. RN #4 indicated she is only one person, she did not get to it yet, and she was doing the best that she could. Review of the Comprehensive Care-Planning policy identified nurses are responsible to develop a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. The care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment. After completing the admission assessment, nursing will use the information available to develop the initial care plan using the 48-hour template in the electronic medical record. The comprehensive care plan will include measurable objective timeframes, describing the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be developed no later than 21 days after admission. The IDT team must update the care plans when the resident has been readmitted to the facility from the hospital and at least quarterly in conjunction with the quarterly MDS assessment. Additionally, ensure matching active diagnosis with care plan problems. 2. Resident #17 was admitted to the facility in October 2023 with diagnoses that included acute and chronic respiratory failure with hypercapnia, malignant neoplasm of the supraglottic and anterior surface of the epiglottis, and chronic obstructive pulmonary disease.The quarterly MDS dated [DATE] identified Resident #17 had intact cognition, was independent with oral hygiene, required supervision or touching assistance with personal hygiene, and had special treatments, procedures, and programs while a resident at the facility and within the last 14-days that included: oxygen therapy, suctioning, and tracheostomy care. The care plan dated 7/10/25 failed to identify Resident #17 that the facility had developed intervention, measurable objectives and timetables for the resident's tracheostomy. Review of the clinical record with the 7:00 AM - 3:00 PM Nursing Supervisor (RN #3) on 8/29/25 at 7:23 AM identified Resident #17 had orders to monitor the tracheostomy site and inner cannula every shift. Interview with RN #3 on 8/29/25 at 7:30 AM identified that she was unsure if Resident #17's tracheostomy had an inner cannula or exactly what type of daily care was required for the tracheostomy, as she was still learning. Review of the clinical record with the interim DNS on 8/29/25 at 8:10 AM identified a comprehensive care plan for Resident #17's tracheostomy had not been developed. Interview with the interim DNS on 8/29/25 at 7:50 AM identified that Resident #17 had just a stoma prior to the July 2025 hospitalization, and returned to the facility with a cuffed, Shiley tracheostomy 6.0. The DNS indicated that the hospital discharge instructions did not include care instructions for the tracheostomy. The DNS indicated she would have expected tracheostomy care orders to have been in place and a comprehensive care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to have been developed for Resident #17's tracheostomy when the resident returned from the hospital. The interim DNS further indicated that the interdisciplinary team participates in the development and revision of the care plan, and that anyone from nursing or the MDS coordinator could have initiated a tracheostomy care plan. After surveyor inquiry, the DNS identified that she would initiate a tracheostomy care plan for Resident #17. The facility's Comprehensive Care Planning policy directs that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan will: include measurable objectives and time frames, describe the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being, include the resident's stated goals upon admission and desired outcomes, incorporate identified problem areas, incorporate risk factors associated with the identified problems, reflect the residents expressed wishes regarding care and treatment goals, identify the professional services that are responsible for each element of care, aid in preventing or reducing decline in the residence functional status and/or functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitative program, and reflect currently recognized standards of practice for problem areas and conditions.

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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** Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 2 of 4 residents (Resident #51 and #105) reviewed for smoking, the facility failed to review and revise the care plan to ensure interventions that addressed the residents history of unsupervised smoking, contraband items, and smoking practices while directly adjacent to the facility property while on LOA to maintain the residents safety, and for 1 of 7 residents (Resident #128) reviewed for nutrition, the facility failed to revise the care plan for an air mattress. The findings include: 1. Resident #51 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, alcohol dependence, and nicotine dependence.A physician's order dated 3/8/23 directed Resident #51 may smoke with supervision.The care plan dated 5/19/25 identified Resident #51 as a smoker. Interventions directed to ensure that the resident abides by the facility smoking policy. The annual MDS dated [DATE] identified Resident #51 had severely impaired cognition, was occasionally incontinent of bowel and bladder and required substantial assistance with bathing, partial assistance with dressing, and supervision with toileting. The MDS also identified Resident #51 as a current tobacco user and required the use of a manual wheelchair.Review of the clinical record identified Resident #51 was hospitalized from [DATE] - 8/20/25 following a fall from the wheelchair while on leave of absence from the facility. Further review of the clinical record identified Resident #51 tested positive for ethanol, and cannabinoids following admission to the hospital. Review of the clinical record failed to identify documentation of smoking assessments for Resident #51 following readmission to the facility on 8/20/25. Further review of the clinical record failed to identify any documentation of smoking assessments for Resident #51 for 2025. Observation on 8/25/25 at 10:35 AM identified Resident #51 in the wheelchair on the street located in front of the facility. Resident #51 was observed self-propelling backwards while attempting to go uphill on the street. Resident #51 stopped near the top of the hill, lit a cigarette with a lighter, and began smoking. Interview with Resident #51 immediately following this observation identified the resident goes out to the street daily to smoke. Resident #51 identified he/she also keep all smoking materials, including cigarettes and a lighter, on his/her person. Interview with the Administrator on 8/25/25 at 10:45 AM identified Resident #51 along with several other residents, sign themselves out on a leave of absence multiple times a day to smoke in the street in front of the facility or at the park located across the street. The Administrator also identified he was not aware of any residents smoking on the facility grounds and the reason the residents were in the street was because the street was not part of the facility. The Administrator also identified that since the residents had independent leave of absence privileges, they were able to go where they wanted once they left the facility. The Administrator identified that the residents that went outside to smoke typically would obtain the cigarettes from the smoking cart, but he was unsure where the lighters came from and identified that the residents were not searched or asked about lighters. The Administrator identified that the facility staff, including himself, had educated the residents multiple times that it was not safe to be in the street due to traffic, however, the residents continued to smoke in the street. The Administrator identified that any education provided to the residents' regarding smoking or staying out of the street was verbal, and there was documentation of those discussions including education, in the residents' clinical record. Review of Resident #51's clinical record failed to identify a care plan related to smoking in unsafe areas (the street) adjacent to the facility while on leave of absence. 2. Resident #105 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, opioid dependence, and peripheral vascular disease.A quarterly smoking assessment dated [DATE] identified Resident #105 did not have a history of unsafe smoking habits and was able to safely smoke on an independent leave of absence from the facility. The quarterly MDS dated [DATE] (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified Resident #105 had severely impaired cognition, was always continent of bowel and bladder and was independent with bathing, toileting, and transfers. The MDS also identified Resident #105 required a manual wheelchair.The care plan dated 6/12/25 identified Resident #105 as a smoker. Interventions included to ensure the resident abides by the facility smoking policy. The care plan also identified Resident #105 was approved for independent leave of absence from the facility. Interventions included educating the resident on contraband and other policies. Review of the clinical record failed to identify any physician's order related to Resident #105 and supervised smoking. Observation on 8/25/25 at 10:04 AM identified Resident #105 knocking at the locked door of the facility smoking area. NA #6 was observed to open the door, ask Resident #105 how many, and provided the resident with 3 cigarettes from the smoking cart. Resident #105 was then observed entering the facility elevator. At 10:06 AM, Resident #105 was observed exiting the elevator, and then returned to the elevator at 10:07 AM.Interview with NA #6 on 8/25/25 at 10:10 AM identified that several residents of the facility would often sign out on independent leave of absence and obtain cigarettes from the staff member who was monitoring the smoking cart and smoking area. The residents' would then go outside to the facility parking lot, the street in front of the facility, or if mobile enough, across the street from the facility to a city park. NA #6 identified that while the facility provided multiple smoking times, the residents wanted to smoke more often. NA #6 identified that the Administrator was aware of the issue, but she was not aware of any interventions put into place to educate the residents regarding not smoking in the parking lot or in the street. NA #6 identified that she was not aware how the cigarettes were being lit, as she only dispensed cigarettes and the facility did not keep individual lighters in the cart for residents. Observation on 8/25/25 at 10:22 AM identified Resident #105 was in the wheelchair on the street directly in front of the facility. Resident #105 was not observed smoking. Interview with the Administrator on 8/25/25 at 10:45 AM identified Resident #105, along with several other residents, sign themselves out on a leave of absence multiple times a day to smoke in the street in front of the facility or at the park located across the street. The Administrator also identified he was not aware of any residents smoking on the facility grounds and the reason the residents were in the street was because the street was not part of the facility. The Administrator also identified that since the residents had independent leave of absence privileges, they were able to go where they wanted once they left the facility. The Administrator identified that the residents that went outside to smoke typically would obtain the cigarettes from the smoking cart, but he was unsure where the lighters came from and identified that the residents were not searched or asked about lighters. The Administrator identified that the facility staff, including himself, had educated the residents multiple times that it was not safe to be in the street due to traffic, however, the residents continued to smoke in the street. The Administrator identified that any education provided to the residents' regarding smoking or staying out of the street was verbal, and there was documentation of those discussions including education, in the residents' clinical record. Review of the clinical record and facility documentation failed to identify any documentation for Resident #105 related to education regarding safe smoking while on leave of absence or regarding contraband items in the facility. Review of a statement dated 8/25/25 at 11:00 AM by RN #4 (MDS Coordinator) identified she and the Administrator requested to do a room search for smoking materials and Resident #105 consented. The statement identified Resident #105's room was not found to have any contraband items, and Resident #105 denied having any items. RN #4 further identified that she stressed safety concerns with the resident regarding smoking materials in the building and that Resident #105 was able to demonstrate understand by repeating the rules and safety concerns. The documents also included room search form dated 8/25/25 at 12:10 PM which identified that Resident #105's room was search and no contraband items were found. Review of the clinical record failed to identify any documentation by RN #4 related to Resident #105 regarding safety concerns with smoking, the room search completed on 8/25/25 related to suspected smoking materials, or any education provided to Resident #105. Observation by the survey team on 8/25/25 at (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:28 PM identified Resident #105 actively smoking in the parking lot of the facility, next to the entrance door bridge and the Administrator was immediately notified.A reportable event form dated 8/25/25 at 3:30 PM identified Resident #105 was seen with a lighter in the facility parking lot and that earlier in the day he/she did not have a lighter in his/her possession. The form identified that Resident #105 initially identified someone had given him/her the lighter in the parking lot and then identified he/she had kept the lighter hidden in his/her underwear. The form further identified that Resident #105 would no longer be given cigarettes when leaving the facility on leave of absence and agreed to noninvasive room and body searches. The form also identified that Resident #105 identified he/she no longer wanted to go on leave of absence from the facility. Review of the form failed to identify any documentation that Resident #105 was observed actively smoking in the parking lot.Review of Resident #105's care plan dated 8/25/25 identified Resident #105 was non-compliant with the prohibited items policy of the facility. Interventions included to observe and assess the cause of non-compliance.Further review of the clinical record failed to identify any smoking assessments or revisions to Resident #105's care plan related to smoking in an undesignated area of the facility, not providing cigarettes to Resident #105 while on leave of absence, Resident #105's consent to noninvasive searches following return from leave of absence, or Resident #105's wish to no longer go on leaves of absence.A facility leave of absence notification form dated 8/26/25 identified Resident #105 went on leave on absence from the facility at 9:50 AM and returned at 11:30 AM. Review of the form failed to identify that Resident #105 had any noninvasive search initiated or completed.A facility leave of absence notification form dated 8/26/25 identified Resident #105 went on leave on absence from the facility at 7:10 PM and returned at 8:00 PM. Review of the form failed to identify that Resident #105 had any noninvasive search initiated or completed.A facility leave of absence notification form dated 8/27/25 identified Resident #105 went on leave on absence from the facility. The form failed to identify what time Resident #105 left. The form identified Resident #105 returned at 12:00 PM and the facility completed a noninvasive search for contraband.Interview with the DNS on 8/29/25 at 11:00 AM identified that Resident #51 and Resident #105 should have had care plan revisions following the identified issues related to smoking, contraband items, and unsafe leave of absence in the street in front of the facility. The DNS identified that it was the responsibility of the nursing staff to update the care plans as needed. The facility smoking policy directed that the policy was in effect to ensure the safety of all residents, staff, and the facility environment. The policy directed that the smoking agreement would be reviewed with residents who actively smoke and that agreement signatures would be obtained. The policy also directed residents would have smoking evaluations completed upon admission, readmission, quarterly, with a significant change of condition, and when a violation of the smoking policy occurred. The policy also directed that individualized smoking care plans would be developed for each resident and that residents may only smoke in the designated area under the direct supervision of a staff member. The policy further directed that residents were not allowed to possess smoking materials.The facility policy on comprehensive care planning directed it was the policy for nursing to develop a comprehensive person-centered care plan that included measurable objectives and timetables to meet the residents physical, psychosocial, and functional needs to develop and implement for each resident. The policy also directed that a comprehensive person-centered care plan would include measurable objectives and time frames, incorporate identified problem areas, incorporate identified risk factors associated with problems, reflect the resident expressed wishes regarding care and treatment goals, and aid in preventing or reducing decline in the residence functional status or functional level. The policy also directed the areas of concern would be identified during the resident assessment and would be evaluated before interventions were added to the care plan. The policy further directed that care plan interventions would be chosen after careful consideration between the relationship between the residence problem area and cause and relevant clinical decision making, and when possible, interventions would address the underlying source of the problem areas not just address symptoms or triggers. 3. Resident #128 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was readmitted to the facility in October 2023 with diagnoses that included stroke affecting the dominant right side, dysphasia, and aphasia. A physician's order dated 3/4/25 directed to set the air mattress at 150 lbs. and check the setting every shift. The care plan dated 4/17/25 identified Resident #128 was at risk for a pressure ulcer related to decreased independence and frequent incontinence of bowel and bladder, with interventions that included the use of absorbent briefs and for staff to report any signs of skin breakdown. The Braden Scale for Predicting Pressure Ulcers Risk dated 5/16/25 identified Resident #128 was at high risk for skin breakdown. The quarterly MDS dated [DATE] identified Resident #128 had severely impaired cognition, was at risk for developing a pressure ulcer or injury and had a pressure reducing device for the bed. Interview with the DNS on 8/26/25 at 7:49 AM indicated RN #1 was responsible for the residents who had wounds and also for updating the care plan if a resident has an air mattress. The DNS indicated her expectation was that the air mattress must be added to the care plan when it is applied to the bed. The DNS indicated Resident #128 received the air mattress because he/she had an area on the coccyx or buttocks and was dependent on staff for repositioning. The DNS indicated the MDS Coordinator was responsible to update the care plan quarterly to make sure everything from quarter to quarter reflected the care for the resident. After reviewing the clinical record, the DNS indicated that Resident #128's comprehensive care plan was not updated to include the air mattress that was applied in March 2025. Interview with RN #1 (wound nurse) on 8/26/25 at 7:49 AM indicated that she was responsible for wounds and she and the interdisciplinary team were responsible for determining if a resident needed an air mattress. RN #1 indicated that Resident #128 is currently at risk for developing pressure ulcers, has an air mattress because he/she had a pressure ulcer that has healed in the last month and is at risk for it to reopen. RN #1 indicated Resident #128 is at risk for skin breakdown due to being in bed most of the time and because the resident can't independently offload him/herself for pressure, has an inability to move, is incontinent, has contractures and stiffness and a recent significant weight loss. RN #1 indicated that she was responsible to update the care plan when the air mattress was added but she did not do it. RN #1 indicated it was not done because she had just started this position and at that time she did not know she was responsible for doing the care plans.Interview with RN #4 (MDS Coordinator) on 8/29/25 at 11:02 AM indicated that she did not know who was responsible to make sure that care plans were updated and accurate. RN #4 indicated that she started in March 2025, and this was her first job doing MDS's and care plans, and she was trying to teach herself. RN #1 indicated that she thinks the nurses were responsible for adding a new air mattresses to the care plan but was not sure. RN #1 indicated that when she does the quarterly MDS, the areas that trigger for a care plan are what she reviews and updates, not the entire care plan. Review of the Comprehensive Care Plan Policy identified for nursing to develop a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident physical, psychosocial and functional needs is developed and implemented for each resident. Comprehensive care plans will incorporate identified problem areas and risk factors associated with identified problems. Comprehensive care plans aid in preventing or reducing decline in the resident's functional status and areas of concern that are identified during the resident's assessment. Assessments of residents are ongoing, and care plans are revised as information about the resident's and the resident's condition change. The interdisciplinary team must review and update the care plan at least quarterly, in conjunction with the required quarterly MDS assessment.

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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** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #14) reviewed for medication administration, the facility failed to administer medication according to professional standards. The findings include: Resident #14 was admitted to the facility in May 2021 and was readmitted in July 2025 with diagnoses that included dysphasia, acid reflux, atrial fibrillation, and hypertension. The care plan dated 5/1/25 identified Resident #14 had alteration in cardiac status related to diagnosis of hypertension and cardiac arrythmia with interventions that included administer medications as directed by the physician. The annual MDS dated [DATE] identified Resident #14 had severely impaired cognition and was totally dependent on staff for ADLs. A physician's order dated 6/24/25 directed to administer the following medications.Iron sulfate (iron supplement) enteric coated 325 mg 1 tablet daily.Pantoprazole, (delayed release, enteric coated)(acid reflux) 40 mg 1 tablet twice a day.Metoprolol 24-hour extended release (slows the heart rate) 100 mg tablet once a day.Seroquel 25 mg (antipsychotic) 1 tablet three times a day.Senna-s 8.6 mg (laxative) 2 tablets twice a day.Nesina 25 mg (diabetes) 1 tablet once a day.Tylenol 325 mg 3 tablets three times a day.Trazodone 50 mg 1 tablet three times a day.Eliquis 2.5 mg (blood thinner) 1 tablet twice a day. Medication observation on 8/25/25 at 8:30 AM identified LPN #2 prepared the 9 medications into 1 medication cup. LPN #2 poured the medications inside a clear pouch, crushed all the medications with a pill crusher and poured the crushed medications into a medication cup with applesauce. LPN #2 entered Resident #14's room and administered the first spoonful of medication to Resident #14 who proceeded to pick out small pieces of medication from his/her mouth and place it on the bed sheet. LPN #2 administered the remaining spoonful of medication and Resident #14 continued to spit out small pieces. LPN #2 exited the room, hand sanitized and moved to the next resident's room. Interview with LPN #2 on 8/25/25 at 8:35 AM indicated that she always crushes Resident #14's medications because Resident #14 has dysphasia. LPN #2 indicated when she went through general orientation upon hire, she was instructed that any resident with a diagnosis of dysphagia must have their medications crushed. Interview with the DNS on 8/25/25 at 10:00 AM indicated the nurses should know when to and when not to crush medications. The DNS indicated if a medication is extended release, delayed release or enteric coated it is not to be crushed. The DNS indicated that if LPN #2 had crushed the Iron sulfate enteric coated, Pantoprazole, (delayed release, enteric coated), and Metoprolol extended release that would be a medication error. Interview with Pharmacist #2 on 8/25/25 at 3:00 PM indicated any medication that is extended release, delayed release, or enteric coated should not be crushed. Pharmacist #2 indicated that enteric coated iron should not be crushed. Pharmacist #2 indicted Resident #14 receives pantoprazole delayed release for acid reflux and that medications should not be crushed. Pharmacist #2 indicated that delayed release Pantoprazole slowly distributes the medication over a period of time, so if it was crushed it would not last all day or until the next dose, and the resident could become symptomatic for acid reflux. Pharmacist #2 indicated the manufacturer recommends not crushing that medication. Pharmacist #2 indicated Resident #14 was on Metoprolol extended release, meaning it is long acting and should not be crushed. Pharmacist #2 indicated if the Metoprolol was crushed, it would not last for 24 hours and the resident could have increased heart rate or increased blood pressure when the medication stops working before the 24 hours.Interview with LPN #2 on 8/26/25 at 1:30 PM indicated that she was aware that she could not crush medications that were enteric coated, extended release, or delayed release. LPN #2 indicated that she thought it was okay to crush them because, upon hire, she was instructed to crush all medications for any resident that had a diagnosis of dysphasia. LPN #2 indicated she did not think at that time it was an error until informed by the DNS. Interview with APRN #1 on 8/27/25 at 2:05 PM indicated that her expectation was that the nurses would follow the physician's orders and should know which medications can be (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crushed or not. APRN #1 indicated that it was [NAME] to her attention on 8/26/25 a day after the error, and her expectation was that she should have been notified when the error occurred. APRN #1 indicated that she will look at the medications today and make changes if necessary. APRN #1 indicated that the enteric coated iron, Pantoprazole delayed release, and Metoprolol extended release should not be crushed because then they will not stay in the system for extended amounts of time. Review of the Medication Administration Policy dated 2/16/18 identified the medications may be prescribed by providers according to federal and state regulatory requirements. A provider order is required before administration of a medication. The order should include the five rights: right person, right medication, right route, right dose, and right time. The right route means the nurse must check the providers order and ensure that the medication can be safely administered to the residents via this route. In the event of a medication administration error, the licensed nurse will immediately provide care to the resident if necessary and notify the provider, supervisor, DNS, or designee. The event will be documented in the resident's chart in the EMR and an incident report is to be completed and forwarded to the immediate supervisor of the licensed nurse who administrated the medication the medication. The incident will be reviewed and may be subject to disciplinary action. Review of the Crushing Medication Policy identified medications may be crushed on the order of the physician or upon the professional discretion of the nurse, provided product bioavailability will not substantially changed. Upon identifying a resident requiring medications to be crushed, the nurse shall check references to ensure the product may be crushed prior to administration. A physician will order medications to be crushed only in instances where a medication effect will not be compromised.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 4 residents (Resident #41) reviewed for activities of daily living, the facility failed to ensure a resident unable to carry out ADLs independently received necessary services to maintain proper grooming. The findings include:Resident #41 was admitted to the facility in June 2024 with diagnoses that included dementia, osteoarthritis, rash, and seborrheic dermatitis.The annual MDS dated [DATE] identified Resident #41 had severely impaired cognition and required a partial/moderate assist with personal hygiene.The care plan dated 6/19/25 identified person-centered objectives to meet Resident #41's medical, nursing, mental, and psycho-social needs that included an assist of 1 with showering on Friday's during the 3:00 PM - 11:00 PM shift and an assist of 1 with grooming, such as shaving and nail care. The care plan did not identify that Resident #41 had a history of refusing care.Observation with NA #1 on 8/24/25 at 8:12 AM identified Resident #41 lying in bed covered with a blanket partially soiled in a black substance. The resident's fingernails were long, and a thick black substance was visible under Digits #1, 2, 3, 6, 7, 8, 9, and 10.Interview with NA #1 on 8/24/25 at 8:12 AM identified that she was not the nurse aide assigned to Resident #41, but she would change the bed linens and notify the assigned nurse aide of the status of the resident's nails. NA #1 was unsure why Resident #41 had a soiled blanket and what the black substance was that was on the blanket and under the resident's nails.Interview with NA #5 on 8/24/25 at 8:20 AM identified that he typically worked the 3:00 PM - 11:00 PM shift, but had just picked up this day shift, at the last minute, and that he had not provided care for Resident #41 in over a month. NA #5 indicated that Resident #41's fingernails were not short and were in need of a trim, and that there was a black substance under Digits #1, 2, 3, 6, 7, 8, 9, and 10. NA #5 indicated that the nurse was responsible for trimming resident nails, and that he would notify the nurse that Resident #41's nails were in need of a trim.Observation with the 7:00 AM - 3:00 PM Nursing Supervisor (RN #3) on 8/25/25 at 9:00 AM identified Resident #41's fingernails were long and Digits #1, 2, 3, 6, 7, 8, 9, and 10 remained soiled. RN #3 asked Resident #41 if he/she would allow her to clean his/her fingernails. Resident #41 replied, yes.Interview with RN #3 on 8/25/25 at 9:00 AM identified that nurse aides, on all shifts, were responsible for grooming and hygiene, including nail care. RN #3 indicated that the nurse aide assigned to the resident on the designated shower day would be responsible for nail care, and if it was identified that a resident had sharp or jagged nails or had requested fingernail clipping, she would expect nail care to be completed on an as needed basis, as well.Interview with the interim DNS on 8/27/25 at 7:25 AM identified that nurse aides were responsible for ensuring nails were trimmed on shower days and as needed. The interim DNS indicated that if the nurse aide had an issue or the resident refused nail care, they should report it to the charge nurse. The DNS further indicated that on shower days she would expect the nurse aide to complete a head-to-toe look-over, and ask the resident what their grooming preferences were.The Bathing and Grooming Care policy directs the facility to promote and maintain skin integrity, and all residents are provided with care as needed to maintain personal hygiene and comfort. The policy further directs that rooms are assigned to either a day or evening shift to enable those residents to be provided with at least a weekly shower; nail care, facial hair care, and skin care are provided as a standard of care with bathing and grooming.

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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 observation, review of the clinical record, facility documentation, facility policy, and interviews for 5 residents (Resident #5, 41, 59, 60 and 128) the facility failed to ensure care according to professional standards. For 1 of 3 residents (Resident #5) reviewed for abuse, the facility failed to complete an assessment of the resident following an allegation of staff-to-resident physical mistreatment. For 1 of 4 residents (Resident #41) reviewed for activities of daily living (ADL), the facility failed to ensure a resident unable to carry out ADLs independently received necessary services to maintain proper grooming. For 1 of 7 residents (Resident #59) reviewed for food, the facility failed to implement recommendations from an Allergy and Immunology consult for 40 days.For 1 of 2 residents (Resident #60) reviewed for skin conditions, the facility failed to ensure that podiatry consultant recommendations were reviewed and implemented.For 1 of 7 residents (Resident #128) reviewed for nutrition, the facility failed to ensure the air mattress was set per the physician order and manufacturer recommendations. The findings include: 1. Resident #5 was admitted to the facility in February 2025 with diagnosis that included stage 4 chronic kidney disease and urinary retention. The quarterly MDS dated [DATE] identified Resident #5 was severely cognitively impaired, dependent with bed mobility and toileting and had an indwelling urinary catheter. The care plan dated 7/31/25 identified Resident #5 had an ADL functional deficit related to the indwelling urinary catheter. Interventions included to keep the catheter below the level of the bladder and monitor the catheter site for signs of infection. Interview with Resident #139 on 8/24/25 at 1:27 PM identified that during the 11:00 PM to 7:00 AM shift on 8/20/25, (during a time where the resident shared a room Resident #5), Resident #139 observed NA #12 pull on Resident #5's urinary catheter twice and tell the resident to shut up while providing care. Resident #139 further identified he/she reported the incident to the Administrator the following morning.The allegation was reported, the employee was removed from the schedule, and an investigation was initiated.Review of the reportable event form and clinical record failed to identify a documented RN assessment of the resident's condition after the allegation that NA #12 pulled on Resident #5's urinary catheter twice and told the resident to shut up while providing care. Interview with the Administrator on 8/28/25 at 10:14 AM identified that an RN assessment of the residents condition should have been completed following the allegation.Review of the facility policy for Resident Abuse directs that a physical exam revealing bruises, lacerations and multiple injuries in various stages of healing assists in identifying physical abuse.A review of the facility policy for change of condition directs an RN assessment to be completed following a change in condition.Efforts to interview RN #5 were unsuccessful. 2. Resident #41 was admitted to the facility in June 2024 with diagnoses that included dementia, osteoarthritis, rash, and seborrheic dermatitis.The annual MDS dated [DATE] identified Resident #41 had severely impaired cognition and required a partial/moderate assist with personal hygiene.The care plan dated 6/19/25 identified person-centered objectives to meet Resident #41's medical, nursing, mental, and psycho-social needs that included an assist of 1 with showering on Friday's during the 3:00 PM - 11:00 PM shift and an assist of 1 with grooming, such as shaving and nail care. The care plan did not identify that Resident #41 had a history of refusing care.Observation with NA #1 on 8/24/25 at 8:12 AM identified Resident #41 lying in bed covered with a blanket partially soiled in a black substance. The resident's fingernails were long, and a thick black substance was visible under Digits #1, 2, 3, 6, 7, 8, 9, and 10.Interview with NA #1 on 8/24/25 at 8:12 AM identified that she was not the nurse aide assigned to Resident #41, but she would change the bed linens and notify the assigned nurse aide of the status of the resident's nails. NA #1 was unsure why Resident #41 had a soiled blanket and what the black substance was that was on the blanket and under the resident's nails.Interview with NA #5 on 8/24/25 at 8:20 AM identified that he typically worked the 3:00 PM - 11:00 PM shift, but had just picked up this day shift, at the last minute, and that he had not provided care for Resident #41 in over (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a month. NA #5 indicated that Resident #41's fingernails were not short and were in need of a trim, and that there was a black substance under Digits #1, 2, 3, 6, 7, 8, 9, and 10. NA #5 indicated that the nurse was responsible for trimming resident nails, and that he would notify the nurse that Resident #41's nails were in need of a trim.Observation with the 7:00 AM - 3:00 PM Nursing Supervisor (RN #3) on 8/25/25 at 9:00 AM identified Resident #41's fingernails were long and Digits #1, 2, 3, 6, 7, 8, 9, and 10 remained soiled. RN #3 asked Resident #41 if he/she would allow her to clean his/her fingernails. Resident #41 replied, yes.Interview with RN #3 on 8/25/25 at 9:00 AM identified that nurse aides, on all shifts, were responsible for grooming and hygiene, including nail care. RN #3 indicated that the nurse aide assigned to the resident on the designated shower day would be responsible for nail care, and if it was identified that a resident had sharp or jagged nails or had requested fingernail clipping, she would expect nail care to be completed on an as needed basis, as well.Interview with the interim DNS on 8/27/25 at 7:25 AM identified that nurse aides were responsible for ensuring nails were trimmed on shower days and as needed. The interim DNS indicated that if the nurse aide had an issue or the resident refused nail care, they should report it to the charge nurse. The DNS further indicated that on shower days she would expect the nurse aide to complete a head-to-toe look-over, and ask the resident what their grooming preferences were.The Bathing and Grooming Care policy directs the facility to promote and maintain skin integrity, and all residents are provided with care as needed to maintain personal hygiene and comfort. The policy further directs that rooms are assigned to either a day or evening shift to enable those residents to be provided with at least a weekly shower; nail care, facial hair care, and skin care are provided as a standard of care with bathing and grooming. 3. Resident #59 was admitted to the facility in December 2023 with diagnoses that included allergies, unspecified asthma and diabetes mellitus.The quarterly MDS dated [DATE] identified Resident #59 had intact cognition, was independent with eating and independently mobile with the use of a wheelchair.The care plan dated 3/10/25 identified Resident #59 had the potential for alteration in nutrition with interventions that included accommodating the resident's food preferences, observe allergies to pork, lactose intolerance and avoid serving pork, dairy, eggs, tomatoes and breaded foods.Physician's order dated 5/16/25 directed the resident had a food allergy to dairy, and directed a regular diet, no breaded foods, and no pre-cooked foods.A dietary note dated 6/19/25 identified there were dietary restrictions and allergies discussed and what foods the resident was able to tolerate. The kitchen was aware of the resident's dietary restrictions and meal preferences.An APRN progress note dated 7/15/25 at 2:22 PM (for 7/10/25 service) identified Resident #59 reported two episodes of suspected allergic reactions with unknown triggers. Resident #59 recently reported diarrhea and tingling in the throat two hours after dinner where there were no known allergens on the tray. Overnight, Resident #59 developed a maculopapular rash on the arms, face, behind the ears, trunk and groin for which allergy medication was prescribed. Resident #59 had a known allergy to dairy and history of chronic diarrhea which may have been exacerbated by food sensitivities. An allergy evaluation and comprehensive allergy testing was prescribed with strict avoidance to all dairy products in the facility.An Allergy and Immunology consult dated 7/16/25 (received subsequent to surveyor inquiry and 40 days post consult) identified Resident #59 was evaluated for clarification of food allergies. Resident #59 reported food allergies since childhood, requiring an EpiPen (auto inject adrenaline used for treating severe allergies). The patient resided in a short- term care facility where he/she was being served food with known allergens and had no recent allergy testing. Recommendations included to strictly avoid all forms of eggs and milk, with a note provided to the facility that these ingredients cannot be in the resident's food. Serum [NAME] was ordered (blood test that checks for allergies) and skin testing was differed due to antihistamine use.Lab results dated 7/16/25 for allergen [NAME] testing for milk, eggs and related properties identified 0 results meaning no allergy to these foods/properties were identified.Interview with Resident #59 on 8/24/25 at 9:02 AM identified he/she was repeatedly served food items containing known allergens. Resident #59 reported he/she filed grievances and concerns to administration and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	setting could lead to Resident #128's skin breaking down or the resident developing a pressure ulcer. Interview with the RN #1 (wound nurse) on 8/26/25 at 7:49 AM indicated that she was responsible for wounds and determining if a resident needs an air mattress. RN #1 indicated that Resident #128 is currently at risk for developing pressure ulcers. The resident has an air mattress because he/she had a pressure ulcer that healed in the last month, is at risk due to being in bed and can't independently offload for pressure, an inability to move, incontinence, contractures and stiffness. Review of the Air Mattress Overlay Policy identified an air mattress overlay is used to prevent skin breakdown in accordance with a physician's order. When the pump is inflated adjust the setting for comfort or as indicated in the physician's order. Evaluate the air mattress functions and proper inflation every shift. Review of the Air Mattress Operation Manual identified to determine the resident's weight and set the control knob to that weight setting on the control unit. Evaluate the air mattress functions and proper inflation every shift. Unless contraindicated, frequent repositioning must continue in conjunction with use of the air mattress.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #76) reviewed for pressure ulcers, the facility failed to ensure an RN assessment and treatment (including an air mattress) was implemented when a new skin condition was found, and failed to complete weekly skin checks. The findings include:Resident #76 was admitted to the facility in July 2023 with diagnoses that included polyneuropathy, bipolar, and diabetes. The care plan dated 4/28/25 identified Resident #76 was at risk for skin impairment related to decreased mobility, with interventions that included to encourage the resident not to sit in the wheelchair for extended periods of time, perform and document weekly skin checks, and notify physician of any changes. The annual MDS dated [DATE] identified Resident #76 had moderately impaired cognition, was always incontinent of bowel and bladder and required maximum assistance with toileting, dressing, personal hygiene, turning side to side in bed, and transfers. Additionally, Resident #76 had a significant weight loss not prescribed by a physician of 5% or more in the last month or 10% or more in the last 6 months. Resident #76 was at risk for developing a pressure ulcer or injury. Resident #76 had a pressure-reducing device for the bed, nutrition or hydration intervention, and application of ointment other than the feet. a. The nurse's note written by LPN #7 dated 7/27/25 at 11:01 PM identified Resident #76 had a reddened area noted to the coccyx and the RN supervisor was notified. The note failed to reflect a description of the area, including size or if the area was blanchable.The nurse's note written by LPN #6 dated 8/10/25 at 2:15 PM identified that Resident #76 was observed with a 0.5 cm by 1.0 cm open area at the top of the coccyx. Resident #76 expressed pain to the area. The RN supervisor was made aware. The nurse's note written by RN #2 dated 8/10/25 at 6:47 PM identified earlier this morning she was notified Resident #76 had an open area. RN #2 measured the area and applied a dry protective dressing. The APRN was notified, and Resident #76 was placed in the skin rounding book for 8/11/25. A physician's order dated 8/11/25 directed to cleanse the coccyx with normal saline, pat dry, apply triad paste to peri wound, apply silver alginate to wound bed, cover with a dry clean protective dressing daily and as needed. The nurse's note written by RN #1 (wound nurse) dated 8/13/25 at 7:59 PM identified Resident #76 had a stage 3 pressure ulcer that measured 0.4 cm by 0.3 cm by 0.2 cm with 100% granulated tissue with moderate serosanguineous drainage and the APRN was updated. The wound physician note dated 8/13/25 identified Resident #76 had a stage 3 pressure ulcer measuring 0.4 cm by 0.3 cm by 0.2 cm with moderate amount of serosanguinous drainage. Treatment recommendations included silver alginate to wound, zinc to surrounding area, follow facility pressure ulcer prevention protocol, pressure redistribution mattress per facility protocol.The nurse's note written by RN #1 dated 8/20/25 at 6:11 PM identified Resident #76 had a stage 3 pressure ulcer measuring 0.5 cm by 0.7 cm by 0.2 cm with 100% granulated tissue with a moderate amount of serosanguineous drainage. The clinical record failed to include the wound physician progress note dated 8/20/25, which the surveyor requested and not provided. The wound physician note dated 8/27/25 identified the wound was debrided on 8/20/25 and 8/27/25 of slough tissue. Post debridement measurement of the wound was 0.6 cm by 0.6 cm by 0.4 cm. Debridement will be performed weekly as needed to remove the devitalized tissue, decrease the risk of infection, and expose viable tissue to promote wound healing. Resident #76 is still awaiting a low air loss mattress. Interview with RN #1 on 8/29/25 at 12:10 PM indicated that when a new pressure ulcer is identified by a nurse aide, he/she is responsible to inform the charge nurse, and the charge nurse is responsible to inform the RN supervisor. RN #1 indicated the RN supervisor is responsible to perform an assessment on the new pressure ulcer and indicated the RN must document the wound assessment with measurements of the area, the surrounding area, and if there is any drainage. RN #1 indicated the RN must notify the physician to receive a new treatment order for the new area the same day. RN #1 indicated that on 7/27/25 Resident #76 had a new pressure ulcer which was noted (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by LPN #7, but an RN assessment was not done until 8/10/25, 14 days later. RN #1 indicated that she was not notified of the new red area (identified on 7/27/25) until Monday 8/11/25, 15 days after, and indicated based on review of the record, there were no measurements or treatment implemented at that time. RN #1 indicated the APRN was first notified on 8/10/25 of the new pressure ulcer and ordered a treatment.Interview with the DNS on 8/29/25 at 12:35 PM identified when a new wound is identified, a RN will assess and document on the wound including measurements and description of the wound and surrounding area. Further, the DNS indicated that the RN would be responsible to notify the wound nurse and wound physician and call the APRN for new treatment orders. After clinical record review, the DNS indicated staff identified a new red area on the resident's coccyx, however, an RN assessment including measurements of the wound was not completed, and a treatment was not obtained until 8/10/25, 14 days later. The DNS indicated the RN supervisor (RN #5) who was on duty 7/27/25 (when the red area was first identified), informed her that she was not notified by LPN #7 that Resident #76 had a new open area on the coccyx. The DNS indicated she had spoken with LPN #7, and LPN #7 indicated he had informed RN #5 of the new red area. The DNS indicated that LPN #7 identified he was instructed by RN #5 to add the new red area on the coccyx to the wound manager book. Interview with RN #5 on 8/29/25 at 1:30 PM indicated that she was not made aware on 7/27/25 of the new red area on the resident coccyx, she did not assess the area, and a treatment was not obtained. If LPN #7 had informed her of the new red area, she would have done and documented an assessment, notified the APRN, and notified the resident's representative.b. A physician's order dated 5/15/25 directed staff to complete a weekly skin assessment on Saturdays during the 3:00 PM to 11:00 PM shift. The weekly skin assessment dated [DATE] at 10:32 PM identified Resident #76 had intact skin.Review of the weekly skin assessments from 7/26/25 to 8/23/25 identified assessments were not completed on 7/26 (the day before the new red area was identified on the coccyx), 8/2, and 8/16/25.The weekly skin assessment dated [DATE] at 1:43 PM failed to reflect the red area on Resident #76's coccyx.The weekly skin assessment dated [DATE] identified Resident #76 had intact skin despite the nurse's note dated 8/20/25 which identified a stage 3 pressure ulcer.Interview with the DNS on 8/29/25 at 12:45 PM identified the nurses are responsible to follow the physician's orders, which include weekly skin assessments and must be documented on the weekly skin assessment form. After clinical record review, the DNS identified the weekly skin assessments were not consistently done.Although attempted, an interview with LPN #7 it was not obtained. Review of the Change of Condition Policy identified it was to ensure that changes in residents' conditions are reported to the providers and families. The purpose is to ensure that every resident's change of condition is assessed and documented properly. All residents with the potential change of condition are identified in a timely manner. Any alteration in a resident's baseline indicates a potential change of condition. Any resident with a change of condition will receive timely and appropriate treatment. The RN will assess and determine if a change of condition has occurred. The RN will make the APRN or physician aware of a resident's current condition by in person notification or telephone call. Documentation will be noted in the residents' medical record and on the 24-hour report to ensure shift-to-shift communication. Review of the Skin and Wound Management Policy identified the nursing staff will assess and document an individual's risk factors for developing pressure ulcers. The nurse shall describe and document and report the following: a full assessment of a pressure sore including location, stage, length, width, depth, presence of exudate or necrotic tissue, a pain assessment, resident's mobility status, and current treatments including support surfaces. The physician will order pertinent wound treatments including pressure reduction surfaces, wound cleansing, dressings, and application of topical agents. Residents with pressure ulcers or other skin conditions will be seen and followed by the facility's wound physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policies, and interviews for 1 of 2 residents (Resident #17) reviewed for respiratory and tracheostomy care, the facility failed to complete tracheostomy care; including care of the inner cannula per facility policy, failed to change the tracheostomy mask and tubing for 7 weeks, failed to assess the resident for his/her ability to care for and suction the tracheostomy independently including obtaining a physician's orders to allow such, and failed to ensure necessary tracheostomy supplies did not run out. The findings include: Resident #17 was admitted to the facility in October 2023 (2 readmissions in July 2025) with diagnoses that included acute and chronic respiratory failure with hypercapnia, malignant neoplasm of the supraglottic and anterior surface of the epiglottis, and chronic obstructive pulmonary disease. The physician's order dated 3/28/25 directed to monitor/check tracheostomy site and inner cannula every shift: days, evenings, and nights. The quarterly MDS dated [DATE] identified Resident #17 had intact cognition, was independent with oral hygiene, required supervision or touching assistance with personal hygiene, and had special treatments, procedures, and programs while a resident at the facility and within the last 14-days that included: oxygen therapy, suctioning, and tracheostomy care. The nurse's note dated 7/3/25 at 1:22 AM identified that this writer received a call from the nurse aide that Resident #17 did not look well. Upon approach to assess the resident, the resident appeared pale and weak. Oxygen was applied and the oxygen saturation was 96%. While attempting to assess the resident, the resident was observed unable to sit upright and kept falling to the side; the resident also endorsed that he/she had not eaten. Upon the writer attempting to call the on-call APRN to update, the resident endorsed that he/she wanted to be transferred out to the hospital. EMS was called at 11:53 PM, no return call from the on-call APRN, and the resident was transferred out via 911 at 12:18 AM. The nurse's note dated 7/9/25 at 1:10 PM identified Resident #17 was readmitted to the facility at 11:25 AM with a diagnosis of acute hypoxic hypercarbia respiratory failure due to Rhinovirus and Serratia tracheobronchitis. Resident #17 was alert and oriented, noted with diminished lung sounds and the oxygen saturation was 90% on room air. Supplemental oxygen was given and the oxygen saturation increased to 95% on 2 liters, the resident denied shortness of breath and was in no apparent distress. Resident #17 had a stoma to the center of the anterior neck with #6 tracheostomy and collar. The physician's order dated 7/9/25 directed to change the suction canister and tubing every Monday on the 11:00 PM - 7:00 AM shift and to apply oxygen via nasal cannula at 2 liters to maintain oxygen saturation at or greater than 90%, as needed. The physician's orders failed to address care or management of the tracheostomy or stoma or orders for self-suctioning and self-tracheostomy care. The care plan dated 7/10/25 failed to identify the resident's tracheostomy or care of such. Review of the clinical record dated 7/9/25 through 8/29/25 failed to identify documentation that Resident #17 was assessed for the capacity and desired willingness to manage his/her own tracheostomy care and suctioning. Observation with RN #3 on 8/29/25 at 7:28 AM identified Resident #17 had a #6 tracheostomy with a collar. Interview with RN #3 on 8/29/25 at 7:30 AM identified that she was unsure if Resident #17's tracheostomy had an inner cannula and was unsure of exactly what type of daily care was required for his/her tracheostomy. Interview with the interim DNS on 8/29/25 at 7:50 AM identified Resident #17 had just a stoma prior to his/her July 2025 hospitalization, and returned to the facility with a cuffed, Shiley tracheostomy 6.0. The DNS indicated that the hospital discharge instructions did not include care instructions for the tracheostomy. The interim DNS indicated she would have expected tracheostomy care orders to have been put in place and a comprehensive care plan to have been developed for Resident #17's tracheostomy management. Clinical record review with the interim DNS on 8/29/25 at 8:10 AM failed to identify orders related to the care or management of the tracheostomy and stoma and/or an assessment and orders for self-suctioning and self-tracheostomy care. During an interview with Resident #17 and the interim (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DNS on 8/29/25 at 8:06 AM, Resident #17 identified that he/she cares for his/her own tracheostomy including changing the disposable inner cannula and suctioning daily. Resident #17 indicated that he/she had run out of supplies, including disposable inner cannulas, suction equipment, and sterile water yesterday, and notified one of the nurses but could not recall her name. Resident #17 indicated he/she had not received the supplies, yet. Resident #17 further indicated that the oxygen tubing connected to the oxygen concentrator had been changed weekly by the nurses, but the tracheostomy oxygen mask and tubing had not been changed since readmission to the facility, and it was the mask and tubing that had been provided by the hospital during the 7/3/25 through 7/9/25 admission. The interim DNS indicated that she would ensure Resident #17's tracheostomy supplies would be restocked, and his/her tracheostomy mask and tubing would be changed right away. Interview with the interim DNS on 8/29/25 at 8:10 AM identified that she would expect Resident #17 to have had an evaluation for the appropriateness of managing his/her own tracheostomy care and physician's orders, and a care plan for self-suctioning and self-tracheostomy care. The interim DNS indicated that Resident #17's tracheostomy mask and tubing should have been changed weekly, per the physician's order. The Tracheostomy Care policy directs that tracheostomy care is ordered by the provider to maintain a patent airway, prevent aspiration of food or secretions, and allow for removal of secretions. Tracheostomy care is performed only by licensed nursing staff with a provider's order. Disposable inner cannulas are changed once per day, and stroma care is done once per shift and as necessary.The Tracheostomy Suctioning policy directs that suctioning is provided to remove secretions from the trachea to maintain a patient airway. Suctioning is performed only by licensed nursing staff with a provider's order. Although requested a policy for self-care of a tracheostomy was not provided; the facility provided the Self-Medication policy which directs that residents have the right to participate in the self-medication program should they desire to do so and are capable of fulfilling established practices of the program. In order to maximize and promote resident independence, self-administration of medication is encouraged for all residents capable of performing this function. The interdisciplinary care team uses various factors in determining a resident's capacity to self-medicate. The complexity of the task must be considered. Each resident's physical abilities and dexterity must be evaluated to allow for proper handling of medication containers, storage, and ingestion. Cognitively, a resident must be capable of all responsibilities involved in the administration, storage, and record keeping practices of the nursing facility. Emotionally, the resident must desire to participate in this medication program and agree to adhere to safety rules and open communication with nursing staff as they monitor compliance and effectiveness of the medication program. The policy further directs that upon admission and periodically each resident is assessed by the interdisciplinary team for capacity to participate in the self-medication program. Upon completion of the interdisciplinary assessment, if the resident is deemed a candidate for self-medication social service staff will describe the self-medication program and participation requirements to the resident. The resident is asked if they wish to exercise their right to self-administer the medication; if the resident does not desire self-medication administration, this request is honored. Should the resident wish to self-medicate, a physician order for self-medication will be maintained and will include drug name, dose, frequency, wrote, and self-medication approval. Nursing staff will in-service the resident on administration directions, storage, procedures, record keeping practices, and provide the medications along with storage containers. The medication nurse will interview the resident each shift to verify all self-administered doses were taken and indicate the verification on the medex using a check mark, and on a weekly basis the medication nurse will conduct a compliance audit to ascertain medication accountability, and protocol follow-up action will be implemented. Residents on program are periodically reassessed for continuation of self-medication. All decisions are documented in the clinical record and comprehensive care plan.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, the facility failed to ensure the medication error rate was less than 5%. The findings include: Resident #14 was admitted to the facility in May 2021 and was a readmission in July 2025 with diagnoses that included dysphasia, acid reflux, atrial fibrillation, and hypertension. The care plan dated 5/1/25 identified Resident #14 had alteration in cardiac status related to diagnosis of hypertension and cardiac arrythmia with interventions that included administer medications as directed by the physician. The annual MDS dated [DATE] identified Resident #14 had severely impaired cognition and was totally dependent on staff for ADLs. A physician's order dated 6/24/25 directed to administer the following medications.Iron sulfate (iron supplement) (enteric coated) 325 mg 1 tablet daily.Pantoprazole, (delayed release, enteric coated)(acid reflux) 40 mg 1 tablet twice a day.Metoprolol 24-hour (extended release) (slows the heart rate) 100 mg tablet once a day.Seroquel 25 mg (antipsychotic) 1 tablet three times a day.Senna-s 8.6 mg (laxative) 2 tablets twice a day.Nesina 25 mg (diabetes) 1 tablet once a day.Tylenol 325 mg 3 tablets three times a day.Trazodone 50 mg 1 tablet three times a day.Eliquis 2.5 mg (blood thinner) 1 tablet twice a day. Medication observation on 8/25/25 at 8:30 AM identified LPN #2 crushed all 9 medications with a pill crusher, poured the crushed medications into a medication cup with applesauce and administered them to Resident #14. Interview with LPN #2 on 8/25/25 at 8:35 AM indicated that she always crushes Resident #14's medications because Resident #14 has dysphasia. LPN #2 indicated when she went through general orientation upon hire, she was instructed that any resident with a diagnosis of dysphagia must have their medications crushed. Interview with the DNS on 8/25/25 at 10:00 AM indicated the nurses should know when to and when not to crush medications. The DNS indicated if a medication is extended release, delayed release or enteric coated it is not to be crushed. The DNS indicated that if LPN #2 had crushed the Iron sulfate enteric coated, Pantoprazole, (delayed release, enteric coated), and Metoprolol extended release that would be considered medication errors. Interview with Pharmacist #2 on 8/25/25 at 3:00 PM indicated any medication that is extended release, delayed release, or enteric coated should not be crushed. Pharmacist #2 indicated that enteric coated iron should not be crushed. Pharmacist #2 indicted Resident #14 receives pantoprazole DR for acid reflux and that medications should not be crushed. Interview with Pharmacist #2 on 8/25/25 at 3:00 PM indicated any medication that is extended release, delayed release, or enteric coated should not be crushed. Pharmacist #2 indicated that enteric coated iron should not be crushed. Pharmacist #2 indicted Resident #14 receives pantoprazole delayed release for acid reflux and that medications should not be crushed. Pharmacist #2 indicated that delayed release Pantoprazole slowly distributes the medication over a period of time, so if it was crushed it would not last all day or until the next dose, and the resident could become symptomatic for acid reflux. Pharmacist #2 indicated the manufacturer recommends not crushing that medication. Pharmacist #2 indicated Resident #14 was on Metoprolol extended release, meaning it is long acting and should not be crushed. Pharmacist #2 indicated if the Metoprolol was crushed, it would not last for 24 hours and the resident could have increased heart rate or increased blood pressure when the medication stops working before the 24 hours. Interview with APRN #1 on 8/27/25 at 2:05 PM indicated that her expectation was the nurses would follow the physician's orders and should know which medications can be crushed or not. APRN #1 indicated that the iron enteric coated, Pantoprazole DR, and Metoprolol ER should not be crushed because they will not stay in the system for extended amounts of time. Review of the Medication Administration Policy dated 2/16/18 identified the Medications may be prescribed by providers according to federal and state regulatory requirements. A provider order is required before administration of a medication. The order should include the five rights: right person, right medication, right route, right dose, and right time. The right route means the nurse must check the providers order and ensure that the medication can be safely (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered to the residents via this route. In the event of a medication administration error, the licensed nurse will immediately provide care to the resident if necessary and notify the provider, supervisor, DNS, or designee. The event will be documented in the residents' chart in the EMR, and an incident report is to be completed and forwarded to the immediate supervisor of the licensed nurse who administrated the medication the medication. The incident will be reviewed and may be subject to disciplinary action. Review of the Crushing Medication Policy identified medications may be crushed on the order of the physician or upon the professional discretion of the nurse, provided product bioavailability will not substantially change. Upon identifying a resident requiring medications crushed, shall check references to ensure the product may be crushed prior to administration. A physician will order medications to be crushed only in instances where a medication effect will not be compromised. During the standard survey, 25 medications observations were made with 3 resulting medication errors; Iron sulfate enteric coated, Pantoprazole delayed release/enteric coated, and Metoprolol 24-hour (extended release) which were crushed. The resulting medication error rate was 12%.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on review of facility documentation, facility policy, and interviews, the facility failed to ensure the dietary staff had appropriate competencies and skills sets to carry out the functions of the kitchen. The findings include:Interview with Dietary Aide (DA #5) with the Dietary Director (Interim) present on 8/26/25 at 12:10 PM identified DA #5 could not explain how to label food going into the refrigerator. DA #5 nodded his head yes and walked away.Interview with DA #4 with the Dietary Director (Interim) present on 8/26/25 at 12:13 PM identified DA #4 could not answer how to date used food items to be stored in the refrigerator. DA #4 shrugged his shoulders and walked away.Interview with the Dietary Director (Interim) on 8/26/25 at 12:15 PM indicated that both DA #4 and DA #5 are sometimes at the end of the tray line to make sure the meal ticket and food on the tray match. Interview with DA #5 with the Assistant Recreation Person #1 (used as a translator) on 8/28/25 at 12:30 PM indicated if he needs to communicate, he can use the translator app on his phone. DA #5 indicated that most of the time he is the last person in the tray line. DA #1 indicates he receives the tray with food and places it onto the food cart to go the unit. DA #1 indicated when he receives each tray it is already done. DA #5 indicated he is not in charge of the tickets. DA #5 indicated if he is not at the end of the tray line and he has to put milk and desert on the tray, and DA #1 and [NAME] #1 will tell him what to put on the tray in his language. Interview with the Dietary Director (Interim) on 8/26/25 at 12:30 PM indicated the problem with the meal tickets not matching the meals is because the former Dietary Director did not like to put the residents like and dislikes on the meal tickets. The Dietary Director (Interim) indicated that he had gone through all the paperwork in the office and was not able to find any education for 2024 or 2025 with the dietary staff regarding reading the meal tickets, the different meal consistencies or the different types of diets like low sodium or low potassium. Interview with DA #1 on 8/28/25 at 8;55 AM indicated that he was the last person on the breakfast tray line, and he was expected to read the meal ticket and make sure it matched the meal on the tray before placing the tray into the cart for delivery. DA #1 indicated he did not read Resident #130's meal ticket this morning when doing the tray line. Interview with the Staff Development Nurse (RN #1) on 8/27/25 at 7:16 AM indicated therapeutic diets, meal system, and resident meal choices are not part of the annual in-services packet and training. RN #1 indicated that since she started here in February 2025, she has not done any dietary education and she went through all prior staff education documentation for 2024 and 2025 and did not find any education to staff, nursing or dietary, regarding the different diets, or resident tickets matching the meal, or making sure the resident receives the right meal.Review of the Policy and Procedure for Meal Type Identification identified the purpose was to ensure identification and delivery of prescribed and preferred meal types (e.g. regular, therapeutic, mechanically altered, texture modified, and cultural or religious diets) to all residents, thereby promoting safety, dignity, and compliance with physician orders and resident choice. Each tray ticket for each meal will have the residents name, room number, diet type (regular, mechanical soft, puree, cardiac, renal, etc), any allergies to food, texture alerts, and beverages and condiments to be placed on the tray. Meal service and cross check for accuracy. The dietary staff prepares and verifies trays before leaving the kitchen. The nursing staff who receive the trays will cross check against the resident's ticket before service. Direct care staff will confirm correct tray delivery to the residents at the bedside or the dining room. All food service and nursing staff will receive annual training on therapeutic and modified diets, meal identification system (labels, tray tickets), resident rights to meal choice, and procedures for resolving discrepancies. The dietary manager will be responsible for random audits at east weekly to ensure accuracy of meal identification any errors or variances will be logged and reported through the monthly QAPI committee meeting for corrective action.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **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 7 residents (Resident #59) reviewed for food, the facility failed to ensure food was served according to resident allergies, intolerances, and preferences. The findings include:Resident #59 was admitted to the facility in December 2023 with diagnoses that included allergies, unspecified asthma and diabetes mellitus.The quarterly MDS dated [DATE] identified Resident #59 was cognitively intact, independent with eating and independently mobile with the use of a wheelchair.The care plan dated 3/10/25 identified Resident #59 had the potential for alteration in nutrition with interventions that included accommodating resident's food preferences, observe allergies to pork, lactose intolerance and avoid serving pork, dairy, eggs, tomatoes and breaded foods.A physician's order dated 3/22/25 identified a food allergy to dairy and directed a regular diet, no concentrated sweets, no breaded foods, no pre-cooked foods.Electronic communication dated 3/22/25 from Resident #59 to the facility Administrator identified that the kitchen that food was being served that Resident #59 was allergic to.A grievance and electronic communication between the Administrator and FSD dated 3/24/25 identified Resident #59 had ongoing concerns related to meals and was available to discuss any adjustments to address his/her needs.Written communication from Resident #59 to the Administrator dated 5/26/25 identified while allergies were clearly listed and all staff were aware, Resident #59 continued to be served foods of which he/she claimed to be allergic to including eggs which were served for breakfast that morning. Resident #59 spoke with kitchen staff and was informed there were no food items to address dietary needs. A request was made to observe dietary staff performance and take appropriate measures to resolve the issue.Electronic communication dated 6/3/25 between the Administrator and FSD identified Resident #59's allergies and food preferences continue not to be observed. A plan was developed to develop a comprehensive list of all allergies and food dislikes and ensure all meal tickets reflected all accurate, relevant information.Dietary note dated 6/19/25 identified dietary restrictions and allergies were discussed with Resident #59 and what foods he/she was able to tolerate. The kitchen was aware of dietary restrictions and meal preferences.An APRN progress note dated 7/15/25 at 2:22 PM (for a 7/10/25 service) identified Resident #59 reported two episodes of suspected allergic reactions with unknown triggers. The most recent where he/she reported diarrhea and tingling in the throat two hours after dinner where no known allergens were on the tray. Overnight, Resident #59 developed a maculopapular rash on the arms face, behind the ears, trunk and groin for which allergy medication was prescribed. Resident #59 had a known allergy to dairy and history of chronic diarrhea which may have been exacerbated by food sensitivities. An allergy evaluation and comprehensive allergy testing was prescribed with strict avoidance to all dairy products in the facility.Allergy and Immunology consult dated 7/16/25 identified Resident #59 was evaluated for clarification of food allergies. Resident #59 reported food allergies since childhood, requiring an EpiPen (auto inject adrenaline used for treating severe allergies), resided in a short- term care facility where he/she was being served food with known allergens and had no recent allergy testing. Recommendations included to strictly avoid all forms of egg, milk with a note provided to the facility that these ingredients cannot be in his/her food, serum [NAME] ordered (blood test that checks for allergies), and skin testing was differed due to daily antihistamine use.Interview with Resident #59 on 8/24/25 at 9:02 AM identified he/she was repeatedly served food items there was allergies to. Resident #59 reported having filed grievances, reported to Administration and Ombudsman with no resolution. Additionally, Resident #59 reported having recently visited a specialist after having symptoms following a meal. Despite being aware, staff continue to serve restricted food items.Interview and facility documentation review with the Regional FSD now serving as the interim FSD on 8/25/25 at 7:32 AM identified he was aware (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59 had numerous dislikes and reported allergies that included pork and dairy that were listed on his/her meal tickets. The FSD indicated kitchen staff were responsible for checking tickets when plating meals. The FSD further identified a new plan was recently implemented for him to meet with Resident #59 daily to review menu choices.Interview with the DNS on 8/25/25 at 12:33 PM identified residents should be served meals in accordance with preferences, tolerances and food allergies.Observation on 8/27/25 at 8:14 AM identified pork sausage was included on the residents breakfast tray despite being listed as an allergy. The tray was held and the ticket was provided to administrative staff for follow-up.Interview and breakfast food supply review with [NAME] #1 on 8/27/25 at 8:30 AM confirmed pork sausage was served for breakfast. However, [NAME] #1 was unable to provide an explanation as to who was responsible for checking meals tickets when plating meals.Interview with Resident #59 on 8/27/25 at 8:40 AM identified he/she did not routinely eat pork for religious reasons and that it was not a true allergy. However, Resident #59 indicated no one had spoken to him prior to the meal being served about his/her meal choices for the day.Interview with Dietary Aide #2 with the FSD on 8/27/25 at 9:01 AM identified that while he was not responsible for verifying the meal selection on that morning, he was aware Resident #59 had numerous documented dislikes and was very particular about food choices. Dietary Staff #2 identified staff were generally aware not to serve food items that were either disliked or listed as an allergy. However, for Resident #59, the Administrator directed staff to honor requests regardless of what was indicated on the meal ticket. Dietary Staff #2 further identified he normally met with Resident #59 daily as a courtesy for meal selections but did not do so prior to breakfast being served earlier.An interview with the FSD on 9/27/25 at 9:41 AM identified that although there was a plan in place to meet daily to discuss meals, he had not done so prior to the breakfast meal being served.An interview with Dietary Staff #1 on 8/27/25 at 9:45 AM identified he was responsible for verifying the breakfast meal ticket prior to serving. Dietary Staff #2 further identified that although he was aware of Resident #59's food dislikes and allergies, he was directed by the Administrator to serve Resident #59 what he/she wants regardless of what was on the meal ticket.An interview with the Administrator (with the FSD present) on 8/27/25 at 9:50 AM identified Resident #59 had numerous dislikes and documented allergies and would often complain to him about being served those food items. The Administrator admitted he directed dietary staff to serve any requested food items even if listed as dislikes or allergy as he wanted assurances that Resident #59 was eating and was aware he/she had requested, acquired and consumed restricted food items previously without any issues.A review of the facility policy for allergies/food directed that all food was to be served that accommodates allergies and intolerances. Food allergies will be documented in the dietary section of the clinical record and printed on each meal slip for identification. The FSD/supervisor/dietitian will make alterations to the food menu for residents with food allergies/intolerances to ensure those items are not reflected on the meal ticket or provided to the resident.A review of the policy for food preferences directed the dietitian identify food preferences and be documented on the care plan.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on review of facility documentation, facility policy, and interview, the facility failed to designate a qualified infection preventionist from August 2024 through February 2025 (approximately 7 months). The findings include:During a review of the infection prevention program on 8/26/25 at 8:07 AM interview with RN #1 (Infection Prevention IP nurse) identified that she began working as the facility IP nurse on 2/20/25. RN #1 further identified that prior to stepping into the role, she had worked as an RN supervisor in the facility, and the facility did not have an IP nurse for several months.Interview on 8/27/25 at 8:00 AM with the acting DNS identified that she had been covering as the DNS for the last five weeks and had worked as a DNS prior to that. The DNS identified that the facility did not have an IP nurse for several months prior to RN #1 taking over the role as there were issues filling the position. The DNS identified she had taken an infection preventionist certification at one point shortly after she started working at the facility in 8/2024 but never covered the infection prevention program. Interview with the Administrator on 8/28/25 at 11:10 AM identified that the facility did not have a designated IP nurse from August of 2024 until RN #1 began in the position in February of 2025. The Administrator identified the facility had several issues with finding a qualified nurse to fill the role.Although requested, the facility failed to provide any documentation related to attempts to hire an infection preventionist from 8/2024 through 2/2025.Although requested, the facility failed to provide a job description for the Infection Preventionist.The policy on infection prevention and control program directed that coordination and oversight of the program would be done by an Infection Preventionist.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #15) reviewed for influenza and pneumococcal immunizations, the facility failed to offer and/or provide flu or pneumococcal immunizations. The findings include: During a review of the facility infection prevention program on 8/26/25 at 8:07 AM, a request was made to RN #1 (Infection Preventionist) to provide documentation for influenza and pneumococcal vaccinations or signed refusals with education for a list of 5 sampled residents (Resident #15, 18, 22, 38, and 60) for the last 12 months (8/2024 - 8/2025).Although requested, the facility failed to provide any documentation related to influenza vaccination or declination for Resident #15 for 2024. Review of a signed pneumococcal consent for Resident #60 dated 10/26/24 identified the resident received the vaccination in the past. Further review of an immunization list for Resident #60 failed to identify any documentation related to pneumococcal vaccination including type and date administered. Interview with RN #1 on 8/27/25 at 8:10 AM identified that she did not have any mechanism for tracking vaccinations for residents of the facility. RN #1 identified she could not locate any tracking information in the IP information that was provided to her when she took the position, and the only way she knew to track vaccinations to look up each individual resident in the electronic medical record to determine if they had been vaccinated. RN #1 identified she did not track any of the consents, declinations, or vaccines for any of the facility residents and was unaware of who needed vaccinations or who had refused them. The policy on influenza vaccines directed that all residents who had no medical contraindications to the vaccine would be offered the vaccination annually to encourage and promote the benefits associated with vaccinations against influenza. The policy further directed if the resident refused, the refusal would be documented on the consent form and placed in the residence medical record, and the infection preventionist would maintain surveillance data on flu vaccination coverage and reported rates of flu among residents and staff. The policy further directed surveillance data would be made available to staff as part of educational efforts to improve vaccination rates among employees.The policy on pneumococcal vaccinations directed that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia and pneumococcal infections. The policy further directed that for residents who received vaccinations, the date of the vaccine, lot number, expiration date, person administering, and the site of the vaccination would be documented in the residence medical record. The policy also directed that administration of pneumococcal vaccines or re vaccinations would be made in accordance with CDC recommendations at the time of the vaccination.