STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075410	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aaron Manor Nursing & Rehabilitation	3 South Wig Hill Rd Chester, CT 06412

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 50179 Based on observations, facility documentation, and interviews during a resident council meeting, the facility failed to identify to ensure the resident's were aware of the location of the survey results. The findings include: Residents #31, #5, #37, #48, #39, #20, #45, #47, #9, and the Ombudsman were present at the resident council meeting on 11/6/24 at 1:30 PM. All of the residents who participated in the meeting stated they were unaware that the state inspection results were available for them to read and were unaware of the location of the state inspection results. During the review of the resident council minutes for the last 3 months, the minutes failed to identify the resident right to access of inspection results was reviewed with the residents. Additionally, the postings on bulletin boards and on recreation calendars failed to identify where the inspection results were located. Observation on 11/6/24 at 3:00 PM identified the Survey binder was located in the lobby entrance. Interview with the administrator on 11/6/24 at 3:00 PM identified that the inspection results were kept in the lobby in a binder and she kept them updated. The administrator was not aware the residents did not know where the survey results were located.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 51183 Based on review of the clinical record, facility documentation, facility policy and interviews for the only sampled resident (Resident #28) reviewed for advanced directives, the facility failed to complete an advance directive form for a resident upon admission. The findings include: Resident #28 was admitted in October of 2024 with diagnoses that included epilepsy, Parkinson's disease, and dysphagia. The admission Minimum Data Set assessment dated [DATE] identified Resident #28 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14), required supervision or touching assistance with eating, was dependent with upper body dressing and transfers. The Resident Care Plan dated [DATE] identified Resident #28's code status. Interventions included Resident #28 was a full code, wanted cardiopulmonary resuscitation (CPR) and directed to document the code status in the electronic medical record (EMR). A physician's order dated [DATE] directed a code status of a full code, and included yes to CPR, intubation, oxygen, hospitalization , intravenous hydration, intravenous antibiotics, and for tube feeding needs to discuss with the family first. A History and Physical examination admission note by Medical Director (MD) #2 on [DATE] identified that Resident #28 appeared lethargic during the visit but was able to answer questions. The note further identified Resident #28 was a full code. Review of Resident #28's paper chart on [DATE] at 3:11 PM, identified a blank unsigned advance directive form in the chart. Interview with Advanced Practice Registered Nurse (APRN) #1 on [DATE] at 12:10 PM identified that she did not review and sign the advance directives in the chart for new admission residents and re-admission residents. APRN #1 stated that advance directives were signed by MD #2. Interview with MD #2 on [DATE] at 9:18 AM identified that he signed the advance directives form for residents newly admitted and readmitted to the facility. MD #2 further identified that if he had reviewed a new admission chart and didn't see an advance directive form filled out, he would have filled one out with the resident. MD #2 could not identify why the advance directive form in Resident #28's chart was not filled out and stated, at times, he verified information with Resident #28's representative because Resident #28 was intermittently confused. MD #2 identified that he would be in the facility the following day and would review the advance directives and include the form in the clinical record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and clinical record review with the Registered Nurse Supervisor (RN) #2 on [DATE] at 1:25 PM, the clinical record failed to reflect documentation of a completed advance directive form and identified a blank admission checklist form. RN #2 identified that she was unaware the advance directive form was blank, and that she had not completed the admission for Resident #28. RN #2 identified the process for filling out the advance directives form was for the resident and/or the resident representative to fill out and sign the form, two staff members verify the information and sign the form, and the provider is notified of the advance directives and an order is added into the EMR. RN #2 stated that there is an admission checklist for staff to follow during the admission process and medications are verified by third shift, but there is no formal process for reviewing all of the admission documents. Review of Resident #28's paper chart on [DATE] at 10:07 AM identified subsequent to surveyor inquiry, the advance directives form was filled out, included telephone consent from Resident #28's representative, and 2 staff signatures, all dated [DATE]. Review of the Advance Directives policy directed, in part, that the plan of care for each resident would be consistent with his or her documented treatment preferences and or advance directive and the nurse Supervisor would be required to inform emergency medical personnel of a resident's advance directives regarding treatment options and provide such personnel with a copy of the directive when transfer from the facility via ambulance or other means is made. Review of the Admission policy does not identify a process for the nursing admission paperwork.

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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 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50167 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 sampled residents, (Resident #3 and Resident #39), the facility failed to fill out grievance forms after being made aware of concerns/complaints by resident representatives for a cognitively impaired resident and by a cognitively intact resident. The findings include: 1. Resident #3 was admitted to the facility in August of 2022 and had diagnoses that included spinal stenosis, dementia and protein-calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0), dependent for bathing, dressing, and bed mobility and required substantial/maximal assistance for eating. Interview with Person #3 on 10/5/24 at 10:07 AM identified multiple concerns/complaints were voiced to the facility regarding personal belongings and an unclean bathroom. Person #3 indicated that on multiple occasions he/she reported clothing in disarray to include dirty clothes thrown on the closet floor rather than placed in the laundry basket, dirty clothes mixed with clean clothes on the closet floor, good quality blouses along with other clothing rolled up in drawers along with multiple other personal care items. Person #3 identified he/she had spoken with facility staff about the clothing issue multiple times. Person #3 indicated he/she would go to the facility to visit but instead would spend a significant amount of time reorganizing belongings and clothes. Person #3 identified the problem with clothing being found in disarray went on for so long he/she taped labels to the dresser drawers. Person #3 indicated he/she reported a dirty bathroom on multiple occasions with a full trash can and facility storage in the unused shower stall. Person #3 identified a complaint about Resident #3 ' s shower day scheduled the day after seeing the hairdresser (which was addressed and shower day rescheduled), about missing shower caps and also complained of the dresser drawers being broken (which the facility repaired). Person #3 identified voicing concerns during care conferences, to nursing supervisors while at the facility and directly to the administrator. Person #3 was not familiar with a grievance process. Interview with Person #4 on 10/5/24 at 1:56 PM identified concerns/complaints voiced to the administrator about a poor customer service interaction with a specific staff member and another encounter where he/she had concerns about wheelchair positioning and a subsequent unpleasant response from a nurse. Person #4 identified he/she would visit during the weekend and reported complaints/concerns to the weekend supervisor who would either work to resolve the complaint/concern or stated he would send an email to the administrator and social worker to report complaints/concerns. Person #4 was not familiar with a grievance process. Interview on 11/6/24 at 2:05 PM with SW #1 identified she did not have any emailed concerns/complaints from any nursing supervisors related to Resident #3 by Person #3 or Person #4. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Observation on 11/7/24 at 9:53 AM identified labels on the exterior of Resident #3 ' s dresser drawers to include Socks, Slippers, Nightgowns , a laundry basket in Resident #3 ' s closet, and multiple items stored in the bathroom shower stall which was not in use but visible and accessible in the bathroom which was shared by 4 residents. Items stored in the shower stall included a commode with 4 buckets stacked inside, a window screen, a door, a walker, 2 wash basins, and a toilet plunger. Interview with RN #6 on 11/8/24 at 2:17 PM identified he had received concerns/complaints from Person #3 and Person #4 on multiple occasions related to dresser drawers, the shower schedule, clothing storage and further concerns/complaints that he could not recall and identified he made attempts to resolved all concerns/complaints in real time and if he was unable to resolve the concern/complaint would email the administrator and social worker. RN #6 identified he did not fill out a grievance form because he would send an email to administration instead for further follow up. Review of the grievance log on 11/12/24 identified no grievances from Person #3 or Person #4. Interview with the Administrator on 11/12/24 at 3:35 PM indicated she had only 1 email from the weekend supervisor regarding concerns/complaints from Person #3 or Person #4. The Administrator identified she did not consider the complaints/concerns voiced by Person #3 and Person #4 grievances. 2. Resident #39 was admitted on [DATE] with diagnoses which included hypertension (high blood pressure), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and end-stage renal disease. Harvest Practice Prescribers Note (behavioral health provider) dated 10/12/24 identified the provider was asked to meet with Resident #39 related to complaints and agitation. Resident #39 reported frustration over another resident on the unit that occasionally wanders into her room. Resident Care Plan dated 10/25/24 identified Resident #39 claimed another resident went into her room (on or around 12/8/23). Interventions included to apply stop sign by resident #39's door, monitor behavior and allow expression of feelings. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #39 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15). Resident #39 required set-up assistance with eating and oral hygiene and was dependent for toileting, upper and lower body dressing, and showering. Interview with the Director of Recreation on 11/8/24 at 12:14 PM indicated that any concerns or complaints identified in the Resident Council meetings are shared with the facility department heads and the administrator. During the following Resident Council meeting, the concerns will be reviewed and if residents report the concerns are unaddressed, the facility department heads and administrator will again be notified. Interview with the Administrator on 11/12/24 at 10:34AM identified that she went to visit Resident #39 for the complaint related to the wandering resident, and Resident #39 did not ask to file a grievance. The Administrator did not file a grievance on Resident #39's behalf. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the DNS #2 on 11/12/24 at 10:38 AM identified that she was aware of the complaint shared on 10/28/24 during the Resident Council meeting and offered Resident #39 a room change, to which she declined. DNS #2 then asked the behavioral health provider to see Resident #39 for emotional support. She further indicated that the facility offered stop signs to place outside of Resident #39's room, and he/she accepted. DNS #2 did not write or offer to write a grievance for Resident #39's complaint. Review of the facility's Concerns, Complaints, and/or Grievance Policy dated 11/25/2016 directed should a concern or complaint be brought to the attention of the charge nurse/nursing supervisor, attempts will be made to resolve/correct the issue. The charge nurse/nursing supervisor will fill out the Grievance Form which would include a concern/complaint and its resolution and submit the complete form to the facility Social Worker.

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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** 51183 Based on review of the clinical record, facility policy and interviews for 2 of 4 residents (Resident #20 and Resident #33) reviewed for care planning, the facility failed to revise the comprehensive Resident Care Plan (RCP) to reflect the current status of a resident's dialysis access and current diagnosis with interventions for a resident with congestive heart failure. The findings include: 1. Resident #20 was admitted in March of 2023 with diagnoses that included diabetes, chronic kidney disease, and hypertension. A history and physical examination note by Medical Doctor (MD) #2 on 9/13/24 identified Resident #20 had a diagnosis of congestive heart failure (CHF), and the treatment plan would continue with Furosemide (medication to help reduce fluid buildup in the body) and monitoring Resident #20 for fluid overload. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13) and required setup or clean-up assistance with eating and was dependent for lower body dressing and chair/bed-to-chair transfers. The MDS assessment did not include congestive heart failure as an active diagnosis. The RCP dated 10/19/24 identified Resident #20 was at risk for dehydration related to chronic kidney disease and use of Furosemide. Interventions included to elevate the extremities if edema was present and to monitor Resident #20's weight as ordered. Further identified was Resident #20 is at risk for cardiac distress related to hypertension, atrial fibrillation and coronary artery disease. Interventions included to monitor for edema and observe for signs and symptoms of cardiac and respiratory distress. The RCP did not include CHF and interventions to monitor for fluid overload (monitor for neck vein distention, monitor for abnormal lung sounds) or the use of furosemide as part of the treatment plan for CHF. Interview and clinical record review of Resident #33's RCP with Registered Nurse (RN) #4 on 11/7/24 at 1:00 PM identified the clinical record failed to reflect CHF and relevant interventions. RN #4 was not aware that MD #2 had included CHF as a diagnosis for Resident #20 in his history and physical note on 9/13/24. RN #4 stated if she had been aware of the diagnosis, she would have included CHF in the RCP. 2. Resident #33 was admitted in November of 2021 with diagnoses that included end stage renal disease with dependence on renal dialysis, dementia, and depression. A Situation, Background, Assessment, and Recommendation (SBAR) note on 5/6/24 at 8:35 PM identified Resident #33 was sent to the hospital emergency room for evaluation related to abnormal vital signs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note on 5/11/24 at 8:54 PM identified Resident #33 was readmitted to the facility from the hospital following hospitalization for sepsis and the right chest hemodialysis catheter had tested positive for MRSA. It is further identified Resident #33 has a new hemodialysis catheter in the left chest and is on Bactrim double strength (DS) antibiotic. Physician's orders dated 5/11/24 directed to monitor the dressing for the left upper chest venous catheter for hemodialysis and ensure it was clean, dry, and intact every shift and Resident #33 was on contact precautions every shift for a positive MRSA culture of the (removed) right chest hemodialysis catheter tip. A physician's order discontinued on 5/11/24 directed to monitor the bruit and thrill of the left AV fistula (clogged, not in use), not to obtain blood pressures in the left arm, and check dressing to the right upper chest venous catheter to ensure it was clean, dry, and intact every shift. The order had initially been written on 5/23/23. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #33 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12), received hemodialysis, and required setup or clean-up assistance with eating, and partial/moderate assistance with upper body dressing and lying to sitting on the side of the bed. The May 2024 RCP identified Resident #33 was at risk for complications of dialysis. Interventions included to not obtain blood pressures or blood work from the left arm or in the limb nearest the chest of presently used permacath (central venous catheter for dialysis) , report signs and symptoms of bleeding or leaking of the arteriovenous (AV) fistula area (surgically created passageway between an artery and vein used for dialysis), report signs and symptoms of infections of permacath or AV fistula and to monitor bruit (swooshing sound) and thrill (vibration) of the left arm every shift and then document findings (bruit and thrill indicate that the AV fistula is functioning properly). All interventions listed for this RCP focus have an initiation date of 11/2/21 and there are no revisions or new interventions identified since 11/21/21. The RCP failed to document revisions related to Resident #33 being hospitalized [DATE] through 5/11/24 for sepsis related to an infected hemodialysis catheter in the right chest which was removed at the hospital due to a methicillin-resistant Staphylococcus aureus (MRSA) positive culture of the catheter tip; a new permanent tunneled (placed under the skin forming a tunnel that the catheter passes through) dialysis catheter was placed into the left chest at the hospital on 5/10/24; and Resident #33 was readmitted on contact precautions until completion of oral antibiotics for MRSA. The RCP further failed to identify the AV fistula was clogged and had not been in use for approximately 1 year thereby not requiring checking of the bruit and thrill which monitors for patency of the AV fistula. A physician progress note by Medical Doctor (MD) #2 on 5/22/24 at 10:01 PM for date of service 5/17/24 identified Resident #33 was hospitalized from 5/6/24 through 5/11/24 for sepsis secondary to an infected hemodialysis catheter requiring intravenous vancomycin and Zosyn antibiotics, and a positive MRSA culture which resulted in the hemodialysis catheter being removed and replaced with a new catheter and Resident #33 was to finish 14 days of Bactrim DS antibiotics. (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 clinical record review of Resident #33's RCP with Registered Nurse (RN) #4 on 11/7/24 at 1:00 PM identified the clinical record failed to reflect documentation of revisions related to Resident #33's hospitalization which resulted in removal of the MRSA infected right chest dialysis catheter, and placement of the new tunneled left chest dialysis catheter, and discontinuation of the AV fistula monitoring due to non-use of the catheter. RN #4 stated any nurse can update the RCP but the ultimate responsibility was hers. RN #4 identified the RCP should have been updated relating to the AV fistula, and she had thought the interventions for checking the dressing were still relevant so it wasn't necessary to update those interventions even though the catheter had been replaced. Review of the Comprehensive Person-Centered Care Plans policy directed, in part, assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change, and the Interdisciplinary Team must review and update the care plan when a resident has been readmitted to the facility from a hospital stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on observation, interviews, clinical record review, and facility policy for 2 out of 3 residents (Resident #10 and Resident #49) reviewed for activities of daily living (ADL) the facility failed to provide oral hygiene for a resident who had mouth pain and required moderate assistance and failed to provide grooming for a dependent resident.The findings include: 1. Resident #10 was admitted to the facility in January of 2024 with diagnoses to include chronic pain, fibromyalgia, rheumatoid arthritis, depression, and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), required set up or clean up assistance with oral care, partial/moderate assistance for personal hygiene, substantial/maximal assistance for upper body dressing, was dependent for bathing, lower body dressing, toileting, bed mobility and transfers. The MDS further identified Resident #10 had pain almost constantly which made it hard to sleep at night and caused limitations in day-to-day activities. The MDS identified Resident #10 without the presence of behavioral symptoms to include no behaviors of rejection of care. The Resident Care Plan (RCP) dated 7/29/24 identified Resident #10 had chronic pain and received psychotropic medications to include Lorazepam (for anxiety) and escitalopram (for depression). The RCP identified ADL's as a focus area but did not include interventions for oral care and identified impaired dentition related to mouth pain with interventions to include daily mouth care and oral brushing with foam brush in the morning and at bedtime. Review of the Treatment Administration Record for October and November of 2024 identified a provider order directing oral brushing with foam brush in the morning and at bedtime documented as completed every day. Review of a Radiology Results Report dated 10/9/24 identified a right hand X-ray was obtained for pain and discomfort with findings that included modest degenerative changes. The report further identified a left wrist X-ray was obtained for pain and discomfort with findings that included mild degenerative joint disease of the wrist. A provider order dated 10/11/24 (initial start date of 1/17/24) directed Orajel Maximum Strength 4x Toothache and Gum to be applied to an effected area every 6 hours as needed for tooth/gum pain up to 4 times per day. A provider order dated 10/11/24 (initial start date of 1/9/24) directed to request a dentist appointment for recurring left sided mouth/gum/tooth pain. A Consultation Record dated 10/17/24 by MD #3 (dentist) directed assisted oral hygiene is required and recommended extractions of 5 teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14), required partial/moderate assistance with oral care, was dependent for bathing, dressing, toileting, bed mobility and transfers. The MDS further identified Resident #10 had pain almost constantly which made it hard to sleep at night and caused limitations in day-to-day activities. The MDS identified Resident #10 without the presence of behavioral symptoms to include no behaviors of rejection of care. The Resident Care Card dated 11/4/24 directed daily mouth care and oral brushing with foam brush in the morning and at bedtime. Interview with Resident #10 on 11/4/24 at 11:25 AM identified he/she had pain all over, was sensitive to all forms of touch and subsequently chose to spend most of his/her time in bed. Resident #10 further stated I have a gum infection. My gums hurt so badly and indicated he/she does not tolerate tooth brushing and can only eat soft foods due to pain in the mouth. Resident #10 indicated he/she has dry mouth from his/her medications. Resident #10 was observed to have an Orajel tube cut in half and a medicine cup containing a pink mouthwash on the overbed table. Resident #10 was using a swab to rub the Orajel and mouthwash over his/her gums repeatedly throughout the interview. Observation of Resident #10's mouth on 11/4/24 at 11:25 AM identified swollen and inflamed gums, thick white and yellow residue (plaque/calculus) covering all teeth and thickly accumulated between the teeth. The inside of Resident #10's mouth was dry. Observation on 11/5/24 at 9:31 AM identified an unchanged presentation of Resident #10's gums and teeth. Interview with MD #4 (dentist) on 11/7/24 at 2:09 PM identified Resident #10 had a dry mouth due to prescribed medications, that plaque develops quickly for people who have a dry mouth and using a swab for oral care would not be sufficient. MD #4 identified Resident #10 allowed the dental hygienists to brush and floss his/her teeth when they see him/her for routine visits. MD #4 indicated Resident #10 would benefit from improved oral care and that the facility had room to improve in regards to providing oral care for Resident #10. Interview with the Speech and Language Pathologist (SLP #1) on 11/7/24 at 4:33 PM identified Resident #10 last received speech therapy services in July of 2024 and during that time she assisted Resident #10 with oral care when Resident #10 was receiving speech therapy services. SLP #1 identified she provided Resident #10 with a soft bristle toothbrush and floss picks and Resident #10 was delighted. SLP #1 identified Resident #10 enjoyed receiving attention and enjoyed the attention received while receiving oral care. Interview with NA #9 on 11/12/24 at 11:22 AM identified she sets Resident #10 up to perform oral care but on days Resident #10 complains of pain she just washes him/her up and does not set him/her up for oral care. Interview with NA #10 on 11/12/24 at 11:25 AM identified she is frequently assigned to perform care for Resident #10 and she assisted Resident #10 with oral care at times. NA #10 indicated Resident #10 does not like his/her teeth brushed. She further identified Resident #10 had pain with chewing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DNS #2 on 11/12/24 12:20 PM identified the facility should be providing oral care assistance to Resident #10 based on the level of assistance identified in the MDS assessment. 2. Resident #49 was admitted to the facility in June of 2023 with diagnosis that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysthymic disorder, and muscle weakness. The Quarterly Minimum Data set assessment dated [DATE] identified Resident #49 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 10), dependent for oral hygiene, toileting, bathing, dressing, bed mobility and transfers. Observation on 11/4/24 at 9:05 AM identified Resident #49 with the presence of scattered chin hair across the entire chin at approximately 0.6cm to 0.8cm long. Observation on 11/5/24 at 10:55 AM identified Resident #49 with the presence of scattered chin hair across the entire chin at approximately 0.6cm to 0.8cm long. Interview with DNS #2 on 11/12/24 at 12:20 PM identified residents who are dependent for grooming should have facial hair shaven unless indicated facial hair is preferred. The facility policy titled Activities of Daily Living (ADLs), Supporting states, in part, residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on observations, interviews, clinical record review and facility policy, for 1 of 3 residents (Resident #3) reviewed for pressure injuries, the facility failed to provide positioning based on the plan of care and provider order for a dependent resident with an active pressure injury and a history of pressure injuries. Resident #3 was admitted to the facility in August of 2022 and had diagnoses that included spinal stenosis, dementia and protein-calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0), dependent for bathing, dressing, and bed mobility and required substantial/maximal assistance for eating. The MDS identified Resident #3 was always incontinent of both bowel and bladder, was at risk for developing pressure injuries and was on a mechanically altered diet. The Resident Care Plan (RCP) dated 7/16/24 identified Resident #3 was at risk for weight loss and dehydration related to poor intake of meals and included interventions to monitor dietary intake and monitor intake and output (I&O). The RCP identified ADL ' s as a focus area with interventions to include out of bed to adaptive wheelchair daily per 24 hour positioning plan. The RCP identified Resident #33 was at risk for [NAME] integrity and was readmitted to the facility with a right heel suspected deep tissue injury (DTI) (pressure injury of unknown depth/significance) with interventions to include an air mattress, incontinent care every 2 to 3 hours and to turn and reposition in bed every 2 to 3 hours. The RCP did not include an intervention to offload heels or apply offloading boots despite the existence of a right heel DTI. Review of the Order Summary Report dated 10/4/24 identified a Provider order directing a topical treatment of skin prep to the right heel and offloading the right heel with a pillow when in bed or in the wheelchair. Review of the Resident Care Card (RCC) dated 11/4/24 identified Resident #3 was to be out of bed daily to his/her custom wheelchair according to a 24 hour positioning plan and incontinence care was to be provided every 2 to 3 hours and as needed. Attached to the RCC was Custom Wheelchair 24 Hour Positioning Plan document which identified changes in wheelchair poisoning every 2 hours. Interview with NA #5 on 11/4/24 at 2:17 PM identified Resident #4 had been out of bed and in his/her wheelchair since prior to breakfast at 7:30 AM. NA #5 identified Resident #3 remained in the wheelchair since 7:30 AM and had not been repositioned in the wheelchair throughout the day. NA #5 further identified that Resident #3 is transferred back to bed between 2 PM and 2:30 PM daily for repositioning purposes and to provide incontinence care. NA #5 identified there was no incontinent care provided to Resident #3 while he/she was in the wheelchair throughout the day until he/she was transferred back to bed. After reviewing the Custom Wheelchair 24 Hour Positioning Plan with NA #5, NA #5 further verified that she does not reposition Resident #3 while in the wheelchair or provide incontinence care until after resident #3 is transferred back to bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/5/24 at 9:16 AM identified Resident #3 sitting in a wheelchair with an offloading boot to the left foot, no offloading boot to the right foot. The right foot was directly on the foot rest. Interview with RN #2 on 11/5/24 at 2:30 PM identified Resident #3 wakes up early and is usually transferred out of bed before breakfast. RN #2 identified Resident #3 is incontinent so should receive incontinence care every 2 hours and should be repositioned in his/her wheelchair according to the 24 Hour Wheelchair Positioning Plan. Observation on 11/7/24 at 9:53 AM identified offloading boots on Resident #3 ' s bed, and feet directly on wheelchair footrests. Further observations at 10:15 AM, 10:36 AM, 10:53 AM, 11:20 AM, and 1:10 PM were unchanged. A Skin Check evaluation dated 11/7/24 at 3:30 PM by RN #5 identified a DTI to the right heel measuring 2 centimeters (cm) by 2.5cm and was noted as improving. Interview with RN #5 (infection control and wound nurse) on 11/12/24 at 12:07 PM identified Resident #3 was readmitted to the facility on [DATE] with a right heel DTI which was not included on the facility wound report for the month of November. RN #5 indicated Resident #3 was not added to the wound report because of an oversight. RN #5 identified Resident #3 ' s right foot should be placed in an offloading boot when he/she is sitting in the wheelchair, is in bed, or anytime he/she does not have offloading support of the heels. RN #5 identified the right heel resting directly on the wheelchair footrest could cause further breakdown of the existing DTI. RN #5 identified she was unaware there was no order or care planned interventions for the offloading boots. RN #5 identified there should be a provider order and care plan to include the offloading boots as an intervention. RN #5 identified Resident #3 should be positioned in his/her wheelchair according to the 24-Hour Wheelchair Positioning Plan. The facility policy titled Positioning and Repositioning states, in part, positioning and repositioning is critical for a resident who is immobile or dependent on staff for positioning and repositioning and further states positioning a resident on an existing pressure ulcer (injury) should be avoided since it puts additional pressure on tissue that is already compromised and may impede healing.

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F 0689 Level of Harm - 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** 50250 Based on observations, clinical record review, review of facility policy, and interviews for 1 of 3 sampled residents (Resident #38) reviewed for falls, the facility failed to ensure the bed was left in a low position following the provision of care and failed to provide the level of assistance according to the plan of care, for a resident who was a high fall risk, which resulted in a fall with a major injury. The findings include: Resident #38 was admitted to the facility in August of 2024 with diagnoses that included history of falling, left hip fracture post hemiarthroplasty (hip replacement surgery), dementia and generalized muscle weakness. The Nursing Admission assessment dated [DATE] identified Resident #38 as verbal, confused, and with severe impairment affecting all areas of judgement. Additionally, the Nursing Admission Assessment identified that Resident #38 was able to move all extremities. The Resident Care Plan (RCP) dated 8/6/24 identified Resident #38 as a fall risk due to impaired mobility post left hip hemiarthroplasty related to a left hip fracture due to a fall and dementia. Interventions included keeping the call bell within reach, ensuring appropriate footwear is worn, providing verbal reminders of individual limitations, encouraging the use of a call bell, physical therapy as ordered, education based on ability to learn, observing for alterations in gait, maintaining a clutter free environment and an assist of 2 staff for bed mobility, transfers and mechanical lift transfers. The fall risk assessment dated [DATE] identified Resident #38 as a high fall risk with a total score of 16 (according to the fall risk assessment tool, a total score of 10 or greater is considered a high risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan). Resident #38's high fall risk predisposing factors included history of falls, altered level of consciousness (always disoriented), predisposing diagnoses, medications, incontinence, being chairbound, having experienced a change in condition in the last 14 days and having had a recent hospitalization in the last 30 days. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #38 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3), was dependent on staff for toileting hygiene, bed mobility and transfers and was incontinent of bowel and urine. In addition, the MDS identified Resident #38 sustained a fall and a fracture related to a fall within a month prior to admission to the facility. The Resident Care Card (RCC) dated 10/11/24 identified Resident #38 required an assist of 2 staff for bathing, toileting, incontinent care at bed level, bed mobility and transfers using a mechanical lift. The Reportable Event form dated 10/12/24 at 11:30 AM identified Resident #38 rolled out of bed onto the floor striking his/her head and was found lying on the floor on the right hip. Resident #38 sustained a laceration to his/her head and was transferred to the Emergency Department for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Post Fall evaluation by RN #1 dated 10/12/24 at 11:30 AM identified that Resident #38 had a fall risk score of 16 when he/she fell out of bed, sustained a 2.5cm by 2cm by 0.2 cm laceration to his/her head and was incontinent at the time of the fall. Additionally, the Post Fall evaluation identified that Resident #38's bed was at an improper height at the time of the fall and identified that an air mattress was applied on 10/11/24 and was subsequently discontinued post fall incident. Review of the hospital Emergency Department Provider Notes dated 10/12/24 identified that Resident #38 struck the top of his/her head in addition to the right side, right shoulder and right hip when he/she fell . Head, Ears, Eyes, Nose and Throat (HEENT) assessment identified that Resident #38 sustained a 4 cm scalp laceration to the crown (top of head) which was repaired surgically (wound was prepped and draped in sterile fashion, cleaned with povidone -iodine, irrigated with sterile water and pressure wash and repaired with tissue adhesive). In addition, a computed tomography scan (CT scan) identified nondisplaced cervical fractures at C1 and C2. A CT scan of the chest, abdomen and pelvis identified non-displaced fractures of the sacrum at S3 and S4. Resident #38 was placed in an Aspen Collar with cervical precautions. Observation on 11/8/24 at 12:10 PM, identified that Resident #38 shared a room with Resident #209. Resident #38 was observed sitting in a customized wheelchair with an Aspen Collar around his/her neck and a healing wound on top of his/her head. A dresser was located to the right side of Resident #38's bed (if Resident #38 is in bed, right side). Interview with RN #1 on 11/6/24 at 10:18 AM identified that she responded when Resident #209 was yelling for help. RN #1 indicated that when she entered the room, she found Resident #38 lying on the floor on his/her right hip and was bleeding from a laceration to his/her head. RN #1 identified that Resident #38 was non-ambulatory and therefore was not considered a fall risk. RN #1 indicated that even though the call bell was within reach, Resident #38 was not physically or mentally able to use it if he needed help. RN #1 identified that the air mattress placed on 10/11/24 (1 day prior to the fall) was immediately discontinued after the fall because Resident #38 did not have any falls within the facility prior to the placement of the air mattress. RN #1 was unable to provide a specific bed level at the time of the fall but confirmed the bed was not in a low position. Interview with Resident #209 on 10/6/24 at 10:35 AM, who is cognitively intact (BIMS score of 15 according to the quarterly MDS assessment dated [DATE]), indicated that Resident #38 was restless before he fell from his/her bed which was in a high position (approximately 3 feet). Resident #209 identified that he/she was laying in his/her bed watching television and heard a thud, he/she then saw Resident #38 lying on the floor on the right side of Resident #38's bed. Resident #209 identified that Resident #38's bed was so high that he/she could see Resident #38 on the floor on the right side of the bed from underneath the bed. Resident #209 indicated he/she yelled for help and pressed the call bell to alert staff. Resident #209 identified that Resident #38's bed was lowered, and floor mats placed on both sides of the bed after the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #1 on 11/6/24 at 12:04 PM identified she was assigned to provide care for Resident #38 on 10/12/24 during the 7 AM to 3 PM shift. NA #1 identified that she was the last person who performed care for Resident #38 at 9:30 AM, 2 hours prior to the fall incident. NA #1 identified that she independently assisted Resident #38 with bathing, dressing and repositioning in bed. NA #1 further identified that she had a difficult time repositioning Resident #38 because he/she was stiff, and she could not turn him/her easily. In addition, NA #1 could not identify at what level she left the bed after providing care. NA #1 indicated that Resident #38 may have attempted to climb out of bed to go to the bathroom since he/she was found to be incontinent of urine and stool when observed on the floor. Interview with Physical Therapist (PT) #1 on 11/7/24 at 1:07 PM identified that Resident #38 received physical therapy services from 8/7/24 to 9/18/24. PT #1 identified that Resident #38 always required a maximum assist of 2 staff during therapy due to the risk of falling. PT #1 indicated that Resident #38's dementia, inability to communicate and little to no command following contributed to a lack of progress towards ambulation. PT #1 further identified that the facility does not evaluate the use of air mattresses from an interdisciplinary approach, but instead, it is the responsibility of the nursing department to evaluate the safety of use, and the risk verses benefit of air mattress use. Interview on 10/7/24 at 10:21 AM with DNS #2 indicated Resident #38 was not a fall risk prior to the fall on 10/12/24 hence no indication for fall risk interventions (e.g. placing floor mats and lowering the bed to a low position). DNS #2 was not aware that Resident #38 was identified as a high fall risk since admission to the facility. DNS #2 indicated that the facility initially identified the cause of the fall incident as the air mattress which was placed on the previous day. DNS #2 further indicated that the air mattress was ruled out as the cause of the fall following the interview with resident #209 who gave a witness statement to the facility that Resident #38 fell out of bed because his/her feet became tangled in bed linens. DNS #2 could not explain why NA #1 performed Resident #38's care independently and left the bed at an inappropriate height after care was provided. The DNS was not able to explain how a resident who was dependent on staff for care was able to roll out of bed and sustain a fall with a head injury and fractures. Interview with NA #1 on 11/8/24 at 2:30 PM indicated that she was not aware that Resident #38 required an assist of 2 for care at bed level and indicated that she did not check the Resident Care Card (RCC) to confirm the level of assistance required before performing care. NA #1 further identified that RCC's are kept in resident rooms, yet did not check the RCC. Review of facility policy, Positioning and Repositioning, identified in part, that, staff should check the care plan, assignment sheet or communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. It also identified that head of bed should be raised to waist level, prior to providing care and bed lowered into lowest position and side rails placed in the appropriate position as indicated in the resident's plan of care after care provision. Documentation of the position in which the resident was placed should be done. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy, Falls: Minimizing Risk of Injury, identified in part, that, residents shall be assessed for risk of falling upon admission, quarterly, annually and after a significant change in condition. Residents who are at risk shall have a care plan that addresses interdisciplinary measures to prevent falls and environmental/equipment recommendations to prevent injuries.

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on observations, interviews, clinical record review and facility policy, for 1 of 3 residents (Resident #3) reviewed for nutrition, the facility failed to monitor and accurately document fluid intake and bowel movements resulting in a prolonged hospitalization related to a severe fecal impaction and failed to make speech therapy and dietician referrals with a documented weight loss and poor meal intake. The findings include: Resident #3 was admitted to the facility in August of 2022 and had diagnoses that included spinal stenosis, dementia and protein-calorie malnutrition. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0), dependent for bathing, dressing, and bed mobility and required substantial/maximal assistance for eating. The MDS identified Resident #3 was always incontinent of both bowel and bladder, was at risk for developing pressure injuries and was on a mechanically altered diet. The Resident Care Plan (RCP) dated 7/16/24 identified Resident #3 was at risk for weight loss and dehydration related to poor intake of meals and included interventions to monitor dietary intake and monitor intake and output (I&O). The RCP identified Resident #3 had pain with interventions to include administering Tylenol and Tramadol (opioid). The RCP did not identify Resident #3 as at risk for constipation despite pain regimen and lack of mobility. a. Review of the facility Laboratory Report dated 8/26/24 identified lab values outside of normal ranges to include an elevated blood urea nitrogen (BUN): 51.3 (normal range: 9-23 mg/dL), creatinine: 1.20 (normal range: 0.55-1.02 mg/dL), and sodium: 146 (normal range: 135-145mmol/L). Elevated BUN, creatinine and sodium levels are all indications of impaired kidney function and/or dehydration. An APRN order dated 8/27/24 directs to encourage an extra 240 milliliters (ml) of fluid every shift. Review of the facility Laboratory Report dated 8/29/24 identified lab values outside of normal ranges to include an elevated BUN (46.2), Creatinine (1.16), and Sodium (146). The physician order dated 8/30/24 directs to decrease Lasix (diuretic) to 20mg for 5 days and then to restart Lasix 40mg daily. Review of the facility Laboratory Report dated 9/4/24 identified lab values outside of normal ranges to include an elevated BUN (50.1), Creatinine (1.11), and Sodium (150). A late entry APRN Progress note dated 9/6/24 at 2:52 PM by APRN #1 identified she spoke at length with Person #3 and that Person #3 was very concerned regarding dehydration. The progress note further identified a plan to continue an extra 240 ml of fluids by mouth every shift, to continue Lasix 40 mg daily, to repeat bloodwork (basic metabolic panel (BMP) the next week and included a new order for a low sodium diet. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Order Summary Report dated 9/10/24 identified an order for Senokot-S 8.6-50 mg (2 tablets) to be administered at bedtime with a start date of 8/23/22, Tramadol 25 mg to be administered 2 times a day with a start date of 1/3/24, and Senna 8.6 mg (2 tabs) to be administered in the morning with a start date of 2/5/24. Review of the facility Laboratory Report dated 9/12/24 identified lab values outside of normal ranges to include an elevated BUN (77.3), Creatinine (1.57), and Sodium (156). A late entry APRN Progress note dated 9/12/24 at 4:14 PM identified Resident #3 continued to have abnormal labs, and that Person #3 and the nursing staff reported Resident #3 as having less alertness and agitation at times. The progress note identified a new order for IV fluids (dextrose 5% water to run at 50ml per hour for 500ml), bloodwork the following morning, a urine analysis and a chest X-ray to rule out pneumonia. The progress note identified the plan for the current situation was discussed with Person #3. Review of the Medication Administration Record (MAR) for August and September of 2024 identified Lasix 20 milligrams (mg) was administered daily from 8/31/24 through 9/4/24 and Lasix 40 mg was administered daily from 9/5/24 through 9/13/24. Review of the facility I&O report from 8/31/24 to 9/13/24 identified large volumes of fluid intake documented by NA #8 during the 7 AM to 3 PM shift as follows: 9/2/24: 1400 ml, 9/4/24: 1800 ml, 9/5/24: 1800ml, 9/6/24: 1400 ml, 9/9/24: 1800 ml, 9/10/24: 1800 ml, and 9/11/24: 1800 ml. Review of the facility Bowel Movement (BM) report from 8/31/24 to 9/13/24 identified NA #8 documented the following BM's: 9/4/24: large loose/diarrhea, 9/5/24: Medium loose/diarrhea, 9/6/24: large loose/diarrhea, 9/9/24: medium formed stool, 9/11/24: medium loose stool/diarrhea. Review of the facility SBAR Communication Form document dated 9/13/24 at 3:22 PM by RN #6 identified Resident #3 was found to have an altered mental status, weakness and was transferred to the hospital for further evaluation and treatment. Review of a hospital Discharge Summary document dated 10/4/24 identified Resident #3 was admitted to the hospital on 9/13/24 and was found to have an acute kidney injury with water deficit (kidneys are suddenly damaged primarily from a lack of fluids in the body), bilateral hydronephrosis (urine unable to drain from the kidneys) related to significant stool impaction, stercoral colitis (rare inflammatory form of colitis that occurs when fecal material leads to distension of the colon) and a urinary tract infection. The Discharge Summary identified Resident #3 had a prolonged hospitalization and initially was ordered to have nothing by mouth, received IV fluids (half normal saline at 100 ml per hour), was treated with IV antibiotics for the urinary tract infection, underwent multiple stool disimpactions, required aggressive bowel regimen, enemas and manual disimpaction. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Medical Director (MD #2) on 11/7/24 at 9:32 AM, the I&O report and BM report for the dates of 8/31/24 to 9/13/24 were reviewed. MD #2 identified Resident #3's fluid intake obviously wasn't great and the ordered Lasix should have been held due to worsening lab values. MD #2 identified that if Resident #3 was having BM's at all, the BM's were not sufficient and the facility should have identified that and ordered an X-ray. MD #2 identified that if the bowel regimen was last reviewed in February 2024, it should have been reevaluated since then, due to Resident #3's progressive decline, decrease in mobility and active order of Tramadol (opioid drug). MD #2 further identified he was not notified of any change in condition leading up to the 9/13/24 hospitalization . Interview on 11/7/24 at 10:58am with NA #8 identified Resident #3 did not drink the large volumes of fluid she documented from 8/31/24 to 9/13/24. NA #8 stated she just did not take the time to add up the numbers like she should have and she just wasn't thinking. NA #8 further identified Resident #8 had frequent loose stools and that she reported BM's to the nurses but did not report that the stools were loose because she thought loose stools were normal for Resident #3. She further identified that when documenting in the electronic medical record, she thought the number options were for the number of times residents had BM's verses stool consistency (1: formed stool, 2: loose/diarrhea). During an interview on 11/7/24 at 11:15 AM, the I&O report and BM report for the dates of 8/31/24 to 9/13/24 were reviewed with APRN #1. APRN #1 identified she ordered IV fluids the day before Resident #3 was transferred to the hospital because that is when the nursing staff reported Resident #3 was refusing fluids and further identified she would have ordered IV fluids sooner if she knew fluid intake was poor. When the Lasix orders were reviewed, APRN #1 identified there was a resident representative (Person #3) who insisted Resident #3 have Lasix for edema. APRN #1 indicated she did not review the risk verses benefit of continuing the Lasix with Person #3. During an interview on 11/12/24 at 11:47 AM, DNS #2 was informed that NA #8 identified she documented I&O's and BM's incorrectly. DNS #2 identified incorrect documentation could affect an accurate assessment of care needs and that the RN supervisor should have identified the incorrect documentation and reported it to the APRN. DNS #2 identified NA #8 should have reported Resident #3's loose stools so the RN supervisor could have performed an assessment. Subsequent to surveyor inquiry of inaccurate documentation, the facility initiated staff education for accurate documentation of I&O, BM's and the reporting of any issues/concerns to the charge nurse or nursing supervisor. b. Review of the facility Nutrition assessment dated [DATE] identified Resident #3 was readmitted to the facility on [DATE] with a significant weight loss. Goals identified in the Nutrition Assessment included Resident #3 tolerating the current diet without signs or symptoms of aspiration and meal intake of 50% or greater for 2 out of 3 meals per day. Review of the facility Weight Summary identified a weight of 145.2 pounds on 10/8/24 and a weight of 136.9 pounds on 10/31/24, identifying a further 5.7% weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an observation in the dining room on 11/4/24 at 12:32 PM, LPN #4 was observed assisting Resident #3 with drinking a chocolate supplement. Resident #3 coughed intermittently with sips of the supplement. By 12:46 PM Resident #3 drank 75% of the supplement and LPN #4 presented a spoonful of mashed potatoes which Resident #3 did not respond to and did not open his/her mouth. At 12:58 PM NA #5 assisted Resident #3 with the remainder of the supplement and removed the meal tray. There was only 1 presentation of food to Resident #3's mouth throughout lunch. Interview with NA #5 on 11/4/24 at 12:58 PM identified Resident #3 ate well prior to a recent hospitalization but since readmission to the facility, Resident #3 does not eat much food. NA #5 identified Resident #3 would eat oatmeal during breakfast on some days but otherwise takes in only fluids. During an observation in the dining room on 11/5/24 at 12:47 PM NA #6 was observed presenting a spoonful of lasagna (mechanical soft) to Resident #3 multiple times. Resident #3 did not respond to the presentation of food, and did not open his/her mouth. NA #7 told NA #6 to stop attempting to feed Resident #3 because Resident #3 only takes in fluids. NA #6 assisted Resident #3 with drinking a chocolate supplement. Resident #3 coughed intermittently with sips of the supplement. Interview with NA #6 on 11/5/24 at 12:55 PM identified she had never previously fed Resident #3 because she usually works on a different nursing unit. Interview on 11/5/24 at 12:56 PM with NA #7 indicated Resident #3 had not been eating food for the past 2 to 3 weeks and Resident #3 often coughed while drinking fluids. NA #7 identified Resident #3 received a meal tray despite not eating food because the nursing supervisor (RN #2) stated it is state mandated for residents to receive meal trays even if they do not eat. Review of the Document Survey Report identified Resident #3 ate less than 50% for more than half of the meals served from 11/1/24 to 11/7/24 and of those meals 5 were documented as refusals. Interview on 11/7/24 at 9:32 AM with MD #2 indicated that due to Resident #3's progressive decline and poor meal intake, the diet should be downgraded to identify if Resident #3 better tolerates a different texture. Interview on 11/7/24 at 4:33 PM with Speech and Language Pathologist (SLP) #1 identified Resident #3 last received speech therapy services from 10/4/24 to 10/10/24 with a recommendation for a mechanical soft texture and thin liquids and stated Resident #3 had a delayed response to presentation of food. SLP #1 indicated food consistency effects palatability of food and when the goal is for residents to take in more food, efforts are made to maintain food consistency. The SLP identified she had not received any reports of poor meal intake or further weight loss for Resident #3 and would have expected to receive a referral if there was a change in condition. SLP #1 further identified that if Resident #3 had poor meal intake, safety would be the priority over palatability and Resident #3 should be evaluated for a diet downgrade. Subsequent to surveyor inquiry, SLP #1 downgraded Resident #3's diet on 11/7/24 to a puree texture and nectar thick liquids. Review of the Speech Therapy SLP Evaluation and Plan of Treatment document dated 11/11/24 identified Resident #4 presented with further decline in swallow function, with decreased intake and observed coughing with thin liquids. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview on 11/12/24 at 11:51 AM with RN #2 identified she was not aware of Resident #3's poor meal intake and if she were aware, she would have referred Resident #3 back to the SLP and the RD for an evaluation. The facility policy titled Intake/Output states, in part, the purpose is to ensure adequate hydration and prevent dehydration to the extent possible based on each residents individualized care needs and choices and that I&O are instituted for a resident with a change in condition which may alter hydration status. The facility policy titled Charting and Documentation states, in part, documentation in the medical record will be complete and accurate. The facility policy titled Notification Change in Condition, Change in Treatment/Services states, in part, that the facility will inform the resident, resident's physician and the resident's family/legal representative when there is a change of condition. The policy states an RN will perform an assessment once a change of condition is identified and the policy provides examples of changes in condition to include diarrhea, vomiting (assess for dehydration and /or constipation) and changes in intake and output (assess for dehydration and/or fecal impaction).

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on interviews, clinical record review and facility policy, for 1 of 3 residents (Resident #3) reviewed for a rehospitalization , the facility failed to provide a social services follow up with a resident's representatives regarding support and education for advance care planning and goals of care after a change in condition resulting in a hospitalization . The findings include: Resident #3 was admitted to the facility in August of 2022 and had diagnoses that included spinal stenosis, dementia and protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 0), was dependent for bathing, dressing, and bed mobility and required substantial/maximal assistance for eating. A progress note by MD #2 on 7/10/24 identified Resident #3 as eligible for hospice. The Social Services Quarterly Note by Social Worker (SW) #1 on 7/12/24 at 12:38 PM indicated Resident #3 was alert/confused, had family who remained involved/supportive and visited regularly and stated the SW would remain available to Resident #3 for support as needed. Review of the hospital Discharge Summary dated 10/4/24 identified Resident #3 as eligible for routine hospice if aligned with the family's goals of care and that the family was contemplating a feeding tube versus hospice on the day of discharge from the hospital. The Discharge Summary identified Resident #3 with a new code status of Do Not Resuscitate (DNR) (which was a change from a full code status) after multiple palliative care and advance care planning conversations were held with family members. The Social Services Quarterly Note by SW #1 on 10/16/24 at 2:05 PM indicated Resident #3 was alert/confused, was readmitted (readmitted [DATE]) after a hospitalization , had family who remained involved/supportive and visited regularly, and stated the SW would remain available to Resident #3 for support as needed. Interview on 11/6/24 at 2:05 PM with SW #1 identified she was present for a care conference on 10/16/24. Review of the facility care conference document dated 10/16/24 identified the document was not signed by SW #1. SW #1 then identified she was not present for the 10/16/24 care conference and the last care conference she was present for was in July 2024. SW #1 indicated she joined care conferences annually or as needed for long term care residents. SW #1 identified she did not follow up with Resident #3's representatives regarding goals of care since the 10/4/24 readmission to the facility. SW #1 identified that there were 2 resident representatives who had differing goals of care and difficulty coping. SW #1 identified the last time she discussed goals of care with the resident representatives was during the July care conference, despite a change in condition since then. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with DNS #2 on 11/6/24 at 4:06 PM the palliative care and advance care planning conversations noted throughout the hospital Discharge Summary dated 10/4/24 were reviewed. DNS #2 identified an RN supervisor or SW #1 should have followed up with the resident representatives regarding goals of care since admission back to the facility. Interview on 11/7/24 at 4:05 PM with SW #1 identified she wrote a readmission note on 10/16/24 after going to see Resident #3 but did not follow up with the resident representatives since Resident #3's readmission to the facility, despite Resident #3's severe cognitive impairment. SW #1 identified there are a lot of nursing areas discussed during care conferences and indicated it would have been important for her to be present for the meeting to support the resident representatives in a discussion related to goals of care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 51183 Based on observations, clinical record review, review of facility policy, interviews for 1 of 3 sampled residents (Resident #206) reviewed for pressure ulcers and observation of 1 of 1 medication rooms for medication storage and labeling, the facility failed to ensure that a resident's medications were stored in a designated secure area per facility policy and failed to discard expired vaccines and insulin vials after the beyond use date. The findings include: 1. Resident #206 was admitted to the facility in October of 2024 with diagnoses that included osteomyelitis of vertebra, sacral and sacrococcygeal region, depression, and generalized muscle weakness. Physician's orders dated 10/21/24 directed to administer Unasyn injection solution reconstituted 1.5(1-0.5) gram (antibiotic) every 6 hours for wound infection, heparin (anticoagulant) flush 5 milliliters (ml) and sodium chloride flush solution 10 ml, intravenously (IV) every shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #206 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14) and required set up assistance for eating. Resident #206 was independent for bed mobility and dependent for transfers. The Resident Care Plan dated 10/28/24 identified Resident #206 was on intravenous antibiotic therapy due to osteomyelitis. Interventions included enhanced barrier precautions as indicated, administration of IV therapy per physician's order, monitoring the infusion rate every hour, maintaining intake and output every shift, and administering medications as ordered. Observation on 11/4/24 at 12:01 PM and 11/5/24 at 11:00 AM, identified heparin flush 5ML syringes in a full 1/2 galloon storage bag and sodium chloride flush solution syringes in full 1/2 galloon storage bag in Resident #206's room on top of the refrigerator. Interview and observation with RN #2 on 11/5/24 at 11:05AM, identified heparin and normal saline flush syringes on top of Resident #206's refrigerator. RN #2 identified that the medications should not have been stored in Resident #206's room but should have been stored in the medication room or in the medication carts. RN #2 could not explain why Resident #206's medications were store in his/her room. Subsequent to the surveyor inquiry, the mentioned bags of heparin and normal saline flush syringes were removed from Resident #206's room and transferred to a secured area (medication room). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation of the 2nd floor medication storage room on 11/8/24 at 1:30 PM, identified an open box containing 10 remaining influenza A & B tests which expired 5/31/22 stored on the bottom storage shelf. Further identified inside the medication refrgerator, were 2 open multi-dose 10 milliliter (ml) vials of insulin Lispro dated with the dates they were opened. 1 insulin Lispro multi-dose vial was dated 9/10/24 and 1 insulin Lispro multi-dose vial was dated 9/15/24, both were approximately half full. Interview with Registered Nurse (RN) #2 on 11/8/24 at 2:00 PM identified she was unaware that there were expired influenza tests and open multi-dose vials of insulin past the beyond use date, in the medication storage room. RN #2 could not identify why they were there. RN #2 indicated that opened vials of insulin should be dated when opened and then discarded within 30 days. RN #2 indicated expired medications should be placed in a plastic bin, stored inside the medication storage room, for pick up by the pharmacy on Mondays. Review of facility policy, Medication Storage in the Facility, identified in part, that, medications and biologicals should be safely, securely and properly stored following manufacturers recommendations or those of the supplier. The medication supply should only be accessible to licensed nursing personnel, pharmacy personnel or staff members who are lawfully authorized to administer the medications. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area. Review of the facility policy, Facility-Storage of Medications directed, in part, that outdated medications are immediately removed from inventory and disposed of according to procedures for medication disposal, and when the original seal of a manufacturer's vial is initially broken, the nurse enter the date opened and the new date of expiration. The expiration date of the vial would be 30 days unless the manufacturer recommends another date. (Insulin Lispro manufacturer instructions specify that opened 10 ml multi-dose vials can only be used for 28 days whether refrigerated or stored at room temperature.)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on tour of the dietary department, observations, interviews, and facility policy, the facility failed to label open food items, failed to dispose of expired food items, and failed to store the ice machine scoop in a clean and sanitary manner. The findings included: Tour and observation of the kitchen on [DATE] at 9:07 AM with the Dietary Director identified the following: 1. Observation of the bread rack identified an unsealed bag containing 3 pieces of cake with multiple spots of green mold and an expiration date of [DATE] and an unsealed bag containing 9 pieces of corn bread with an expiration date of [DATE]. 2. Observation of the bread rack additionally identified an unsealed bag containing 2 hotdog rolls, an unsealed bag containing 5 hotdog rolls and an unsealed bag containing 3 hamburger rolls. None of the above bags contained an expiration date or an open date. 3. Observation of the ice machine identified the ice machine scoop holder, which was adhered to the wall near the ice machine, had an inner removable tray which the end of the scoop slid into. There was water within the tray, approximately ,d+[DATE]cm deep, which the scoop was in. The ice machine scoop holder and inner tray had scattered areas of white residue. The scoop was 95% covered in white residue. Observation of the Ice Scoop Sanitizing form which was taped to the wall beside the ice machine identified twice daily (at the end of each shift) sections to sign off running the ice machine scoop through the dish machine. Initials were missing for the second wash on [DATE], and initials were present for the wash [DATE] at 6:10 AM. 4. Observation of the nursing unit nourishment room refrigerator identified a box of Danishes with a date of [DATE] written on the box and a half empty container of thickened cranberry cocktail which included a deliverey date of ,d+[DATE] but no open date. During an interview on [DATE] at 9:37 AM the Dietary Director identified that the expired foods should have been thrown away and the open unlabeled bags should have been labeled with an open date by whoever opened them. The Dietary Director further identified the ice machine scoop holder, inner tray and scoop needed to be run through the dishwasher. Interview with the Administrator on [DATE] at 10:17 AM identified the Danishes and thickened cranberry cocktail in the nourishment room refrigerator needed to be thrown away, and threw them in the garbage. The facility policy titled Food states, in part, all food items should be labeled and dated, all items stored in the refrigerator will be covered, labeled with the contents and the date. All potentially hazardous foods must be discarded within 3 calendar days after the date prepared. The facility policy titled Policy for Ice Machines and Ice Storage Containers stated, in part, that all ice machines and ice storage containers will be maintained in a clean and sanitary manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observation, review of the clinical record, facility policy and interviews for 1 of 3 residents (Resident #209) reviewed for pressure ulcers, the facility failed to follow infection control practices when providing wound care. The findings include: Resident #206 was admitted in October of 2024 with diagnoses that included complete paraplegia, osteomyelitis of the sacral, sacrococcygeal region, pressure ulcer right buttock stage 4, pressure ulcer left buttock stage 3. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #206 was cognitively intact (brief interview for mental status (BIMS) score of 14), required set up assistance for eating, partial moderate to dependent assistance for dressing, was dependent for transfers and toileting, independent for bed mobility and had an indwelling catheter for urinary drainage. The Resident Care Plan dated 10/21/24 identified Resident #206 was at risk for skin integrity and was admitted to the facility with a left buttock stage 3 pressure ulcer and a right buttock stage 4 pressure ulcer which since merged into 1 large wound measuring: 10.5 centimeters (cm) by 5cm by 3cm. Interventions included to follow facility skin care protocol, physical therapy (PT)/Occupational therapy (OT) consultation for positioning, measure and document any areas on admission, preventative measures in place, reposition as it meets the resident needs, dietary consult as needed, report any new areas to physician, nurse, nurse practitioner (APRN), pressure redistribution devices as ordered, treatment as ordered, record any new changes to physician, nurse, and air mattress set at 110 per protocol to offload pressure. A Nurse's Note dated 10/25/24 at 12:57 PM identified in part, a right gluteus stage 4 pressure ulcer with full thickness skin and tissue loss which was present upon admission to the facility and included measurements of 10.5cm by 5cm by 2.5 cm with undermining at 10 o'clock and 3 o'clock. The note identified a wound bed of 70% granulation (healthy tissue), 20% slough (layer of dead tissue) 0% eschar (dry dead tissue) and heavy serosanguinous exudate (clear drainage mixed with blood). A Physician Progress Note dated 10/24/24 at 5:10 PM identified a consultation for evaluation and management of the wound. The note identified this was the first evaluation of the wound which was present on admission to the facility for osteomyelitis (infection in the bone) of the sacral area and had been treated with long term intravenous antibiotics. The note identified wound measurements as follows: coccyx stage 4 pressure ulcer: 6cm by 4cm by 1.5cm with undermining at 3 o 'clock to 10 o 'clock measuring 2cm with a wound base of 75% granulation, 25% slough and a large amount of serosanguineous exudate, left buttock stage 3 pressure ulcer: 3.2cm by 2cm by 0.2cm with 75-99% epithelial tissue and a moderate amount of serosanguinous exudate. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of a dressing change performed by LPN #3 on 11/6/24 at 10:30 AM, identified LPN #3 performed hand hygiene prior to donning gloves and removed a dirty dressing to the left buttock wound. She then wet the old stuck dressing with normal saline for removal and cleansed the wound with normal saline. LPN #3 then cleansed the wound bed with Dakin's solution. LPN #3 did not provide a clean field to perform further wound care and application of a new clean dressing. The surveyor intervened prior to LPN # 3 beginning preparation of a clean dressing and reminded LPN #3 to remove dirty gloves, perform hand hygiene and don clean gloves. LPN #3 verbalized understanding, performed hand hygiene and then failed to apply clean gloves. LPN #3 then opened the dressing (xeroform gauze), cut the dressing with scissors and then covered the wound with an adherent dressing, all without the benefit of wearing gloves. Interview with LPN # 3 on 11/6/24 at 11:00 AM identified that she did not know the dressing change policy and identified she should have changed her gloves and performed hand hygiene after removing the dirty dressing and before preparing the clean dressing. LPN #3 further identified she did not clean the scissors she used to cut the clean dressing that she applied directly to the wound bed. LPN #3 identified she should have cleansed the scissors prior to cutting the clean dressing and she should have worn gloves when touching the clean dressing. Review of the wound care policy directed, in part, use a disposable cloth to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field. Put on gloves and remove dressing, pull glove over dressing and discard. Wash and dry your hands thoroughly, put on gloves using a no touch technique, pour liquid solutions directly on gauze sponges on their papers. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over wound. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Dress the wound by picking up the sponge by the paper and apply directly to the area. Be certain all clean items are on the clean field.