STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Lord Chamberlain Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7003 Main Street Stratford, CT 06614	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, review of facility policy, and interviews for 1 of 3 sampled residents (Resident #374) reviewed for accidents, the facility failed to ensure that a resident was treated with dignity when requesting wheel chair foot rests/pedals. The findings include: Resident #374's diagnoses included acquired absence of left leg below knee, generalized muscle weakness, end stage renal disease, and hypertension. The Nursing Admission assessment dated [DATE] identified Resident #374 was alert and oriented but forgetful and required a wheel chair for mobility. The Resident Care Plan (RCP) dated 10/18/24 identified Resident #374 required assistance with activities of daily living (ADLs). Interventions included to provide assistance with bathing, dressing, hygiene, ambulation and transfers. Additionally, Resident #374 required physical therapy and occupational therapy as ordered. Observation on 10/25/24 at 9:40 AM identified Resident #374 in the hallway, sitting in wheelchair without leg rests/pedals applied to the wheelchair. Resident #374 was wearing shoes and resting his/her feet on the floor/ground. Resident #374 requested the surveyor to inform his/her nurse that he/she wanted wheel chair leg rests applied before being transported to a scheduled appointment (dialysis). LPN #5 was notified by the surveyor of Resident #374's request for leg rests to be applied to the wheelchair before he/she was transported out. LPN #5 immediately grabbed the wheel chair handles and began pushing the wheelchair forward. LPN #5 did not inform Resident #374 that she was pushing the wheel chair forward. LPN #5 stated she needed to wheel Resident #374 to the physical therapy room to obtain leg rests and once again attempted to push the wheelchair forward. Resident #374 stated out loud multiple times that his/her braces (wheel chair leg rests/pedals) were needed fast as his/her transportation had already arrived. LPN #5 sought assistance from other staff members and leg rests/pedals were located and applied on Resident #374's wheelchair. Interview with LPN #5 on 10/25/24 at 9:43 AM, identified that she intended to transport Resident #374 to the physical therapy room for wheelchair leg rests to be applied before being transported out for dialysis. LPN #5 indicated that she had transported Resident #374 in the wheelchair from Resident #374's room into the hallway without leg rests. LPN #5 indicated that she was aware that Resident # 374 should have had wheelchair leg rests applied first before being transported. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024

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Lord Chamberlain Manor	7003 Main Street Stratford, CT 06614

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DNS and the Administrator on 10/25/24 at 11:37 AM, the Administrator identified that residents have a right to be listened to and treated with dignity. The Administrator identified that LPN #5 should have listened to Resident #374 when he/she was asking for the leg rests to be applied. Additionally, the Administrator indicated that it was protocol for residents to be transported with wheelchair leg rests/pedals unless the resident requested not to have them. Interview with Occupational Therapist (OT) #2 on 10/25/24 at 11:57 AM, identified that it was protocol that residents in a wheel chair have leg rests/pedals applied before residents were transported unless the resident requested not to have them. Review of facility policy, chair/wheelchairs, identified in part, that, once a resident is transferred to a wheel chair, extremities should be supported . Legs rests are used if a resident is unable to self-propel the wheel chair.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observation, staff interviews, review of clinical records, and facility policy for 1 of 1 resident (Resident #525) reviewed for environment, the facility failed to provide a call bell that accommodated Resident #525's physical limitation needs. The findings include: Resident #525's diagnoses included a fracture of the right femur, history of falling, and muscle weakness. A Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 10/14/24 identified that Resident #525 walked occasionally, had no limitations, and made major and frequent changes in position. The admission nursing assessment dated [DATE] identified Resident #525 was alert and oriented to person, place, and time. The Baseline Resident Care Plan (RCP) dated 10/16/24 identified Resident #525 was at risk for falls and had a fracture of the hip. Interventions included the use of his/her call bell when assistance was needed. An interview with Person #2 on 10/21/24 at 12:37 PM identified that Resident #525's call bell buttons were too stiff, and he/she cannot press the Nurse button to call for help. An interview and observation with Licensed Practical Nurse (LPN) #2 on 10/23/24 at 10:41 AM identified that Resident #525 was unable to depress the buttons on his/her call bell to call for the nurse. LPN #2 indicated that the nurse assigned to a resident upon admission was responsible to ensure the call bell was working. LPN #2 further noted that upon a resident admission, required documentation to complete in the Electronic Health Record (EHR) asked if the call bell was working but did not ask if the resident can use the call bell. LPN #2 noted the facility did have manual handheld bells and soft touch pads available for those residents who cannot use a standard call bell. A subsequent interview and observation with LPN #2 on 10/23/24 at 3:05 PM identified that Resident #525's call bell had not been exchanged for a different call bell since the previous observation on 10/23/24. Further, when Resident #525 was instructed by LPN #2 to press the call bell Nurse button Resident #525 was unable to depress the buttons on his/her call bell to call the Nurse. LPN #2 pressed the call bell button, and the call button was found to be in working order. LPN #2 stated he would contact Central Storage to have them send up a new call bell for the resident that worked differently. A Nursing Progress note dated 10/24/24 at 12:00 PM identified that Resident #525 attempted to get out of bed without assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/24/24 at 12:47 PM identified that Resident #525's call bell had not been changed since the 10/23/24 observations. Person #2 was asked to instruct Resident #525 to press his/her call bell and again it was noted that the resident was unable to depress the buttons on his/her call bell to call for the nurse. An interview with the Nursing Supervisor on 10/24/24 at 1:56 PM identified that orientation of a resident to the facility included showing a resident the call bell; educating that the red button was to call the nurse; and informing the resident if he/she rings the bell staff can help with all his/her needs. Further, the Nursing Supervisor noted it was the responsibility of both nurses and supervisors to orient the resident to the call bell therefor ensuring the resident was educated twice on call bell usage. The Nursing Supervisor identified that a resident's ability to use a call bell was evaluated through asking the resident to demonstrate they can use the call bell. The Nursing Supervisor indicated that currently all residents within the facility's unit were alert and oriented, therefore all the residents can use a standard call bell and no touch pad call bells were in use. Further, it was identified that touch pad call bells were not stocked on the unit and would need to be requested from Maintenance by a Supervisor, with an estimated delivery time to the unit in 15 minutes. The facility's Call Bell Policy identified that if call lights are defective, a report should be sent to the maintenance department. The Call Bell Policy failed to address what procedure should be followed in the event a resident is not able to use a standard call bell.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on staff interviews, clinical record review, and facility policy for 1 of 1 sampled resident (Resident #374) reviewed for dialysis, the facility failed to implement a baseline care plan that met the immediate needs of a hemodynamically managed resident. The findings include: Resident #374's was admitted to the facility in October 2024 with diagnoses that included end stage renal disease with dependence on renal dialysis, type 2 diabetes with diabetic chronic kidney disease, and bipolar disorder. Physician orders dated 10/17/24 identified Resident #374 received dialysis at an outpatient dialysis facility every Monday, Wednesday, and Friday. The physician orders further identified Resident #374 received Lamotrigine 25 mg by mouth one time a day (a medication to stabilize mood in bipolar disorder). The Baseline Resident Care Plan (RCP) dated 10/18/24 identified Resident #374 had experienced a subdural hematoma and was to have his/her vital signs monitored for changes and had fall interventions due to multiple falls. Although the Baseline RCP did address the categories: Activities of Daily Living; Elimination; Pain; Falls; and Behavior, it failed to address Resident #374's dialysis's needs or medication monitoring. The admission nursing assessment dated [DATE] identified Resident #374 was alert and oriented to person, place, and time. The Admission Nursing Assessment further identified that Resident #374 was on hemodialysis, was able to move all his/her extremities, and used a wheelchair to assist with his/her mobility. An interview with Resident #374 on 10/25/24 at 9:35 AM identified he/she had no food limitations on dialysis days and had a Arteriovenous (AV) fistula located to his/her left arm. An interview with the Director of Nursing Services (DNS) on 10/25/24 at 10:13 AM identified a Baseline RCP should include: psychotropic medication evaluation, bowel and bladder, safety, and pain. For residents on dialysis, the Baseline RCP should also include their goals, weights, diet, and other elements for dialysis. The DNS stated the reason dialysis and psychotropic medication evaluation were not included in the Baseline RCP for Resident #374 was staff oversight by the team. Review of the facility's Baseline Care Plan Policy identified that a baseline care plan is to be completed within 48 hours of a resident's admission, include resident goals, include services and treatments to be administer by the facility or personnel acting on behalf of the facility, and include a summary of the resident's medications and dietary instructions.

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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** 41018 Based on interviews, a review of the clinical record, and facility policy for 1 of 2 sampled residents (Resident #175) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure Resident #175 was assisted with bed mobility according to the physician's orders and the resident's needs. The findings include: Resident #175 was admitted to the facility in October 2024 with diagnoses that included congestive heart and respiratory failure, muscle weakness and obesity. A Nursing Admission assessment dated [DATE] identified Resident #175 had a history of one to two falls within the past three months and was hospitalized between the dates of 10/4/24 through 10/16/24 for congestive heart failure and a right foot chronic ulcer that was debrided surgically with the placement of a wound vacuum. The Nursing Admission Assessment further identified Resident #175 was non-ambulatory, was bed/chair-bound, and was incontinent. Although the Admission Care Plan dated 10/16/24 did not identify that Resident #175 was to receive assistance with bed mobility, the Nurse Aid Care Card did identify that Resident #175 was to have assistance of two for bed mobility and activities of daily living. A Physical Therapy (PT) Evaluation and Plan of Treatment dated 10/17/24 identified Resident #175 had impaired upper and lower extremity strength, was non-ambulatory and transferred via a Hoyer lift, he/she displayed impairments in muscle strength, and had sensation deficits with a baseline of Total Dependence (TD) for all bed mobility with max assistance of two. A physician's order dated 10/17/24 directed to provide assist of two for bed mobility. Observation of Resident #175 on 10/23/24 at 10:27 AM identified he/she had the call light on. Nurse Aide (NA) #4 entered the room and Resident #175 requested assist re-positioning in bed. NA #4 was observed to assist Resident #175 without the benefit of another staff member to assist. NA #4 was observed asking the resident to hold onto the bed railing to help adjust with positioning, Resident #175 then reached onto the rail at the direction of NA #4, who then proceeded to reposition Resident #175 by pulling up on the blue positioning pad that was underneath the resident. NA #4 then asked Resident #175 if he/she was comfortable, and the resident identified he/she was not comfortable. NA #4 subsequently proceeded to position a pillow underneath Resident #175's left side to attempt to make the resident more comfortable. Resident #175 then stated being lopsided and would like another pillow for the other side. NA #4 was observed leaving Resident #175 in a lopsided position, leaving the room and retrieved another pillow. After approximately 30-40 seconds, NA #4 returned with another pillow and directed Resident #175, again, to hold onto the side rail and to roll him/herself as much as possible to the other side. NA #4 was observed struggling to successfully wedge a pillow underneath Resident #175's right side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #175 on 10/23/24 at 11:30 AM identified that he/she received assistance with bed mobility; however, it varied as to whether he/she had one or two NAs to assist. Further interview identified she was not aware that she required assistance from two people with all bed mobility and the inconsistency in the amount of assistance she received made him/her feel annoyed because she assumed some of the NAs didn't want to position him/her alone because of his/her weight. The interview further identified it was easier with two people assisting because he/she did not have upper body strength. Interview with NA #4 on 10/23/24 at 11:40 AM identified that she normally positions and washes Resident #175 daily by herself without assistance from another NA because Resident #175 can help him/herself and takes the direction to hold on to the bed rails with no indication of needing the help of another NA. Further interview identified she was aware of other NAs having a difficult time when moving Resident #175 alone because the resident was sometimes unable to help him/herself by holding the rail and that other NAs would ask for assistance from another NA. Additionally, NA #4 identified that he/she did not perform care for the resident yet; however, if she was not aware of a resident's ability, she would review the resident care plan binder at the nurse's desk. An interview with Physical Therapist #1 (Rehab Director) on 10/23/24 at 11:53 AM identified that the NAs should always look at and follow the Care Card/Physician/PT orders when assisting the resident. Further interviews identified that a resident with an order for bed mobility with a maximum assist of two could get injured if only one person was completing the bed mobility when there should have been assistance of two. PT #1 further identified that there were no acceptable reasons for the NAs to not follow the Physical Therapy/Occupational Therapy/Physician order. Facility Policy for Positioning/Repositioning identified the steps to take when positioning/repositioning the residents in bed is to first check the care plan, assignment sheet, or communication system to determine the resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete this procedure. Facility policy for Activities of Daily Living (ADLs) identified that total dependence means full staff performance of an activity with no participation by the resident for any aspect of the ADL.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on interviews, review of the clinical record, facility documentation, and facility policy for the only sampled resident (Resident #326) reviewed for tube feeding, the facility failed to ensure medication orders indicated an appropriate route of administration for a resident who was to have nothing by mouth (NPO). The findings include: Resident #326 was admitted to the facility in October 2024 with diagnoses that included dysphagia of oropharyngeal phase, gastrostomy (g-tube) status and gastro-esophageal reflux disease (GERD) with esophagitis. A physician's order dated 10/8/24 in the electronic health record (EHR) directed nothing by mouth (NPO) and to provide mouth care every shift and as needed. A physician's order dated 10/9/24 in the EHR directed NPO diet, NPO texture and NPO consistency. A physician's order dated 10/9/24 in the EHR directed Aspirin 81 mg oral tablet chewable give one tablet by mouth at bedtime (a discrepancy in the route of administration from the physician order NPO status on 10/9/24). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #326 was cognitively intact and required substantial/maximal assistance with bed mobility and transfers and was dependent with toileting. The MDS assessment further indicated diagnoses of GERD, dysphagia and feeding tube (g-tube). Physician's orders dated 10/21/24 in the EHR directed Ferrous Sulfate oral solution give 2.5 ml by mouth two times a day and Sodium Chloride oral tablet give one tablet by mouth four times a day (a discrepancy in the route of administration from the physician order of NPO status on 10/9/24). The Resident Care Plan dated 10/22/24 identified a feeding tube for all nutrition and hydration. Interventions included aspiration precautions, administer tube feeding per order and mouth care every shift. Physician's orders dated 10/23/24 in the EHR directed Calcium Carbonate 600 mg plus Vitamin D 10 mcg give two tablets by mouth two times daily and Pro-Stat Oral Liquid give 30 ml by mouth three times daily (a discrepancy in the route of administration from the physician order of NPO status on 10/9/24). Interview with Resident #326 on 10/24/24 at 1:00 PM identified that Resident #326 was in bed and indicated that he/she had not received any medications by mouth since his/her admission to the facility. Resident #326 indicated that he/she was aware of his/her condition, does not take anything by mouth and his/her medications and nutrition should be ordered to be administered via his/her gastrostomy tube only. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with APRN #2 on 10/24/24 at 1:20 PM indicated that Resident #326 was strictly NPO and that all of his/her medications and nutrition were to be administered via the gastrostomy tube. APRN #2 identified that due to Resident #326's NPO status, all of his/her medication orders should be written to be administered via his/her gastrostomy tube and that when APRN #2 initiated new orders, they were handwritten by her into the paper chart and then transcribed by the nurse into the EHR. Review of the clinical record (paper chart) for Resident #326 with APRN #2 identified her written medication orders for Ferrous Sulfate liquid, Sodium Chloride tablets, and Calcium/Vitamin D tablets failed to indicate a route of administration. Review of the EHR for Resident #326 with APRN #2 identified that the transcribed and active orders for Ferrous Sulfate liquid, Sodium Chloride tablets, Calcium Carbonate/Vitamin D tablets, Aspirin tablet and Prostat liquid were directed to be administered 'by mouth'. APRN #2 identified that due to Resident #326's NPO status, all of his/her medication and nutrition orders should be written for administration via gastrostomy tube only and the orders had been transcribed incorrectly. APRN #2 further indicated that in the absence of a route of administration for written prescriber/provider orders for Resident #326, the nurse who transcribed the orders should have contacted the prescriber/practitioner for clarification before a route of 'by mouth' was transcribed into the EHR. Interview and record review with LPN #1 on 10/24/24 at 1:30 PM indicated that Resident #326 was strictly NPO and that all of his/her medications and nutrition were to be administered via the gastrostomy tube. Review of Resident #326's EHR with LPN #1 identified that Resident #326's orders for Ferrous Sulfate liquid, Sodium Chloride tablets, Calcium Carbonate/Vitamin D tablets, Aspirin tablet and Prostat liquid had a route of administration indicated as 'by mouth'. LPN #1 identified that although she was aware that Resident #326 was NPO, she was accustomed to most medications being administered by mouth so she did not realize 'by mouth' had been transcribed incorrectly into the resident's EHR. LPN #1 further identified that in the absence of a route of administration being indicated on a physician/practitioner medication order, she would have contacted the physician/practitioner and clarified the route of administration before the order was transcribed. LPN #1 was unable to indicate the reason the medication orders for Ferrous Sulfate liquid, Sodium Chloride tablets, Calcium Carbonate/Vitamin D tablets, Aspirin tablet and Prostat Liquid were not clarified and corrected before being transcribed. Interview and record review with the DNS on 10/24/24 at 1:40 PM identified that Resident #326 was strictly NPO and that all of his/her medications and nutrition were to be administered via the gastrostomy tube. The DNS indicated in the absence of a route of administration being identified on a physician/practitioner medication order, nursing staff should have contacted the physician/practitioner to clarify the route of administration before the order was transcribed. The DNS further identified that all physician/practitioner medication orders need to specify a route of administration and that it was an oversight that the orders for Ferrous Sulfate liquid, Sodium Chloride tablets, Calcium Carbonate/Vitamin D tablets, Aspirin tablet and Prostat liquid were transcribed as 'by mouth' for Resident #326, who was NPO. On 10/24/24, subsequent to surveyor inquiry, an order was written by APRN #2 into Resident #326's paper chart which directed to 'change all oral medications to be given per g-tube'. Review of facility policy, Medication and Treatment Orders, undated, directed that orders for medications will be consistent with principles of safe and effective order writing and must include a route of administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Electronic Medication and Treatment Administration Records, dated 9/2014, directed that all physician's orders will be added to the resident's electronic medical record by a licensed nurse as they are obtained from the physician. The policy further directed that any discrepancies will be brought to the attention of the nursing supervisor who would clarify and correct the orders accordingly.

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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** 50249 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #1) reviewed for accidents, the facility failed to implement bumper guards and floor mats per the physician's order for a resident on seizure precautions and for 1 of 2 sampled residents (Resident #11) reviewed edema, facility failed to follow physicians order for the application of heel booties. The findings include: 1. Resident #1's diagnoses included seizures, encephalopathy, and hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting the right dominant side. A physician's order dated 10/8/24 directed seizure precautions to be in place every shift. A physician's order dated 10/9/24 directed to apply bumper guards to bed rails when in bed and floor mats at bedside when in bed, every shift related to seizures. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required substantial/maximal assistance with bed mobility and was dependent with transfers and toileting. The MDS further indicated a diagnosis of seizure disorder or epilepsy. The Resident Care Plan dated 10/22/24 identified a risk for injury secondary to seizure activity. Interventions included to pad rails with bumper guards, keep rails up and bed in its lowest position. Observations on 10/21/24 at 12:00 PM, 10/22/24 at 9:30 AM and 10/22/24 at 11:30 AM identified Resident #1 was in bed without the benefit of bumper guards to the bed rails and floor mats at the bedside. Observation and interview with Nurse Aide (NA) #1 on 10/23/24 at 9:20 AM identified Resident #1 was in bed without bumper guards to his/her bed rails and without floor mats at the bedside. NA #1 indicated that Resident #1 used to have the bumper guards and floor mats but they were not being used anymore. After locating a floor mat behind Resident #1's bedside recliner, NA #1 placed the floor mat on the floor to the left side of Resident #1's bed. NA #1 was unable to locate a second floor mat or the bumper guards for the bed rails. NA #1 further identified that she would need to speak to the nurse to find out if the bumper guards and floor mats were still ordered. (continued on next page)

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Lord Chamberlain Manor	7003 Main Street Stratford, CT 06614

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, interview and record review with Licensed Practical Nurse (LPN) #3 on 10/24/24 at 7:40 AM identified Resident #1 was in bed without bumper guards to his/her bed rails and without floor mats at the bedside. LPN #3 indicated that per the physician's orders bumper guards to the bed rails and floor mats at the bedside should be in place when Resident #1 was in bed. LPN #3 was able to locate one floor mat stuck under Resident #1's bed and the second floor mat was found folded and placed under Resident #1's bedside recliner. LPN #3 also located the bumper guards for the bed rails which were sitting on the floor between Resident #1's bedside recliner and closet. LPN #3 placed the floor mats next to each side of Resident #1's bed and placed the bumper guards on the bed rails. LPN #3 indicated that she or the NA should have put the floor mats and bumper guards in place and the NA would know to have them both in place by reviewing the NA care card. Review of the NA care card for Resident #1 failed to identify the use of bumper guards to the bed rails and floor mats to the bedside. LPN #3 indicated that without the necessary information on the care card it would have been up to her to let the NA know to place the bumper guards to the bed rails and the floor mats at the bedside for Resident #1. Although review of the facility's Treatment Administration Record (TAR) documentation for 10/24/24 identified a staff signature indicating that the bumper guards and floor mats were in place for Resident #1, LPN #3 indicated that she signed for the bumper guards and floor mats on 10/24/24 without them actually being in place. Interview with NA #3 (responsible for updating the care cards) on 10/24/24 at 7:50 AM identified that she was not aware that Resident #1 needed bumper guards to the bed rails and floor mats at the bedside and that she would have had to receive a note from the nurse or supervisor in order to put those interventions on Resident #1's NA care card. NA #3 indicated that without the necessary information from the nurse or the nurse telling her directly, she would not have been able to update the NA care card for Resident #1. Review of the facility policy, Seizure Precautions, undated, directed to keep the resident safe from injury include all interventions to afford protection from traumatic injury. The policy further directed that the seizure protocol is implemented for residents with active seizure disorders or at high risk for seizures and to pad the side rails of the bed. 2. Resident #11's diagnoses included acute respiratory failure with hypoxia, congestive heart failure, chronic kidney failure and muscle weakness. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 was moderately cognitively impaired, was dependent on staff for personal hygiene, bed mobility and transfers and supervision assistance with eating. A physician's order dated 10/14/24 directed to off load heels on heel booties while in bed or in the recliner chair, every shift for an abrasion. Observations on 10/21/24 at 12:31 PM, 10/22/24 at 9:32 AM and 10/23/24 at 11:10 AM identified Resident#11 sitting in a recliner chair without the benefit of heel booties being applied. Review of Medication Administration Record (MAR) on 10/21/22 and 10/22/24 identified that staff had been signing off that Resident #11's heels were being offloaded by heel booties in bed or in the recliner chair, every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, observation, and record review with LPN #4 on 10/23/24 at 11:10 AM identified that Resident #11 did not have heel booties applied while sitting in the recliner chair. LPN #4 indicated that both nurses and NAs were responsible for the application of the heel booties and indicated that it was failure on her part that Resident #11 did not have heel booties applied. LPN #4 further indicated that she would normally check to confirm that leg booties were applied before signing off the MAR orders. Subsequent to surveyor inquiry, heel booties were applied on 10/23/24 at 11:10 AM. Interview and record review with the DNS on 10/23/24 at 11:30 AM identified that Resident #11's heels should have been offloaded while in the recliner chair. The DNS identified that both nurses and NAs were responsible for the application of heel booties but could not explain the reason staff failed to apply the heel booties. Review of facility policy on physician orders was not specific about the application of leg booties. 50250

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 2 of 3 sampled residents (Resident #374) reviewed for accidents, the facility failed to ensure that appropriate assistance was provided with transfer of a resident, and for the only sampled resident (Resident #624) reviewed for smoking, the facility failed to ensure a smoking assessment was conducted as part of the initial admission assessment. Additionally, the facility failed to ensure appropriate disposal of used cigarette materials. The findings include: 1. Resident #374's diagnoses included acquired absence of left leg below knee, generalized muscle weakness, end stage renal disease, and hypertension. The Nursing Admission assessment dated [DATE] identified Resident #374 was alert, oriented but forgetful and required a wheel chair for mobility. An Occupational Therapy (OT) assessment dated [DATE] identified Resident #374 with impairments in balance, fine motor coordination, gross motor coordination, mobility, sensation, strength, attention, follow through, planning, problem solving and use of coping strategies resulting in activity limitation and participation restrictions. Additionally, the OT assessment identified Resident #374 required maximum assist of 2 staff for pivot transfers and assist of 1 staff for activities of daily living (ADLs) at bed level. The Resident Care Plan (RCP) dated 10/18/24 identified Resident #374 required assistance with ADL's. Interventions included assistance with bathing, dressing, hygiene, ambulation and transfers. Additionally, Resident #374 required physical therapy and occupational therapy as ordered. A Reportable Event form dated 10/22/24 at 1:05 AM identified that Resident #374 was being transferred from the toilet to the wheel chair by Nurse Aide (NA) #5 (without the benefit of 2 staff members per the RCP and PT recommendations). When Resident #374 attempted to stand up, his/her right leg gave out and the resident landed on the floor. Resident #374 had been offered a bed pan prior to being taken to the bathroom by NA #5 but the resident refused and requested to be taken to the toilet. Resident #374 was assisted back to wheel chair with assist of 2 staff. Resident #374's provider, and family were notified and investigation into the incident was initiated. Telephone interview with NA #5 on 10/25/24 at 10:06 AM was was attempted, and although contact was made, NA #5 would not answer questions. Further attempts to reach NA #5 were unsuccessful and the DNS was updated. Interview with the DNS on 10/25/24 at 10:16 AM identified that Resident #374 required maximum assist of 2 staff for pivot transfers. The DNS further identified that NA #5 did not use a second person while transferring Resident #374 to and from the toilet. The DNS indicated that Resident care cards were printed daily and distributed to all units and NAs have the obligation of reviewing resident care cards for their assigned residents before providing care. The DNS was unable to explain the reason NA #5 failed to follow Resident #374's transfer orders but identified that re-education had been provided to NA #5 after the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Occupational Therapist (OT) #1 on 10/25/24 at 10:45 AM, identified that Resident #374 was non-ambulatory, had decreased cognition, was impulsive and required maximum assistance of 2 staff for transfers. OT #1 further identified that it was not safe for NA #5 to transfer Resident #374 alone because he/she was at risk of falling. Review of facility policy, Activities of Daily Living (ADLs), Supporting, identified in part, that, appropriate care and services will be provided to residents who are unable to carry out ADLs independently . and in accordance with the plan of care, including appropriate support and assistance with hygiene, mobility, elimination, dining and communication. 2. Resident #624 was admitted on [DATE] with diagnoses that included sepsis, peripheral vascular disease, and type 2 diabetes mellitus. Interview with Resident #624 on 10/21/24 at 11:30 AM identified that his/her only activity was that he/she smoked and went outside on facility grounds 3 times per day for a cigarette. Resident #624 stated that he/she informed the unit staff (nurse and NA) he/she was going for a cigarette and then stopped at the front desk to inform the receptionist. Further, Resident #624 stated that he/she smoked across the driveway on grounds from the front entrance and extinguished his/her cigarette in the water fountain before tossing the cigarette butt aside. a. Review of the Resident's Nursing Admission Assessment identified a blank smoking assessment form. Interview with the Administrator, Director of Nursing, and the [NAME] President of Nursing on 10/21/24 at 1:18 PM indicated the facility was a non-smoking facility, and they were not aware that Resident #624 had been smoking since admission (despite the receptionist being informed by Resident #624). The DNS indicated that all residents were made aware of the no smoking policy on admission, and when smokers were identified using the initial smoking assessment, they were offered alternatives and asked to surrender their smoking materials. When a resident refused to surrender their smoking materials, they were placed on 1:1 supervision. The [NAME] President of Nursing indicated that a smoking assessment was completed on admission for all residents regardless of smoking status, however Resident #624's smoking assessment was blank and should have been completed by the admission nurse performing the intake assessment within 24 hours of the resident being admitted . Subsequent to surveyor inquiry, the Director of Nurses spoke with the resident and confiscated cigarettes and a lighter. Interview with Receptionist #1 on 10/21/24 at 1:30 PM indicated that she was aware of Resident #624 was smoking outside, because the resident notified her, and she then placed a smoking apron on Resident #624. The Receptionist indicated that she notified the Resident #624's unit when the resident went outside to smoke. Receptionist #1 stated that smoking was permitted for both this facility and the facility next door. Interview with LPN #2 and NA #2 on 10/21/24 at 1:36 PM indicated that there were no smokers in the facility. Although Receptionist #1 indicated that she routinely notified the unit that Resident #624 was in the front and going out to smoke, neither LPN #2 nor NA #2 reported they had ever been informed Resident #624 had been going outside to smoke, and had they been, they would have reported it to management. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Observation on 10/21/24 at 2:30 PM of the smoking area outside of the front door identified over 100 cigarette butts in the mulch surrounding the seating area by the water fountain. There was one cigarette disposal container with clogged openings preventing further cigarette disposal. Interview and observation in the smoking area with Administrator #1 (Resident #624's Administrator) and Administrator #2 (of the adjacent facility) on 10/21/24 at 2:45 PM identified that smoking was not permitted at Resident #624's facility but was allowed at the adjacent facility next door. Nursing Administrator #2 stated that there were no current smokers next door. Administrator #2 further stated that the grounds were littered with cigarette butts, landscaping staff were responsible for cleaning the mulch area, and he would have the housekeeping staff clean up the area. Review of facility smoking policy indicated (Resident #624's facility) was a No Smoking facility. 51313

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41018 50250 Based on observation, clinical record review, review of facility policy, and interviews for 1 of 3 sampled residents (Resident #11) reviewed for respiratory care, the facility failed to administer oxygen per physician orders. The findings include: Resident #11's diagnoses included acute respiratory failure with hypoxia, heart failure and muscle weakness. A physician's order dated 9/7/24 directed to apply oxygen as needed to maintain oxygen saturations over 92% for heart failure. A physician's order dated 9/7/24 directed to apply oxygen at 15L via nasal cannula or non-rebreather mask as needed if oxygen saturation (blood oxygen level) fall below 90%. A physician's order dated 9/11/24 directed to administer oxygen at 2 liters via nasal cannula at baseline every shift. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #11 was moderately cognitively impaired, was dependent on staff for personal hygiene, bed mobility and transfers and supervision assistance with eating. Observations on 10/21/24 at 12:31 PM, 10/22/24 at 9:32 AM, and 10/23/24 at 11:10 AM, identified Resident #11 sitting in a recliner chair in his/her room without oxygen despite a physician order dated 9/11/24 directing oxygen at 2 liters via nasal cannula at baseline. Review of Medication Administration Record on 10/21/22 and 10/22/24 identified that staff had been signing off that oxygen was being administered to Resident #11 at 2 liters via nasal cannula at baseline. Interview, observation, and record review with LPN #4 on 10/23/24 at 11:10 AM identified that Resident #11 did not have oxygen on. LPN #4 indicated that Resident #11 was on as needed oxygen order and did not require to be on oxygen all the time. LPN #4 further indicated that oxygen levels were checked every shift and if below 92% oxygen was given at 2 liters, and the as needed oxygen order signed off. LPN #4 could not explain the reason Resident #11 had 3 different oxygen orders or why staff was signing off that Resident #11 was on continuous oxygen. LPN #4 requested time to re-view the oxygen orders. Re-interview with LPN #4 on 10/23/24 at 11:30 AM indicated that the baseline oxygen order had been discontinued because Resident #11 did not need oxygen currently. LPN #4 stated that she thought that the PRN and the regular oxygen orders had been duplicated. LPN #4 indicated that she should have sought clarification of the duplicate orders from the nursing supervisor or the respiratory therapist but did not. LPN #4 indicated that she instead was signing off both orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DNS on 10/23/24 at 11:30 AM identified 3 different current oxygen orders. Further record review identified that staff was signing off that Resident #11 was on continuous oxygen at 2 liters via nasal cannula. The DNS could not explain the reason Resident #11 had 3 different oxygen orders or why staff was signing off that Resident #11 was on continuous oxygen when he/she was not on oxygen. The DNS identified that according to the nursing progress notes, it seemed that Resident #11 was trialed on oxygen from 10/1/24 and had progressed well and therefore no longer required oxygen. The DNS could not produce a physician's order for Resident #11 to be trialed on oxygen. The DNS identified that staff should have consulted the Nursing Supervisor or Respiratory therapist to discontinue the unwanted oxygen orders after 3 different orders for O2 administration were placed. Subsequent to surveyor inquiry, the oxygen order directing oxygen to be administered at 2 liters via nasal cannula at baseline every shift was discontinued. Review of facility policy, Electronic Medication and Treatment Administration Records, identified in part, that, every 24 hours, the physician orders will be reviewed by 11PM to 7AM nurse for accuracy. Corrections will be made as necessary. Any discrepancies will be brought to the attention of the nurse supervisor who will clarify and correct the orders accordingly. 51756

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observation, staff interviews, review of clinical records, and facility policy for the only sampled resident (Resident #374) reviewed for dialysis, the facility failed to identify and monitor Resident #374 Arteriovenous (AV) fistula (an artificial connection made between an artery and a vein for dialysis access). The findings include: Resident #374's diagnoses included end stage renal disease with dependence on renal dialysis, type 2 diabetes with diabetic chronic kidney disease, and bipolar disorder. Physician orders dated 10/17/24 identified Resident #374 received dialysis at an outpatient dialysis facility every Monday, Wednesday, and Friday. The Baseline Resident Care Plan (RCP) dated 10/18/24 identified Resident #374 had experienced a subdural hematoma and was to have his/her vital signs monitored for changes and had fall interventions due to multiple falls but failed to identify Resident #374 received dialysis and had a AV fistula in place. The admission nursing assessment dated [DATE] identified Resident #374 was alert and oriented to person, place, and time. The Admission Nursing Assessment further identified Resident #374 was on hendiadys, was able to move all his/her extremities, and used a wheelchair to assist with his/her mobility, but failed to identify Resident #374 had an AV fistula in place. An interview with Resident #374 on 10/25/24 at 9:35 AM identified he/she had an AV fistula located on his/her left upper arm. Review of Resident #374's facility admission assessment, provider and nurse progress notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), and baseline care plan did not identify Resident #374 had an AV fistula, the location of his/her fistula or an assessment and ongoing monitoring of the fistula. An interview with LPN #5 on 10/25/24 at 10:43 AM identified when a resident had a fistula, the facility nurses assess the site during medication administration and document it in a progress note at the end of the shift. An interview with the Nursing Supervisor on 10/25/24 at 9:58 AM identified that there had been no documented assessments of Resident #374's fistula initially and since admission to the facility on [DATE]. The Nursing Supervisor stated he believed the nurses did not know to assess the fistula because the MAR failed to identify to check the fistula. An interview with the DNS on 10/25/24 at 10:15 AM identified that batch orders were placed for dialysis residents upon admission. The DNS confirmed that assessments of a fistula had not been documented or completed for Resident #374 because the batch orders for Resident #374 had not been entered due to staff oversight. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hemodialysis Policy identified fistulas are to be monitored every shift for bruit and thrill and documented on the MAR or TAR, and the dialysis site should be monitored with immediate provider notification of signs of infection (for oozing, drainage, redness, elevated temperature, etc.) or bleeding. The facility's A-V Fistula Policy identified that a resident's dialysis site should be checked immediately upon return to the facility from dialysis, the access site should be palpated and auscultated daily for bruit and thrill, and the presence of bruit and thrill will be documented on the TAR daily.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 5 residents (Resident #674) reviewed for unnecessary medications, the facility failed to ensure that a resident receiving an antipsychotic medication had an appropriate diagnosis and monitoring. Resident #674 was admitted to the facility in October 2024 with diagnoses that included anxiety/depression disorder, chronic obstructive pulmonary disease, and breast cancer. The Nursing Admission assessment dated [DATE] identified Resident #674 was alert and oriented to person, place and time, communicated verbally, speech was clear and was able to understand and be understood when speaking. The Nursing Admission Assessment further identified Resident #674's mood was pleasant with no unwanted behaviors. A physician's order dated 10/14/24 directed to give Zyprexa (an antipsychotic medication) 2.5 milligrams(mg), give 1 tablet by mouth at bedtime related to anxiety disorder. a. A physician's order dated 10/14/24 directed orthostatic blood pressures (BP) once a week for 4 weeks then monthly. Documentation on Medication Administration Record (MAR) indicated BPs were not completed until 10/21/24 on the 7:00 AM to 3:00 PM shift (7 days after the initial physician's order). b. Advanced Practice Registered Nurse (APRN) #2's progress note dated 10/15/24 identified Resident # 674 as being calm and depressed but failed to identify an appropriate diagnosis for the use of Zyprexa. The History and Physical completed by the attending physician on 10/17/24 indicated medications were reviewed but did not specifically address the reason for the use of Zyprexa. The mentation/psychiatric section was blank. APRN #1's progress notes dated 10/18/24, 10/22/24 and 10/23/24 identified that Resident #674 was receiving Zyprexa 2.5 mg nightly for anxiety disorder but failed to identify an appropriate diagnosis for the use of Zyprexa (anxiety was not an appropriate diagnosis). APRN #1's progress note dated 10/23/24 at 8:00 AM continued to identify the use of Zyprexa 2.5 mg and noted Resident #674 was calm had a normal appearance, behavior, normal speech, mood, affect, normal thought process and content. Additionally, the progress note identified Resident #674 had no abnormal thoughts, delusions, or hallucinations had normal cognition including orientation, attention and memory, normal insight and judgement. A review of the clinical record on 10/23/24 at 1:00 PM with RN # 2 failed to reflect an appropriate diagnosis to support the use of Zyprexa (anxiety was not an appropriate diagnosis). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. A Pharmacy consultant evaluation dated 10/17/24 recommended an Abnormal Involuntary Movement Scale (AIMS) test be completed for the use of Zyprexa, monitor specific behavior, and monitor orthostatic BPs weekly for 4 weeks then monthly. APRN #1's progress notes dated 10/18/24, 10/22/24 and 10/23/24 failed to identify AIMS testing was completed. A review of the physician's orders and MAR on 10/23/24 with RN #2 failed to reflect documentation of behavior monitoring. An interview with the DNS on 10/25/24 at 11:45 AM identified that a resident admitted to the facility on an antipsychotic should have an approved/appropriate diagnosis to support its use. The DNS indicated that anxiety disorder was not a supporting diagnosis for the use of an antipsychotic medication. Furthermore, the DNS identified AIMS testing needed to be completed by either psychiatric services if a referral was in place or the medical APRN. The DNS also indicated behavioral monitoring was completed by nursing staff and orthostatic BPs were to be completed as ordered. An interview with Resident #674 on 10/25/24 at 12:00 PM identified that he/she was unaware for the reason he/she was taking an antipsychotic medication and was unsure who started the medication and when it was initiated. Facility policy regarding Antipsychotic Medication Use directed in part, that residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms and risks to the resident and others. Antipsychotic medications will not be used if the only symptoms are one or more of the following: Wandering; Poor self care; Restlessness; Impaired memory; Mild anxiety; Insomnia; Inattention or indifference to surroundings; Sadness or crying alone that is not relate to depression or other psychiatric disorders; Fidgeting; and Nervousness or uncooperativeness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Lord Chamberlain Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7003 Main Street Stratford, CT 06614	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51313 Based on review of the clinical record and interviews, for 1 of 2 sampled residents (Resident #625) reviewed for food concerns, the facility failed to provide the requested alternative menu option. The findings include: Resident #625's diagnoses included dysphagia, depression, and gastro-esophageal reflux disease. The nurse's admission note dated 10/3/24 indicated that Resident #625 was taking nutrition orally and that his/her appetite had decreased since surgery. The Resident Care Plan dated 10/3/24 identified nutritional status and diet as a concern. Interventions included to provide diet and fluids as ordered. Interview with Resident #625 on 10/21/24 at 11:32 AM identified that he/she had not been receiving the menu substitutions that he/she had requested. Review of Resident #625's weight record identified that he/she had gained 3.8 pounds between 10/3/24 and 10/22/24. Observation on 10/25/24 at 9:00 AM, identified that Resident #625 had received pudding and not yogurt as indicated on their meal slip. Interview with Dietary Aide (DA) #1 on 10/25/24 at 9:14 AM indicated that the dietary aide and the Nurse Aides (NAs) were responsible for checking the dietary slips and to ensure meal tray contents were correct. Interview with NA #2 on 10/25/24 at 9:30 AM indicated that the dietary aide was responsible to check that the dietary slip and that the meal tray contents match. NA #2 stated that she did not always have time to check the dietary slip and tray contents as she was too busy. She stated that when residents called to ask for an alternative or missing item that she obtained the item from the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, interviews, review of the clinical record, facility documentation, and facility policy for 1 of 5 residents (Resident #326) reviewed for infection control, the facility failed to implement Enhanced Barrier Precautions (EBP) for a resident with a gastrostomy (feeding) tube and a peripherally inserted central catheter (PICC). The findings include: Resident #326's diagnoses included severe sepsis with septic shock, infection and inflammatory reaction due to internal orthopedic prosthetic device and elevated white blood cell count. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #326 was cognitively intact and required substantial/maximal assistance with bed mobility and transfers and was dependent with toileting. The MDS assessment also indicated major orthopedic surgery, a feeding tube, an antibiotic and intravenous (IV) medications/access. The Resident Care Plan dated 10/22/24 identified IV therapy and a feeding tube. Interventions included to change IV insertion site dressing per policy, observe IV and feeding tube insertion sites for signs or symptoms of infection and perform tube feeding site care per order. Observation on 10/22/23 at 9:40 AM identified that although Resident #326 was in bed with a right upper arm PICC and a gastrostomy tube in place, the outside of Resident #326's room failed to indicate posted signage for Enhanced Barrier Precautions (EBP). Observation on 10/23/24 at 11:20 AM with NA #1 identified that she was providing incontinent care for Resident #326 without the benefit of an isolation gown. NA #1 indicated that she was not aware that Resident #326 was on EBP or any other precautions and that she had not worn personal protective equipment (PPE), other than gloves, when providing care to Resident #326. NA #1 identified that the NA care card failed to indicate EBP and due to the lack of EBP signage and PPE outside of Resident #326's room, she would not have known Resident #326 was on EBP. NA #1 further identified that the nurse did not tell her Resident #326 was on EBP and that she would need check with the nurse. Observation, interview and record review with LPN #1 on 10/23/24 at 11:55 AM indicated that Resident #326 had a gastrostomy tube and a PICC and that the resident should be on EBP. LPN #1 identified that there was no posted signage or PPE in place outside of Resident #326's room. Review of the NA care card also failed to identify EBP for Resident #326. Additionally, a review of the physician's orders with LPN #1 failed to identify an order for EBP was in place. LPN #1 indicated that the NA would be aware Resident #326 was on EBP by being told by the nurse, referring to the NA care card or observing EBP signage outside of the resident's room. LPN #1 further indicated that placing Resident #326 on EBP had been overlooked and the charge nurse who admitted the resident should have obtained a physician's order, posted the EBP signage and placed a PPE cart outside of Resident 326's room. Observation on 10/23/24 at 12:35 PM identified that, subsequent to surveyor inquiry, LPN #1 had placed EBP signage and a 3 drawer plastic cart containing PPE outside of Resident #326's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review on 10/23/24 at 1:00 PM with the DNS and the Infection Previonist(RN #1) identified that Resident #326 had a gastrostomy tube and a PICC line and should have been on EBP. RN #1 indicated that for EBP, staff should have worn gloves and a gown when providing IV, gastrostomy or incontinent care for Resident #326. Review of the clinical record with the DNS for Resident #326 failed to indicate the necessary special instructions on the resident's profile page indicating EBP. The DNS and RN#1 further identified that they would have been responsible for initiating EBP when Resident #326 was admitted and in their absence the charge nurse or supervisor would have been responsible. When initiating EBP, RN #1 indicated that the residents profile page would have been updated and signage and PPE would have been placed outside of his/her room. Additionally, the DNS indicated that not placing Resident #326 on EBP was an oversight. Review of the facility policy, Enhanced Barrier Precautions, undated, directed that an order for EBP would be obtained and EBP would be implemented for residents with indwelling medical devices (central lines and feeding tubes). The policy further directed that signage would be posted on the door or wall outside of resident's room indicating the need for EBP and a cart with appropriate PPE would be placed outside of the resident's room. Review of the facility provided memorandum, Centers for Medicare and Medicaid Services (CMS) Guidance on Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, directed that EBP expands the use of PPE to donning of gown and gloves during high-contact resident care activities for residents with indwelling medical devices. The memorandum further directed that indwelling medical device examples included central lines and feeding tubes.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on staff interviews, review of clinical records, and facility policy for 1 of 5 residents (Resident #624) reviewed for immunizations, the facility failed to offer a resident an influenza vaccine or document a refusal or proof of prior immunization of an influenza vaccine. The findings include: Resident #624 was admitted to the facility in October 2024 with diagnoses that included sepsis, chronic kidney disease, and type 2 diabetes. The Baseline Resident Care Plan (RCP) dated 10/16/24 identified Resident #624 was at risk for falls and interventions included use of a call bell when assistance was needed. The admission nursing assessment dated [DATE] identified Resident #624 was alert and oriented to person, place, and time. The Admission Nursing Assessment further identified that he/she had a right hip incision. Physician orders dated 10/16/24 identified that Resident #624 was weight bearing as tolerated with a rolling walker and directed to administer the Pneumovax 23 vaccine for pneumonia prophylaxis if the resident had not been previously vaccinated. The facility failed to enter an order for an influenza vaccine for influenza prophylaxis. An interview with Registered Nurse (RN) #1 on 10/24/24 at 2:20 PM identified that the admitting nurse, the charge nurse, and infection preventionist were responsible to offer Resident #624 an influenza vaccine and document an acceptance or refusal of the influenza vaccine by the resident. RN #1 failed to provide documentation of Resident #624 being offered an influenza vaccine, declination of an influenza vaccine, or past evidence of a previous influenza vaccination for the 2024-2025 flu season. Facility policy regarding Influenza vaccines identified that between October 1st and March 31st, all residents with no medical contraindication to the influenza vaccine and no evidence of previous immunization will be offered an influenza vaccine upon admission to the facility.