STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075405	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Madison	34 Wildwood Avenue Madison, CT 06443

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on clinical record review, observations, facility policy, and interviews for 1 of 1 sampled resident (Resident #477) reviewed for dignity, the facility failed to ensure a urinary privacy bag was utilized. The findings include: Resident #477's diagnosis included fracture of the left femur, benign prostatic hyperplasia with lower urinary tract symptoms, and dementia. A Nursing Admission assessment dated [DATE] identified Resident #477 was moderately cognitively impaired, required limited assistance of 1 for bed mobility, extensive assistance of 1 for personal hygiene, bathing, toileting, dressing, and transfers. The Nursing Admission Assessment further identified Resident #477 had a suprapubic catheter in place. The Resident Care Plan dated 11/4/23 identified Resident #477 required an indwelling suprapubic catheter. Interventions included to provide privacy and comfort and to keep the catheter off the floor. Observation on 11/7/23 at 12:00 PM identified Resident #477 was sitting in a wheelchair in the resident dining area with numerous other residents from the facility waiting for lunch to be served. Resident #477 was further observed to have a urinary collection bag secured to the wheelchair. The urinary collection bag was noted to contain a large amount of yellow fluid inside without the benefit of a privacy covering in place. Interview with Occupational Therapist (OT) #1 on 11/7/23 at 12:30 PM identified that she assisted Resident #477 out of bed to his/her wheelchair that morning. OT #1 stated Resident #477 had a urinary collection bag but she did not know that it needed a privacy covering to be placed nor was she aware of the policy for using a privacy cover. Interview with the DNS (Director of Nursing) on 11/8/23 at 1:20 PM identified that the standards/policy was for all urinary collection bags to have a privacy covering in place and that staff was educated on this including the therapy department. She also stated that urine bags should not be exposed and needed to be covered. The facility was unable to provide a policy regarding privacy covering for urinary collection bags.

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 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. 49100 Based on review of facility Resident Council meeting documentation, interviews, and facility policy, the facility failed to adequately respond to resident grievances. The findings include: 1. Review of Resident Council minutes dated 9/21/23 identified the following concerns: A. The supper meal was arriving too early, at approximately 4:10 PM, and residents were not receiving their alternative meal choices. Review of the Resident Council minutes identified that cooks were made aware of the concern. B. Residents remained in bed until lunch due to the lack of staff, resident beds are not made or changed after residents get up, and staff can be heard discussing concerns regarding staffing issues at the facility. C. The 3:00 PM to 11:00 PM staff were heard loudly discussing residents' personal information in the hallways, using inappropriate language, and nurses were heard yelling down the hall instead of going to directly to speak with staff. 2. Review of the Resident Council minutes dated 10/19/23 identified the following: A. Residents were informed by the Dietary Department of a new dinner delivery time, 4:30 PM, but residents still objected to the new time, and had requested a later dinner delivery. B. Residents continued to express concerns with the 3:00 PM to 11:00 PM staff being loud in the hallways and at the nurse's station. Review of the Resident Council minutes identified that Nursing was aware of the concern. During the Resident Council meeting on 11/2/23 at 1:30 PM, Resident #28 indicated continued concerns with the early arrival time of dinner and that alternative meals were still not being provided as requested. Additionally, members of the Resident Council collectively expressed concerns that staff continue to speak loudly at night yelling information down the hall. Interview and review of facility documentation with the Director of Dietary on 11/2/23 at 2:15 PM identified that dinner was being provided to residents at 4:30 PM, despite the Resident Council meeting minute objections. Interview with DNS on 11/8/23 at 10:30 AM indicated that she was aware of the staffing issue and that this was a common Resident Council complaint. The DNS identified that the facility lacked a Human Resources staff member and that this had contributed to the lack of hiring new staff. Additionally, the DNS indicated that the facility corporate office did not allow the use of agency to replace the missing staff due to the associated high cost. The DNS stated that current staff does what they can to assist on the units. The DNS indicated that she had not been made aware of Resident Council concerns for the early arrival of dinner. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Dietary on 11/08/23 at 10:43 AM, identified he was aware of the concern that dinner was being sent to the units too early. The Director of Dietary stated that his staff had been educated not to serve dinner so early, but if a manager was not present in the building, the problem continued. Review of the facility Grievance policy identified that service location leadership would investigate, document, and follow up on all concerns and grievances. Additionally, the facility would receive prompt receipt and resolution of grievances/concerns.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48881 Based on review of the clinical record, facility policy, and interviews for 3 of 4 residents, (Resident #21, 428, and 527), reviewed for advance directive, the facility failed to ensure Resident #21's current preference for code status was present in the clinical (paper and electronic) health record to appropriately direct staff in the event of a medical emergency and failed to ensure Resident #428 and 527 had an advance directive code status present in the clinical record. The findings include: 1. Resident #21's diagnoses included heart failure, dementia, and anemia. Review of Face Sheet documentation in the clinical record identified Person #3 was the resident representative for Resident #21. The Resident Care Plan (RCP) dated [DATE] identified Resident #21 had an established advanced directive of full code. Interventions included activating resident's advanced directive as indicated, informing resident/healthcare decision maker of any change in status or care needs, provide resident/healthcare decision maker sufficient information to make an informed decision, and offer the opportunity to complete an advanced directive. A review of Resident #21's paper medical record identified a Resident Healthcare Instruction form, dated [DATE] that was signed by Person #3, a facility RN, and physician indicating that Resident #21 opted to be resuscitated (Cardiopulmonary resuscitation (CPR) be performed). Resident #21 returned from a hospitalization with a transfer document form dated [DATE] indicating a Do Not Resuscitate (DNR) status. Review of the Electronic Health Record (EHR) failed to indicate a physician's order or preference for an advance directive. The Resident Healthcare Instruction form dated [DATE] and transfer document dated [DATE] were noted to have 2 different advance directive choices. Interview and record review with LPN #3 on [DATE] at 11:55 AM failed to identify a physician order or identification of a code status in the EHR. LPN #3 was unsure who was responsible for entering the code status, why the record lacked a physician order, and lacked the identification of a code status in the EHR. Review of the paper clinical record with LPN #3 identified the Resident Healthcare Instruction form dated [DATE] directing a full code. LPN #3 indicated Resident #21 would be considered a full code and that Cardiopulmonary Resuscitation (CPR) would be initiated in an emergency, as facility policy was to follow what the current Resident Healthcare Instruction form and not the DNR transfer order from another facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on [DATE] at 11:18 AM identified that the Registered Nurse who was present upon a resident's admission/readmission was responsible for obtaining a code status on the Resident Health Instruction form from the resident/resident representative, which was then reviewed and signed by the physician. The DNS indicated that facility policy was to follow what was written in the paper chart, and if nothing was signed, then the resident was considered to be a full code. Review of the EHR with the DNS failed to identify a code status for Resident #21. The DNS also indicated that Resident #21 had numerous hospitalization s and that a new Resident Healthcare Instruction form should have been completed with each return from the hospital. Further review of the paper chart with the DNS identified that the Resident Healthcare Instruction form was last completed on [DATE] and identified Resident #21 as a full code. The DNS identified that Resident #21 would be considered a full code in an emergency until a new Resident Healthcare Instruction form was completed (a discrepancy from the transfer document dated [DATE] that identified Resident #21 was DNR). Interview and record review with the Administrator on [DATE] at 12:58 PM identified the facility failed to obtain an advance directive upon return to the facility after Resident #21's hospitalization s. The Administrator indicated that the signed and completed Resident Healthcare Instruction form located in the paper chart, dated [DATE], identified Resident #21 as full code. A further review of the clinical record identified a Resident Healthcare Instruction form, dated [DATE], had been completed by Person #3 and signed by the physician on [DATE] indicating a code status of DNR/may transfer/may hospitalize. The Administrator stated that the completed form had not been in the paper chart because it was on the desk of the Advanced Practice Registered Nurse for reconciliation. The Administrator identified that the family was involved in care plan meetings and visits Resident #21 on a regular basis. The Administrator further indicated that facility policy does not require a physician order, as the completed and signed Resident Healthcare Instructions form was considered the physician order. 2. Resident #428's diagnoses included diabetes mellitus type 2, dementia, and chronic kidney disease. The Nursing Admission assessment dated [DATE] identified Resident #428 was moderately cognitively impaired and required supervision with bed mobility and transfers. Review of the Resident Care Plan dated [DATE] failed to include an advance directive problem. Review of Resident #428's medical record identified that, although there was a State of Connecticut transfer order for a Do Not Resuscitate (DNR), the paper chart and Electronic Health Record (EHR) failed to indicate the facility had provided Resident #428 with an opportunity to choose an advance directive. Interview with Licensed Practical Nurse (LPN) #1 on [DATE] at 2:15 PM identified that there was no documentation present in the paper clinical record or EHR that Resident #428 or his/her representative had been given the opportunity to choose a preference for an advance directive. Further, LPN #1 indicated that this should have been completed upon admission to the facility but was unable to provide any documentation of a current advance directive status. Subsequent to surveyor inquiry, a signed advance directive consent and a physician's order dated [DATE] were obtained and identified that Resident #428 had been given an opportunity to make a choice and opted for a DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #527 was admitted to the facility with diagnoses that included Alzheimer's Dementia, bacterial pneumonia, and Type 2 Diabetes. Review of Face Sheet documentation in the clinical record identified Person #4 was the resident representative for Resident #527. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 was admitted to the facility on [DATE] and was dependent on staff for bathing, transferring, walking, and toilet use. A review of Resident #527's paper medical record and Electronic Health Record (EHR) on [DATE] at 11:00 AM failed to identify a physician order or identification of code status in the HER, and the paper chart contained a blank and unsigned Resident Healthcare instruction form. Interview and record review with Registered Nurse (RN) #1 on [DATE] at 11:22 AM identified there was no code status for Resident #527 reflected in the paper chart or in the EHR. RN #1 indicated that any nursing staff, supervisor, or admissions personnel was responsible for completing an advance directive with a resident upon admission. RN #1 further indicated that code status was documented in the EHR and paper chart. According to facility policy, if there was no identified code status in the paper chart or EHR, a resident was considered a full code. RN #1 identified Resident #527 would be provided Cardiopulmonary Resuscitation (CPR) in an emergency. Further, if a resident had a responsible party, that individual would be contacted to identify code status, either in person, via fax or email, for a resident's Resident Healthcare Instruction form to be completed and a code status determined. RN #1 indicated being unsure of the reason an advanced directive was not obtained for Resident #527 upon admission or subsequently during stay. Subsequent to surveyor inquiry, RN #1 contacted Person #4 regarding obtaining an advanced directive for Resident #527. A nursing note dated [DATE] at 11:30 AM identified a call was placed to Person #4 and a message was left with request to call the facility. Review of Code Status Orders policy identified that code status will be easily accessible to the clinical staff and that upon admission/readmission, a code status order is required as soon as possible as part of the admission order set. Further, if the admission orders do not address the patient's code status and the patient does not want to receive CPR, the facility should immediately document the patient's wishes in the medical record and immediately notify the physician to obtain a physician's order. 49021

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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** 48950 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #47) reviewed for nutrition, the facility failed to ensure the resident representative was notified of a significant weight loss. The findings include: Resident #47's diagnosis included dementia, myocardial infarction, and hypertension. Review of a face sheet document in the clinical record identified that Resident #47 was not responsible for him/herself and maintained a resident representative. An Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #47 was severely cognitively impaired and required set up assistance with eating. The MDS also identified Resident #47 had not had a significant weight loss/gain. Review of Resident #47's weight summary identified the following: on 7/1/23 Resident #47 weighed 139.1 pounds (lbs), on 8/1/23 Resident #47 weighed 133.7 lbs which was a 5.4 lb/7.6 percent (%) weight loss. A physician order dated 8/9/23 directed to weigh Resident #47 monthly, the first of every month. The Resident Care Plan dated 8/29/23 identified Resident #47 was at nutritional risk related to weight loss with interventions that included to provide large portions, to monitor changes to nutritional status (unplanned weight loss), weigh and alert Dietician/physician of any significant loss or gain. The Nutritional assessment dated [DATE] at 9:52 AM and completed by the Dietician identified a significant weight loss, significant unintentional weight loss of 5.9% in 1 month. Review of Resident #47 weight summary identified the following: on 7/1/23 Resident #47 weighed 139.1 lbs and on 10/2/23 weighed 127.1 lbs which was a 12 lb/8.6 % loss in 3 months. The Dietician's note dated 10/3/23 at 1:37 PM identified Resident #47 continued with a significant weight loss trend of 8.6% weight loss times 3 months. Interview with the Dietician on 11/7/23 at 11:15 AM failed to identify Resident #47's representative was notified of a significant weight loss and she stated the facility did not have a specific policy regarding notifying family/representatives of a significant weight loss. She identified that no one person was responsible for making the notification and that it was a team effort.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48881 Based on observations and interviews for 2 of 2 nursing units reviewed for the environment, the facility failed to ensure equipment and furniture was maintained in a clean, comfortable home-like manner. The findings included: During the initial facility tour, observation 10/31/23 at 10:30 AM, on the Tuxis Unit identified trash on the floors in the hallways and in resident's rooms #224, #226, #227, and #228. In room [ROOM NUMBER], Resident #51, surveyor observed a medicine cup on the floor with a white powder that had fallen out of the cup. The white powder was noted to be all over the floor and on the side of the bedside table. Used medical gloves rolled into balls were seen in the flower boxes on both the [NAME] and Tuxis units. Observation on 11/7/23 at 10:00 AM with the Director of Maintenance, in room [ROOM NUMBER] of the [NAME] Unit, identified a piece of wood molding under the window seat that was broken off, exposing a very sharp, rough edge of the wood. Observation of all resident rooms on the Tuxis unit on 11/7/23 at 11:05 AM, with the Director of Maintenance identified that the window seat in room [ROOM NUMBER], Resident #51, had been significantly deteriorated and was cracked, peeling, discolored, and ripped. Continued observation of all resident rooms on the Tuxis unit on 11/7/23 at 11:16 AM, with the Director of Maintenance, identified multiple rooms with window seats that were in disrepair. Almost all the seats have ripped covers, and the padding is cracked, peeling, and discolored. All wood cabinets which were built into the rooms were very worn and the protective finish was gone. Interview on 11/7/23 at 11:30 AM with the Director of Maintenance identified that maintenance was responsible for maintaining the furnishings in the rooms and the window seats should be replaced. The Director of Maintenance indicated that they had begun changing the window seats in the [NAME] Unit. The Director of Maintenance further identified that they rely on the staff to notify maintenance when items are in need of repair. The Director of Maintenance indicated that he had not been made aware that the built in furniture in the [NAME] Unit rooms and in Resident #27's room were in need of repair. Interview on 11/7/23 at 3:10 PM with the Maintenance Assistant identified that maintenance does not perform routine audits or rounds to observe resident room conditions. Further, the Maintenance Assistant reported that an assessment of the environment is performed when an issue is reported to maintenance. Although requested, the facility failed to provide an environmental condition and/or repair policy.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on observations, review of the clinical record, facility documentation, and interviews for the only sampled resident (Resident #527) who was reviewed for a physical restraint, the facility failed to ensure the resident's right to be free from a physical restraint. The findings include: Resident #527's was admitted with diagnoses that included Down Syndrome, Alzheimer's Disease, and diabetes mellitus. The admission nursing assessment dated [DATE] identified Resident #527 was admitted due to psychiatric/behavior/mental health issues and for therapy following a fall. Additionally, Resident #527 had agitation/restlessness and was hyperactive. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 had long and short term memory problems and required extensive assistance of 2 staff for bed mobility, transfers, and extensive assistance of 1 staff with toileting. The Resident Care Plan dated 10/25/23 identified Resident #527 had behaviors, was resistive to care, removed clothing in public, threw items on the floor, attempted to self-transfer, and self-ambulate, and used a wheelchair to set him/herself on the floor. Additionally, the resident was at risk for falls and lacked safety awareness. Interventions for behaviors included allowing time to express feelings, provide empathy encouragement and reassurance, provide a consistent trusted caregiver, and a provide a structured daily routine when possible. Interventions for falls included encourage the resident to remain in a supervised area while awake. Review of APRN notes dated 10/16/23 through 11/6/23 directed staff to remain with the resident and keep the resident in his/her bed or chair for safety. Review of the Medication Administration Record and the Treatment Administration Records from 10/13/23 through 11/7/23 failed to indicate that Resident #527 was to have staff remain with h/her and/or to keep the resident in the bed or chair for safety reasons. Review of nurse's notes dated 10/14/23 through 10/30/23 identified the following: 1. On 10/14/23 at 9:42 PM Resident #527 was found on the floor after independently transferring out of bed. 2. On 10/30/23 at 8:37 PM Resident #527 flipped a chair over, causing it to land on Resident #527's leg/foot, and that s/he was bleeding from the left great toe. Observations on 10/31/23 at 11:00 AM, identified Resident #527 in his/her wheelchair being assisted to the resident lounge. Once seated in the TV room, Resident #527 was noted to be removing his/her socks. The resident was redirected by the Recreation Therapist. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 10/31/23 at 11:52 AM identified Resident #527 attempting to stand up from his/her wheelchair. Resident #527 was redirected to sit back down by staff 3 times. Review of the nurse's note dated 10/31/23 at 11:35 PM Identified that Resident #527 was frequently standing unassisted and had pulled the fire alarm. Review of the Reportable Event dated 11/7/23 at 4:30 PM identified staff to resident abuse without injury. Resident #527 was found to be restrained to his/her wheelchair by a bed sheet that was tied around his/her waist. Review of facility staffing dated 11/3/23 identified the facility had 2 NA assigned to work the 3:00 PM to 11:00 PM shift, 1 NA assigned to work 4:00 PM to 11:00 PM shift, and 2 LPNs assigned to work from 3:00 PM to 11:00 PM. The facility census on Resident #527's unit was noted to be 35 residents. Interview with the Administrator and the corporate Clinical Specialist, RN #6, on 11/08/23 at 2:43 PM identified upon investigation of the incident, NA #12 admitted to tying Resident #527 to his/her wheelchair. The Administrator indicated NA #12 explained the shift had been hectic, Resident #527 had been disrobing, throwing his/her clothes on the floor, and was restless. The Administrator identified staffing that evening consisted of 1 NA who came in at 3:00 PM, 1 NA who came in at 4:00 PM, and 1 NA came in at 5:00 PM. In the interim, managerial staff had covered the floor until there were 2 or 3 NA's present. Additionally, the charge nurse, LPN #6, had also been assisting with resident care. The Administrator indicated that normal staffing for that unit depended on acuity and there should have been 3 or 4 NAs to care for the 35 residents. The Administrator determined through the investigation process, the Speech Language Pathologist (SLP) had observed Resident #527's waist restraint, removed the restraint, worked with Resident #527, and then informed LPN #6 that Resident #527 had been restrained. Additionally, the SLP also informed her Supervisor, the Rehabilitation Director. Interview with the Director of Rehabilitation on 11/8/23 at 3:16 PM identified the SLP had notified her late night on 11/3/23 that she had found Resident #527, restrained in his/her wheelchair, untied him/her, and then reported the incident to LPN #6. The Director of Rehabilitation indicated that she had informed the DNS of the incident on 11/6/23 (3 days after the restraint was reported). The Director of Rehabilitation conveyed that since the SLP had notified LPN #6 of the issue, she did not have to make any further notifications. Interview and review of the facility statement dated 11/8/23 with LPN #6, on 11/9/23 at 12:56 PM identified she started medication pass between 4:00 PM and 4:30 PM. Although LPN #6 saw the SLP, she denied the SLP informed her of the restraint and indicated a NA had made her aware. LPN #6 stated she untied the restraint from Resident #527, questioned the NA as to whether she had applied Resident #527's restraint. The NA denied doing so and added it was not acceptable to apply a restraint when the state was here. LPN #6 identified that it was either NA #12 or NA #13 but got their names confused. LPN #6 further stated that she would usually bring Resident #527 with her during medication pass to watch him/her and keep him/her from falling because the facility was always short of help. LPN #6 indicated that NA #14 had been at the facility, she was informed by another NA that NA #14 left but was unaware of what time. LPN #6 indicated that she had informed the DNS that Resident #527 was not appropriate for the facility due to behaviors and the DNS informed her that the resident's former living arrangements were not currently available. LPN #6 identified that the unit should have 5 NA to adequately care for residents but they were lucky to get 3. LPN #6 denied seeing any managerial staff assisting residents on 11/3/23. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility statement dated 11/6/23 with the SLP on 11/9/23 at 1:00 PM identified that she had come to the facility on [DATE] sometime between 5:30 PM and 6:00 PM and went directly to Resident #527's unit. When she arrived, she identified Resident #527 had been seated in his/her wheelchair with a sheet around his/her waist that was knotted at the back of the wheelchair. The SLP identified that she removed the waist restraint, brought the resident to the dining room, treated the resident, then brought Resident #527 back to the nurse's station for observation. The SLP was unable to recall the name of the nurse, but knew it was Resident #527's charge nurse. When she reported the restraint to the nurse, she was informed it was being used to keep Resident #527's pants on. The SLP denied any ill effect on Resident #527 stating that s/he was laughing and smiling but indicated that the nurse whom she informed seemed to be aware that Resident #527 was restrained. The SLP indicated that around 8:00 PM she notified the Rehabilitation Director via text message. Interview and review of the facility statement dated 11/8/23 with NA #12 on 11/9/23 at 1:31 PM identified that the facility had been short-staffed for the past 3 months, the unit often had only 2 NAs for 45 residents on the 3:00 PM to 11:00 PM shift, and that she had complained about staffing to the DNS and Administrator. Additionally, she had informed the Administrator, and been informed by both the Administrator and LPN #7, that Resident #527 needed 1 to 1 supervision due to his/her behaviors. NA #12 had witnessed the Administrator see Resident #527 remove his/her clothing, but no additional staff was ever provided. NA #12 indicated she felt Resident #527 required a belt and/or a special chair but failed to voice this to any staff members. According to NA #12, on 11/3/23, LPN #6, stated that she had things to do, could not watch Resident #527 all the time, and was done with Resident #527. NA#12 identified, at approximately 3:45 PM, she was the only NA on the unit, and saw Resident #527 removing his/her clothing. She took Resident #527 to the bathroom, completed incontinent care, and tied a sheet around his/her waist to restrain Resident #527. NA #12 identified she intended to inform LPN #6 she was restraining Resident #527 but could not locate her. NA #12 expressed she did not know what else to do as call lights were ringing and other residents were calling for water and no other staff were present. NA #12 felt in order to keep Resident #527's from falling and from grabbing items that might cause an injury, she placed a sheet around his/her waist. NA #12 noted that Resident #527 was known to throw paper off counters, had pulled the fire alarm, and had grabbed the fire extinguisher. NA #12 identified that she could not possibly watch Resident #527 and care for her other 17 residents at the same time. NA #12 indicated that NA #13 did not arrive at the facility until 4:00 PM and that she had not seen any managerial staff on the unit. NA #12 identified that she knew placing the resident in a restraint was bad, but she didn't want Resident #527 to break a bone. NA #12 identified that when she saw Resident #527 with the SLP, the belt was off, and she was thankful that someone was there to watch him/her. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Madison	34 Wildwood Avenue Madison, CT 06443

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility statement dated 11/7/23 with the DNS on 11/13/23 at 2:30 PM identified that nurses ambulated Resident #527 multiple times per day as well as kept Resident #527 in view of a nurse or another staff member. The DNS indicated that Resident #527 was as close to a 1 to 1 as you get, adding, on 11/3/23, there was not sufficient staff to watch Resident #527 due to a call out as well as a NA who did not show up. The DNS identified that she and the Administrator had stayed until 4:45 PM to help staff. Although the DNS indicated that no staff had ever come to her to complain about their assignment, she could see that Resident #527 had many behaviors. The DNS indicated that to address Resident #527's behaviors, staff assisted with meals, did not leave him/her next to the fire alarm, and did not leave a tray table in from of him/her, but failed to provide resident specific documentation for interventions in the care plan that could be implemented when Resident #527 was exhibiting his/her behaviors. These behaviors included disrobing, throwing objects, trying to ambulate, or trying to get onto the floor. The DNS identified that Resident #527, was discussed daily at morning meeting and staff were in agreement Resident #527 was not an appropriate placement for the facility due to his/her need for additional attention and lack of facility staff. The DNS indicated that she had not requested additional help from the Administrator for a 1 to 1 as the corporate office prohibited agency use and told the facility management to instead offer bonuses to current staff. The facility had previously used licensed staff to work as NAs, but was told by corporate this was not in the budget. The DNS stated there was no excuse for restraining Resident #527 and felt that his/her behavioral needs were met. The DNS indicated that previously she was able to decide which residents the facility would admit, but now admissions were approved remotely, and she knew relatively nothing about Resident #527 until s/he arrived at the facility. Further, the DNS identified that if she had known that Resident #527 had used a SOMA bed (a bed that is surrounded by a net not allowing independent exit) in the hospital, she would have denied the resident's admission. The DNS indicated that she had tried calling all his/her staff to fill the staff vacancies on 11/3/23 but had been unsuccessful. Interview and review of facility statement dated 11/8/23 with the Administrator on 11/13/23 at 3:32 PM identified that she had been made aware of the abuse allegation for a physical restraint on 11/6/23. The Administrator identified that no staff had come to her in the past with concerns regarding Resident #527's behavior and that from Resident #527's admission, staff knew s/he needed to be closely observed. The Administrator identified that Resident #527 enjoyed throwing items to the floor and it was like a game to him/her. The Administrator indicated that she was not aware that Resident #527 had used a SOMA bed in the hospital and would not have accepted the resident, on that basis, for admission, but no longer had the authority to determine which residents were admitted . Although she felt that staff had been sufficiently trained to care for a resident with Resident #527's diagnoses, the facility had staffing challenges. Continued interview and review of facility staffing for 11/3/23 with the Administrator identified the following: 1. NA #12 arrived at 3:14 PM and punched out at 11:09 PM. 2. NA #13's arrived at 4:00 PM and punched out at 11:08 PM. 3. NA #14 arrived at 3:00 PM and lacked further information except that she was unpaid. 4. LPN #6 arrived at the facility on 11/2/23 at 7:15 AM and left at 11:04 PM. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. LPN #7 arrived at 3:30 PM and left at 11:45 PM. Re-interview with the DNS on 11/13/23 at 3:40 identified that although she had a statement denying knowledge of Resident #527's restraint and a text indicating NA #14 was at the facility, the DNS indicated that NA #14 was not actually there. Attempts to interview NA#13 and LPN #7 were unsuccessful. Review of the facility Abuse, Neglect and Exploitation policy directed, in part, that the facility prohibited abuse including physical restraint not required to treat the resident's medical symptoms.

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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** 31357 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #527) who was reviewed for a physical restraint, the facility failed to report the allegation of mistreatment to the state agency in a timely manner. The findings include: Resident #527's was admitted with diagnoses that included Down Syndrome, Alzheimer's Disease, and diabetes mellitus. The admission nursing assessment dated [DATE] identified that Resident #527 was admitted due to psychiatric/behavior/mental health issues and for therapy following a fall. Additionally, Resident #527 had agitation/restlessness and was hyperactive. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 had long and short term memory problems and required extensive assistance of 2 staff for bed mobility, transfers, and extensive assistance of 1 staff with toileting. The Resident Care Plan dated 10/25/23 identified Resident #527 had a behavioral problem, was resistive to care, removed clothing in public, threw items on the floor, attempted to self-transfer, and self-ambulate, and used a wheelchair to set him/herself on the floor. Additionally, the resident was at risk for falls and lacked safety awareness. Interventions for behaviors included allowing time to express feelings, provide empathy encouragement and reassurance, provide a consistent trusted caregiver, and provide a structured daily routine when possible. Interventions for falls included to encourage the resident to remain in a supervised area while awake. Review of the Reportable Event dated 11/7/23 at 4:30 PM identified on 11/3/23 a staff to resident abuse without injury occurred. Resident #527 was found to be restrained to his/her wheelchair by a bed sheet that was tied around his/her waist. Interview with the Administrator and the corporate Clinical Specialist RN #6, on 11/08/23 at 2:43 PM identified that upon investigation of the incident, NA #12 admitted to tying Resident #527 to his/her wheelchair. The Administrator indicated that neither the Rehabilitation Director nor LPN #6 had reported the incident to the RN Supervisor or any managerial staff until 11/6/23 (3 days later) when the Rehabilitation Director informed the DNS. The Administrator identified that she had not reported the incident to the state agency until 11/7/23 (the next day) because she lacked information from the witness, the Speech Language Pathologist (SLP). Although the Administrator indicated she was aware of the 2 hour reporting window for an allegation of mistreatment, she had not done so. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Abuse, Neglect and Exploitation policy directed, in part, that the facility prohibited abuse including physical restraint not required to treat the resident's medical symptoms. Anyone who witnesses an incident of suspected abuse is to report the incident to his/her supervisor immediately regardless of shift work, the notified supervisor would report the suspected abuse immediately to the Administrator or designee in accordance with state law. Additionally, the Administrator or designee would report the allegation involving abuse not later than 2 hours after the allegation is made.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021 Based on clinical record review, review of facility policy, and interviews for one sampled resident (Resident #21) reviewed for hospitalization , the facility failed to provide notice to the Ombudsman regarding resident transfers to the hospital. The findings include: Resident #21 was admitted to the facility on [DATE] and diagnoses that included heart failure, anemia, and dementia. A Nursing Change in Condition Evaluation dated 9/25/22 noted Resident #21 had an elevated temperature and a change in vital signs. Resident #21 was transferred to the emergency room (ER) upon physician order and was admitted to the hospital. Resident #21 was readmitted to the facility on [DATE]. An electronic physician's order dated 12/1/22 at 8:35 AM directed Resident #21 be sent to the ER for evaluation following a fall with a head injury. Resident #21 was admitted to the hospital and returned to the facility on [DATE]. An electronic physician's order dated 12/24/22 at 8:10 PM directed Resident #21 be sent to the ER for further evaluation due to his/her cholecystectomy drain dislodging. Resident #21 was admitted to the hospital and returned to the facility on [DATE]. A Nursing Change in Condition Evaluation dated 1/29/23 identified Resident #21 had abnormal vital signs, fever, and nausea/vomiting. Resident #21 was transferred to theER on [DATE] upon physician's order and admitted . Resident #21 returned to facility on 1/31/23. A Nursing Change in Condition Evaluation dated 2/12/23 identified Resident #21 was noted with abdominal pain and vomiting. Resident #21 was transferred to the ER for evaluation and treatment per physician order. Resident #21 was admitted to the hospital at that time and returned to facility on 2/16/23. A Nursing Change in Condition Evaluation dated 3/19/23 indicated Resident #21 had an uncontrollable nose bleed and was transferred to the hospital at 10:40 PM by ambulance upon physician order. Resident #21 was admitted to the hospital on 3/19/23 and returned to the facility on [DATE]. A Nursing Change in Condition Evaluation dated 7/20/23 indicated Resident #21 had abnormal blood test results (abnormal hemoglobin levels). Resident #21 was transferred to the ER for evaluation and treatment at per physician order. Resident #21 was admitted to the hospital on 7/20/23 and was readmitted to the facility on [DATE]. A physician's order dated 7/29/23 at 12:53 AM directed transfer of Resident #21 to the ER for evaluation and treatment secondary to projectile vomiting, distended abdomen, and elevated temperature. Resident #21 was admitted to the hospital on 7/29/23 and was readmitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	A Nursing Change in Condition Evaluation dated 8/14/23 at 4:36 AM identified that Resident #21 had emesis (vomiting) and a firm and distended abdomen. Resident #21 was transferred to the ER for evaluation and treatment upon physician order. Resident #21 was admitted to the hospital on 8/14/23 and returned to facility on 8/17/23. Interview with Social Worker (SW) #1 on 11/6/23 at 11:40 AM identified that Social Services was responsible for notifying the Ombudsman of resident discharges and transfers from the facility. SW #1 further identified the process was to use the Office of Ombudsman online reporting system every 30 days and the report included all the residents discharged or transferred during the past 30 days. Although requested, documentation of reports made to the Ombudsman including Resident #21's transfers to the hospital was not provided. Interview with the Ombudsman on 11/8/23 at 3:35 PM identified that the facility failed to provide notice to the Ombudsman regarding transfers to the hospital for Resident #21. The Ombudsman identified that Resident #21's name did not appear in the electronic system, which indicated that a report of transfers to the hospital for Resident # 21 was not received from the facility. Additionally, the Ombudsman identified that only 3 months of reporting completed by the facility appeared in the system from 2021 to current. Review of Discharge and Transfer Policy, dated 11/15/22, identified that a resident and resident representative, if applicable, will be notified verbally followed by written notification when transferred to a hospital for unplanned, acute transfers. Additionally, copies of notices for emergency transfers must also be sent to the Ombudsman.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49021 Based on clinical record review, review of facility documentation, staff interview, and review of facility policy for one sampled resident (Resident #21) reviewed for hospitalization , the facility failed to provide the required notification of bed hold policy. The findings include: Resident # 21's diagnoses included heart failure, anemia, and dementia. Review of Face Sheet documentation in the clinical record identified Person #3 was the resident representative for Resident #21. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #21 was moderately cognitively impaired, required supervision from staff for transferring and walking, and required extensive assistance of one for dressing and personal hygiene. Review of a census list provided by the Business Office Manager (BOM), dated 11/7/23 at 11:03 AM, identified Resident #21 was transferred to the emergency room (ER) and admitted to the hospital on: 9/25/22 and returned to facility on 10/18/22, 12/1/22 and returned to the facility on [DATE], 12/24/22 and returned to facility on 12/29/22, 1/29/23 and returned to facility on 1/31/23, 2/12/23 and returned to facility on 2/16/23, 7/20/23 and returned to facility on 7/26/23, 7/29/23 and returned to facility on 8/4/23, and on 8/14/23 and returned to facility on 8/17/23. Review of a Bed Hold Notice of Policy & Authorization document for Resident #21 indicated that a Bed Hold Notice of Policy & Authorization form, dated 7/21/23, was completed by facility staff and verbally reviewed with Person #3 on 7/24/23 at 11:00 AM, but failed to reflect notification from hospital admission of 9/25/22, 12/1/22, 12/24/22, 1/29/23, 2/12/23, 7/29/23 and 8/14/23. An Administrative progress note dated 7/24/23 at 1:17 PM identified that Admissions spoke with Person #3 to notify him/her regarding the Bed Hold Policy. No questions or concerns were identified by Person #3. Interview with the BOM on 11/7/23 at 9:52 AM identified that the facility Business Office was responsible for completing the Bed Hold Notice of Policy & Authorization form with the resident or resident representative when a resident was transferred to the hospital. Additionally, the BOM indicated that the policy was for a resident or resident representative to be contacted and notified about the Bed Hold policy each time a resident was transferred out of the facility, and that a resident representative may be sent the Bed Hold Notice of Policy & Authorization form by fax or email when not present at the facility at the time of transfer. Furthermore, the BOM indicated that the completed forms are kept as a hard copy in the resident file in addition to being scanned into the electronic medical record. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review with the BOM on 11/7/23 at 9:58 AM reflected that the facility failed to provide the required notification of the bed hold policy for Resident #21 upon transfers from the facility and hospital admissions of 9/25/22, 12/1/22, 12/24/22, 1/29/23, 2/12/23, 7/29/23 and 8/14/23. The BOM identified being unsure of the reason the bed hold notice was not provided, indicated being new to the facility and that up until one month ago the Admission department at the facility was responsible for completing the Bed Hold Notice Policy & Authorization form with the resident or resident representative upon resident transfer. Review of the Bed Hold policy identified that the resident and resident representative, if applicable, will be provided with the written Bed Hold Policy Notice & Authorization form upon transfer out of the facility. Further, the policy indicated that if the resident representative is not present to receive the written notice upon transfer, the notice would be delivered via e-mail, fax, or hard copy by mail within 24 hours. Additionally, the policy identified that a copy of the signed notification would be maintained in the medical record as well as the resident's financial file.

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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** 31357 Based on review of the clinical record, observation, facility documentation, facility policy, and interviews for 3 of 3 residents (Resident #6, #68 and #527) reviewed for falls, and for 1 of 6 residents reviewed for pressure ulcers, (Resident #9), the facility failed to update the resident care plan and failed to implement interventions to the resident's care plan. The findings include: 1. Resident #6 's diagnoses included muscle weakness, Alzheimer's disease, and seizures. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 with moderate cognitive impairment for decision making and poor long and short-term memory. Additionally, Resident #6 was dependent on staff for rolling side to side in bed, for lower body dressing, and transfers to and from bed. The Resident Care Plan dated 9/3/23 identified Resident #6 as a fall risk. Interventions included the use of floor mats for safety and encouraging Resident #6 to use the call bell for assistance. A. The Reportable Event dated 10/14/23 at 10:55 PM identified that Resident #6 had fallen, was on the floor, bed was in the high position, the resident was noted to be leaning against the wall and was complaining of pain. B. The Reportable Event dated 10/31/23 at 1:15 PM identified Resident #6 had an unwitnessed fall and was found on the floor in the dining room. The investigation identified that Resident #6 was sitting in his/her wheelchair in the dining room prior to the fall. The investigation failed to identify that Resident #6 was in view of a staff member and that the fall was unwitnessed. Review of the Residents care plan in effect from 10/14/23 to 11/6/23, failed to identify that new interventions were added for Resident #6's falls that had occurred on 10/14/23 and 10/31/23. Observation of Resident #6 on 11/06/23 at 12:45 PM identified s/he was in bed without the implementation of a floor mat according to the care plan dated 9/3/23. Interview and review of the facility policy with the DNS on 11/7/23 at 9:45 AM indicated that when Resident #6 fell on [DATE] and 10/31/23 the facility staff should have implemented new interventions in the care plan with each fall to prevent future falls and according to the facility policy, should have been closely monitored (within staff view) for the fall that occurred on 10/31/23. 2. Resident #9 's diagnoses included pneumonia, urinary tract infection, dementia, and bipolar disorder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set assessment dated [DATE] identified that Resident #9 was severely cognitively impaired and required supervision with bed mobility and transfers. Additionally, Resident #9 was not at risk for pressure injury or development, a pressure reducing bed and chair were in use, and Resident #9 did not have a turning or repositioning schedule. The Resident Care Plan dated 10/10/23 identified a risk for skin breakdown related to impaired mobility. Interventions directed to encourage the resident to offload/float heels while in bed and to turn and reposition frequently. Review of the Nurse Aid (NA) flow sheets from 10/1/23 through 10/4/23 identified Resident #9 required supervision with bed mobility and transfers. APRN notes dated 10/5/23 through 10/10/23 identified that Resident #9 was seen in follow-up of pneumonia, urinary tract infection, acute kidney injury on chronic kidney disease, anemia, and decreased platelet count. Resident #9 was noted to be fatigued, lacked an appetite, was not taking food or fluids well, had increased confusion, dysuria (pain on urination), increased lethargy, and weakness/tiredness due to his/her infection. Review of the NA flow sheets from 10/5/23 to 10/13/23 identified that Resident #9 had required substantial/maximal assistance to total dependence on staff for bed mobility. Review of the facility Skin and Wound evaluation dated 10/13/23 identified a new, in house acquired, unstageable pressure ulcer to the left heel that was 100 percent eschar (hardened dead tissue debris) measuring 3.5 centimeters (cm) by 4.6 cm. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #9 was moderately cognitively impaired and required extensive assistance of 2 staff with bed mobility and transfers. Additionally Resident #9 had 1 unable to stage pressure ulcer and was not on a turning or repositioning program. The revised Resident Care Plan dated 10/13/23 identified that Resident #9 was at risk for skin breakdown related to fragile skin. Interventions directed to encourage the resident to offload/float heels while in bed and encourage to turn and reposition frequently, provide wound treatment as ordered and conduct a weekly wound assessment. The care plan failed to reflect Resident #9's increased need for assistance as documented on the NA flow sheet. m, Review of the weekly wound care provider measurements dated 10/16/23 identified a left heel, pressure induced, deep tissue pressure injury that measured 6.5 cm x 8 cm (an increase in size over 3 days.) Review of the weekly wound care provider measurements dated 11/6/23 identified the left heel pressure ulcer measured 6.5 cm x 7.0 cm (an increase in size over 7 days.) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 11/6/23 at 1:10 PM identified that Resident #9 had been reasonably independent prior to becoming ill but had been bedbound following the development of his/her illness. APRN #1 stated after observing Resident #9's new pressure wound, she directed skin prep and off-loading at all times. APRN #1 stated that pressure ulcers develop as a result of not off-loading heels, and that potentially, the pressure ulcer could have been avoided if preventative measures were put in place. Interview and review of Resident #9's clinical record/care plan with the Wound Nurse, RN #3, on 11/8/23 at 9:45 AM identified that she became responsible for the wound program on 10/16/23. RN #3 identified that, according to the care plan, Resident #9 had been encouraged to independently perform turning and positioning and off-loading since 2/12/23. RN #3 stated that when Resident #9 became ill, and more dependent on staff, and when the pressure ulcer was noted to increase in size on 10/16/23 and 11/6/23, the clinical record/care plan failed to reflect new interventions to prevent pressure ulcer development or prevent further deterioration (increase in size). Interview and review of Resident #9's clinical record with the DNS on 11/13/23 at 1:34 PM identified that after the pressure ulcer developed, and with a deterioration of the pressure injury, no new measures had been implemented. 3. Resident #68 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia and an infection of the right hip prosthesis. An Admission Nursing Fall Risk assessment dated [DATE] identified Resident #68 was a low fall risk. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 was severely cognitively impaired and required limited assistance of one person for bed mobility and transferring. Additionally, Resident #68 had only walked in the room and corridor once or twice with the physical assistance of one person. The MDS also identified Resident #68 had not had a fall in the six months before admission. The Resident Care Plan (RCP) dated 8/11/23 identified Resident #68 was at risk for falls due to impaired mobility. Interventions included having the bed in a low position, providing verbal cues, and assisting the resident or caregiver to organize belongings for a clutter-free environment in the resident's room. A facility Incident Report document dated 10/27/23 identified Resident #68 had an unwitnessed fall on 10/27/23 at 3:00 PM. The facility Incident Report indicated that Resident #68 was found lying on the floor in the hallway, the physician and family were notified, and Resident #68 was referred to physical therapy. A Physical Therapy evaluation dated 11/2/23 identified Resident #68 had fall risk factors of impaired gait, a history of falls, impaired activities of daily living, impaired cognition, incontinence, and five or more medications. The physical therapy evaluation also indicated that the resident had a fall risk of greater than 78%, which indicated a high fall risk. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Madison	34 Wildwood Avenue Madison, CT 06443

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and review of the RCP with the Director of Nursing on 11/7/23 at 12:59 PM failed to identify the RCP had been revised after Resident #68's fall on 10/27/23 to include additional interventions to prevent a fall. Additionally, the Director of Nursing indicated the nursing supervisor who responded to the fall would have updated the care plan after Resident #68's fell . 4. Resident #527's was admitted with diagnoses that included Down Syndrome, Alzheimer's Disease, and diabetes mellitus. The admission nursing assessment dated [DATE] identified Resident #527 was admitted due to psychiatric/behavior/mental health issues and for therapy following a fall. Additionally, Resident #527 had agitation/restlessness and was hyperactive. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 had long and short term memory problems and required extensive assistance of 2 staff for bed mobility, transfers, and extensive assistance of 1 staff with toileting. The Resident Care Plan dated 10/25/23 identified Resident #527 had behaviors, was resistive to care, removed clothing in public, threw items on the floor, attempted to self-transfer, and self-ambulate, and used a wheelchair to set him/herself on the floor. Additionally, the resident was at risk for falls and lacked safety awareness. Interventions for behaviors included allowing time to express feelings, provide empathy encouragement and reassurance, provide a consistent trusted caregiver, and a provide a structured daily routine when possible. Interventions for falls included encourage the resident to remain in a supervised area while awake. Review of APRN notes dated 10/16/23 through 11/6/23 directed staff to remain with the resident and keep the resident in his/her bed or chair for safety. Review of the Medication Administration Record and the Treatment Administration Records from 10/13/23 through 11/7/23 failed to indicate that Resident #527 was to have staff remain with h/her and/or to keep the resident in the bed or chair for safety reasons. Review of nurse's notes dated 10/14/23 through 10/31/23 identified the following: 1. On 10/14/23 at 9:42 PM Resident #527 was found on the floor after independently transferring out of bed. 2. On 10/30/23 at 8:37 PM Resident #527 flipped a chair over, causing it to land on Resident #527's leg/foot, and that s/he was bleeding from the left great toe. 3. On 10/31/23 at 11:35 PM Resident #527 was frequently standing unassisted and had pulled the fire alarm. Review of the Reportable Event dated 11/7/23 at 4:30 PM identified staff to resident abuse without injury. Resident #527 was found to be restrained to his/her wheelchair by a bed sheet that was tied around his/her waist. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the facility statement dated 11/8/23 with NA #12 on 11/9/23 at 1:31 PM identified on 11/3/23, LPN #6, stated that she had things to do, could not watch Resident #527 all the time, and was done with Resident #527. NA#12 identified, at approximately 3:45 PM, she was the only NA on the unit, and saw Resident #527 removing his/her clothing. NA #12 fell in order to keep Resident #527's from falling and from grabbing items that might cause an injury, she placed a sheet around his/her waist. NA #12 noted that Resident #527 was known to throw paper off counters, had pulled the fire alarm, and had grabbed the fire extinguisher. NA #12 identified that she could not possibly watch Resident #527 and care for her other 17 residents at the same time. NA #12 identified that she knew placing the resident in a restraint was bad, but she didn't want Resident #527 to break a bone. NA #12 was unable to identify measures to implement, according to the plan of care, that directed her what to do when she could not continually observe Resident #527. NA #12 identified that when she saw Resident #527 with the SLP, the belt was off, and she was thankful that someone was there to watch him/her. Interview and review of the facility statement dated 11/7/23 with the DNS on 11/13/23 at 2:30 PM identified that nurses ambulated Resident #527 multiple times per day as well as kept Resident #527 in view of a nurse or another staff member. The DNS indicated that Resident #527 was as close to a 1 to 1 as you get, adding, on 11/3/23, there was not sufficient staff to watch Resident #527. Although the DNS indicated that no staff had ever come to her to complain about their assignment, she could see that Resident #527 had many behaviors. The DNS indicated that to address Resident #527's behaviors, staff assisted with meals, did not leave him/her next to the fire alarm, and did not leave a tray table in from of him/her, but failed to provide resident specific documentation for interventions in the care plan that could be implemented when Resident #527 was exhibiting his/her behaviors. These behaviors included disrobing, throwing objects, trying to ambulate, or trying to get onto the floor. The facility Care Plan policy indicated, care plans will be reviewed and revised by the interdisciplinary team after each assessment, and as needed to reflect the response care and changing needs and goals of the resident. The facility Fall Management policy indicated that staff should implement and document patient centered interventions according to individual risk factors in the patient's plan of care. Review of the facility Skin Integrity and Wound Management policy dated 2/1/23 identified, in part, that staff would continually observe and monitor patients for changes and implement revisions to the plan of care as needed. 48880 48881 49100

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31357 Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 5 of 35 residents (Resident #21, #27, #46, #53 and #69) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure personal hygiene care and services was provided to dependent residents. The findings include: 1. Resident #21 's diagnoses included dementia, heart disease, and communication deficit. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #21 was moderately cognitively impaired and required supervision with transfers and extensive assistance with dressing and personal hygiene. The Resident Care Plan dated 9/1/22 identified Resident #21 required assistance with Activities of Daily Living. Interventions included providing staff assistance with personal hygiene. Observation on 11/6/23 at 3:10 PM, identified Resident #21 at the nursing station, with dark debris under 9/10 fingernails that were long, as well as long facial hair was noted. Review of NA flow sheets (amount of care required) from 11/1/23 through 11/7/23 identified that Resident #21 had ranged from requiring supervision to being totally dependent on staff for personal hygiene. Observation on 11/7/23 at 11:00 AM, identified Resident #21 in attendance at an activity. Resident #21 was noted with dark debris under 9/10 fingernails and was noted with long facial hair. Interview and observation with NA #2 on 11/7/23 at 12:20 PM identified Resident #21 was probably last shaved on his/her shower day, 5 days prior. NA #2 indicated that if there weren't enough staff, then residents' fingernails and shaves did not get completed. Although NA #5 indicated that the facility required 5 staff on the unit to complete hygiene care and services, and had 5 staff present on 11/7/23, she indicated that 5 NA staff on the unit during the 7:00 AM to 3:00 PM shift did not happen often. Review of nursing notes and APRN/MD notes from 11/1/23 through 11/7/23 failed to identify that Resident #27 had been refusing assistance with Activities of Daily Living. 2. Resident #27 's diagnoses included dementia, depression, and cancer. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #27 was severely cognitively impaired and required extensive assistance with transfers, dressing and personal hygiene. The Resident Care Plan dated 10/6/23 identified Resident #27 required extensive assistance with transfers, dressing and personal hygiene. Interventions directed to provide staff assistance. Observation of Resident #27 on 11/6/23 at 3:10 PM identified the resident seated at the nursing station with dark debris under all his/her fingernails and with long facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/7/23 at 11:02 AM identified Resident #27 in bed, a washbasin at the bedside, and NA #1 was providing care. Observation on 11/7/23 at 11:55 AM identified Resident #27 with dark debris under all his/her nails and was not noted to have been shaved. Review of NA flow sheets (amount of care required) from 11/1/23 through 11/7/23 identified that Resident #27 required partial/moderate assistance to being totally dependent on staff for personal hygiene. Interview and observation with NA #1 on 11/7/23 at 12:00 PM identified Resident #27 with dark debris under his/her nails and s/he was unshaven. NA #1 indicated that she had been off, and the resident's facial hair had become too long for her to shave with facility provided razors. NA #1 indicated that although a resident's facial hair was too long, she would not have informed any staff, but would sometimes complain about staffing to the DNS. NA #1 identified that that she had not noticed Resident #27 had dirty nails or was unshaven, but that NAs were responsible to ensure nail care and shaving. Review of nursing notes and APRN/MD notes from 11/1/23 through 11/7/23 failed to identify that Resident #27 had been refusing assistance with Activities of Daily Living. 3. Resident #46's diagnosis included dementia, anxiety, and muscle weakness. The Resident Care Plan dated 9/14/23 identified Resident #46 required assistance/was dependent for activities of daily living care in personal hygiene with interventions that included to supervise activities of daily living, set Resident #46 up with bathing, and set up for eating. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was severely cognitively impaired, required supervision and assist of 1 for transfers, and eating, limited assistance of 1 for bed mobility, personal hygiene, and toilet use. Observations on 10/31/23 at 12:00 PM and 11/7/23 at 12:00 PM identified Resident #46 had long fingernails, that were soiled beneath the nails and had a substantial amount of facial hair growth. Interview with Nurse Aide (NA) #1 on 11/7/23 at 12:00 PM identified she did not attempt to shave Resident #46 because the razors were dull and had attempted to trim Resident #46's nails in the past but did not on 11/7/23. 4. Resident #53's diagnoses included Alzheimer's disease, major depressive disorder, and cognitive communication deficit. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #53 was severely cognitively impaired and required the assistance of 1 staff with bed mobility and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/1/23 at 12:55 PM identified Resident #53 with long, jagged nails with a dark substance beneath and the appearance of dried blood on his/her hands. Licensed Practical Nurse (LPN) #3 was notified of Resident #53's hand/nails and stated Resident #53 had a history of picking at the lesion to the top of his/her head and LPN #3 identified she would get a Nurse Aide (NA) to provide care to the resident. The Resident Care Plan dated 11/2/23 identified Resident #53 was at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing related to recent illness, fall, hospitalization resulting in fatigue, activity intolerance, confusion. Interventions included monitoring conditions that may contribute to ADL decline, monitoring for decline in ADL function, and to provide resident with extensive assist of 1 for bed mobility, dressing, personal hygiene and bathing. Observation of Resident #53 on 11/7/23 at 9:35 AM identified dark brown debris beneath Resident #53's nails and his/her nails continued to be long and jagged. Interview with NA #9 on 11/7/23 at 10:37 AM identified that nail care, shaving, and weights are only completed when they are fully staffed. She stated if she sees long nails, she will go back to the resident when she's done with regular daily care, otherwise she will pass it on to the next shift. Interview with NA #4 on 11/7/23 at 11:42 AM identified that she was not able to get work done the way she wants due to staffing but will always try to go back the same day and complete care when time permits. She stated that when the facility was not short staffed, she tried to catch up on care like nails and shaving whenever she could. 5. Resident #69 's diagnoses included Alzheimer's Disease, dementia, and cancer. The annual Minimum Data Set assessment dated [DATE] identified Resident #69 had both long and short term memory impairment and was severely impaired for decision making. The Resident Care Plan dated 10/11/23 identified Resident #69 as dependent on staff for Activities of Daily Living. Interventions directed to provide Resident #69 with total assistance for personal hygiene. Observation of Resident #69 on 11/6/23 at 3:10 PM identified long fingernails and that the resident had not been recently shaved. Resident #69 had a dark orange material on his/her face that was caked on his/her facial hair. Observation of Resident #69 on 11/7/23 at 11:04 AM identified the resident in bed, nails remained long, and the dark orange material was still within his/her facial hair. Review of NA flow sheets (amount of care required document) from 11/1/23 through 11/7/23 identified that Resident #69 was totally dependent on staff for personal hygiene. Interview and observation with NA #3 on 11/7/23 at 12:26 PM identified Resident #69 with long nails. NA #3 indicated that Resident #69 needed his/her nails cut, that NAs are responsible to cut long fingernails, that she was the primary NA assigned to Resident #69, and that she could not recall the last time she had trimmed the resident's fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nursing notes and APRN/MD notes from 11/1/23 through 11/7/23 failed to identify that Resident #69 had been refusing assistance with Activities of Daily Living. Interview with LPN #3 on 11/7/23 at 12:30 PM identified that she was aware that Resident #21 and Resident #27 required hygiene assistance, but that Resident #21 got agitated, and that, depending on the day, Resident #27 would or would not allow care. Interview with APRN #1 on 11/7/23 at 1:30 PM identified that for Resident #21, #27, #46, #53 and #69, no staff had approached her about any unwillingness by residents to cooperate with hygiene care and services. APRN #1 indicated that if she had been approached, she could have implemented measures to improve resident hygiene such as conduct a medication review, medication time changes, or changes to activity of daily living schedules or staff. Further, APRN #1 indicated that sometimes outside people, recreation therapy, or psychiatric services could become involved to assist. APRN #1 identified that it would be her expectation for facility staff, including nursing and NAs to seek assistance with hygiene issues. Review of the facility Fingernail Care Policy identified that fingernails will be cleaned and trimmed as needed or requested. Review of the Facility Shaving Policy identified that shaving will be provided on a routine and as needed basis or as requested. 48879 48950

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F 0686 Level of Harm - 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** 31357 Based on observations, record review policy and interviews for 2 of 6 residents (Resident #9 and Resident #62) reviewed for pressure ulcers, the facility failed to prevent the development of pressure ulcers and failed to provide the necessary treatment and services for residents with a pressure ulcer. For Resident #9, the facility failed to prevent the development of a pressure ulcer in a dependent resident, failed to ensure timely turning and repositioning and off-loading/floating (removal of pressure from a body part), failed to conduct pressure ulcer risk assessments per the facility policy, and failed to conduct weekly skin assessments. For Resident #62, the facility failed to conduct an initial pressure ulcer assessment, failed to obtain initial pressure ulcer measurements, failed to inform the wound nurse of the development of a new pressure ulcer, and failed to ensure off-loading/floating of a pressure area. The findings include: 1. Resident #9 's diagnoses included pneumonia, urinary tract infection, dementia, and bipolar disorder. The quarterly Minimum Data Set assessment dated [DATE] identified that Resident #9 was severely cognitively impaired and required supervision with bed mobility and transfers. Additionally, Resident #9 was not at risk for pressure injury or development, a pressure reducing bed and chair were in use, and Resident #9 did not have a turning or repositioning schedule. The Resident Care Plan dated 10/10/23 identified a risk for skin breakdown related to impaired mobility. Interventions directed to encourage the resident to offload/float heels while in bed and encourage the resident to turn and reposition frequently. Review of the nurse aid flow sheets dated 10/1/23 to 10/4/23 identified that Resident #9 had been independent with bed mobility. Review of APRN orders dated 10/5/23 through 10/10/23 directed to administer antibiotics to treat Resident #9's urinary tract infection and pneumonia. APRN notes dated 10/5/23 through 10/10/23 identified that Resident #9 was seen in follow-up of pneumonia, urinary tract infection, acute kidney injury on chronic kidney disease, anemia, and decreased platelet count. Resident #9 was noted to be fatigued, lacked an appetite, was not taking food or fluids well, had increased confusion, dysuria (pain on urination), increased lethargy, and weakness/tiredness due to his/her infection. A change in condition nurse's note dated 10/8/2023 at 2:48 AM identified Resident #9 had an exacerbation (worsening of an already present) respiratory condition and that antibiotics were being used to treat pneumonia. Resident #9 was noted to be alert/verbal, appeared comfortable, was resting in bed without issue, and was provided with incontinent care and repositioning in bed, however the note failed to indicate encouragement or assistance with heel off-loading. Review of the nurse Situation, Background, Assessment, and Recommendation documentation dated 10/10/23 at 10:50 AM identified that Resident #9 was noted with generalized weakness. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the nurse Situation, Background, Assessment, and Recommendation documentation dated 10/11/23 identified Resident #9 was resting in bed without issue, was weak, incontinent care and repositioning in bed was provided, and the resident had a peripheral intravenous catheter inserted at 1:30 AM for antibiotic administration. The documentation failed to indicate encouragement or assistance with heel off-loading. Review of the facility Skin and Wound evaluation dated 10/13/23 identified a new, in house acquired, unstageable pressure ulcer to the left heel that was 100 percent eschar (hardened dead tissue debris) measuring 3.5 centimeters (cm) by 4.6 cm. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #9 was moderately cognitively impaired and required extensive assistance of 2 staff with bed mobility and transfers. Additionally Resident #9 had one unstageable pressure ulcer and was not on a turning or repositioning program. Review of the NA flow sheets from 10/5/23 to 10/13/23 identified that Resident #9 had required substantial/maximal assistance to total dependence on staff for bed mobility. The revised Resident Care Plan dated 10/13/23 identified that Resident #9 was at risk for skin breakdown related to fragile skin. Interventions directed to encourage the resident to offload/float heels while in bed and encourage to turn and reposition frequently. The care plan failed to reflect Resident #9's increased need for assistance as documented on the NA flow sheet. An APRN note dated 10/13/23 identified Resident #9 was seen in follow-up. Nursing staff reported a new blister to Resident #9's left heel noted during care. Resident #9 admitted to discomfort and was noted to have large intact blister to the left heel filled with light blue/red fluid. The plan included applying skin prep twice daily, off load heels at all times, and the wound team was to follow up. Additionally, Resident #9 admitted to discomfort. An APRN order dated 10/13/23 directed to apply skin prep to Resident #9's left heel unstageable pressure ulcer twice daily and keep heels elevated at all times. Review of the transcribed APRN order dated 10/13/23 directed to off load heels every day and evening shift. The transcribed order failed to include the night shift. Review of the wound care provider note dated 10/16/23 identified a left heel, pressure induced, deep tissue pressure injury that measured 6.5 cm x 8 cm (an increase in size from the initial measurement from 3 days prior). The plan included cleansing the wound with normal saline, apply xeroform, apply an abdominal pad followed by kerlix, change twice weekly, and ensure off-loading per facility protocol. Review of the facility wound tracking log and wound care provider note dated 10/30/23 identified that Resident #9 had refused to be seen the previous week. The wound care provider note identified a left heel deep tissue pressure injury that measured 5.8 cm by 7.5 cm and modifying factors included poor off-loading. Review of the weekly wound care provider measurements dated 11/6/23 identified the left heel pressure ulcer measured 6.5 cm x 7.0 cm (an increase in size from 7 days prior.) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Every 15 minute observations on 11/6/23 from 10:45 AM to 1:50 PM, identified Resident #9, lying on his/her left side, in bed, with his/her head at the foot of the bed. A pillow was noted on the floor at the foot of the bed. Resident #9 had 1 slipper sock on his/her left foot, and both heels were noted to be in direct contact with the mattress throughout each 15 minute observation time. Although staff was observed to enter the room on 4 separate occasions for 30 seconds to 1 minute, the Resident's position remained unchanged and Resident #9's left heel (the heel with the pressure ulcer) remained in direct contact with the mattress without the benefit of off-loading. Interview with NA #5 on 11/6/23 at 1:45 PM identified that she had looked in on Resident #9 after breakfast. The next time she saw Resident #9 was when she dropped off his/her lunch tray. NA #5 told Resident #9 that lunch was available, Resident #9 was noted to open his/her eyes, lift his/her head, and returned back to sleep. NA #5 denied she had offered Resident #9 assistance to reposition or move prior to leaving the room after breakfast or when dropping off Resident #9's lunch tray. Interview with APRN #1 on 11/6/23 at 1:10 PM identified that Resident #9 had been reasonably independent prior to becoming ill around 10/5/23 but had been bed bound following the development of his/her illness. APRN #1 stated after observing Resident #9's new pressure wound, she directed skin prep and off-loading at all times (off-loading was transcribed to indicate the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts only). APRN #1 indicated that once Resident #9 had declined due to his/her illness, potentially, measures for off-loading such as booties or off-loading pillows would have been appropriate. APRN #1 stated that pressure ulcers develop as a result of not off-loading heels, and that potentially, the pressure ulcer could have been avoided if preventative measures had been put in place. Interview with NA #6 on 11/6/23 at 1:50 PM identified that prior to becoming ill Resident #9 was fiercely independent. NA #6 stated that Resident #9 had developed his/her pressure ulcer a few weeks ago when s/he was sick. NA #6 indicated that when Resident #9 became sick, s/he required full care. Although Resident #9 was able to use the grab bar to turn and reposition his/her upper body, s/he required full assistance with his/her lower extremities to reposition. NA #6 indicated that in order to prevent Resident #9 from developing a pressure ulcer, pillows were to be placed for off-loading, however, NA #6 was unable to explain why Resident #9's left heel had been observed resting on the mattress for 3 hours. Interview and review of Resident #9's clinical record on 11/6/23 at 2:20 PM with LPN #2 identified Resident #9 had developed the left heel pressure ulcer when s/he was not feeling well, wasn't moving as much, and was not getting out of bed. LPN #2 indicated that Resident #9 was relatively independent prior to becoming ill but was unable to find supporting documentation that measures to prevent pressure ulcer development were implemented when Resident #9 became more dependent on staff. LPN #2 identified that when preventative measures were put in place, they were typically directed by the physician/APRN and were written on the Medication Administration or Treatment Administration Records for staff to implement and sign as being completed. LPN #2 identified that Resident #9 was known to refuse care at times, but she was unable to find documentation that Resident #9 had been refusing off-loading. Additionally, if Resident #9 had refused off-loading during her shift, she would have expected the NA to notify her immediately so she could intervene. LPN #2 indicated that although she had given Resident #9 medications around 1:00 PM, she had not repositioned or offered off-loading assistance to Resident #9 and staff had not reported that Resident #9 had refused assistance. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #4 on 11/6/23 at 2:38 PM identified that she had last seen Resident #9 between 9:00 AM and 9:30 AM when s/he refused care at the time. The next time NA #4 entered the room was approximately 2:10 PM. NA #4 indicated that when any resident has a pressure ulcer, the foot should be propped up but that Resident #9 didn't have sufficient off-loading under his/her feet when she arrived to provide care. Further, NA #4 indicated that initially the unit had 4 staff scheduled for 11/6/23, but that 1 NA had been taken to work on the other unit. NA #4 indicated that everybody was responsible to ensure that resident heels were off-loaded and that it was common sense. NA #4 indicated that Resident #9's heels were not appropriately off-loaded because it was a crazy day due to staffing issues, and she was unable to get to assist Resident #9 with care needs any sooner than she had. Interview and review of Resident #9's clinical record with the Wound Nurse, RN #3, on 11/8/23 at 9:45 AM identified that she became responsible for the wound program on 10/16/23. RN #3 identified that, according to the care plan, Resident #9 had been encouraged to independently perform turning and positioning and off-loading since 2/12/23. RN #3 stated that when Resident #9 became ill, and more dependent on staff, the clinical record failed to reflect new interventions to prevent pressure ulcer development. Although Resident #9's left heel pressure ulcer had become worse and increased in size between 10/13/23 and 10/16/23, and again between 10/30/23 and 11/6/23, no new interventions were implemented to prevent further deterioration. RN #3 identified a nurse's note she had written on 11/7/23 indicating that she had offered Resident #9 an off-loading boot on 10/23/23, which was subsequently refused by Resident #9, but failed to indicate further attempts to provide Resident #9 with other alternatives to prevent deterioration of his/her pressure wound. Further, RN #3 had thought about providing the resident with a different type of mattress but had not followed through. RN #3 was unable to find a pressure ulcer risk assessment prior to or upon development of Resident #9's left heel pressure ulcer, but that upon development Resident #9 should absolutely have had a risk assessment performed. Additionally, although RN #3 indicated that the facility should be documenting weekly skin assessments, the facility had not conducted any weekly skin assessments in some time. Interview and review of Resident #9's clinical record with the DNS on 11/13/23 at 1:34 PM identified that when a resident has a newly developed pressure ulcer, a pressure ulcer risk assessment should be conducted. The DNS identified that Resident #9's last pressure ulcer risk assessment had been completed on 2/14/2019. The DNS indicated that the facility policy was to conduct risk assessments quarterly and with a change in condition. Although the DNS indicated new interventions should have been put in place first when Resident #9 had a decline in bed mobility, after the pressure ulcer developed, and with a deterioration of the pressure injury, the DNS failed to identify any new measures had been documented or implemented. Additionally, the DNS identified that weekly skin checks should have been conducted on Resident #9's scheduled bath/shower days, however, Resident #9 had not had a weekly skin assessment conducted since 8/4/2020. 2. Resident #62's diagnoses included dementia with agitation, muscle weakness and Type II diabetes mellitus. A Braden skin risk assessment completed on 7/30/23 identified a score of 14 indicating that Resident #62 was at high risk for pressure ulcer development. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #62 was severely cognitively impaired and required the assistance of 2 staff with bed mobility and transfers. Additionally, Resident #62 was identified as at risk for pressure ulcer development and had a current pressure injury to the right heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Resident Care Plan dated 9/18/23 identified that Resident #62 was at risk for skin breakdown related to a history of a pressure ulcer, advanced age, nephrostomy tube, decreased activity, and impaired cognition, Interventions included to turn and reposition every 1-2 hours, observe skin condition daily with care and report abnormalities, off load/float heels (remove pressure) using heel boots at all times, and conduct a weekly skin check by licensed nurse. A physician's order originally dated 8/23/23 and still in effect as of 11/7/23 directed heel boots at all times, remove every shift for skin checks, daily hygiene, and treatment. Review of the Treatment Administration Record from 10/1/23 through 11/7/23 identified that Resident #62 had been directed to wear heel boots to both lower extremities, at all times, and that facility staff had signed off that the heel boots were in place every day on every shift. Review of the facility weekly skin check dated 10/26/23 indicated that Resident #62 had a previously identified pressure ulcer of the heel but failed to indicate which heel was affected. A new physician's order dated 10/27/23 directed skin prep to be applied to the left heel twice daily. Observation on 10/31/23 at 1:08 PM identified Resident #62 sitting in wheelchair wearing slipper socks without the benefit of heel boots. Review of the facility provided current resident pressure ulcer tracking received on 11/1/23 failed to indicate that Resident #62 had a pressure ulcer. Interview and review of facility documentation with the wound nurse, RN#3, on 11/1/23 at 11:43 AM identified that Resident #62 previously had a pressure ulcer of the right heel which developed on 8/30/23 but had subsequently healed as of 9/18/23. RN #3 indicated that her tracking documentation failed to identify that Resident #62 had a current pressure ulcer to his/her right or left heel. RN #3 indicated that she would have to review the clinical record. Re-interview with RN #3 on 11/1/23 at 12:05 PM identified that after reviewing Resident #62's clinical record, that Resident #62 did have a new facility acquired, stage 2 pressure ulcer of the left heel that had been identified on 10/26/23. RN #3 indicated that facility staff had never informed her of Resident #62's newly developed pressure ulcer. Further, RN #3 was unable to locate documentation in the clinical record, nursing notes, of the new pressure ulcer or that the left heel pressure ulcer had been measured since 10/26/23, when the pressure ulcer had been identified. Subsequent to surveyor inquiry, RN #3 indicated she would obtain left heel pressure ulcer measurements. Interview and review of facility documentation with the DNS on 11/1/23 at 12:41 PM indicated an APRN note dated 10/26/23 identified a new pressure ulcer to Resident #62's left heel. The APRN ordered skin prep to be applied twice daily beginning on 10/27/23, off-loading heels at all times, and the wound team was to follow-up. The DNS indicated that per facility policy her expectation with a new pressure ulcer, would have been that staff conduct a full skin assessment, document wound measurements in the medical record, conduct a change in condition assessment, and notify the wound nurse. Observation on 11/1/23 at 12:49 PM, identified Resident #62 sitting in wheelchair wearing slipper socks without the benefit of heel boots. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the revised Resident Care Plan dated 11/1/23 indicated a potential for impaired skin integrity as evidenced by Braden scale (used to predict pressure ulcer risk) and that Resident #62 was at high risk for pressure ulcer development. Interventions included the use of heel boots to bilateral lower extremities while in bed and wound care to the left heel as ordered. Although the Resident Care Plan indicated heel boots to bilateral lower extremities while in bed, the physician order continued to direct heel boots at all times and the new APRN order dated 10/27/23 directed off-loading heels at all times. Review of RN #3's wound note dated 11/1/23 at 2:04 PM identified a new left heel blister (pressure ulcer) measuring 4 (centimeters) cm by 4 cm, lacking depth. A new treatment order included skin prep twice daily and offloading boots while in bed. Although the wound note identified a change to the physician's order, review of the physician's orders failed to indicate that the physician had changed the order from wearing the boot at all times to wearing the boot while in bed. Observation on 11/7/23 at 2:24 PM, identified that Resident #62 was in the television room wearing slipper socks and a green, foam waffle boot to his/her left foot. Although Resident #62 was noted to be wearing the green foam waffle boot, his/her left heel was resting on the wheelchair foot pedal. Observation of the heel area of the green foam boot failed to identify that the boot had off-loading properties such as a cut out which would relieve pressure off the pressure injury. Additionally, Resident #62's right heel lacked a heel boot and failed to be off-loaded from the wheelchair foot pedal. Interview with NA #8 on 11/7/23 at 2:28 PM identified she had not seen Resident #62 wearing shoes or heel boots recently. Review of a late entry nursing change in condition assessment note entered by LPN #1 on 11/1/23 at 2:44 PM indicating that a blister was present on the left heel and that s/he had mistaken the new blister to be the one that was a previously documented wound on the right heel. Interview with LPN #1 on 11/7/23 at 3:42 PM identified she was on duty on 10/26/23 on the 7:00 AM to 3:00 PM shift when the pressure ulcer to the left heel was identified. LPN #1 stated that she floated between units and was not initially aware that the left heel was a new skin impairment when it was brought to her attention. LPN #1 indicated that she believed the pressure ulcer was still the same pressure ulcer of the right heel (that had been noted to have been healed on 9/18/23). LPN #1 identified that the facility policy was to measure new pressure ulcers and notify the wound nurse, but she had not known the left heel was a new pressure ulcer. LPN #1 identified she was directed, by the DNS, on 11/1/23 to write a late entry nursing note. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Skin Integrity and Wound Management policy dated 2/1/23 identified, in part, that a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal would be performed. The plan of care for the patient would be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff would continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Risk evaluations would be conducted quarterly and with a significant change in condition, and a complete wound evaluation with new in-house acquired wounds and with unanticipated decline in the wounds would be conducted. Pressure injury prevention would be implemented for identified, modifiable risk factors. Determination of appropriate support surfaces for the bed and chair would be made as well as the need for heel off-loading and revise the care plan as indicated. 48879

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48881 Based on interviews, record review, and observation for the only sampled resident (Resident #23) reviewed for foot care, the facility failed to provide podiatry services. The findings include: Resident #23's was admitted on [DATE] with diagnoses that included chronic kidney disease, total hip arthroplasty, and gout. The admission Minimum Data Set assessment dated [DATE] identified Resident #23 was cognitively intact and required extensive assistance with bed mobility, toilet use, and personal hygiene. The Resident Care Plan dated 8/25/23 identified Resident #23 was at risk for alterations in comfort. Interventions included assisting resident to a position of comfort. A physician's order dated 8/25/23 directed to consult podiatry as needed. A physician's progress note dated 9/7/23 identified Resident #23's right great toe was swollen. No referral to podiatry was noted in the medical record. Observations and interview on 11/7/23 at 11:27 AM, with Person #2, identified that the toenails of Resident #23 were long and curling forward. Person #2 identified that he/she had requested several times for Resident #23 to receive foot care, specifically regarding Resident #23's long nails. Person #2 was unable to recall who he/she told or when. Person #2 further indicated that Resident #23 had an appointment just prior to admission with his/her podiatrist to trim the residents nails, but then Resident #23 was admitted to the faciliy. Interview and clinical record review with RN #1 on 11/7/23 at 12:55 PM identified that if there was a physician's order to consult podiatry (a physician order on admission directed to consult with podiatry as needed) with any concerns, that any staff member could bring those concerns forward to the nurse and the consult would have been requested. RN #1 was unable to locate any concern being raised by the family or staff regarding Resident #23's toenails (despite Resident #23's toenails being long and curling forward). Review of the Foot Care policy 8/7/23 directed, in part, that residents who have complicating disease processes requiring foot care including, but not limited to, infections/fungus, ingrown toenails, diabetes mellitus, neurological disorders, renal failure, and peripheral vascular disease must be referred to qualified professionals such as podiatrists or other qualified providers.

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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** 48880 Based on observation, review of the clinical records, facility documentation, facility policy, and interviews for 3 of 5 sampled residents (Residents #6, 68, & 527) reviewed for falls, the facility failed to ensure care plan interventions were implemented, failed to provide adequate supervision to prevent a fall, and failed to conduct a risk assessment following falls. The findings include: 1. Resident #6 's diagnoses included muscle weakness, Alzheimer's disease, and seizures. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 with moderate cognitive impairment for decision making and poor long and short term memory. Additionally, Resident #6 was dependent on staff for rolling side to side in bed, for lower body dressing, and transfers to and from bed. The Resident Care Plan dated 9/3/23 identified Resident #6 as a fall risk. Interventions included the use of floor mats for safety and encouraging Resident #6 to use the call bell for assistance. A. The Reportable Event dated 10/14/23 at 10:55 PM identified that Resident #6 was status post fall, was on the floor, the bed was in high position, and the resident was noted to be leaning against the wall complaining of pain. B. The Reportable Event dated 10/31/23 at 1:15 PM identified Resident #6 had an unwitnessed fall and was found on the floor in the dining room. The investigation identified that Resident #6 was sitting in his/her wheelchair in the dining room prior to the fall. The investigation failed to identify that Resident #6 was in view of a staff member. Observation of Resident #6 on 11/06/23 at 12:45 PM identified him/her in bed without the benefit of a floor mat, and the bed was in the raised and high position. Review of the facility fall protocol directed that residents should be closely monitored. Interview with LPN#3 on 11/7/23 at 8:55 AM indicated close monitoring for ambulatory residents meant to check the resident every 15 minutes, while those residents who were unable to ambulate needed to be kept within a staff members view. Interview with DNS on 11/7/23 at 9:45 AM indicated that residents that are not mobile should be within view while in the environment (i.e., dining room), but that Resident #6 had not been in view when s/he fell on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Re-interview with LPN #3 on 11/7/23 at 12:16 PM indicated that when Resident #6 fell on [DATE], staff had been moving residents out of the dining room after lunch to other facility locations. LPN #3 reported that there weren't enough staff to adequately monitor Resident# 6 closely, according to the fall protocol, that was why Resident #6 was not in staff's view, and the resident's fall was unwitnessed. LPN #3 indicated that when Resident #6 had been observed in bed on 11/6/23 at 12:45 PM by the surveyor, according to the care plan, s/he should have had a fall mat in place on both sides of the bed. LPN #3 was unable to explain why the fall mats had not been in place. LPN #3 indicated that the 3:00 PM to 11:00 PM staff were responsible to ensure Resident #6's fall mats were in place. Attempts to interview the 3:00 PM to 11:00 PM staff were unsuccessful. 2. Resident #68 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia and an infection of the right hip prosthesis. An Admission Nursing Fall Risk assessment dated [DATE] identified Resident #68 was a low fall risk. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 was severely cognitively impaired and required limited assistance of one person for bed mobility, transferring, and toilet use. The MDS assessment also identified that Resident #68 had not had a fall in the six months before admission. The Resident Care Plan dated 8/11/23 identified that Resident #68 was at risk for falls due to impaired mobility with interventions that included having the bed in a low position and providing verbal cues. A Physical Therapy discharge summary dated 9/5/23 indicated Resident #68 had met their short and long-term goals of walking 300 feet (ft) with a rolling walker with supervision and verbal cues for orientation to the environment and for safety. A facility Incident Report dated 10/27/23 identified Resident #68 had an unwitnessed fall on 10/27/23 at 3:00 PM, Resident #68 was found lying on the floor in the hallway, the physician and family were notified, and Resident #68 was referred to physical therapy. A Physical Therapy Evaluation dated 11/2/23 identified Resident #68 had fall risk factors of impaired gait, a history of falls, impaired activities of daily living, impaired cognition, incontinence, and five or more medications. The Physical Therapy Evaluation also indicated the resident had a fall risk of greater than 78%. An interview with the Director of Nursing on 11/7/23 at 12:59 PM failed to identify quarterly fall risk assessments had been completed since Resident #68's admission on 8/10/23. Additionally, the DNS indicated that there should have been a fall risk assessment done after Resident #68's fall on 10/27/23. The Director of Nursing indicated that the nursing supervisor on shift at the time of the fall should have documented a fall risk assessment, however, the Director of Nursing was unable to provide a reason the assessment had not been completed after Resident #68 fell on [DATE]. Interview with Physical Therapist #1 on 11/7/23 at 3:00 PM indicated that Resident #65 was classified as a high fall risk based on the physical therapy evaluation dated 11/2/23, but that nursing had a separate fall risk assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for falls indicated that all residents were to be assessed for risk of falls on admission and on reassessments, including quarterly and after a fall. 3. Resident #527 was admitted to the facility with diagnoses that included Alzheimer's disease, bacterial pneumonia, and Type 2 Diabetes. An admission History and Physical Examination dated 10/13/23 identified Resident #527 was severely cognitively impaired, had a history of falls prior to admission, and was referred for physical therapy services. A Resident Care Plan dated 10/13/23 identified Resident #527 was at risk for falls due to cognitive loss, lack of safety awareness, and impaired mobility. Interventions included physical therapy evaluation and treatment, maintain a clutter-free environment in resident's room and consistent furniture arrangement, and encourage resident to attend activities that maximize full potential while meeting need to socialize. A Physical Therapy Evaluation dated 10/13/23 identified Resident #527 had fall risk factors of balance impairment, gait impairment, diabetes, history of falls, impaired Activities of Daily Living (ADL), impaired cognition, impaired strength, incontinence, and taking five or more medications. The Physical Therapy Evaluation also indicated Resident #527 had a fall risk of greater than 78%. A facility Incident Report dated 10/14/23 identified Resident #527 had a witnessed fall on 10/14/23 at 11:15 AM when Resident #527 was observed on the floor sitting on his/her buttocks after getting up from bed and attempting to self-ambulate. Nursing staff assessed Resident #527 for injury and Resident #527 was brought closer to the nursing station for supervision. The physician and family were notified. Interview and review of facility policy with the DNS on 11/8/23 at 10:14 AM reflected that Resident #527 fell on [DATE] and that the facility failed to complete a fall risk assessment post-fall. The DNS indicated that although facility policy identified a fall risk assessment is performed post-fall, the facility process post-fall is to complete a Nursing Change of Condition Evaluation and make a verbal referral to Physical Therapy in morning report. Review of facility Fall Management policy identified, in part, that all residents were to be assessed for risk of falls on admission and on reassessments, including quarterly and after a fall. Additionally, interventions to identify risk of falls and minimize the risk of recurrence of falls, reduce risk and minimize falls should be implemented as appropriate. 49021 49100

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on observations, review of the clinical record, facility policy, and interviews for 1 of 2 units for Resident #2, #51, #57 and #279 reviewed for oxygen therapy, the facility failed to appropriately label oxygen tubing. The findings include: 1. Resident # 4's diagnoses included anoxic brain damage, hypertension, and anxiety. The annual Minimum Data Set assessment dated [DATE] identified Resident #4 was moderately cognitively impaired and required assistance of 2 staff for bed mobility, transfers, and personal hygiene. The Resident Care Plan dated [DATE] identified Resident #4 was at risk for respiratory complications related to recent hospitalization for upper respiratory infection. Interventions included observing respiratory rate, signs/symptoms of dyspnea (shortness of breath), use of accessory muscles, indicating respiratory distress, and report any signs of respiratory distress to the physician. A physician's order dated [DATE] directed oxygen administration via nasal canula at ,d+[DATE] liters per minute to maintain oxygen saturation levels greater than 92%. A nurse's note dated [DATE] at 6:59 AM specified that Resident #4 was receiving oxygen at 2 liters per minute via nasal canula. Observations on [DATE] at 11:56 AM, demonstrated that Resident #4 was in bed with oxygen at 2 liters per minute via nasal canula and the tubing was not labeled with date, time or nurse initials. 2. Resident #51's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and obstructive sleep apnea. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #51 was moderately cognitively impaired and required extensive assistance with transfers, bed mobility, and dressing. The Resident Care Plan dated [DATE], identified Resident #51 had COPD. Interventions included monitoring for difficulty breathing, rapid, shallow breathing, and cough. A physician's order dated [DATE] directed Resident #51 to receive 4 liters of oxygen via nasal canula continuously, change oxygen tubing weekly, and label each with the date and nurse's initials. Observation on [DATE] at 11:40 AM, identified that Resident #51 was receiving oxygen via a nasal canula. The tubing was unlabeled with a date and nurse's initials. Observation and Interview with LPN #1 on [DATE] at 10:51 AM identified that Resident #51 was receiving oxygen at 4 liters per minute via nasal canula. LPN #1 indicated that the tubing was not labeled. LPN #1 identified that the MD order was to change and label the tubing weekly. LPN #1 was unable to identify why the tubing had not been changed and labeled. Subsequent to surveyor inquiry, LPN #1 changed Resident #51's nasal canula tubing and dated/initialed the tubing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Madison		STREET ADDRESS, CITY, STATE, ZIP CODE 34 Wildwood Avenue Madison, CT 06443	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident # 57's diagnosis included non-rheumatic aortic valve insufficiency, non-rheumatic valve stenosis, and dementia. The admission Minimum Data Set assessment dated [DATE] identified Resident #57 was moderately cognitively impaired and required assistance of 2 staff for bed mobility, transfers, and assist of 1 person for personal hygiene. The Resident Care Plan dated [DATE] identified Resident #57's health care decision maker wanted palliative care measures implemented related to end of life care. Interventions included a referral for hospice services. A physician's order dated [DATE] directed Oxygen administration via nasal canula at 2 liters per minute as needed for hypoxia and to maintain oxygen saturation levels greater than 90%. Observations on [DATE] at 11:00 AM, identified Resident # 57 was in bed with oxygen at 2 liters per minute via nasal canula and the tubing was not labeled with date, time, or nurse initials. A nurse's note dated [DATE] at 6:16 AM identified that Resident # 57 was receiving oxygen via nasal canula. Oxygen saturation was at 96%. A nurse's note dated [DATE] at 3:25 PM stated that Resident had died at 3:08 PM. 4. Resident # 279's diagnosis included Chronic Obstructive Pulmonary Disease (COPD), heart failure, and morbid obesity. A physician's order dated [DATE] directed oxygen administration at 3 liters per minute via nasal canula. Additionally, the order directed that Oxygen tubing be changed weekly and labeled with date, time, and nurse initials every Sunday at bedtime. The admission Minimum Data Set assessment dated [DATE] identified Resident #279 as cognitively intact. Resident #279 required maximal assistance with lower body dressing, partial assistance with upper body assistance and toileting. The Resident Care Plan dated [DATE] indicated that Resident #279 had Chronic Obstructive Pulmonary Disease. Interventions included Oxygen as ordered, obtain pulse oximeter each shift and report to physician if below 90%. Observation and interview with Resident #279 on [DATE] at 11:25 AM identified oxygen at 3 liters per minute via nasal canula and the tubing was not labeled with date, time, or nurse initials. Resident #279 stated that he tells the staff when the tubing needs to be changed and that the staff does not change tubing routinely. Interview with RN #1 on [DATE] at 11:19 AM identified that oxygen tubing should be labeled and dated. Tubing should be replaced every seven (7) days. The nurse working Sunday on the 11:00 PM to 7:00 AM shift was responsible for labeling and changing the tubing. RN #1 was unable to indicate why Resident #4, #57 or #279's tubing was not labeled, dated, or initialed by the nurse. Although requested, a facility policy for oxygen equipment was not provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48881

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48879

Based on observations, facility documentation, resident council minutes, facility policy, review of facility staffing hours, and interviews, the facility failed to adequately staff Nurse Aides (NA) throughout the facility resulting in resident care needs not being met. The findings include:

1. Resident #21 's diagnoses included dementia, heart disease, and communication deficit.

The quarterly Minimum Data Set assessment dated [DATE] identified Resident #21 was moderately cognitively impaired and required supervision with transfers and extensive assistance with dressing and personal hygiene.

The Resident Care Plan dated 9/1/22 identified Resident #21 required assistance with Activities of Daily Living. Interventions included providing staff assistance with personal hygiene.

Observation on 11/6/23 at 3:10 PM, identified Resident #21 at the nursing station, with dark debris under 9/10 fingernails that were long, as well as long facial hair.

Review of NA flow sheets (amount of care required) from 11/1/23 through 11/7/23 identified that Resident #21 had ranged from requiring supervision to being totally dependent on staff for personal hygiene.

Observation on 11/7/23 at 11:00 AM, identified Resident #21 in attendance at an activity. Resident #21 was noted with dark debris under 9/10 fingernails and was noted with long facial hair.

Interview and observation with NA #2 on 11/7/23 at 12:20 PM identified Resident #21 was probably last shaved on his/her shower day, 5 days prior. NA #2 indicated that if there weren't enough staff, then residents' fingernails and shaves did not get completed. Although NA #5 indicated that the facility required 5 staff on the unit to complete hygiene care and services, and had 5 staff present on 11/7/23, she indicated that 5 NA staff on the unit during the 7:00 AM to 3:00 PM shift did not happen often.

Review of nursing notes and APRN/MD notes from 11/1/23 through 11/7/23 failed to identify that Resident #27 had been refusing assistance with Activities of Daily Living.

2. Resident #53's diagnoses included Alzheimer's disease, major depressive disorder and cognitive communication deficit.

The quarterly Minimum Data Set assessment dated [DATE] identified Resident #53 was severely cognitively impaired and required the assistance of 1 staff with bed mobility and transfers.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/1/23 at 12:55 PM identified Resident #53 with long, jagged nails with a dark substance beneath and the appearance of dried blood on his/her hands. Licensed Practical Nurse (LPN) #3 was notified of Resident #53's hand/nails and stated Resident #53 had a history of picking at the lesion to the top of his/her head and LPN #3 identified she would get a Nurse Aide (NA) to provide care to the resident. The Resident Care Plan dated 11/2/23 identified Resident #53 was at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing related to recent illness, fall, hospitalization resulting in fatigue, activity intolerance, confusion. Interventions included monitoring conditions that may contribute to ADL decline, monitor for decline in ADL function, and to provide resident with extensive assist of 1 for bed mobility, dressing, personal hygiene and bathing. Observation of Resident #53 on 11/7/23 at 9:35 AM identified dark brown debris beneath Resident #53's nails and his/her nails continued to be long and jagged. Interview with NA #9 on 11/7/23 at 10:37 AM identified that nail care, shaving, and weights are only completed when they are fully staffed. She stated if she sees long nails, she will go back to the resident when she's done with regular daily care, otherwise she will pass it on to the next shift. Additionally, NA #9 identified when the NA's are short staffed, they can have assignments up to 12 residents. Interview with NA #4 on 11/7/23 at 11:42 AM identified that she was not able to get work done the way she wants to due to short staffing but will always try to go back the same day and complete care when time permits. She stated that when the facility was not short staffed, she tried to catch up on care like nails and shaving whenever she could. 3. Review of Resident Council minutes dated 9/21/23 identified residents remain in bed until lunch due to the lack of staff, resident beds are not made or changed after residents get up, and staff can be heard discussing concerns regarding staffing issues at the facility. Interview with DNS on 11/8/23 at 10:30 AM indicated that she was aware of the staffing issue and that this was a common Resident Council complaint. The DNS identified that the facility lacked a Human Resources staff member and that this had contributed to the lack of hiring new staff. Additionally, the DNS indicated that the facility corporate office did not allow the use of agency to replace the missing staff due to the associated high cost. The DNS stated that current staff does what they can to assist on the units. 4. Resident #527's was admitted with diagnoses that included Down Syndrome, Alzheimer's Disease, and diabetes mellitus. The admission nursing assessment dated [DATE] identified that Resident #527 was admitted due to psychiatric/behavior/mental health issues and for therapy following a fall. Additionally, Resident #527 had agitation/restlessness and was hyperactive. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 had long and short term memory problems and required extensive assistance of 2 staff for bed mobility, transfers, and extensive assistance of 1 staff with toileting. (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

The Resident Care Plan dated 10/25/23 identified Resident #527 with behaviors including resistance to care, removal of clothing in public, throwing items on the floor, attempts to self-transfer, and self-ambulate, and using a wheelchair to set him/herself on the floor.

Interventions included allowing time to express feelings, provide empathy encouragement and reassurance, provide a consistent trusted caregiver, and provide a structured daily routine when possible.

Review of APRN notes dated 10/16/23 through 11/6/23 directed staff to remain with the resident and keep the resident in his/her bed or chair for safety.

Review of the Medication Administration Record and the Treatment Administration Records from 10/13/23 through 11/7/23 failed to document that staff had remained with Resident #527.

Review of nurse's notes dated 10/14/23 through 11/7/23 identified the following:

A. On 10/14/23 at 9:42 PM Resident #527 was found on the floor after independently transferring out of bed.

B. On 10/30/23 at 8:37 PM Resident #527 flipped a chair over, causing it to land on Resident #527's leg/foot, and that s/he was bleeding from the left great toe.

C. On 10/31/23 at 11:35 PM Identified that Resident #527 was frequently standing unassisted and had pulled the fire alarm.

Review of the Reportable Event dated 11/7/23 at 4:30 PM identified staff to resident abuse without injury. Resident #527 was found to be restrained to his/her wheelchair by a bed sheet that was tied around his/her waist.

Review of facility staffing dated 11/3/23 identified that the facility had 2 NAs assigned to work the 3:00 PM to 11:00 PM shift, 1 NA assigned to work 4:00 PM to 11:00 PM shift, and 2 LPNs were assigned to work from 3:00 PM to 11:00 PM. The facility census on Resident #527's unit was noted to be 35 residents.

Interview with the Administrator and the corporate Clinical Specialist, RN #6, on 11/08/23 at 2:43 PM identified that upon investigation of the incident, NA #12 admitted to tying Resident #527 to his/her wheelchair. The Administrator stated that NA #12 indicated the shift had been hectic, Resident #527 had been disrobing, throwing his/her clothes on the floor, and was restless. The Administrator indicated staffing that evening consisted of 1 NA who came in at 3:00 PM, 1 NA who came in at 4:00 PM, and 1 NA came in at 5:00 PM. In the interim, managerial staff covered the floor until there were 2 or 3 NA's present. Additionally, the charge nurse, LPN #6, had also been assisting with resident care. The Administrator identified that normal staffing for that unit depended on acuity and there should have been 3 or 4 NAs to care for the 35 residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and review of the facility statement dated 11/8/23 with LPN #6, on 11/9/23 at 12:56 PM indicated that Resident #527 had been shirtless and that she untied Resident #527 from the wheelchair. LPN #6 stated that she would usually bring Resident #527 with her during medication pass to watch him/her and keep him/her from falling because the facility was always short of help. LPN #6 indicated that NA #14 had been at the facility but had left early according to another NA, at an unknown time and without notifying her. LPN #6 indicated that she had informed the DNS that Resident #527 was not appropriate for the facility/environment and the DNS informed her that the resident's former living arrangements were not currently available. LPN #6 identified that the unit should have 5 NA to adequately care for residents on the unit but were lucky to get 3. LPN #6 denied seeing any managerial staff assisting the staff on 11/3/23. Interview and review of the facility statement dated 11/8/23 with NA #12 on 11/9/23 at 1:31 PM identified that the facility had been short-staffed for the past 3 months, the unit often had only 2 NAs for 45 residents on the 3:00 PM to 11:00 PM shift, and that she had complained about staffing to the DNS and Administrator. Additionally, she had informed the Administrator, and been informed by both the Administrator and LPN #7, that Resident #527 needed 1 to 1 supervision due to his/her behaviors. NA #12 had witnessed the Administrator see Resident #527 remove his/her clothing, but no additional staff was ever provided. NA #12 indicated she felt Resident #527 required a belt and/or a special chair but failed to voice this to any staff members. According to NA #12, on 11/3/23, LPN #6, stated that she had things to do, could not watch Resident #527 all the time, and was done with Resident #527. NA#12 identified, at approximately 3:45 PM, she was the only NA on the unit, and saw Resident #527 removing his/her clothing. She took Resident #527 to the bathroom, completed incontinent care, and tied a sheet around his/her waist to restrain Resident #527. NA #12 identified that she intended to inform LPN #6 she was restraining Resident #527 but could not locate her. NA #12 said she did not know what else to do as call lights were ringing and other residents were calling for water and no other staff were present. NA #12 felt in order to keep Resident #527's from falling and from grabbing items that might cause an injury, she placed a sheet around his/her waist. NA #12 noted that Resident #527 was known to throw paper off counters, had pulled the fire alarm, and had grabbed the fire extinguisher. NA #12 identified that she could not possibly watch Resident #527 and care for her other 17 residents at the same time. NA #12 indicated that NA #13 did not arrive at the facility until 4:00 PM and that she had not seen any managerial staff on the unit. NA #12 identified that she knew placing the resident in a restraint was bad, but she didn't want Resident #527 to break a bone. NA #12 identified that when she saw Resident #527 with the SLP, the belt was off, and she was thankful that someone was there to watch him/her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview and review of the facility statement dated 11/7/23 with the DNS on 11/13/23 at 2:30 PM identified Resident #527 was as close to a 1 to 1 as you get, adding, on 11/3/23, there was not sufficient staff to watch Resident #527 due to a call out as well as a NA who did not show up. The DNS identified that she and the Administrator had stayed until 4:45 PM to help staff. Although the DNS indicated that no staff had ever come to her to complain about their assignment, she could see that Resident #527 had many behaviors. These behaviors included disrobing, throwing objects, trying to ambulate, or trying to get onto the floor. The DNS identified that Resident #527, was discussed daily at morning meeting and staff were in agreement Resident #527 was not an appropriate placement for the facility due to his/her need for additional attention and lack of facility staff. The DNS indicated that she had not requested additional help from the Administrator for a 1 to 1 as the corporate office prohibited agency use and told the facility management to instead offer bonuses to current staff. The facility had previously used licensed staff to work as NAs but was told by corporate this was not in the budget. The DNS indicated that she had tried calling all his/her staff to fill the staff vacancies on 11/3/23 but had been unsuccessful. Interview and review of facility staffing with the Administrator on 11/13/23 at 3:32 PM identified the following staffing for 11/3/23: 1. NA #12 arrived at 3:14 PM and punched out at 11:09 PM. 2. NA #13's arrived at 4:00 PM and punched out at 11:08 PM. 3. NA #14 arrived at 3:00 PM and lacked further information except that she was unpaid. 4. LPN #6 arrived at the facility on 11/2/23 at 7:15 AM and left at 11:04 PM. 5. LPN #7 arrived at 3:30 PM and left at 11:45 PM. Re-interview with the DNS on 11/13/23 at 3:40 identified that although she had a statement denying knowledge of Resident #527's restraint and a text indicating NA #14 was at the facility, the DNS indicated that NA #14 was not actually there. Attempts to interview NA#13 and LPN #7 were unsuccessful. Review of the Staffing/Center Plan policy last revised 8/7/23 directed, Centers will provide qualified and appropriate staffing levels to meet the needs of the patient population. The staffing plan will include all shifts, seven days per week and will meet or exceed the staffing levels mandated by state and federal staffing requirements. Staffing levels are reviewed on an ongoing basis by Center staff to evaluate compliance and provide appropriate levels of care by qualified employees.

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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. 48879 Based on review of personnel files for 2 of 3 Nurse Aides (NA #10 and NA #11), facility policy and interviews, the facility failed to complete annual performance appraisals. The findings include: NA #10's last performance appraisal in NA #10's personnel file was not dated by NA #10 or the next level manager. NA #11's last performance appraisal in NA #11's personnel file was dated 1/23/18 (5 years ago). Interview and facility documentation review with the Administrator on 11/8/23 at 4:04 PM identified she was aware that NA #11's performance appraisals had not been done since 2018 and indicated being aware they should be completed annually. She stated they were not completed due to not having consistent staff, reporting that they had not had payroll, scheduling, or Human Resource staff, and that the Director of Nursing (DNS), had changed numerous times. She indicated the current DNS was trying to catch up on tasks that were not completed by previous staff. The Administrator indicated that the DNS was responsible for completing nursing performance appraisals until all facility vacancies were filled, but that normally, Human Resources should be the one starting the performance appraisal process. Once the performance appraisal was started, managers would provide information, and the the DNS and the Administrator would complete the appraisal with a final sign off. The facility Performance Appraisals policy dated 7/1/22 directed, in part, that managers would meet with regular full-time, part-time, and casual employees at least annually to conduct a performance appraisal or have a performance-based conversation. In-service education would be provided based on the outcome of these reviews.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one of five residents (Resident #62) reviewed for unnecessary medication, and for the only sampled resident (Resident #527) reviewed for physical restraint, the facility failed to ensure that behavior monitoring was completed on a resident receiving psychotropic medications. The findings include: 1. Resident #62's diagnoses included dementia with agitation, anxiety and paranoid personality disorder. An admission physician's order dated 3/10/23 directed to administer Risperidone (an antipsychotic medication) 0.25 milligrams (mg), one tablet by mouth once daily for agitation. Review of APRN #2 orders dated 8/29/23 directed Risperdal 0.25 mg, be given, one tablet by mouth, every evening at 9:00 PM for extreme fear and agitation. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #62 was severely cognitively impaired and required the assistance of 1 staff with bed mobility and 2 staff for transfers. The Resident Care Plan dated 7/18/23 identified Resident #62 was at risk for complications related to the use of psychotropic drugs. Interventions included to monitor for changes in mental status and functional level and report to MD as indicated, monitor for continued need of medication as related to behavior and mood, monitor for side effects, consult physician and/or pharmacist as needed, and obtain psych evaluation as ordered. Review of physician's orders from 6/21/23 to 11/6/23 identified that no behavioral monitoring order was in place. Nurse's notes reviewed from 7/5/23 to 8/29/23 identified no identified target behaviors or documented behavior monitoring. Psychiatric notes documented by APRN #2 included the dates of service 8/11/23 and 9/15/23, which reported that Resident #62 was discussed with nursing on any new behaviors since last assessment and that no new or acute psychiatric concerns were noted at those times. Interview with LPN #3 on 11/6/23 at 11:18 AM identified that she could not recall any behaviors from Resident #62 or any staff reported behaviors on the 7:00 AM to 3:00 PM shift. She also reviewed a red Psychiatric concerns binder on the unit, where she was unable to find any documented concerns in the book from August 2023 to November of 2023. LPN #3 reviewed and confirmed there was no behavior monitoring on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) for Resident #62. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with APRN #2 on 11/6/23 at 11:39 AM identified that she could not recall exactly the reason Resident #62's Risperdal was increased, but indicated she thought it was related to calling out behaviors. She indicated she was unable to retrieve her notes at that time, but that if she made recommendations for any medication changes, she would also recommend and expect staff to be monitoring target behaviors. She also indicated that it was difficult to evaluate and assess resident's accurately when facilities were not documenting behaviors for resident's receiving antipsychotics. Interview and clinical record review with the DNS on 11/6/23 at 12:59 PM identified she also could not locate any behavior monitoring for Resident #62. She indicated it was an expectation and per facility policy that any resident receiving antipsychotic medication would be monitored every shift for behaviors and it should be signed off in the electronic system by the nursing staff in the MAR. She further identified the interdisciplinary team would not know if the resident was having behaviors or if the medication was working, if behavior monitoring was not being completed. Subsequent to surveyor inquiry, the DNS obtained a physician order for behavior monitoring effective 11/6/23. 2. Resident #527's was admitted with diagnoses that included Down Syndrome, Alzheimer's Disease, and diabetes mellitus. The admission nursing assessment dated [DATE] identified that Resident #527 was admitted due to psychiatric/behavior/mental health issues and for therapy following a fall. Additionally, Resident #527 had agitation/restlessness and was hyperactive. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #527 had long and short term memory problems and required extensive assistance of 2 staff for bed mobility, transfers, and extensive assistance of 1 staff with toileting. The Resident Care Plan dated 10/25/23 identified Resident #527 had a behavioral problem, was resistive to care, removed clothing in public, threw items on the floor, attempted to self-transfer, and self-ambulate, and used a wheelchair to set him/herself on the floor. Interventions included allowing time to express feelings, provide empathy encouragement and reassurance, provide a consistent trusted caregiver, and a provide a structured daily routine when possible. The physician orders dated 10/13/23 through 11/7/23 directed to administer Olanzapine (an antipsychotic) 7.5 milligrams (mg) in the morning and 12.5 mg at bedtime for behavioral disturbance. The physician's order failed to include behavioral monitoring. Review of the Medication Administration Record (MAR) and the Treatment Administration Records (TAR) from 10/13/23 through 11/7/23 failed to indicate that behavioral monitoring was being conducted. Review of the NA flow sheets from 10/13/23 through 11/13/23 failed to indicate behavioral monitoring. Nurse's notes reviewed from 10/13/23 to 11/13/23 failed to identify target behaviors or documented behavior monitoring. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Madison		STREET ADDRESS, CITY, STATE, ZIP CODE 34 Wildwood Avenue Madison, CT 06443	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 11/13/23 at 2:30 PM identified that behavioral monitoring should be conducted for residents with dementia who were on antipsychotic medications without a psychiatric diagnosis. The DNS was unable to locate documentation of behavior monitoring in the clinical record. Review of the Behaviors: Management of Symptoms policy last revised 10/24/22 identified staff will monitor for and document in the medical records any exhibited behavioral symptoms, and identify underlying causes of behavioral symptoms.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on the clinical record review, facility policy and interviews for 1 sampled resident (Resident #61) reviewed for dentition, the facility failed to provide dental services. The findings include: Resident #6 was admitted to the facility on [DATE] with diagnosis that included end stage renal disease, right above knee amputation, and coronary artery disease. A Resident Care Plan dated 2/25/22 identified Resident #61 was at risk for oral health or dental care problems as evidence by tooth decay. Interventions included to obtain dental consultation as ordered, assess for oral lesions, inflammation, bleeding and signs and symptoms of pain during care and to report to MD as indicated. An oral health evaluation completed on 2/25/22 at 1:47 PM by Register Nurse (RN) #1 indicated a dental consult as ordered. Resident #61 had an oral health evaluation done on 2/26/23 at 4:51 PM by RN #4 which indicated a dental consult as ordered. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #61 was cognitively intact, required supervision and assist of 1 for bed mobility, dressing, toileting, personal hygiene, and transfers. Observation on 11/1/23 at 11:40 AM identified Resident #61 had scattered broken teeth that were discolored and stated he/she expressed to RN #4 that he/she would like to see a dentist. Interview and record review with the Director of Nurses (DNS) on 11/7/23 at 1:35 PM failed to identify Resident #61 had ever been seen by a dentist since being admitted to the facility on [DATE] (over one year and 8 months). Additionally, permission for a dental consultation had not been obtained on admission, although vision consultation had been obtained. The DNS identified the admitting nurse was responsible for ensuring the permission forms are completed for dental, hearing, podiatry, and vision. She stated that the admission nurse was responsible for having the consent forms filled out and signed. Interview with RN #4 on 11/7/23 at 3:00 PM identified that she was not the admitting nurse, so therefore she did not complete the dental permission form with Resident #61. Additionally, on 11/8/23 at 8:00 AM, RN #4 identified that if permission was not obtained on admission, the facility had 24 hours to complete all paperwork and if not completed it would be passed on for the next shift to complete. Review of the facility Dental service policy identified that residents will have routine dental services (routine dental services means annual inspection of the oral cavity). The policy is to ensure that residents obtain needed dental services, including routine dental care.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48881 Based on observations, facility policy, facility documentation, and interviews for 2 of 2 resident units, for Resident #'s 28, 51, 61, 278, and 428, who were reviewed for receiving a nourishing snack when mealtimes exceeded 14 hours, the facility failed to provide adequate snacks. The findings include: Intermittent interviews on 10/31/23 between 10:30 AM and 2:00 PM and 11/2/23 between 12:00 PM and 2:00 PM with Resident's #28, 51, 61, 278, and 428 identified that the residents were receiving a small snack in the evening only upon request. The resident's reported examples of the snacks brought when requested were a cookie, cookie bar, apple sauce, or juice and they did not feel that this was an adequate and substantive snack. Interview and review of facility documentation with Dietary Supervisor #2 on 10/31/23 at 10:45 AM during the initial kitchen tour identified that meals were served at 7:30 AM, 11:30 AM, and 4:30 PM and that snacks were given in the evening hours and consist of small items. A 15-hour gap was noted between the dinner service at 4:30 PM and breakfast service at 7:30 AM. A Resident Council meeting was held on 11/2/23 at 1:30 PM, during which Resident #28 indicated continued concerns with the too early arrival time of dinner, and objected to the 15 hour gap between dinner and breakfast. An observation of the nourishment station on the Tuxis unit on 11/7/23 at 11: 00 AM failed to identify any available resident snacks. An interview with Dietary Aide (DA) #1 on 11/7/23 at 12:45 PM identified that nourishments are delivered to residents when facility staff reported that residents would like to have a snack. DA #1 identified that DA's are responsible for preparing and delivering the snacks to the unit. Interview with Director of Dietary on 11/08/23 at 10:43 AM, indicated that nourishment carts (cookies, peanut butter and jelly sandwiches, pudding, and fruit cups) were put into each unit kitchenette by evening staff. Interview with NA#2 on 11/8/23 at 10:50 AM indicated that it was very rare that the Dietary Department delivered a snack cart to the unit. NA #2 identified that if a resident requested a snack, NA's had to go to the kitchen themselves and obtain the snack. Further, NA #2 indicated that nursing units have not received a snack car, sometimes for weeks at a time. Although attempted, an interview with the Dietician could not be completed due to unavailability. Review of the Snack, Nourishments, Supplements, and Pantry Stock policy dated 5/1/23 directed, in part, that the evening snack is a planned as part of the menu and that established par levels for stock foods would be stored for use on the nursing units.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observation, facility documentation, facility policy, and interviews, the facility failed to follow infection control practices on 1 of 2 units to provide a clean environment for Resident #53, and for the Infection Control Program, failed to ensure all required infection control policies and procedures were present in the Infection Control Manuals. The findings include: 1. Resident #53's diagnoses included Alzheimer's disease, cognitive communication deficit, and inflammatory polyarthropathy (arthritis affecting 5 or more joints). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #53 was severely cognitively impaired and required the assistance of 1 staff with bed mobility and transfers. The Resident Care Plan dated 11/2/23 identified Resident #53 was at risk for decreased ability to perform activities of daily living (ADLs) in bathing, grooming, personal hygiene, and dressing related to recent illness, fall, hospitalization resulting in fatigue, activity intolerance, confusion. Interventions included to monitor conditions that may contribute to ADL decline, monitor for decline in ADL function, provide resident with extensive assist of 1 for bed mobility, dressing, personal hygiene and bathing. Observation on 10/31/23 at 11:12 AM, identified Resident #53's room with a full trash can on the bedside chair by the door, as well as soiled linens and incontinent pads on the floor. Interview with Housekeeper #1 on 10/31/23 at 11:15 AM identified the trash can and linens/incontinent pads should not be there. She stated from her experience on this unit, the residents in that room were not capable of picking up and putting the trash can on the chair. She picked up a clean brief that was sitting next to the chair and stated her guess was that it was a staff member that left the room in disarray. She indicated that the staff often leave rooms messy and that she does the best she can but that she has 40 rooms to clean on her shift. 2. During a review of the facility infection control program, facility policy manuals, the facility lacked the required policies for: Undiagnosed respiratory illness (requiring containment) and Plan for early detection, management of a potentially infectious, symptomatic resident requiring lab testing or implementation of appropriate Transmission Based Precautions/Personal Protective Equipment (TBP/PPE). Interview on 11/8/23 at 11:05 AM with Registered Nurse (RN) #3 indicated she was unable to locate the policies or state what guidance the facility followed in regard to the policies that were not located within the infection control policy manuals. RN #3 indicated she would follow up with the Director of Nursing Services (DNS) to see if they were able to locate them. Interview on 11/8/23 at 2:09 PM with RN #3 identified she nor the DNS had not been able to find the missing policies, and that they were not aware of all of the infection control policies required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Infection Control Outcome and Process Surveillance and Reporting policy last revised 2/1/23, directed, in part, that the Infection Preventionist will conduct regular outcome surveillance consisting of collecting/documenting data to standard, written definitions of infection. They will also conduct process surveillance to review practices directly related to resident care to include monitoring of compliance with Transmission Based Precautions, proper hand hygiene, the use and disposal of gloves, and observation of the environment. This is done to detect possible communicable diseases or infections, plan control activities before communicable diseases or infections can spread to others, and identify and manage potential outbreaks of disease, as well as identify whether the practices comply with established prevention and control procedures and policies based on recognized standards. Although a policy was requested on Infection Control practices within the facility, one was not provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, facility documentation, facility policy and interviews, the facility failed to ensure safe water temperatures for 1 of 2 units in resident areas. The findings include: Observation on 10/31/23 at 10:46 AM identified the bathroom sink water temperature for Resident #19 and Residents #43 was 125.6 degrees Fahrenheit. Observations on 10/31/23 at 11:20 AM with the Director of Maintenance identified the following: For Resident #19 and Resident's #43, the Director of Maintenance identified the bathroom sink temperature to be 123.4 degrees Fahrenheit (F), and 125.1 degrees F was measured by the surveyor. For Resident #29 and Resident's #41, the Director of Maintenance identified the bathroom sink water temperature to be 122.6 degrees F, and 124.5 degrees F was measured by the surveyor. For Resident #52 and Resident's #62, the Director of Maintenance identified the bathroom sink temperature to be 125.3 degrees F, and 127.0 degrees F was measured by the surveyor. For Resident #327, the Director of Maintenance identified the bathroom sink temperature to be 124.2 degrees F, and 126.7 degrees F was measured by the surveyor. For Resident's #38 and Resident #65, the Director of Maintenance identified the bathroom sink temperature to be 123.8 degrees F, and 126.8 degrees F was measured by the surveyor. Interview with the Director of Maintenance on 10/31/23 at 11:22 AM identified that he thought sink temperatures in resident areas were supposed to be under 124 degrees F. Interview with the Administrator on 10/31/23 at 12:36 PM identified that water temperatures were taken regularly and she had never been notified that the water temperatures have exceeded 120 degrees Fahrenheit. Interview with the Director of Maintenance and review of facility documentation on 10/31/23 at 12:54 PM identified that he checked the boiler, the water log book, and the water temperatures should be between 118-124 degrees F. He was only able to provide water temperature logs for 10/14/23, although a month of logs were requested. The Director of Maintenance further indicated that he had not notified the Administrator for any excessive temperatures taken and stated he didn't think 1 to 2 degrees above 124 degrees F was significant, and denied turning off the water valve in those affected rooms. He stated the process had just been to adjust the cold water to bring the hot water down. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator and review of facility documentation on 10/31/23 at 1:02 PM identified that the water temperature logs from 10/14/23 on the [NAME] unit showed nine resident rooms with water temperatures above 120 degrees. She identified that the water temperatures were to be between 105 and 120 degrees and indicated these temperatures were excessive. The Administrator stated that the Director of Maintenance had not followed the facility policy for taking water temperatures and that she would discuss her expectations with the Director of Maintenance. Subsequent to surveyor inquiry, on 11/1/23, signs were hung on all bathroom doors alerting staff to be mindful of water temperatures and to check the water temperature prior to using on residents. Interview with the Administrator on 11/2/23 at 10:50 AM identified that the HVAC vendor had been at the facility on 10/31/23 to recalibrate the boiler. She indicated that there have since been no water temperatures above 120 degrees, stating the highest temperature has been 114 degrees F and they are now taking water temperatures twice daily, in the morning, and again in the afternoon. Review of the Hot Water Temperatures: Inspection policy last revised 6/1/23 directed that hot water temperatures will be tested weekly to ensure temperatures are at proper levels. They are to conduct tests in at least three locations per generating system and use the Hot Water Temperatures: Weekly Inspection form to document test results. If temperature does not meet state or local regulations, adjust accordingly. Inspection forms will be filed and maintained for one year.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48879 Based on facility documentation, facility policy, and interviews, the facility failed to ensure Nurse Aide (NA) #1 and NA #10 completed 12 hours of in-service education annually, and failed to provide evidence that all NAs were provided the mandatory 12 hours of in-service training. The findings include: NA #1 completed 5.78 hours of online training, plus an in-person facility training on Personal Protective Equipment (PPE) and hand washing on 12/10/22 (did not specify length) and an in-person training on Abuse, Neglect and Exploitation on 2/10/23 (did not specify length). The training failed to reflect NA #1 received any dementia care training. NA #10 did not complete any of the online training, but did complete an in-person facility training on PPE and hand washing on 12/10/22 (did not specify length) and an in-person training on Abuse, Neglect, and Exploitation on 2/10/23 (did not specify length). The training failed to reflect NA #10 received any training on dementia care. Interview with RN #5 on 11/8/23 at 3:58 PM identified she provided all of their education and in-service training, which was through their online portal, as well as in-person training, for which she provided the sign-in sheets. Additionally, RN #5 provided a spreadsheet for 2022, as she was not able to access the in-services to print for 2022. She indicated that the topics for each quarter are due by the end of the quarter, i.e.: quarter 1 was due by 3/31/23 and it was the expectation that all staff members complete the in-services on time. RN #5 did not give an explanation as to why the mandatory in-service training was not completed. Although requested, an annual in-service training policy was not provided.