STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility documentation, facility policy and interviews for 4 of 12 residents (Resident # 10, Resident #15, Resident #22, and Resident # 23 reviewed for smoking, the facility failed to revise the care plan to indicate smoking privileges, concerns or restrictions. The findings included: 1. Resident #10 ?s diagnoses included necrotizing fasciitis, Fournier gangrene and anxiety disorder.The Resident Care Plan dated 11/24/2025 failed to identify smoking in the care plan. The admission Minimum Data Set assessment dated [DATE] identified Resident #10 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and required substantial maximum assistance for lower body dressing, toileting, partial moderate assistance with upper body dressing, bed mobility, transfer, set up assistance with hygiene, independent eating and no current tobacco use.2.Resident # 15's diagnoses included moderate protein calorie malnutrition, chronic obstructive pulmonary disease and nicotine dependence.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #15 as cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and required supervision for hygiene, set up assistance for dressing and independent with eating, bed mobility, transfer, and toileting.The Resident Care Plan dated 11/18/2025 failed to identify smoking in the care plan.3. Resident #22's diagnosis included bipolar disorder, anxiety disorder and nicotine dependence.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #22 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and was independent with hygiene, dressing, toileting, bed mobility, transfers and eating.The Resident Care Plan revised dated 11/28/2025 identified as a safe supervised smoker- may not go on independent smoking due to safety. Interventions included ensure that the resident and responsible party are made aware of the facility smoking policy, all smoking materials will be stored in a secure location, ensure smoking occurs in designated smoking areas, ensure that no oxygen is located in the smoking area while the resident is smoking, no smoking materials or igniter's will be stored in the resident rooms, resident will be escorted 3 times a day for opportunity to smoke with supervision to ensure safety. The Resident Care Plan failed to identify unsafe smoking incidents on 8/1/2025, 8/13/2025 and 12/21/2025 or interventions related to a behavioral contract.4. Resident # 23's diagnoses included chronic obstructive pulmonary disease, adjustment disorder with depressed mood and nicotine dependence.The admission Minimum Data Set assessment dated [DATE] identified Resident # 23 was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 and required substantial maximum assistance with lower body dressing, partial moderate assistance with upper body dressing, toileting, bed mobility, transfers, set up assistance with hygiene and eating and current tobacco use.The Resident Care Plan dated 11/20/2025 failed to identify smoking in the care plan.Observation of smoking on 12/24/2025 at 11:11AM with 7 residents present, (Resident # 9, Resident #10, Resident #15, Resident #17, Resident #20, Resident #22, and Resident #29) were observed smoking accompanied by RN #2, NA #3, NA #4 and Front desk #2. Each resident was given 1 cigarette which was lit by Front desk #2. Observation identified all residents were able to smoke independently and extinguish smoking material in the self-extinguishing ashtray.Interview and clinical record review with (continued on next page)

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Director of Nursing (DNS) on 12/29/25 at 10:52AM identified care plans are completed by the MDS Coordinator and the admission nurse, moving forward it will be completed by nursing. The care plan was updated with the care plan schedule. The DNS could not explain why the medical record failed to reflect current smoking care plans.Review of the Care Plans Comprehensive Person-Centered policy dated 2001 directed, in part, the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. And reflects currently recognized standards of practice for problem areas and conditions.Review of the Care Plan -Interdisciplinary Team policy dated 2001 directed, in part, comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #34) reviewed for discharges, the facility failed to ensure the Ombudsman was notified of a hospitalization and a discharge to community and for (Resident #7) reviewed for discharge, the facility failed to provide written notification to the resident's conservator explaining why the resident was being transferred to the hospital The findings included: 1 a. Resident #34 was admitted to the facility in [DATE] with diagnoses that included chronic hepatitis, and cardiomyopathy. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 had moderately impaired cognition. The nurse's note dated [DATE] at 11:52 PM identified Resident #34 was alert and oriented. Resident #34's left side of the chest where there was a pacemaker appeared swollen and the resident complained of itchiness. The Advanced Practiced Registered Nurse (APRN) was notified and gave an order to send Resident #34 to the emergency room for further evaluation. The nurse's note dated [DATE] at 12:21 AM identified Resident #34 was transferred to the emergency room for evaluation at 12:20 AM. A physician's order dated [DATE] directed to send Resident #34 to the emergency room for further evaluation. Resident #34's census report identified Resident #34 was sent to the hospital on [DATE] and was readmitted back to the facility on [DATE]. An Ombudsman notification dated [DATE] at 10:43 AM identified the hospitalizations for the month of June, month of July, and the month of [DATE] was submitted, but the report did not have Resident #34 listed for the hospitalization on [DATE]. This was submitted by Social Worker (SW #1). b. The nurse's note dated [DATE] at 2:10 PM identified Resident #34 had received last dose of Intravenous Therapy (IV) antibiotics and was seen by the infectious disease physician who cleared Resident #34 for discharge home. The social worker note dated [DATE] at 2:10 PM indicated Resident #34 was safely discharged home with home care services. The nurse's note dated [DATE] at 5:50 PM identified Resident #34 was discharged today with discharge papers and medications were given. Resident #34 left at 5:35 PM via taxi. Resident #34's census report identified Resident #34 was discharged on [DATE]. An Ombudsman notification dated [DATE] at 12:56 PM identified notification of routine monthly hospital discharges. Hospital discharges for month of [DATE] and [DATE] which did not identify Resident #34 was discharged home to the community. An attempt to interview with SW #1 was unsuccessful. Interview with the Administrator on [DATE] at 12:52 PM indicated the SW#1 was on vacation but was responsible for notifying the Ombudsman monthly of all residents sent to the hospital and all residents that were discharged voluntary and involuntary as needed for the month prior. The Administrator indicated there was only one social worker for the facility. The Administrator indicated he had the administrator assistant working on printing out the confirmation receipts to the Ombudsman's office for the monthly submissions. Interview with the Administrator on [DATE] at 1:01 PM indicated the social worker updated the Ombudsman on [DATE] for the hospitalizations for the months of June, July, and [DATE]. The Administrator indicated the discharges were not on these submissions and maybe the social worker did it on a separate piece of paper. The Administrator indicated SW #1 updated the ombudsman on [DATE] for September and [DATE]. The Administrator indicated on [DATE] for October and [DATE] discharges to the hospital. Interview with the Administrator on [DATE] at 2:00 PM indicated SW #1 was out of the country and would not return until [DATE]. The Administrator indicated he was aware that the Ombudsman must be notified of all discharges monthly and not just the hospitalizations. Review of the facility Transfer or Discharge Facility Initiated Policy identified Notice of transfer or discharge is provided to the resident and resident representative as soon as practicable before the transfer and to the long-term care Ombudsman when practicable (e.g. in a monthly list of residents that includes all notice content requirements). The facility will send a copy of the discharge notice to a representative of the office of (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the Longterm Care (LTC) Ombudsman. Notice to the Office of the LTC Ombudsman will occur at the same time as the notice of discharge is provided to the resident and the resident's representative. Although requested a policy of ombudsman monthly notification requirements was not provided. 2.Interview with the Administrator on [DATE] at 12:52 PM indicated the SW #1who is on vacation is responsible for notifying the Ombudsman monthly of all residents sent to the hospital and all notification of discharges voluntary and involuntary as needed. There is only one social worker in the facility. The Administrator indicated he had an assistant administrator working on printing out the confirmation receipts to the Ombudsman's office. Interview with the Administrator on [DATE] at 1:01 PM indicated the social worker updated the Ombudsman of the June, July and [DATE] discharges on 8/14/ 25. The Administrator indicated SW#1 updated the ombudsman on [DATE] for September and [DATE]. The Administrator indicated on [DATE] for October and [DATE] discharges to the hospital. It is not completed monthly and is only for residents hospitalized , not discharged home. Interview with the Director of Nursing Services (DNS) on [DATE] 1:31 PM identified the nurse sending the resident out is responsible for ensuring a copy goes to the hospital, one to the resident, and one to social worker who places it in the chart. The DNS indicated the bed hold policy for the residents would be in the medical record or maybe the social worker has it since it is not in the old medical records. copy provided. Resident #34 were sent to the hospital on [DATE] and [DATE]. The DNS indicated they do not scan the bed hold policy provided to the residents. Interview with the DNS on [DATE] at 1:43 PM after review of the social worker bed hold 3 ring binder book in the social worker office with the DNS indicated there were no bed hold forms with Resident #34's name on it was not there. 3. Resident #7's diagnoses included urinary tract infection, acute on chronic congestive heart failure, Alzheimer's disease, schizophrenia, dementia with other behavioral disturbances.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident # 7's Resident Care Plan (RCP) dated [DATE], identified the resident's code status as a full code. Interventions included for staff/medical professionals to attempt Cardiopulmonary Resuscitation (CPR) and life saving measures as needed when medically necessary. Review of Resident #7's clinical record identified nurses notes dated [DATE], [DATE], [DATE], [DATE] and [DATE] indicated the resident was transferred to the hospital. Further review failed to identify the facility notified the resident's conservator in writing of any of the transfers.Interview with facility Assistant Administrator, as well as the Administrator on [DATE] at 9:30 AM identified they could not locate any documentation related to updating Resident #7's conservator in writing notifying them of the resident's transfer, and why the resident was transferred to the hospital. The administrator stated, I didn't know that was a thing. At 10:53 AM, a call was placed to the resident's conservator to follow up regarding if the facility sent her/him in writing a reason for Resident #7's transfers. Surveyor received an automated message identifying the recipient had a voice mail box that had not been set up. Review of the Discharge-Planning policy, indicated, in part, that a copy of the written notification of a resident's planned transfer or discharge be provided to the resident and their representative are notified in writing of the following information: the specific reason for the transfer or discharge, including the basis under S483.15(c)(l)(i)(A)-(F); the effective date of the transfer or discharge; the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged . Facility policy further indicates that under emergent circumstances, the notice (of transfer) is given as soon as it is practicable but before the transfer or discharge, and that notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy, review of documentation, and an interviews for 1 of 1 sampled resident (Resident #7) reviewed for hospitalization, the facility failed to develop and implement comprehensive care plans addressing ongoing recurrent diagnoses, which the resident was subsequently hospitalized and for (Resident #2) reviewed for a urinary tract infection (UTI), the facility failed to develop and implement a comprehensive care plan reflecting a new diagnosis post a hospitalization The findings included: 1.Resident #7's diagnoses included urinary tract infection (UTI), acute on chronic congestive heart failure (CHF), Alzheimer's disease, schizophrenia, dementia with other behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Resident #7's Resident Care Plan (RCP) dated 12/30/25, identified the resident had congestive heart failure. Interventions included to encourage adequate nutrition, to offer small frequent feedings; to give cardiac medications as ordered and monitor the resident's intake and output (I & O). The RCP failed to identify the resident would be at an increased risk for rapid weight gain, shortness of breath, fatigue, increased swelling, increased cough, decreased oxygenation. The RCP also failed to identify Resident #7's reoccurring UTI diagnoses. The resident was hospitalized for complications from a UTI three times in the past six months, with discharge date s of 6/28/25, 9/9/25 and 10/8/25. The resident was also hospitalized for complications related to CHF complications, discharged on 7/6/25, 9/30/25, and 10/20/25. An interview with the Minimum Data Set (MDS) Coordinator on 12/30/25 at 11:11 AM identifies she is responsible for updating residents' care plans. She also identified that she is responsible for updating residents' care plans upon facility admission, falls, behaviors/symptoms, quarterly and comprehensively. She confirmed she should initiate a care plan for a resident with a UTI. The MDS Coordinator identified if the surveyor was unable to locate the resident's care plan under resolved care plans, that it was safe to conclude the care plan was not implemented, she stated yes, but I don't remember the resident (in question.) She also noted she would be responsible for updating residents' care plans when they are hospitalized and returning to the facility. The MDS Coordinator also was unable to provide an answer why the care plan was not done or updated following Resident #7's hospitalizations. When questioned regarding why a more comprehensive care plan for CHF was not implemented for the resident, as opposed to just encouraging adequate nutrition, offer small frequent feedings; to give cardiac medications as ordered and to monitor the resident's intake and output, she replied if weights were not ordered to be checked daily (by the physician), then I would not have care planned for it. She also identified the Nurse Aides (NA) are responsible for documenting I's & O for the resident, and that would be reflected in the electronic medical record, and not the resident's hard chart. Review of facility charting failed to reflect any evidence of NA's performing I &O monitoring for the resident. Review of Care Plans policy indicated, in part, that care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment and reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's diagnoses included chronic kidney disease, benign prostatic hyperplasia and endocarditis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment, and required substantial/maximal assistance for toileting hygiene, toilet transfer and lower body dressing. A review of the hospital transport handoff dated 12/17/25 identified Resident #2 was to start Cefuroxime (an antibiotic) oral tablet 250 Milligrams (MG), one tablet two times a day for 7 days, for a UTI. (Although hospital discharge documentation was requested from the facility, an interview with the DNS on 12/30/25 at 1:46 PM identified the facility was not in possession of the document as Resident #2 did not return with any paperwork.) A physician's order dated 12/19/25 directed to administer Cefuroxime Axetil (an antibiotic) oral tablet 250 Milligrams (MG), one tablet two times a day for 7 days, for a UTI. The Resident Care Plan dated 12/23/25 failed to identify Resident #2 had a care plan for UTI. Interview with the MDS Coordinator (RN) 1 on 12/30/25 at 11:11 AM identified she was responsible for initiating care plans, and it was facility policy to implement care plans on admission, with falls, behaviors and any other updates quarterly and comprehensively. A review of the current and completed care plans for Resident #2 with RN #1 failed to identify a present or completed care plan for a UTI. RN #1 identified a care plan for the diagnosis of a UTI should have been initiated but she could not identify why it was not done. Review of the Comprehensive Care Plan Policy directed in part that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility policy and interviews for the only sampled resident (Resident #4) reviewed for limitation in range of motion, the facility failed to ensure the resident's right hand splint was applied per the Occupational Therapy (OT) recommendation, an accurate physician's order to reflect the Occupational Therapy recommendations was in place and the care plan revised to include the current OT recommendation and for the only resident reviewed for hospice (Resident #5), the facility failed to follow physician's orders to obtain weights for a resident with Congestive Heart Failure The findings include: 1. Resident #4's diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, schizophrenia and metabolic encephalopathy. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and required partial moderate assistance with lower body dressing, supervision with upper body dressing, hygiene, toileting, transfers, set up assistance with bed mobility, eating and had functional limitation in range of motion on one side for both upper and lower extremities. An Occupational Therapy (OT) evaluation dated 3/7/2025 identified Resident #4 will tolerate right hand splint for 2 hours with no signs of impaired skin integrity and will tolerate right hand splint per wearing schedule. A physician's order dated 5/19/2025 directed to apply right hand splint for contracture as tolerated. An OT recertification, progress note and updated therapy plan dated 6/24/2025 through 7/21/2025 identified Resident #4 expressed a desire to wear the right-hand splint on after evening care and off before morning care. An OT clarification order dated 8/11/2025 directed right hand splint on with evening care and off with morning care. An OT clarification order dated 11/4/2025 directed right hand splint at night. Observation on 12/24/2025 at 1:33 PM, Resident #4 was in the dining room without the benefit of a right-hand splint on while in the wheelchair. The Resident Care Plan dated 12/28/2025 identified resident uses appliance for daily functioning, splint: right hand splint for contracture as tolerated. Interventions included applying right hand splint for contractures as tolerated. The current physician's orders 12/2025 failed to reflect right hand splint orders or a wear schedule. Resident #4's care card identified right hand brace/splint as ordered. Interview with the DNS on 12/29/2025 at 3:15 PM indicated hand splints are not signed off when they are applied and removed anywhere in the medical record. Therapy was able to enter electronic orders in the electronic medical record, and a communication sheet was placed in the orders in the paper (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chart. The DNS failed to identify evidence of physician orders for the right-hand splint. She further indicated that applying and removing the hand splint would be signed off in the Medication Administration or Treatment Administration Record (MAR). The DNS was unable to explain why the medical record failed to identify a physician order for the wear schedule for the right-hand splint. Observations on 12/30/2025 at 7:55 AM and 8:20 AM identified right hand splint was on the nightstand in Resident # 4's room. Resident # 4 indicated the right-hand splint had not been worn all night. Resident # 4 further indicated that she/he tried to wear the right hand splint every day. Interview with NA # 1 on 12/30/2025 at 8:30AM identified Resident # 4 was supposed to wear the splint at night when in bed. NA # 1 indicated he did not know why Resident #4 did not wear the hand splint last night, Resident #4 may have refused to wear it. Interview with RN #2 on 12/30/2025 at 10:31 AM identified Resident # 4 was supposed to wear the right-hand splint at night. RN # 2 was unable to explain why Resident #4 did not wear the right-hand splint. After surveyor request NA #1 applied the right-hand splint to ensure the hand splint fit appropriately. Resident #4 wore the hand splint during the day once it was applied. Although requested, a facility policy for Therapy Communication, splints and adaptive equipment were not provided. 2. Resident #5's diagnoses included emphysema, congestive obstructive pulmonary disease and congestive heart failure. The physician's order dated 9/18/25 directed to obtain weights weekly x 4 weeks, on admission then monthly. The physician's order active on 9/18/25 directed to obtain a monthly weight (between 1-7 of every month). The handwritten physician/provider order sheet dated 10/3/25 located in Resident # 5's physical chart identified Resident #5 was admitted to hospice with new orders consisting of medications to manage pain and orders to discontinue laboratory and x-ray (without any note to discontinue weights when reviewed by surveyor on 12/29/25). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Interview of Mental Status (BIMS) score of 12 indicating intact cognition and required set up with eating and substantial/maximal assistance with toileting and dressing. The Resident Care Plan dated 10/10/25 identified nutritional problems related to COPD, CHF, respiratory failure and hypertension. Interventions included providing and serving the diet as ordered and obtaining weights as ordered. A physician's visit note dated 10/21/25 at 7:52 PM identified Resident #5 had chronic diastolic heart failure, was on a low sodium diet, currently euvolemic (normal balance of blood and fluid in the body), had no shortness of breath above baseline, no chest pain or leg swelling, and will monitor weights. A physician's regulatory visit note dated 12/11/25 at 2:03 PM identified Resident #5 had chronic diastolic heart failure, was on a low sodium diet, was currently euvolemic, had no shortness of breath (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above baseline, no chest pain or leg swelling, and will monitor weights. A review of the Treatment Administration Record for September 2025, October 2025, November 2025 and December 2025 failed to identify recorded weights. Interview and facility record review with Nurse Aide (NA) #2 on 12/29/25 at 2:38 PM identified the facility policy was that NA's obtain weights daily, weekly or monthly as specified on the assignment sheet then record on the assignment sheet or reported to the nurse. Review of the Assignment Sheet with NA #2 identified Resident #5 was a monthly weight, NA #2 could not identify why the weights were not obtained. Interview and record review with Registered Nurse (RN) #2 on 12/29/25 at 2:47 PM identified it was facility policy to obtain weights per physician's order and then document them in the electronic health record. Review of Resident #5's electronic health record identified he/she had active orders to obtain weekly weights for 4 weeks then monthly. A review of Resident #5's weights identified the only weight taken was on 9/18/25 of 167 pounds. RN #2 could not identify why the weights were not obtained but speculated Resident #5 might have refused or because the orders were discontinued by hospice. A review of Resident #5's physical chart with RN #2, including a handwritten physician's order sheet from hospice dated 10/3/25 failed to identify a recommendation or order to discontinue weights. Additionally, RN #2 stated that since the weights were not discontinued by hospice, the physician's order should have been followed, and weights should have been obtained. (Although the paper physician/provider orders dated 10/3/25 only specified to discontinue laboratory and x-rays when it was reviewed with RN #2 on 12/29/25 at 2:47 PM, copies of the document received 12/30/25 identified weights was added at the end of the sentence in a pen thickness that did not match the rest of the sheet). Although the electronic health record weights sheet was requested multiple times the facility failed to provide a copy. Review of the Heart Failure Clinical Protocol Policy directed in part that the physician will review and make recommendations for relevant aspects of the nursing care plan; for example, what symptoms to expect, how often and what (weights, renal function, digoxin level, etc.) to monitor, when to report to the physician. Review of the Weight Assessment and Intervention Policy directed in part that weights are obtained upon admission and at intervals established by the interdisciplinary team. Weights are recorded in each individual's medical record.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, facility documentation, facility policy and interviews for 2 of 12 residents (Resident # 10, and Resident # 29) reviewed for smoking, the facility failed to assess for smoking quarterly and for 1 of 3 residents at risk for smoking (Resident # 22), the facility failed to investigation an allegation of smoking non-compliance and failed to develop intervention to ensure that all smoking material given to residents on Social Leave Absence are verified and returned to nursing staff and for 1 of 4 residents reviewed for accidents (Resident # 4), the facility failed to assess the resident after a fall, implement measure to prevent future fall and monitor the resident 72 hours post fall monitoring per facility practice . The findings include: 1. Resident #10 ?s diagnoses included necrotizing fasciitis, Fournier gangrene and anxiety disorder.The admission nursing assessment dated [DATE] identified smoking evaluation was incomplete.The Resident Care Plan dated 11/24/2025 failed to identify smoking in the care plan. The admission Minimum Data Set assessment dated [DATE] identified Resident #10 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 and required substantial maximum assistance for lower body dressing, toileting, partial moderate assistance with upper body dressing, bed mobility, transfer, set up assistance with hygiene, independent eating and no current tobacco use.2. Resident #29's diagnosis acquired absence of left leg above the knee, neuro muscular dysfunction of the bladder and systolic congestive heart failure.The smoking evaluation dated 8/28/2025 identified Resident #29 as an everyday smoker. No additional smoking evaluations were provided or noted in the medical record.The annual Minimum Data Set assessment dated [DATE] identified Resident #29 as moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 and required partial moderate assistance with hygiene, supervision with transfer, toileting, set up assistance with eating, independent with bed mobility and current tobacco use.The Resident Care Plan revision dated 12/12/2025 identified Resident #29 has been assessed as a safe supervised smoker while in the facility. Interventions including all smoking materials will be stored in a secure location and will be escorted 3 times a day for the opportunity to smoke with supervision to ensure safety.Observation of smoking on 12/24/2025 at 11:11AM with 7 residents present, (Resident # 9, Resident #10, Resident #15, Resident #17, Resident #20, Resident #22, and Resident #29) were observed smoking accompanied by RN #2, NA #3, NA #4 and Front desk #2. Each resident was given 1 cigarette and was lit by Front desk #2. Observed all residents were able to smoke independently and extinguish smoking material in the self-extinguishing ashtray.Interview and clinical record review with Director of Nursing Services (DNS) on 12/29/25 at 10:52AM identified the smoking assessment and care plan were completed by the MDS Coordinator and the admission nurse, moving forward it will be completed by nursing. The smoking assessments were completed upon admission, quarterly and with any changes. The care plan was updated with the care plan schedule. All of the smoking residents should have an assessment and should follow the MDS schedule, and the schedule should alert that an assessment was due under the Point Click Care (PCC) software assessments. Resident # 10 was identified on the admission assessment that she/he was a smoker and Resident # 29 did not have a current quarterly smoking assessment. The DNS could not explain why the medical record failed to reflect current smoking assessments or care plan.3. Resident # 22's diagnosis included bipolar disorder, anxiety disorder and diabetes.The quarterly Minimum Data Set assessment dated [DATE] identified Resident # 22 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 and was independent with hygiene, dressing, bed mobility, transfers and eating.A nurse's note dated 8/1/2025 identified Resident #22 was previously on social leave of absence (SLOA) and due to repeated safety concerns Resident #22 was no longer permitted to leave. Resident #22 continued to fail to abide by smoking safely outside of the building. In addition, Resident #22 had given money (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	away to others on multiple occasions despite prior education regarding financial safety, continued to smoke in room against facility policy and to hide smoking paraphernalia creating a significant fire risk. This behavior presents a danger to self and others particularly due to the presence of oxygen use by other residents within the building. Resident #22 was reeducated regarding facility smoking policy, safety regulations and risk associated with noncompliance. Interdisciplinary (IDT) team notified Resident #22 required staff supervision for all smoking activities and will only be permitted by SLOA with responsible party. On going monitoring continued and psych eval requested.A review of the Accident Incident report dated 8/1/2025 at 3:12 PM identified Resident # 22 had given money away to others to buy cigarettes, then accused the individual of taking money. The camera was checked and observed smoking in room against policy. Investigation contained statement by DNS, that staff called her because they found a lighter on the resident and had concerns about Resident # 22 in other residents' rooms. Camera checked and observed Resident #22 requested another resident buy cigarettes. No other witness statements or interviews provided.A nurse's note dated 8/13/2025 at 10:42 AM identified Resident #22 smoking status and safety awareness was discussed during the Interdisciplinary Team (IDT) meeting. Resident #22 received ongoing education regarding facility smoking policies and the fire safety procedures including the appropriate use and storage of lighters. Resident # 22 verbalized understanding of these safety guidelines and demonstrated the ability to articulate associated skills.A Nurse's note dated 8/13/2025 at 2:55 PM identified Resident # 22 was reported by security and other staff to have attempted to give money to individuals outside the building while requesting marijuana. When approached by nursing staff to discuss the incident, Resident # 22 stated I am weak. Nursing staff reviewed safety concerns with resident, including previously agreed upon safety protocols. Resident # 22 failed to adhere to these protocols during the incident. Due to ongoing safety concerns Resident # 22 will be restricted to supervised smoking and supervised leave of absences at this time.A review of the Accident Incident report dated 8/13/2025 identified Resident # 22 requested cigarette money for cigarettes from others and due to behavior concerns of giving money, Resident #22 agreed for safety to be a supervised smoker. No investigation or witness statements identified. Monitor by psychiatry and behavior contract.A behavioral contract dated 9/19/25 was issued in response to repeated violations of facility policy during independent social leave of absence. Resident # 22 had engaged in behaviors on multiple occasions: bringing drug paraphernalia and smoking related items into the facility, violating the facility's smoking policy, soliciting or distributing money to other residents and harassing or intimidating others before or after LOA. Resident # 22 agreed to no contraband, smoking policy compliance, respectful conduct and safe return protocol. The failure to comply with the agreement may result in suspension or revocation of independent SLOA privileges, implementation of supervised LOA, Involvement of the interdisciplinary team to reassess care plan and notification of appropriate authorities if illegal activity suspected. This was signed by Resident # 22.The Resident Care Plan dated revised 11/28/2025 identified socially inappropriate behavior as evidenced by asking for money from another resident, knocking on doors asking for cigarettes, not complying with smoking policy, (bringing a lighter to room, smoking in room) false accusations towards other residents and staff. Interventions included all staff to deal with resident consistently, assess resident's understanding of situation, may not go on independent leave of absence for safety, set goals with resident for appropriate behavior. The Resident Care Plan identified history of non-compliance with safety. Interventions included consulting with social services as needed, emphasizing positive aspects of compliance. The Resident Care Plan identified as a safe supervised smoker- may not go on independent smoking due to safety. Interventions included ensure that the resident and responsible party are made aware of the facility smoking policy, all smoking materials will be stored in a secure location, ensure smoking occurs in designated smoking areas, ensure that no oxygen is located in the smoking area while the resident is smoking, no smoking materials or igniter's will be stored in the resident rooms, resident will be escorted 3 times a day for opportunity to smoke with supervision to ensure safety.A Late Entry Note dated 12/21/2025 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified Resident # 22 returned from a supervised LOA. During this writer's medication pass, Resident # 22 was observed standing near the doorway of her/his room holding a cigarette and lighter. Items were immediately confiscated by this writer. Resident # 22 educated on the facility's smoking policy and safety risks. Resident # 22 verbalized understanding and agreed to a room search. A room search was conducted by 2 staff members, and no additional contraband was noted. The Director of Nursing (DNS) and Advanced Practice Nurse Practitioner (APRN) were notified, no new orders at this time.A nurse's note dated 12/22/2025 identified Resident # 22 continued to demonstrate noncompliance with the facility smoking policy. Over the weekend, the staff observed the resident smoking in her/his room and found smoking paraphernalia present, Resident #22 was reeducated regarding the facility's non-smoking policy within resident rooms and the significant safety risks posed to him/herself and others, particularly due to the presence of oxygen use within the building. Resident # 22 verbalized understanding of the safety concerns. Resident # 22 was reminded that per the facility policy and Centers for Medicare Medicaid Services (CMS) safety guidelines, continued violation of smoking rules may result in loss of supervised smoking privileges in order to maintain a safe environment for all residents and staff. Resident # 22 again verbalized understanding and agreement with the information provided. Will reinforce safety education and ensure adherence to facility policy.In an interview and clinical record review with the Director of Nursing Services (DNS) on 12/23/2025 at 1:49 PM regarding the smoking incident that occurred on 12/21/25. The DNS indicated Resident #22 did not actually light the cigarette but was going to when the medication nurse saw the resident and stopped Resident # 22. The medical record failed to accurately reflect the incident described. The DNS indicated that she wrote a note on 12/22/2025 but the staff called her on 12/21/2025 regarding the incident. Late entry nurse's notes were added to the medical record to indicate the incident that occurred on 12/21/2025. The DNS further indicated that the smoking materials were confiscated from Resident # 22 and Resident # 22 must have obtained a lighter when she was out on SLOA. The late Entry note indicated Resident # 22 consented to a room search by 2 staff members and no other smoking materials were found.An interview on 12/24/2025 at 11:20 AM with Licensed Practical Nurse (LPN # 2) identified that she was the charge nurse on the day Resident #22 had a lighter and cigarette in her/his possession in the room. LPN # 2 had difficulty recalling the events but thinks that Resident #22 went out with family and returned and staff smelled cigarette smoke on Resident # 22. Resident #22 was allowed to smoke with family and was given 2 cigarettes by security to take out. LPN #2 had the medication cart and moved it in front of Resident #22's room when LPN #2 noticed a cigarette aroma, it could have been from smoking prior when LPN #2 noticed a lighter. LPN # 2 told the DNS and Resident #22 agreed to a noninvasive search. No cigarettes or cigarette butts were found. There was no evidence that Resident #22 was actually smoking.In an interview and clinical record review with the DNS on 12/24/2025 at 1:05 PM, the clinical record failed to reflect documentation of an investigation for the smoking incident on 8/1/2025 or for 8/13/2025. Interview and review of logbooks on 12/29/2025 at 12:21 PM with Front desk #1 indicated that smoking materials including lighters are tracked by the front desk/security personnel by utilizing a logbook that indicates how many cigarettes and lighters were given out to residents going out. The lighters are not always written down in the book but sometimes verbally told to the staff. Security is on duty 24 hours /7 days a week. There is no policy on giving out and receiving back lighters. Front desk #1 was unable to explain how a staff member would know if a lighter was given out to a resident to look to receive it back when they returned. Review of the smoking policy revised 2025 directed, in part, prior to and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas and the extent to which the facility can accommodate their smoking or no smoking preferences. Smoking is only permitted in designated smoking areas which are located outside the building. Smoking is not allowed inside the facility under any circumstance. The resident will be evaluated on admission to determine if he/she is a smoker or non-smoker. If a smoker, the evaluation will include current level of tobacco consumption, method of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tobacco consumption, desire to quit smoking and ability to smoke safely per a completed smoking evaluation. The staff shall consult with the attending physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the safe smoking evaluation. A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change and as determined by the staff. Any smoking-related privileges, restrictions and concerns shall be noted in the care plan and all personnel caring for the resident shall be alerted to these issues. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. Residents are not permitted to give smoking articles to other residents. Only designated staff members and volunteer workers are permitted to purchase or provide any smoking articles for residents. All smoking materials will be held at the facility's security office and distributed to residents in accordance with their care plan and supervision requirements. The facility maintains the right to confiscate smoking articles found in violation of our smoking policies. Confiscated property will be itemized and ultimately returned to the resident, or legal representative. When the property is returned it will be determined during a meeting with the resident or representative regarding the circumstance that led to the confiscation.Review of the Accident and Incidents-investigating and reporting policy dated 2025 directed, in part, all accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy failed to identify when an Accident Incident is reportable to the state agency.4. a. Resident #4's diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, schizophrenia and metabolic encephalopathy.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and required partial moderate assistance with lower body dressing, supervision with upper body dressing, hygiene, toileting, transfers, set up assistance with bed mobility, eating and had 2 falls without injury and 1 fall with a major injury.The Resident Care Plan revised 12/28/2025 identified a fall on 1/15/2025, 2/16/2025, 2/26/2025, unwitnessed fall 3/10/2025, witnessed falls 4/13/2025, fall 5/23/2025 and unwitnessed fall 8/20/2025. Interventions included to continue interventions on the at risk plan, determine and address causative factors of the fall, frequent rounding, grabber bar for reaching items on floor away from resident, reminder to lock wheelchair, gripper socks to prevent slipping, monitor and document, report to physician as needed for 72 hours for signs or symptoms of pain, bruises, changes in mental status, new onset of confusion, sleepiness, inability to maintain posture or agitation, neuro checks for 72 hours, physical therapy consult for strength and mobility, redirection on self-release positioning belt, remind to ask for assistance with toileting and transfers, offer to move to a room closer to the nurses station for frequent monitoring, send to the emergency room for evaluation, staff to allow resident to pick out outfit for the next day prior to assisting to bed, x-ray to right shoulder, knees, hip, x- rays to shoulder humerus and clavicle.A physician's order dated 1/1/2025 through 5/5/2025 directed to assist with 1 staff for transfer to adaptive wheelchair with Roho cushion per positioning plan, independent mobility and repositioning with wheelchair. Assist of 1 staff with transfer to adaptive wheelchair and ambulation with hemi walker as tolerated.An Accident Incident report dated 1/15/2025 at 5:30PM identified Resident # 4 noted to be in a sitting position in front of the wheelchair and denies hitting head.A nurse's note dated 1/15/2025 at 9:46 PM identified Resident #4 was alert, verbal, oriented with garbled speech at baseline and was able to make needs known. Resident #4 was noted in a seated position in front of the wheelchair when asked what happened, Resident #4 stated s/he slid from wheelchair. Neurological checks initiated and within normal limits. Resident # 4 assessed by RN supervisor then assisted back to bed. Reminded of transfer status and urged to call for assistance for transfers. Resident #4 stated understanding, had been compliant thus far without visible injury noted, and denied pain or discomfort. At this time message left for conservator of person, awaiting return (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call for update. Call bell within reach.The Resident Care Plan failed to indicate a new intervention after the fall to prevent future falls.An Accident Incident report dated 2/26/2025 at 7:00PM identified Resident #4 was found on the right side of bed lying on the right side. Complaint of right sided pain. Right hip, shoulder and knee x-ray ordered.A nurse's note dated 2/26/2025 at 11:06 PM identified Resident #4 had an unwitnessed fall, the on-duty LPN for 3:00PM - 11:00PM shift notified RN supervisor Resident #4 was observed on the floor next to the wheelchair. Resident #4 did not say how they fell, RN assessment done, Range of Motion within normal limits, positive movement to left side of body. Hemiplegia and hemiparesis following cerebral infarction affected right dominant side, denied hitting head, no cuts, bruises or lacerations noted. Conservator and Advanced Practice Registered Nurse (APRN) notified. Resident #4 made complaints of pain on right side. x-ray ordered.The Resident Care Plan failed to indicate a new intervention after the fall to prevent future falls.An Accident Incident report dated 4/13/2025 at 8:00AM indicated Resident #4 was washing, tried to move his/her chair, did not lock it and slipped out while reaching for something. No injuries.A nurse's note dated 4/13/2025 at 3:44 PM indicated Resident # 4 was pleasant and alert. Upon entering Resident #4's room, s/he was noted to be washing and reached for an item on the bed and slipped out of the wheelchair because it was not locked. No injuries noted. APRN notified, conservator notified, message left, incident report completed as well as a screen for PT to eval on Monday.The medical record failed to identify evidence of an RN assessment after the fall.b. An Accident incident report dated 5/23/2025 at 10:00PM identified Resident #4 was found in a seated position on the right side of the bed.A nurse's note dated 5/23/2025 at 11:19 PM indicated the nurse was alerted to Resident #4's room by staff, upon arrival noted Resident # 4 in a seated position on the right side of bed. Resident #4 stated s/he was trying to get in bed from the wheelchair. Vital signs were stable, neurological checks initiated immediately and without deficit. No visible injury but facial grimacing noted when moving right leg. Refusing pain management at this time, assisted back to bed by staff. Gripper socks in place. Encouraged to call for assistance as needed and has been compliant thus far. Nurse Practitioner made aware with no new orders. A message left for conservator to call the facility for update. Awaiting return call. No complaints at this time, no distress noted, call light within reach. Safety maintained.The medical record failed to identify evidence of an RN assessment, and a 72 hour follow up nurse's note after the fall.Interview and record review with the DNS on 12/29/2025 at 3:15PM identified an RN assessment was to be completed after every fall and interventions were to be in place in the care plan to prevent future falls if there were interventions that could be put in place as well as follow up notes for 72 hours after a fall. The DNS failed to identify in the medical record new interventions in the plan of care for Resident #4 for the falls on 1/15/2025 and 2/26/2025. Additionally, the DNS could not identify in the medical record an RN assessment was completed and documented after the 4/13/2025 and 5/23/2025 falls or a 72 hour follow up note for the 5/23/2025 fall. The DNS indicated she did not know why this was not documented. The nursing staff were responsible for completing this documentation.Review of the Accident and Incidents-investigating and reporting policy dated 2025 directed, in part, all accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and department director or supervisor shall promptly initiate and document investigation of the accident or incident.Review of Falls and Fall risk Managing policy dated 2001 directed, in part, if a resident continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling, instead of or in addition to those that have already been identified and also reconsider the current interventions. As needed and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and interviews for 1 of 2 residents (Resident #23) reviewed for bladder and bowel incontinence, the facility failed to ensure Resident #23 was started on a bladder retraining program. The findings included: Resident #23 was admitted in October 2025 for short term rehabilitation with diagnoses that included a new cerebral infarction (stroke) with left side weakness, adjustment disorder with depressed mood, and cognitive communication deficit. The admission Minimum Data Set assessment dated [DATE] identified Resident #23 with a Brief Interview for Mental Status score of 15 indicating cognitively intact and required moderate assistance with toileting transfers, was frequently incontinent, and not on a urinary toileting trail plan. Resident #23's Bladder and Bowel Screener assessment dated [DATE] identified Resident #23 as a good candidate for bladder retraining program.The Care Plan dated 11/20/25 identified occasional bladder incontinence. Interventions included establishing voiding patterns, checking for incontinence every 2 hours, and monitoring for signs and symptoms of a urinary tract infection and reporting to physicians. The care plan failed to reflect a bladder retraining program for Resident #23. The physician's orders dated 12/9/25 identified Resident #23 was independent with toileting.Interview with Resident #23 on 12/23/25 at 11:10AM identified that he/she had a recent decline in urinary function and did not have good control of urine since having a stroke.A three-day voiding pattern assessment tool reviewed on 12/24/25 dated 10/28/25-10/30/25 revealed that out of 35 voiding occurrences, Resident #23 was very wet with urine 20 times, a little wet with urine 15 times and no episodes of being dry. Interview with LPN #1 on 12/24/25 at 11:20AM identified she was unaware of any bladder retraining for Resident #23 and that she believed that therapy would be responsible for doing bladder retraining. Furthermore, she indicated that she could not locate any bladder retraining documentation for Resident #23 and nursing did not perform bladder retraining with Resident #23. LPN #1 stated she was unaware of the facility policy related to bladder retraining and who exactly is responsible for ensuring it is completed once a bladder incontinence assessment is completed determining a resident is good candidate for bladder retraining. Interview with the Occupational Therapist (OT #1) identified therapy does not perform any bladder retraining and it would be nursing that is responsible for completing any bladder retraining for Resident #23. OT #1 indicated that therapy worked Resident #23 regarding transferring on and off the toilet and managing incontinence independently to prepare for discharge home.Although requested a policy on bladder retraining was not provided.The policy Urinary Continence and Incontinence- Assessment and Management dated 2001, directed, in part, as a part of the initial and ongoing assessment, the nursing staff and physician will screen for information related to urinary continence. Examples of sources of such information may include the resident, family or a hospital discharge summary. Relevant information related to urinary continence includes history of urinary incontinence including signs and symptoms, pertinent diagnoses, and previous treatment management attempts and responses to interventions.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Post nurse staffing information every day. Based on observation and interview, the facility failed to ensure the facility daily census and staffing data was posted with complete staffing for the upcoming 24-hour period and posted in a location easily visible to residents and visitors. The findings include: On 12/24/2025 at 1:02 PM an observation and interview with the front desk supervisor, Security/ Front Desk #1 and the security officer, Security/ Front Desk #2 pointed out the daily facility census and staffing located to the far right on the top shelf in a tall, closed glass cabinet (display case). Security/Front desk #2 indicated security staff fill out the form after verifying each staff member had arrived to work for the shift. She/he further indicated there was no policy or procedure they were told by the administrator to ensure the form was accurate. Security/Front desk #2 indicated security staff are on duty 24-hours and staffing for each shift is completed by the person on duty, and prior daily sheets were in a binder behind the security reception desk. Review of the binder found prior 24-hour census staffing sheets completed for all 3 shifts (24 hours total). An interview and observation with the Administrator and the Administrator in training on 12/30/2025 at 11:08 AM identified the daily census staffing sheet located in the same place on the top shelf of the display cabinet with only the 7-3 PM shift staffing and the daily census data. The Administrator in training indicated the 11-7 AM shift was responsible for completing the form for the 24 hours. The Administrator indicated the way it was being completed was more accurate than posting the full 24 hours at a time. The Administrator further indicated she/he understands having shifts blank did not allow visitors and residents to know the expected staffing for 24 hours. Further observation on the skilled nursing unit with the Administrator and administrator in training identified no posting of the daily census and staffing allowing residents on the unit easy access to the data especially if they were unable to leave the unit. The administrator provided a form labeled Proper way to fill out a daily census log for the display case on 12/30/2025 at 1:50 PM indicating the security/front desk #1 provided the form to the security staff. No facility policy and procedure was provided.

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F 0882 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility Infection Control Program and staff interviews, the facility failed to ensure the Infection Prevention and Control Nurse received a specialized training certificate. The findings include: Interview with the Director of Nurses Services (DNS) on 12/29/25 at 11:04 AM identified the Infection Prevention nurse was on vacation and she was currently covering for him from time to time even though she herself does not hold a certificate. Additionally, the DNS identified the Infection Prevention nurse started working at the facility on 4/25/22 and conveyed to her he had completed the Centers for Disease Control (CDC) training. However, the DNS at time did not have the certificate on hand but indicated she would obtain the certificate. Additional attempts to obtain a copy of the specialized training Infection Control certificate for the Infection Control nurse were made on initial entrance to the facility on [DATE] at 9:30 AM, during the review of the Infection Control task on 12/29/25 at 10:30 AM, on 12/30/25 at 12:04 PM prior to exciting the facility, and again on 12/31/25 at 10:35 AM, but were unsuccessful.