STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075400	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Health Care Center	13 Park Lawn Drive Bethel, CT 06801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**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 3 of 4 residents (Resident #8, 60 and 117) reviewed for dignity, the facility failed to ensure signs that included personal and health information, were not posted and visible in the residents' room. The findings include:1. Resident #8 was admitted to the facility in January 2022 with diagnoses that included metabolic encephalopathy, dysphagia, and muscle weakness. A dysphagia evaluation report dated 11/14/24 identified Resident #8 was being evaluated for life limiting or threatening dysphagia with feeding difficulties and coughing with the purpose of the evaluation to determine the least restrictive diet and appropriate swallowing maneuvers and strategies. Further Resident #8 was unable to feed him/herself and was fully dependent due to physical limitations. The report identified Resident #8 should not use straws, be positioned upright and take small bites/sips. Staff should monitor oral intake rate and cue multiple swallows. The report also directed that strategies were dependent on caregiver assistance and that Resident #8 required supervised oral feeding due to aspiration precautions.The quarterly MDS dated [DATE] identified Resident #8 had severely impaired cognition, required with moderate assistance with eating, substantial assistance with bathing, and was dependent on staff to assist with toileting. The care plan dated 3/5/25 identified Resident #8 had an ADL self-care performance deficit. Interventions included providing one staff member to assist with eating/feeding.A physician's order dated 3/5/25 directed to elevate the head of the bed or use multiple pillows for aspiration precautions. A physician's order dated 3/7/25 directed a regular diet with regular texture and mildly thick (nectar) consistency for liquids.A speech therapy note dated 3/21/25 identified Resident #8 had documented silent aspiration with thin liquids and required total assistance with all meals and appropriate body position to decrease risk of aspiration. 2. Resident #60 was admitted to the facility in July 2022 with diagnoses that included hemiplegia of the left non dominant side following a stroke, dysphagia, and weakness.Review of the clinical record identified Resident #60 was hospitalized from [DATE] - 9/17/24 for right sided weakness.The 5-day MDS dated [DATE] identified Resident # 60 had severely impaired cognition, was frequently incontinent of bowel and bladder, required substantial assistance with eating and was dependent on staff to assist with toileting and transfers.Review of the clinical record identified Resident #60 was sent to the hospital for evaluation on 9/30/24 due to hypotension and bradycardia.An APRN note dated 10/11/24 identified Resident #60 had a history of becoming hypotensive easily and was to have the head of the bed elevated at all times with some decline at bedtime.A physician's order dated 10/11/24 directed to keep the head of bed elevated at all times and may decline some at bedtime.Review of the care plan failed to identify interventions to address the hypotensive episodes with a need to always remain upright in bed.Observation on 7/15/25 at 12:45 PM identified Resident #8 and Resident #60 resided in the same room.Observation of Resident #8 identified multiple signs placed above his/her bed and on the bathroom door directly in front of his/her bed. Resident #8 was observed being provided feeding assistance by a staff member. Observation identified Resident #60 was seated in a wheelchair inside the room near the entryway. There was a sign placed above Resident #60's bed. Further observation identified the sign was visible prior to entering the room. Observation on 7/16/25 at 2:15 PM identified that the signs placed above the bed and on the bathroom door for Resident #8, and the sign above Resident #60's head of bed were still in place. Observation of the signs above Resident #8's head of bed identified the following:NO STRAWS (repeated 5 times).NO! Water Pitcher.Patient is total assist with all meals.Please keep head of the bed elevated.Please make sure the phone is on hook and ringer is on. During this observation, 2 additional signs were identified posted on the bathroom door directly in front of Resident #8's bed with the following:Safe Swallowing Strategies.Diet Level: Regular.Liquids: Mild Thick Liquids.Positioning: Upright at 90 degrees-Place pillow under left shoulder to avoid leaning.Supervision: 1:1 assistance during meals.Give small bites.Feed slowly. Have patient clear throat and swallow after each bite, alternate between solids and liquids.NO STRAWS ALLOWED. Ice Chip ProtocolSit upright in bed at 90 , pillow under left arm to avoid leaning.Assist patient with mouth care before giving any ice chips.Patient allowed to have ice chips between meals when given by staff one at a time.Patient not to be left alone with ice chips.Patient not allowed to drink water melted from the ice chips.Patient to remain upright for 30 minutes following ice chips. This observation also identified a sign located above Resident #60's head of bed which read Please keep head of bed ELEVATED. Resident #60 was observed lying completely flat in the bed with a sheet covering him/her. Observation and interview

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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 interviews for 1 of 2 residents (Resident #17) reviewed for comfort measures/hospice, the facility failed to ensure that the comprehensive care plan was reviewed and revised to include interventions related to comfort measures only. The findings include.Resident #17 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), hypertensive heart disease with heart failure, and chronic pain.Facility documentation dated 5/24/24 identified Resident #17 was placed on hospice care due to heart failure and chronic pain.The quarterly MDS dated [DATE] identified Resident #17 had intact cognition, was frequently incontinent of bowel and bladder and required substantial assistance with toileting, bathing, and dressing. The clinical record dated 1/28/25 identified hospice care was discontinued.A physician's order dated 2/12/25 directed comfort measures only. Review of the clinical record failed to identify a care plan with interventions related to comfort measures. Interview with Resident #17 on 7/15/25 at 2:00 PM identified he/she was aware of the order for comfort measures and that it was in place to ensure he/she was comfortable. Resident #17 identified he/she was not sure what specific treatments were in place related to keeping him/her comfortable. Interview and review of the care plans for Resident #17 with the MDS director on 7/22/25 at 11:41 AM identified she was responsible to review and revise the resident's care plans with scheduled resident assessment dates to coincide with the resident's MDS review schedule. The MDS director identified that for Resident #17, the social worker was responsible to review and revise the care plan related to hospice services initially, and then subsequent order for comfort measures. The MDS director identified that the facility social work staff should have added a terminal diagnosis care plan in 2/2025 and amended it to reflect the order for comfort measures, but that it did not appear there was a care plan in place related to comfort measures.The facility policy on comprehensive person-centered care planning directed that the person-centered care plan was developed to include information necessary to properly care for the resident and would address the resident's preferences, goals, desired outcomes, and plan for discharge. The policy further directed that the comprehensive person-centered care plan would be reviewed and revised following a significant change in status and episodically as the plan of care changed for the resident. The policy further directed that the comprehensive person-centered care plan would be kept current by all disciplines on an ongoing basis and that disciplines would be responsible for updating the care plan when there was a new problem that required that discipline to intervene. The policy also directed that the interdisciplinary team would periodically review and revise the comprehensive care plan upon any change in status including when a problem, goal, or intervention was changed. The policy also directed that all clinical department heads were responsible to ensure there was a system for monitoring implementation of the resident care plans and that corrective action would be carried out when problems with implementation of care plans had been modified.

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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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 resident (Resident #8) who were dependent on staff for feeding assistance, the facility failed to ensure that a resident was provided feeding assistance for a meal. The findings include:Resident #8 was admitted to the facility in January 2022 with diagnoses that included metabolic encephalopathy, dysphagia, and muscle weakness. A dysphagia evaluation dated 11/14/24 identified Resident #8 was being evaluated for life limiting or threatening dysphagia with feeding difficulties and coughing with the purpose of the evaluation to determine the least restrictive diet and appropriate swallowing maneuvers and strategies. Further, Resident #8 was unable to feed him/herself and was fully dependent due to physical limitations. The report identified Resident #8 should not use straws, be positioned upright, take small bites/sips, and staff should monitor oral intake rate, and cue multiple swallows. The report also directed that strategies were dependent on caregiver assistance and that Resident #8 required supervised oral feeding due to aspiration precautions.The quarterly MDS dated [DATE] identified Resident # 8 had severely impaired cognition, required moderate assistance with eating, substantial assistance with bathing, and was dependent on staff to assist with toileting. The care plan dated 3/5/25 identified Resident #8 had an ADL self-care performance deficit. Interventions included providing one staff member to assist with eating/feeding. A physician's order dated 3/5/25 directed to elevate the head of the bed or use multiple pillows for aspiration precautions. A physician's order dated 3/7/25 directed to provide a regular diet with regular texture and mildly thick (nectar) consistency for liquids. A speech therapy note dated 3/21/25 identified Resident #8 had documented silent aspiration with thin liquids and required total assistance with all meals with appropriate body position to decrease risk of aspiration. The nurse aide care card for Resident #8 identified nurse aide staff were to provide total assistance at meal time and that Resident #8 was dependent on staff for all meals. Constant observation on 7/21/25 from 1:50 PM to 2:10 PM identified the resident's untouched meal tray was on the bedside table located approximately 4 feet directly to the right of Resident #8's bed. During this observation, Resident #8 was observed sleeping with a large towel placed over his/her chest area tucked into his/her gown, and the towel appeared clean with no food or debris observed. The meal tray had utensils including a spoon, butter knife, and fork which appeared clean and not used. During this observation, 5 signs were observed to be attached directly behind and above Resident #8's bed. The signs included the following:NO STRAWS (repeated 5 times). NO! Water Pitcher. Patient is total assist with all meals.Please keep head of the bed elevated.Please make sure the phone is on hook and ringer is on. An additional sign was also observed posted on the bathroom room directed in front of Resident #8's bed with the following: Safe Swallowing Strategies.Diet Level: Regular.Liquids: Mild Thick Liquids.Positioning: Upright at 90 degrees.Place pillow under left shoulder to avoid leaning.Supervision: 1:1 assistance during meals.Give small bites.Feed slowly.Have patient clear throat and swallow after each bite, alternate between solids and liquids.NO STRAWS ALLOWED. Observation and interview with NA #7 on 7/21/25 at 2:07 PM identified she was the nurse aide assigned to care for Resident #8 and had brought in the residents lunch tray at 1:00 PM and attempted to wake Resident #8 in order to feed him/her lunch. NA #7 identified Resident #8 declined to eat and continued sleeping. NA #7 was unable to identify how many attempts she made but at 1:30 PM, she left the unit to go on her lunch break and left Resident #8's meal tray on bedside table. NA #7 identified she planned to return after her lunch to offer Resident #8 the same meal tray. NA #7 identified that she did not report off to any other nursing staff that she had left the meal tray in the room or that Resident #8 had not been feed lunch yet since she was planning to address it once her break was over. Observation and interview with the DNS of Resident #8's meal tray on 7/21/25 at 2:11 PM identified that the meal trays should not have been left in Resident #8's room unattended and that Resident #8 requires total assistance with feeding due to aspiration risk. During this observation, the DNS identified Resident #8 was unable to reach the tray due to the need for staff to assist with repositioning and transfers. Interview with Speech Therapists (SP #1 and 2) on 7/21/25 at 2:47 PM identified Resident #8 was a high risk for aspiration and had confirmed silent aspiration with thin liquids when testing was completed on 11/14/24. SP #2 identified Resident #8 would be unable to access a meal tray positioned out of reach and would need staff assistance to sit up and transfer and typically required a hoyer lift to be out of bed. SP #1 identified that Resident #8 was unable to feed hand to mouth and required staff to provide direct supervision and prompts and identified that Resident #8 also had issues with impulsivity with meals, often taking large bites and eating

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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 1 of 4 residents (Resident #60) reviewed for dignity, the facility failed to follow the physician's order related to the resident's position in bed. The findings include:Facility documentation identified Resident #60 was hospitalized from [DATE] - 9/17/24 for right sided weakness. The 5-day MDS dated [DATE] identified Resident #60 had severely impaired cognition, required substantial assistance with eating and was dependent on staff to assist with toileting and transfers.Facility documentation identified Resident #60 was sent to the hospital for evaluation on 9/30/24 due to hypotension and bradycardia. An APRN note dated 10/11/24 identified Resident #60 had a history of becoming hypotensive easily and was to have the head of the bed elevated at all times with some decline at bedtime. A physician's order dated 10/11/24 directed to keep the head of bed elevated at all times and may decline some at bedtime.Review of the care plan failed to identify interventions related to hypotensive episodes with a need for the resident to always remain upright in bed. Observation on 7/16/25 at 2:15 PM identified a sign located above Resident #60's head of bed with the following: Please keep head of bed ELEVATED. During this observation Resident #60 was observed lying completely flat in the bed covered by a sheet. Observation and interview on 7/16/25 at 2:27 PM with NA #8 identified she was assigned to care for Resident #60 that shift and indicated Resident #60 had a history of yelling out when the head of the bed was elevated, so the nursing staff on the unit routinely repositioned the resident flat in bed. Observation and interview on 7/16/25 at 2:29 PM with LPN #3 identified she was assigned to Resident #60 regularly, and that every morning that she was assigned to the resident she would reposition the resident with the head of the bed elevated, but Resident #60 would yell out to be lowered and the nurse aide staff on the unit would then lower the resident because of the amount of yelling. LPN #3 was unable to identify why Resident #8 had an order for with the head of the bed elevated, how long the resident had been yelling while his/her bed was elevated, or if the physician had ever been notified. Review of the clinical record failed to identify notification to the physician or APRN regarding Resident #60's inability to be maintained upright in bed per the physician's order. Observation on 7/17/25 at 11:23 AM identified Resident #60 observed lying completely flat in the bed. Observation on 7/21/25 at 12:20 PM identified Resident #60 observed lying completely flat in the bed. Observation on 7/22/25 at 11:14 AM identified Resident #60 observed lying completely flat in bed. Interview on 7/22/25 at 12:54 PM with APRN #1 and Clinical Lead Director APRN identified the resident had issues with orthostatic hypotension since October 2024 and that is why the head of the bed was to remain up. Further, APRN #1 and Clinical Lead Director APRN identified they had not been notified that Resident #60 would yell while upright in bed and staff was not maintaining the residents head of the bed elevated. The Clinical Lead Director APRN identified that Resident #60 had not had any documented issues with hypotension recently and identified she would discontinue the order. Although requested, the facility failed to provide a policy on physician's orders. The facility policy on change of condition notification directed that the facility would inform the resident, resident's healthcare provider, and the resident's family or legal representative when there was a change in condition. The policy further directed that a resident's change of condition should be evaluated and documented appropriately and reported to the residence healthcare provider and family or legal representative. The facility policy on comprehensive person-centered care planning directed that the person-centered care plan was developed to include information necessary to properly care for the resident and would address the resident's preferences, goals, desired outcomes, and plan for discharge. The policy further directed that the comprehensive person-centered care plan would be reviewed and revised following a significant change in status and episodically as the plan of care changed for the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 of 8 residents (Resident #84), reviewed for accidents, the facility failed to ensure that two staff transferred the resident via a sit to stand lift per physician's orders and professional standards of practice, and for 3 of 6 residents (Resident #51, 71 and 95) reviewed for smoking, the facility failed to ensure that residents who had a history of smoking and/or had been found smoking and/or verbalized to staff that they currently smoked, adhered to the smoking policy and did not smoke on the facility grounds to ensure a hazard free environment, and for 1 of 4 residents (Resident #8) reviewed for dignity, the facility failed to ensure the environment was free of hazards for a resident assessed at risk to aspirate, and for 1 of 8 residents (Resident #138) reviewed for accidents, the facility failed to provide adequate supervision to prevent a fall. The findings include:1.Resident #84 was admitted to the facility in May 2022 with diagnoses that included hemiplegia and hemiparesis of the left side following a stroke and muscle weakness. The quarterly MDS dated [DATE] identified Resident #84 had intact cognition, impairment of the upper and lower extremity on one side, used a wheelchair, and was dependent on staff for transfers. The care plan dated 5/7/25 identified Resident #84 had limited physical mobility and required the assistance of two staff via a mechanical lift. Interview with Resident #84 on 7/15/25 at 11:30 AM identified that approximately 2 weeks ago, NA #9 transferred him/her via the sit to stand mechanical lift alone without the benefit of a second staff member. Further, Resident #84 indicated that during the transfer one of the straps popped off. Review of facility documentation identified the DNS interviewed NA #9 on 7/16/25. NA #9 indicated he was transferring Resident #84 from the toilet via the sit to stand lift and the resident became impatient waiting for a second staff member. NA #9 identified he began to transfer the resident without a second staff member and as the resident was lifted, one of the straps popped off. NA #9 indicated he lowered the resident onto the toilet, reattached the strap and transferred the resident with the lift. NA #9 indicated the resident did not fall. A written warning dated 7/16/25 identified NA #9 performed a sit to stand transfer without a second staff member. Corrective action identified NA #9 will always have a second staff member to assist with lift transfers. Further, a sit to stand lift competency was conducted with NA #9. Review of the manufacturer safety summary for the sit to stand lift identified the stand up lift may be operated by 1 healthcare professional with a cooperative, weigh-bearing individual able to support the majority of his/her own weight. However, since medical conditions vary, the recommendations include that the healthcare professional evaluate the need for assistance and determine whether more than 1 healthcare professional is appropriate in each case to safely perform the transfer. Review of the facility sit to stand lift competency identified 2 staff members are required. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the ADL policy identified ADLs are the essential tasks that each person needs to perform, on a regular basis, to sustain basic survival and well-being. The term ADL helps healthcare professionals quickly communicate the level of assistance an individual might need or how their health is impacting their day-to-day life. Staff provide assistance to complete ADLs per the person-centered evaluation care plan including functional mobility. 2. Resident #138 was admitted to the facility in February 2025 with diagnoses that included a fall with multiple rib fractures, repeated falls, and dementia. The admission assessment dated [DATE] at 10:21 PM identified Resident #138 was at high risk for falls due to a fall in past 6 months, confusion at times, the need for assistance with elimination and mobility, the need to use a walker, the inability of the resident to indicate if he/she feels unsteady when walking or is afraid of falling when walking. Further, Resident #138 has an unsteady gait and balance. The APRN note dated 2/10/25 identified Resident #138 has dementia and was in the hospital due to falling while smoking a cigarette. The resident sustained moderately displaced left anterior second and third rib fractures and nondisplaced left anterior lateral fourth through seventh rib fractures. The admission MDS dated [DATE] identified Resident #138 had severely impaired cognition, was occasionally incontinent of bowel and bladder, required moderate assistance with toileting, toilet transfers, wheelchair to and from bed transfers, sit to stand, and maximum assistance with dressing. The care plan dated 2/20/25 identified Resident #138 had impaired mobility and rib fractures. Interventions included providing maximum assistance with dressing and personal hygiene. Resident #138 requires a 2 wheeled walker and touching assistance for toileting by 1 staff person. Additionally Resident #138 has the potential for falls. Intervention included to ensure the resident is wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Review of the activities of daily living flowsheet dated 4/1/25 to 5/2/25, which the nurse aides are required to sign off as having been completed every shift identified Resident #138 was a high fall risk, ask resident if he/she needs to use the bathroom, ensure the resident’s belongings were within reach. The APRN note dated 5/2/25 at 8:00 AM identified staff requested evaluation of the resident due to pain on urination. Recommendations included to encourage fluids and monitor for a urinary tract infection for 3 days. If symptoms persist or worsen, a urine culture will be needed. Additionally, a psychiatric evaluation referral was placed for gradual dose reduction due to increased lethargy. A reportable event form dated 5/2/25 at 7:05 PM indicated Resident #138 was in the bathroom and had an unwitnessed fall. Resident #138 complained of back of head and back pain and was transferred to the emergency room. The nurses note dated 5/2/25 at 7:05 PM identified the nurse aide came to this writer stating Resident #138 had fallen. This writer went to see Resident #138 who was sitting on the toilet. Resident #138 indicated he/she hit his/her head and complained of low back pain. The Resident Representative requested the resident be sent to emergency room. The APRN was notified and ordered the resident to be transferred to the emergency room for evaluation. Resident #138 was transferred to at 8:10 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by NA #3 dated 5/2/25 indicated she had assisted Resident #138 to the bathroom at approximately 6:50 PM with a walker. NA #3 indicated she wanted to give Resident #138 some privacy and informed Resident #138 to pull the string when finished. Resident #138 did not pull the string, and a few minutes later she heard Resident #138 yelling. NA #3 indicated at that time she went to Resident #138’s room and Resident #138 was on the floor, so she left the room to get the nurse. NA #3 indicated when she returned to Resident #138’s bathroom there were 2 EMT’s there, and Resident #138 was sitting on the toilet. NA #3 indicated while Resident #138 was on toilet the RN Supervisor came. The hospital Discharge summary dated [DATE] identified Resident #138 was admitted on [DATE] due to an unwitnessed fall and was diagnosed with a urinary tract infection and a T12 compression fracture. Resident #138 was discharged with a back brace to be worn when ambulating and follow up with orthopedics in one week. A physician’s order dated 5/7/25 directed an orthopedic consultation as needed and thoracic lumbar sacral orthosis (horizon brace) should be on when Resident #138 is out of bed and off while lying in bed daily for back support. Interview with NA #3 on 7/21/25 at 9:57 AM indicated Resident #138 was on her assignment on 5/2/25 and she did not think Resident #138 was a fall risk, so she told Resident #138 to pull the call light string when he/she was done and left Resident #138 alone in the bathroom. NA #3 indicated that she left the room to assist another resident, and while she was assisting the other resident, she heard Resident #138 screaming. NA #3 indicated Resident #138 did not put the call light and when she entered the bathroom Resident #138 was on the floor. NA #3 indicated she left Resident #138 alone in the bathroom and went to the nurse’s station to find the nurse. NA #3 indicated the charge nurse called for the supervisor and then they both came to assess Resident #138. NA #3 indicated while she was getting the nurse, 2 EMT’s had gotten Resident #138 off the floor and put the resident back on the toilet. NA #3 indicated when she was heading back to Resident #138’s room she saw the 2 EMT’s leaving the room. NA #3 indicated Resident #138 was complaining of back pain and dizziness from hitting his/her head against the wall. NA #3 indicated Resident #138 could not stand on his/her own at that time. Interview with OTR #1 (covering for Director of Rehab) on 7/21/25 at 10:49 AM identified that based on therapy notes Resident #138 required partial to moderate assistance with 1 staff for transfers to and from the toilet. OTR #1 indicated Resident #138 was forgetful and had a diagnosis of dementia and should not be left alone in the bathroom. OTR #1 indicated based on the therapy fall risk assessment Resident #138 was at risk for falls. OTR #1 indicated therapy will tell the charge nurse if a resident should not be left alone in the bathroom and it is up to the charge nurse to communicate that information with the nursing staff. OTR #1 indicated Resident #138 was not to be left alone in the bathroom because Resident #138 did not have the recall or awareness of the assistance he/she needed, and he/she was a fall risk. OTR #1 could not identify who in the nursing department was notified that the resident should not be left alone in the bathroom. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/22/25 at 10:29 AM indicated Resident #138 was admitted with a diagnosis of dementia and is confused at times. The DNS indicated that Resident 138 was a high fall risk and interventions were to make sure the resident wore appropriate footwear and have the resident evaluated by the therapy department. The DNS indicated Resident #138 had a couple of falls prior to the fall on 5/3/25. The DNS indicated NA #3 should have stayed with Resident #138 in the bathroom and not leave the resident alone because of the fall risk and confusion. The DNS indicated that NA #3 was educated on not leaving a confused resident that required the assistance of 1 staff alone in a bathroom. Interview with the DNS on 7/22/25 at 12:10 PM indicated that the nurse and nurse aides should stay with any resident that required the assistance of 1 or 2 staff for ambulation to the bathroom, however, prior to 5/2/25 there was no education provided to nursing staff regarding who could or could not be left alone in the bathroom. The DNS indicated after the fall on 5/2/25 she educated nursing staff that any resident that needed assistance to go to the bathroom could not be left alone. Review of the Fall Prevention Program Policy identified the purpose was to reduce the incidence of falls for residents identified at high risk. All residents will be evaluated for risk for falls on admission, readmission, and with a change in condition. Residents at high risk for falls will have interventions initiated to prevent falls. Interventions may include providing staff supervision for activities of daily living and being on a toileting program. Implementing fall interventions included placing interventions on the nurse aide kardex and assignment. If a fall occurs keep resident immobile until resident is examined and determined to be free from fractures. 3. Resident #8 was admitted to the facility in January 2022 with diagnoses that included metabolic encephalopathy, dysphagia, and muscle weakness. A dysphagia evaluation report dated 11/14/24 identified Resident #8 was being evaluated for life limiting or threatening dysphagia with feeding difficulties and coughing with the purpose of the evaluation to determine the least restrictive diet and appropriate swallowing maneuvers and strategies. Further, the evaluation report identified Resident #8 was unable to feed him/herself and was fully dependent due to physical limitations. The report identified Resident #8 should not use straws, take small bites/sips and be positioned upright. Staff should monitor oral intake rate, and cue multiple swallows. The report also directed that strategies were dependent on caregiver assistance and that Resident #8 required supervised oral feeding due to aspiration precautions. The quarterly MDS dated [DATE] identified Resident #8 had severely impaired cognition, required with moderate assistance with eating, substantial assistance with bathing, and was dependent on staff to assist with toileting. The care plan dated 3/5/25 identified Resident #8 had an ADL self-care performance deficit. Interventions included providing one staff member to assist with eating/feeding. A physician’s order dated 3/5/25 directed to elevate the head of the bed or use multiple pillows for aspiration precautions. A physician’s order dated 3/7/25 directed for a regular diet with regular texture and mildly thick (nectar) consistency for liquids. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A speech therapy note dated 3/21/25 identified Resident #8 had documented silent aspiration with thin liquids and required total assistance with all meals and appropriate body position to decrease risk of aspiration. A constant observation on 7/21/25 from 1:50 PM to 2:10 PM identified Resident #8’s untouched meal tray on the bedside table located approximately 4 feet directly to the right of Resident #8’s bed. During this observation, Resident #8 was observed sleeping. Observation and interview with the DNS of the meal tray on 7/21/25 at 2:11 PM identified that the resident’s meal tray should not have been left in Resident #8’s room unattended and that Resident #8 required total assistance with feeding due to aspiration risk. During this observation, the DNS identified Resident #8 was unable to reach the tray due to the need for staff to assist with repositioning and transfers. Interview with Speech Therapist SP #1 and 2 on 7/21/25 at 2:47 PM identified Resident #8 was a high risk for aspiration and had confirmed silent aspiration with thin liquids with testing on 11/14/24. SP #2 identified Resident #8 would be unable to access a meal tray positioned out of reach and would need staff assistance to sit up. SP #1 identified that Resident #8 was unable to feed hand to mouth and required staff to provide direct supervision and prompts and identified that Resident #8 also had issues with impulsivity with meals, often taking large bites and eating quickly, which also increased his/her risk to aspirate. SP #2 identified that Resident #8 had chronic dysphagia and would always be a risk to aspirate. Observation on 7/22/25 at 11:14 AM identified Resident #8 was in his/her room alone, in bed, and the bedside table was positioned directly over the resident’s bed. Three separate cups of liquids were on the table within the residents reach. The liquids included a clear thickened liquid in a clear plastic cup approximately 1/3 full; an orange thickened liquid in a white Styrofoam cup filled completely covered with a white plastic lid; and a dark blue plastic mug with thickened brown liquid, approximately 75% full. Observation and interview on 7/22/25 at 11:24 AM with LPN #3 identified the cups of liquid should not have been placed on Resident #8’s bedside table and instead that staff routinely filled a pitcher with thickened water to put on Resident #8’s bedside table. LPN #3 identified that Resident #8 required feeding assistance and supervision with meals, but she was not aware of any issues related to Resident #8 having access to a pitcher of thickened liquid other than that Resident #8 should not use straws when drinking liquids. LPN #3 was unable to identify if Resident #8 should have access to a pitcher of liquid without supervision, or if Resident #8 had the cognitive ability to call out for assistance when he/she wanted liquid from the pitcher. Interview with the DNS on 7/22/25 at 11:33 AM identified Resident #8 should not have had any fluids at the bedside within his/her reach, in a cup or pitcher, because Resident #8 is high risk to aspirate and needs 1:1 supervision. The DNS identified that she would need to provide additional education to the clinical staff regarding this issue. Interview with SP #1 and SP #2 on 7/22/25 at 12:03 PM identified Resident #8 should not have any fluids at the bedside due to aspiration risk and that staff should be assisting and supervising fluid intake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 and Clinical Lead Director APRN on 7/22/25 at 12:54 PM identified that Resident #8 was at risk for aspiration and any orders related to this were directed by the Speech Therapy department. The facility policy on dysphasia management directed that residents who had swallowing difficulties or dysphasia would have treatment interventions to promote adequate nutrition and hydration. The facility assessment directed that the facility would provide person centered directed care which included identifying hazards and risks to residents. The assessment also directed that the facility would provide management of medical conditions that would include assessment, early detection of problems, management of medical conditions, and address individualized dietary requirements. The assessment further directed that the facility would provide care related to activities of daily living including supporting with needs related to eating. 4. Resident #51 had diagnoses that included low back pain. A review of the admission record identified Resident #51 was self-responsible. The admissions packet dated 6/23/22 identified the facility did not permit smoking on the premises and was signed by Resident #51. An APRN note dated 6/23/22 identified Resident #51 was a former smoker who had quit 2 years previously. The quarterly MDS dated [DATE] identified Resident #51 was cognitively intact, was independent with locomotion on the unit, and supervised off the unit with the use of a wheelchair. The care plan dated 4/27/23 identified Resident #51 had a self-care deficit and required assistance of 1 with a wheelchair and supervision with locomotion. An APRN note dated 4/27/23 at 1:00 AM identified Resident #51 and staff reported he/she and another resident would go outside and smoke together, smoking 1 cigarette a day. Resident #51 requested smoking cessation medication. Orders were prescribed to start Wellbutrin SR 150 mg daily for 3 days then increase to 150 mg twice daily for 12 weeks. The care plan dated 5/2/25 identified Resident #51was noncompliant with the facility nonsmoking policy. Interventions included informing the resident the facility did not permit smoking and praise efforts of policy compliance. A social service note dated 6/27/24 at 12:02 PM identified on 6/26/24 three packs of cigarettes were found by staff in the resident’s possession and brought to the Social Service Department. Social services met with Resident #51 to reinforce that the facility is non-smoking. Resident #51 told the writer he/she did not realize he/she could not have the smoking materials in his/her room, and he/she had no objection to them being kept in the social service office. An APRN note dated 2/7/25 at 8:09 AM identified Resident #51 was a smoker and went outside frequently. Resident #51 was counseled on smoking with a plan to continue to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #51 on 7/21/25 at 12:22 PM identified he/she smoked in the past. Resident #51 indicated he/she obtained cigarettes from a former roommate who also smoked, or from a visitor known to him/her from the community. Resident #51 identified he/she would walk around grounds smoking unsupervised or smoke near the employee parking lot. Resident #51 was aware of the nonsmoking policy but was not aware at the time that there was no smoking permitted outside on the premises as well. Resident #51 further identified staff never made requests to search his/her living space for smoking materials following smoking violations. Resident #51 recalled that he/she last smoked on New Years while on a LOA visit and never resumed smoking in the facility thereafter as it was a hassle. An interview with the DNS on 7/21/23 1:51 PM identified Resident #51 was noncompliant with smoking in the past but had since quit. The DNS indicated Resident #51 likely obtained smoking materials from a former roommate who also smoked but did not formally analyze the root cause following each smoking violation or implement any additional measures outside of education to reduce the environmental risk of future smoking policy violations adding she was not aware of all the violations. A review of the non-smoking facility policy and agreement directs that the facility does not permit smoking in the facility or on the premises at any time. A review of the facility policy for safe smoking identified residents noncompliant with the smoking policy will be re-evaluated by the interdisciplinary team (IDT). New interventions will ensure the safety of the residents and other residents. 5. Resident #71 has diagnoses that included right side hemiplegia (paralysis) and history of alcohol use. A review of the admission record identified Resident #71 was self-responsible. A nursing smoking safety screen dated 1/31/25 identified Resident #71 currently smoked 1 - 2 cigarettes daily, had no cognitive or dexterity deficits and determined safe to smoke without supervision. The Admissions packet dated 2/4/25 identified the facility did not permit smoking on the premises and was signed by Resident #71. The resident smoking policy dated 2/4/25 identified Resident #71 was informed there were no smoking privileges at the facility, including the use of any smoking devices and was signed by Resident #71. The quarterly MDS dated [DATE] identified Resident #71 was cognitively intact, independent with bed mobility, transfers and required set up assist with transfers supervision/touch assist with locomotion using a wheelchair. The care plan dated 5/29/25 identified Resident #71 had a self-care deficit in functional mobility and coronary artery disease. Interventions included ambulation with supervision/touch assist using of one using a two wheeled walker and observe/evaluate respiratory status including shortness of breath and dyspnea. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An APRN note dated 6/13/25 at 11:00 AM identified Resident #71 had a significant history of smoking approximately 1 pack per day for over 20 years and has not smoked since admission. Resident #71 previously used a Nicotine Patch with good results and was experiencing increased cravings, requesting to resume the Nicotine Patch. Resident #71 was started on the Nicotine Patch at lowest dose for three weeks on 5/16/25 and will continue to monitor for effectiveness. An interview with NA #4 on 7/15/25 at 11:30 AM identified there was an area, pointing to the patio of the unit identified as “Plumtrees,” where the residents go to smoke. An observation with the DNS on 7/15/25 at 11:43 AM identified Resident #71 sitting under a covered patio located outside the unit known as “Plumtrees” with a visitor with visible lingering haze and the odor of smoke. Resident #71 was holding a now out cigarette butt, with three additional cigarette butts in front of him/her, a pack of cigarettes (undetermined amount) and a lighter. There were no visible staff, no fire safe cigarette receptacles or fire safety equipment in the area. Resident #71 stated “I was smoking” to the DNS. The visitor indicated he/she was sorry, that it was his/her fault because he/she brought them in for him/her. Resident #71 agreed to give the smoking materials to the DNS who also provided education regarding safety concerns. An interview with Resident #71 on 7/16/25 at 8:32 AM identified he/she never smoked in the facility and only smoked on the Plumtrees patio where there was no signage posted that smoking was prohibited outside. Resident #71 indicated he/she had never been spoken to previously about not being able to smoke outside and was unsure if any staff were aware. An interview with the DNS on 7/16/2025 at12:54 PM identified she was not previously aware Resident #71 had been smoking on grounds which was prohibited. A visitor who was with Resident #71 admitted to bringing in the smoking materials which were removed at the time smoking was observed. The DNS further identified Resident #71 was placed on enhanced monitoring every 15 minutes. However, he/she subsequently went outside with staff and pulled a cigarette and lighter out of his/her undergarments, smoked the cigarette and refused to provide the staff with the lighter. The APRN was notified. Resident #71 was placed on 1:1 supervision following the second smoking observation and verbalized he/she will continue to seek out opportunities to smoke on the grounds. Following the event, as an immediate corrective action, all unit managers were notified of the smoking incident, and efforts were in progress to identify any additional residents who smoked. Staff were interviewed regarding any knowledge they had of residents smoking on the grounds, education was provided about the smoking policy and staff were instructed to report any resident observed smoking or in possession of smoking materials. Additional signage was ordered, electronic communication to residents and family informing them the facility was strictly non-smoking, and residents were not to have smoking/lighting materials in the facility or on the grounds. LOA instructions were provided to staff directing 1:1 supervision for Resident #71 until departure in a vehicle and to resume upon return to the facility with a request for a room search and non invasive search for smoking/vaping materials. Resident #71 was offered to transfer to a smoking facility, has agreed, but has since declined the first offering. Resident #71 subsequently signed a behavioral agreement dated 7/16/25 indicating he/she understands and agrees not to smoke in the facility, on the grounds or possess any smoking materials. A review of the non-smoking facility policy and agreement directs that the facility does not permit smoking in the facility or on the premises at any time. 6. Resident #95 had diagnoses that included nicoti (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ne dependence on cigarettes. A review of the admission record identified Resident #95 was self-responsible. Original physician orders dated 1/23/25 directed the resident may go on a leave of absence, (LOA), authorized leave, with responsible party. The resident smoking policy dated 2/3/25 identified Resident #95 was informed there were no smoking privileges at the center, including the use of any smoking devices. Resident #95 signed the smoking policy acknowledging and agreeing to abide by those rules. The quarterly MDS dated [DATE] identified Resident #95 was cognitively intact, independent with bed mobility and required supervision with transfers and ambulation. The care plan dated 6/17/25 identified Resident #95 had the potential to be a smoker. Interventions included educating the resident on the smoking policy. An APRN note dated 6/18/25 at 12:45 PM identified Resident #95 smoked cigarettes daily, was seen for smoking cessation request, and was reporting concerns regarding the Nicotine Patch use, stating it was causing nightmares. The resident indicated he/she no longer wished to use the Nicotine Patch. Resident #95 also reported that when leaving the building for LOA, he/she was frequently with people who smoked and he/she smoked with them. Lozenge 4 mg (Nicotine) 1 tablet by mouth was ordered every 4 hours as needed for smoke cessation for 30 days. A nurse’s note dated 7/12/25 at 2:48 PM identified Resident #95 signed out for LOA. Observation on 7/15/25 at 11:22 AM identified a faint smell of lingering smoke as Resident #95 was observed walking in his/her room with no visible signs of smoking. Interview with Resident #95 on 7/15/25 at 11:22 AM identified he/she was currently an active smoker who went outside unsupervised on a covered patio (identified as Plumtrees) to smoke. Resident #95 indicated he/she was aware the facility was nonsmoking, and that signs were posted. According to Resident #95, staff were aware he/she smoked and had told him/her, in the past, they could call the police due to the smoking. Resident #95 further identified he/she did not smoke in the building and secured the smoking materials, which he\she purchased while out on LOA. The unit manager was immediately notified of the possession of smoking materials. An interview with NA #4 on 7/15/25 at 11:30 AM identified that although she had not specifically observed Resident #95 smoking, there was an area (pointing to the patio of the unit identified as “Plumtrees” where residents were known to smoke, and had observed Resident #95 in that area frequently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 7/16/2025 at 12:54 PM identified she was not aware that residents were smoking anywhere on grounds. The DNS indicated Resident #95 wanted to quit and lozenges have been prescribed. Resident #95 has since agreed to keep all smoking materials at a friend’s house to use when on LOA and will no longer store them in his/her bag. As an immediate corrective action, all unit managers were notified of the smoking violation, and efforts were in progress to identify any additional residents who smoked. Staff were interviewed regarding any knowledge they had of residents smoking on the grounds, education was provided about the smoking policy and staff were instructed to report any observed resident smoking, or any resident in possession of smoking materials. Additional signage was ordered, electronic communication was sent to residents and family informing them the campus was strictly non-smoking, and that residents were not to have smoking/lighting materials in the facility or on grounds. A subsequent interview with NA #4 on 7/17/25 at 9:25 AM identified she had observed residents outside smoking in the past. NA #4 last observed residents smoking within the past three weeks but was unable to recall which residents. NA #4 further identified she reported the residents smoking to the nurse or nursing supervisor but was unable to recall who. A review of the non- smoking facility policy and agreement directs that the facility does not permit smoking in the facility or on the premises at any time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy and interview the facility failed to date Insulin pens when opened and ensure medications were within their expiration. The findings include. Observation on [DATE] at 1:50 PM in the medication storage room on the first floor with LPN #3 identified the following. Ipratropium and Bromide and Albuterol, 1 box, 6 pouches, expired 6/2025. IV 5% dextrose 1000ml, outside of the manufacturer plastic cover, label states use by [DATE]. Lansoprazole syrup 3mg/ml, 2 bottles, 1 bottle expired [DATE], 1 bottle expired [DATE]. Observation on [DATE] at 2:00 PM of the [NAME] Medication Cart with LPN #3 identified the following. Humalog Kwikpen, opened 6/11. Lantus Solostar Insulin pen, 100u/ml, opened, no resident name on pen, no date opened. Per LPN #3 she believes the Lantus Insulin pen belongs to Resident #147 because he/she is the only resident on Insulin on that medication cart. Interview with the DNS on [DATE] at 9:30 AM identified that for the IV Dextrose 1000 ml, when the pharmacy sends IV supplies for specific residents, they are sent out of the manufacturers bag and labeled with an expiration date which is 28 days after they remove it from the manufacturer bag. After that date it should be discarded. The DNS indicated the pharmacy does a monthly review to check for expiration of medications and the nurses should also be checking, however, the DNS was unable to identify which nurse/shift would complete that task or how often it should be done.Review of medication storage policy identified that open dose vials of Insulin shall be maintained no longer than the duration indicated on the manufacturer storage and handling instructions or the manufacturer list expiration date on the vial, whichever is shorter. Lantus Insulin shall be maintained no longer than 28 days or the manufacturer list expiration date on the vial, whichever is shorter.