STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075415	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Manor of Bristol	1660 Stafford Avenue Bristol, CT 06010

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 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 51182 Based on staff interviews and interviews during the Resident Council meeting, the facility failed to verbally and periodically inform residents of resident rights. An interview with Resident Council members on 9/26/24 at 11:30 AM identified that facility staff do not periodically review resident rights with them. An interview with the Recreation Director on 9/26/24 at 12:56 PM identified she included resident rights in Resident Council meetings during past years but stopped sometime around the COVID-19 pandemic when everything stopped. An interview with the Social Worker on 9/26/24 at 2:33 PM identified that she was the facility representative responsible for informing residents of resident's rights. The Social Worker identified she had not joined a Resident Council meeting since prior to the COVID-19 pandemic. The Social Worker stated residents were provided a pamphlet, upon admission to the facility, that reviewed some resident rights and that she shows residents where the full set of resident rights are posted in the facility. The Social Worker stated resident rights were not reviewed verbally with residents during the admission process or periodically after admission.

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48950 Based on observations, interviews and tour of the facility for 6 resident rooms and for 2 of 2 shower rooms, the facility failed to provide a homelike and sanitary, and environment. The findings include: a. Observation during the initial facility tour on 9/19/24 at 10:28 AM of the C Wing shower room identified 12 burgundy facility dining chairs were being stored in the shower room. Observation during the initial facility tour on 9/19/24 at 10:28 AM of the B wing shower room identified a metal 4 step foldable ladder was observed to be stored in the shower room. A fly strip was noted to be hanging in the shower room with dead bugs on it. An interview and observation with Registered Nurse (RN) #2 who was the facility Infection Control Nurse on 9/23/24 at 10:15 AM identified that the B wing shower room should not contain a ladder, or the fly strip which was hanging from the ceiling with dead bugs. Also, she identified that C Wing shower room had 12 chairs stored in it. RN #2 identified that she observed that a resident was being showered in shower room B that had contained the fly strip which was hanging from the ceiling. RN #2 further identified that the items were not supposed to be stored in the shower rooms and that the environment was not home like. An interview and observation with the Maintenance Director on 9/23/24 at 10:45 AM identified that B Wing shower contained a ladder, the fly strip hanging from the ceiling had dead bugs on it, and the C Wing shower had 12 dining chairs in it. The Maintenance Director further identified that the items were not to be stored in the shower room and that the environment was not homelike. An interview on 9/23/24 at 2:30 PM with The Director of Housekeeping identified that the 12 dining chairs that had been stored in the shower room were removed and being cleaned, and that the chairs would be distributed throughout the building, being place in resident's rooms, the dining room, and other areas other than the shower rooms. Subsequent to surveyor inquiry, the 12 dining room chairs were removed from the shower room, along with the fly strip, ladder, and rolling cart. b Observation and interview with the Maintenance Director on 9/24/24 at 1:40 PM identified broken blinds in Resident's Rooms #5, #8, #14, #15, #37, and #43. Additionally, he indicated he had performed an audit of the blinds after state Building, Fire, Safety Inspectors (BFSI) came on 9/20/24, that he had ordered replacements and was waiting for the delivery to replace the blinds. The Maintenance Director further identified that the rooms with the broken blinds were not homelike.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on interviews, review of the clinical record, and facility policy for 2 of 2 residents (Resident #14 and Resident #49) reviewed for mistreatment, the facility failed to report allegations of mistreatment to the State Agency (SA) and to Connecticut Protective Services for the Elderly (PSE). The findings include: 1. Resident #14's diagnoses included history of traumatic brain injury, hemiplegia affecting the left side, and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #14 was severely cognitively impaired and was dependent for upper body dressing, required substantial/maximal assistance with personal hygiene, and was dependent for bed to chair transfers. The Resident Care Plan (RCP) dated 8/1/24 identified Resident #14 was at risk for skin breakdown related to impaired mobility. Interventions included padding to the left siderail in bed and skin inspection with care to monitor for redness, irritation or breakdown. Interview with Person #2 on 9/26/24 at 12:53 PM identified that he/she had called the police on 8/8/24 when a bruise was observed to Resident #14's left hand. Person #2 indicated that the police had told him/her the bruise could have resulted from pressure from a finger or thumb. Person #2 indicated that during a family meeting on 8/9/24, although the DNS had informed him/her that the left-hand bruise had been the result of blood being drawn, another family member was present for the blood draw and indicated that blood had been taken from the right arm, not the left hand. Person #2 further identified that after the DNS was made aware the blood draw was not from the left hand, and she indicated she would re-investigate the cause of Resident #14's bruise. Person #2 indicated that the facility never communicated the results of the re-investigation of Resident #14's bruise. A late entry nurse's note dated 8/8/24 at 9:40 PM identified that the police had arrived at the facility due to concerns from the family related to a bruise on top of Resident #14's left hand. Resident #14's bruise had not been reported to facility staff. The note further identified that Resident #14 had a recent blood draw, that correlation to the bruise would be investigated, and the facility Advanced Practice Registered Nurse (APRN) was notified of bruise. An Accident and Incident (A&I) report for an event dated 8/8/24 at 9:30 PM identified that the family had called the police to report a bruise to the top of the left hand and that the facility APRN was notified at 10:00 PM. A grievance form dated 8/8/24 identified the Director of Nursing Services (DNS) had received concerns from Person #2 related to Resident #14. The documented concerns included, in part, discoloration to Resident #14's hand. Documented follow up identified that Resident #14's hand was assessed, the resident had blood drawn on 8/6/24 consistent with the bruising, and that Person #2 was updated on 8/9/24 of the results. Person #2 indicated that he/she was not satisfied with the results of the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A staff statement 72 hour look back form dated 8/12/24 identified that on 8/7/24 during the day shift, Resident #14 had bumped his/her left hand on the bar of the stand assist equipment during a transfer, but that no redness or discoloration were noted to the hand at that time. Interview with the DNS on 9/26/24 at 3:15 PM identified that on 8/8/24 Resident #14's family called the police due to a left-hand bruise. The DNS indicated that a grievance form and an Accident/Incident form (A&I) were completed. Further, the DNS identified that she found out, during a family meeting on 8/9/24, that a family member was present at the time of the blood draw and that the blood had been drawn from Resident #14's right arm. The DNS indicated that when she was made aware of the location of the blood draw, she informed the family that she would conduct a reinvestigation to determine the cause of Resident #14's left hand bruise but did not report the bruise of unknown origin to the State Agency. Subsequently, through the investigation, it was found that Resident #14 had bumped his/her hand during a transfer on 8/7/24. Although the DNS indicated she had informed the family of the outcome, she was unable to provide documentation that the family had been notified and in a subsequent interview on 9/27/24 at 11:15 AM identified that she had not updated Person #2 of results of the re-investigation. Interview with the DNS on 9/27/24 at 1:00 PM identified that when she was first made aware that the family had called 911 regarding a bruise, she was on the phone with the Supervisor who had commented that the bruise was from Resident #14's blood draw. The DNS identified the rationale for not reporting the bruise to the state agency as an injury of unknown origin was because when she started the three days look back she hadn't determined if the origin of the injury was unknown, and that this was her usual method. The DNS had not reported the bruise of unknown origin to the State Agency, when she was made aware on 8/9/24 that the the resident did not have a blood draow to the left hand.The DNS was unaware of the 24 hour reporting to the state agency requirement. Review of the Grievance Policy directed, in part, that if a grievance involves an injury of unknown source, the incident or allegation would be investigated and reported pursuant to the facility policy on Abuse Prohibition. Review of the Abuse Prohibition Policy directed, in part, that injuries of unknown source would be reported within 2 hours to the Department of Public Health, and results of all investigations would be reported to the State Agency and responsible party within 5 working days of the incident. Review of the Reportable Event policy directed, in part, that all reportable events should be documented in a format required by the Department of Health, a class B event required immediate notice by telephone to the department, and the Administrator, DNS or designee would ensure there was written documentation of the internal investigative results in the resident's medical record regarding the incident and any interventions. 2. Resident #49's diagnoses included Alzheimer's disease, dementia, and legal blindness. The annual Minimum Data Set assessment dated [DATE] identified Resident #49 was cognitively intact, independent with eating, and required moderate assistance with toilet use and transfers. The Resident Care Plan dated 9/7/23 identified Resident #49 had episodes of anxiety, a history of anxiety, and interventions to include administering anti-anxiety medication per physician order and monitoring for effectiveness. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 10/5/23 at 3:09 PM identified a witnessed verbal altercation between Resident #49 and a family member. The family member was observed yelling at Resident #49 and stated he/she did not understand Resident #49 and that Resident #49 was not listening. The family member was observed banging his/her hands on a table in front of Resident #49 and threw an object on the table and then the floor. The family member was asked to leave the building by facility staff. An Advanced Practice Registered Nurse (APRN) order dated 10/5/23 directed supervised visitation between Resident #49 and the family member. The facility did not complete a Reportable Event form and did not report the incident of verbal/mental abuse to the SA or PSE. A Social Work progress note dated 5/2/24 at 3:05 PM identified the Social Worker was notified of an altercation between Resident #49 and a family member. The note indicated the family member was observed yelling at Resident #49, slammed his/her hand down on the table near Resident #49 and exited the building following the altercation. The facility did not complete a Reportable Event form and did not report the incident of verbal/mental abuse to the SA or PSE. An interview with the Director of Nursing Services (DNS) on 9/23/24 at 12:05 PM identified she was aware of a pattern of inappropriate behavior by a family member toward Resident #49 and the need for supervised visits to ensure Resident #49's safety during visits with that family member. An interview with APRN #1 on 9/27/24 at 9:50 AM identified she witnessed several incidents between Resident #49 and the family member. She stated the incidents have not risen to the level of the 10/5/23 altercation. APRN #1 indicated she was uncertain if expletives used in the witnessed incidents were used generally or directly towards Resident #49. APRN #1 indicated she was unsure if the abuse by Resident #49's family member was intentional abuse. An interview with Person #1 on 9/27/24 at 10:15 AM identified that Resident #49's family member was witnessed, on several occasions, yelling at Resident #49 and banging his/her hands on the table next to Resident #49. Person #1 stated he/she heard the family member call Resident #49 a b_tch. An interview with the Social Worker on 9/27/24 at 10:40 AM identified she received facility training on the reporting of abuse and was aware of the 2-hour reporting timeframe to the SA. The Social Worker stated the facility only reported incidents to PSE after a resident was discharged from the facility because residents are considered in a safe environment while at the facility. The Social worker further stated she did not report the incidents to the SA because reporting to the SA is the responsibility of the DNS. An interview with the DNS and Administrator on 9/27/24 at 11:03 AM identified incidents of witnessed or reported abuse of a resident should be reported to both the SA and PSE. The DNS stated she notified corporate of the 10/5/23 incident and was told the incident did not need to be reported. The DNS indicated she did not report the incidents of verbal/mental abuse because she didn't view the incidents as abuse. She further stated she was now unsure. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, on 9/27/24 at 5:00 PM, the facility generated a report of the 10/5/23 incident, to the SA. Review of the facility's Abuse Prohibition Policy defined verbal abuse to be the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. The policy identified any incidents of actual or suspected abuse should have an incident report completed and immediate verbal notification, but not later than two hours after the allegation is made, should be made to the Department of Public Health (SA) and to other agencies including adult protective services (PSE). 51183

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	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 1 of 2 residents (Resident #18) reviewed for pain, the facility failed to revise the Resident Care Plan (RCP) to accurately reflect the current goals and interventions related to Resident #18's pain needs. The findings include: Resident #18's diagnoses included quadriplegia, chronic pain syndrome, and intermittent explosive disorder. a. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was cognitively intact and dependent for eating, upper body dressing, and wheelchair mobility. An Advanced Practice Registered Nurse (APRN) note dated 2/7/23 at 12:01 AM identified Resident #18 was readmitted to the facility after a hospitalization for an abdominal wall hematoma and infection related to an existing Baclofen pump (surgically implanted device that delivers the muscle relaxant, Baclofen). The APRN note further identified that while at the hospital, the Baclofen pump was removed, on 1/31/23, by neurosurgery, and Baclofen 20 milligrams by mouth, was started. The Interdisciplinary Care Plan Meeting document dated 2/10/23 did not include a review of Resident #18's hospitalization from [DATE] through 2/6/23 or the removal of the Baclofen pump on 1/31/23. The RCP dated 2/14/23 identified Resident #18 had the potential for pain related to chronic pain and contractures. Interventions included administering pain medications as ordered and arranging appointments every 3 months for a Baclofen pump refill (despite the Baclofen pump being removed on 1/31/23). The RCP was not revised to include the Baclofen pump removal or change in the Baclofen administration route (by mouth) following the Care Plan meeting. The RCP dated 7/31/24 was last revised on 5/3/24 and identified no revisions related to pain or the Baclofen pump removal. Interview with Registered Nurse (RN) #4 on 9/27/24 at 9:40 AM identified she completes most of the RCP revisions but that all nurses and department heads can revise the RCP's as necessary. RN #4 identified she attended Care Plan meetings. b. The quarterly MDS assessment dated [DATE] identified Resident #18 was cognitively intact, dependent for eating and personal hygiene, and independent for wheeling 50 feet with 2 turns once seated in his/her motorized custom wheelchair. The RCP dated 7/31/24 identified Resident #18 reacted emotionally, demonstrated verbal abusiveness towards staff, and refused medications and care at times. Interventions for medication administration refusals included to honor requests and attempt administration later, to use a calm, gentle approach and to encourage cooperation. The RCP further identified Resident #18 presented with paranoia and delusions and would follow staff in his/her power wheelchair to confront them. Interventions included to allow time for Resident #18 to reorient and reapproach and encourage expression of feelings. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	A nursing note dated 9/15/24 at 10:30 PM identified Resident #18 was upset and verbally aggressive related to not receiving afternoon medications, and subsequently, called 911. An interview with the DNS on 9/24/24 at 3:10 PM identified Resident #18 had a history of frequently calling 911 with concerns and thought the tendency of calling 911 was documented in the RCP, but it was not. An interview with RN #4 on 9/27/24 at 9:40 AM identified that subsequent to surveyor inquiry, the DNS asked her to update the RCP to include Resident #18's tendency to call 911 and coinciding interventions. Review of the Comprehensive Care Plan policy directed, in part, that a comprehensive care plan for each resident includes measurable objectives and timelines to accommodate preferences, special medical, nursing, and psychosocial needs which are evaluated and revised as needed.

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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** 50177 Based on observations, interviews, review of the clinical record, and facility policy for the only sampled resident (Resident #76) reviewed for Activities of Daily Living (ADLs), the facility failed to maintain adequate grooming on a dependent resident. The findings include: Resident #76 was admitted to the facility on [DATE] with diagnoses that included enterocolitis, weakness, and abnormalities of gait and mobility. A physician's order dated 8/20/24 directed to provide assistance of one person with ADLs and toileting. The admission Minimum Data Set assessment dated [DATE] identified Resident #76 was moderately cognitively impaired and was dependent with toileting, hygiene, and positioning. The Resident Care Plan dated 9/5/24 identified Resident #76 had an ADL deficit related to generalized weakness, recent hospitalization , and recent illness/injury. Interventions included to provide assistance of one person with ADLs and toileting. Observation on 9/19/24 at 11:05 AM identified that Resident #76 had excessively long fingernails and the presence of facial hair. Observation and interview with Resident #76 on 9/23/24 at 10:47 AM identified that Resident #76 continued to have excessively long fingernails and the presence of facial hair. Resident #76 identified that his/her fingernails were longer than he/she preferred and that he/she preferred his/her facial hair to be shaven. Resident #76 further indicated that he/she had not been provided with nail care or had facial hair shaven since admission to the facility (8/26/24). Resident #76 was observed to continuously pick underneath his/her fingernails to remove debris, that fell on to his/her shirt, during the interview. Observation on 9/24/24 at 11:07 AM identified that Resident #76 continued to have excessively long fingernails and the presence of facial hair. Nurse Aide (NA) #2 entered Resident #76's room to provide his/her weekly bed bath (Resident #76 preferred a bed bath instead of a shower) but failed to provide nail trimming and shaving. Observation and interview with Resident #76 on 9/24/24 at 12:01 PM identified that Resident #76 continued to have excessively long fingernails and the presence of facial hair after NA #2 provided Resident #76 with his/her weekly bed bath. Resident #76 identified that NA #2 had not offered to shorten his/her fingernails or shave his/her facial hair during the weekly bed bath. Interview with NA #2 on 9/24/24 at 12:10 PM identified that she was not aware that Resident #76 wanted his/her fingernails to be trimmed. NA #2 further indicated that nail care would be provided when a resident's nails appeared dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LPN #2 on 9/24/24 at 12:54 PM identified that the NAs were responsible for providing nail care and shaving the residents on their weekly shower days. LPN #2 identified that Resident #76's fingernails appeared long in length. LPN #2 confirmed with Resident #76 that he/she wanted his/her fingernails to be shortened. Resident #76 further indicated that food would get stuck underneath his/her fingernails and that he/she would have to constantly clean underneath fingernails throughout the day. Interview with NA #2 on 9/24/24 at 1:25 PM identified that she was not aware that Resident #76 wanted his/her facial hair to be shaven. Additionally, NA #2 identified that she did not offer to shave Resident #76's facial hair during the bed bath (in addition to not providing nail care). Subsequent to surveyor inquiry, observation of Resident #76 on 9/26/24 at 12:33 PM identified shortened fingernails on both hands and shaven facial hair. Review of the Nail Care policy dated 4/15 directed, in part, that the NAs were to provide nail care to the residents.

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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 and interviews for the only sampled resident (Resident #24) reviewed for skin conditions, the facility failed to follow a physician's order for the application of a protective skin device (geri-sleeves). The findings include: Resident #24's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left dominant side and unspecified dementia. The annual Minimum Data Set assessment dated [DATE] identified Resident #24 was severely cognitively impaired and was dependent for bed mobility, toileting and transfers. The Resident Care Plan (RCP) dated 8/22/24 identified a risk for skin breakdown. Interventions included to inspect Resident #24's skin for redness, irritation and breakdown during care and to apply skin treatments as ordered. A physician's order dated 9/11/24 directed to apply geri-sleeves to bilateral upper extremities in the AM as tolerated by the resident for preventive maintenance. Observation on 9/19/24 at 12:30 PM, identified Resident #24 was sitting in his/her wheelchair in the dining room with geri-sleeves not in place to his/her bilateral upper extremities. Resident #24 was wearing a short-sleeved shirt with skin exposed from his/her bilateral upper arms to his/her hands. Observations on 9/23/24 at 10:20 AM and 9/24/24 at 10:30 AM identified Resident #24 was in bed with geri-sleeves not in place to his/her bilateral upper extremities. Resident #24 was wearing a short-sleeved garment with skin exposed from his/her bilateral upper arms to his/her hands. Interview and observation with LPN #1 on 9/24/24 at 12:40 PM identified that although Resident #24's geri-sleeves were not in place, she had signed the Treatment Administration Record (TAR) indicating their placement on 9/24/24. LPN #1 indicated that the NA should have applied the geri-sleeves during AM care however LPN #1 was unable to locate geri-sleeves in Resident #24's room. Interview, observation and record review with the DNS on 9/24/24 at 12:50 PM identified Resident #24 was in bed and did not have his/her geri-sleeves on bilaterally. Resident #24 was wearing a short-sleeved garment with exposed skin from both of his/her upper arms to his/her hands. The DNS indicated that Resident #24 needed the geri-sleeves due to a history of scratching him/herself and that the NA was responsible for putting applying the geri-sleeves. Although the DNS identified that Resident #24 had a current physician's order for the geri-sleeves, the NA care card failed to identify the need for their daily application. The DNS indicated that the NA care card should have been updated by the nurse when the order for the geri-sleeves was obtained. The DNS further identified that if Resident #24 had refused to have the geri-sleeves applied it would be documented as refused in the TAR. Review of the TAR with the DNS indicated that the geri-sleeves had been signed as administered on 9/19/24, 9/23/24 and 9/24/24. Additionally, the DNS was unable to locate geri-sleeves in Resident #24's room and indicated she would need to obtain a new pair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Countryside Manor of Bristol		STREET ADDRESS, CITY, STATE, ZIP CODE 1660 Stafford Avenue Bristol, CT 06010	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 9/24/24 at 2:40 PM indicated that, subsequent to surveyor inquiry, the need for the geri-sleeves to be applied daily for Resident #24 would be discussed further with the ordering physician. A nursing progress note dated 9/24/2024 at 5:07 PM identified that the application of geri-sleeves for Resident #24 was discussed with the ordering physician and that Resident #24's skin was intact, not dry and had no issues. The nursing progress note further indicated that, per physician, the geri-sleeves were to be discontinued and revisited if needed. Although requested, a facility policy regarding the application of geri-sleeves was not provided.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **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 the only sampled resident (Resident #24) reviewed for positioning and mobility, the facility failed to follow a physician's order for the application of a resting hand splint. The findings include: Resident #24's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left dominant side and unspecified dementia. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was severely cognitively impaired and was dependent for bed mobility, toileting and transfers. The MDS failed to identify the usage of a splint or brace. The Resident Care Plan dated 8/22/24 identified CVA (cerebral vascular accident) and left sided hemiparesis. Interventions included placement of a left resting hand splint (splint) to be applied in the morning and removed at bedtime. A physician's order dated 9/11/24 directed the left resting hand splint to be applied on the 7:00 AM to 3:00 PM shift, removed at bedtime and to check Resident #24's skin each shift. Observations on 9/19/24 at 12:35 PM identified Resident #24 was out of bed, seated in a wheelchair, eating lunch in the dining room without the benefit of a left resting hand splint. Observations of 9/23/24 at 10:20 AM and 9/24/24 at 10:30 AM identified Resident #24 had already received AM care, was fully dressed, lying in bed but failed to identify placement of Resident #24's left resting hand splint. Although observations of Resident #24 failed to identify placement of the ordered left resting hand splint, review of the facility Treatment Administration Record (TAR) dated 9/19/24, 9/23/24 and 9/24/24 identified staff signatures indicating that Resident #24 was wearing his/her left resting hand splint. Interview, observation and record review with the DNS and LPN #1 on 9/24/24 at 12:50 PM identified that Resident #24 did not have his/her left resting hand splint in place but that he/she should have. After locating Resident #24's left resting hand splint under blankets on Resident #24's bedside table, the DNS and LPN #1 applied the splint. The DNS indicated that LPN #1 should have applied the splint. The DNS further indicated the nurses were trained by the rehabilitation department on splint placement. LPN #1 identified that Resident #24 had not refused the splint and that, although she signed the TAR documenting application of the splint, she overlooked the application. Observation of Resident #24 on 9/26/24 at 10:43 AM identified Resident #24 was seated in a wheelchair attending a church service with the recreation department and his/her left resting hand splint was not in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation with Physical Therapist (PT) #1 on 9/26/24 at 11:45 AM identified that Resident #24 did not have the left resting hand splint in place but that he/she should have. PT #1 indicated that Resident #24 was to wear the left resting hand splint to prevent further tightness and contracture to his/her left hand and to maintain skin integrity. PT #1 further identified that nursing was trained on placement of Resident #24's left resting hand splint and that nursing should have applied the splint during AM care. After locating Resident #24's left resting hand splint, PT #1 applied the splint and indicated that he would need to conduct an in-service with the nurses regarding Resident #24's splint placement. Review of the facility policy, Splints/Orthotics/Prosthetics, dated 4/2015, directed that residents will receive splint devices as deemed appropriate by the physician and rehabilitation services. The policy further directed that nursing staff will apply and remove the designated splint device during scheduled wearing times.

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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** 48950 Based on facility tour, observations, review of the clinical record, facility policy, and interviews for 2 of 2 residents (Resident #34 and Resident #51) reviewed for smoking, the facility failed to ensure a smoking assessment was updated with a change in smoking status and failed to perform accurate smoking assessments and failed to ensure the courtyard gazebo was free from hazards. The findings include: 1. Resident #34 was admitted to the facility in January of 2024 with diagnoses that included diabetes, alcohol dependence, and depression. A physician's order dated 1/12/24 directed that Resident #34 may smoke during the facility smoking times with staff supervision. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #34 was cognitively intact, independent with transfers and mobility and was a smoker. A Smoking Evaluation and Safety Screen dated 7/1/24 identified Resident #34 was a former smoker. A Resident Care Plan (RCP) dated 7/15/24 identified Resident #34 had a smoking history with interventions that included to instruct Resident #34 on the facility smoking policy, ascertain wishes related to smoking, and respect personal decisions. Observation of the smoking group on 9/24/24 at 2:00 PM in the secured [NAME] Courtyard identified Resident #34 was smoking under the supervision of the Director of Admissions. An interview on 9/24/24 at 2:39 PM with the Director of Admissions identified Resident #34 was a smoker since he/she was admitted to the facility in January 2024. An interview on 9/24/24 at 2:47 PM with the Director of Nursing (DNS) identified there was a time Resident #34 stopped smoking, and during that time, the Smoking Evaluation and Safety Screen dated 7/1/24, identified Resident #34 was a former smoker. An interview on 9/26/24 at 10:32 AM with the DNS identified Resident #34 began to smoke again on 8/7/24 and, according to facility policy, the Smoking Evaluation and Safety Screen should have been completed on 8/8/24. Subsequent to surveyor inquiry, the Smoking Evaluation and Safety Screen was completed on 9/24/24. 2. Resident #51's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), nicotine dependence, schizoaffective disorder. Smoking Evaluation and Safety Screens were completed on 3/6/24 and 6/26/24 indicating Resident #51 had the ability to hold a cigarette, dispose of ashes and cigarettes into an ashtray, feel hot and cold and could smell. No additional safety measures were warranted. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Smoking Evaluation and Safety Screen dated 8/13/24 indicated that Resident #51 was a nonsmoker, did not have any smoking materials, and did not wish to smoke. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #51 was cognitively intact and required set up for eating, partial moderate assistance for dressing, substantial maximum assistance for personal hygiene, and was independent for transfers and mobility. The Resident Care Plan (RCP) dated 8/27/24 identified Resident #51 had a history of smoking and would comply with the smoking policy. Interventions included to instruct Resident #51 on the facility smoking policy, lock all smoking materials in the medication room, keep facial hair trimmed for safety, and address emotional issues related to smoking cessation. A physician's order dated 9/18/24 directed that Resident #51 may smoke during facility smoking times with staff supervision. An Advanced Practice Registered Nurse (APRN) note dated 9/18/24 identified Resident #51 continued to smoke 3 times a day and was counseled on smoking cessation but not interested in quitting. Observation of the smoking group on 9/24/24 at 2:12 PM, identified Resident #51 smoked appropriately, outside under the gazebo, with constant supervision in place. Interview and record review with the Director of Nursing (DNS) on 9/24/24 at 2:23 PM identified that Resident #51's Smoking Evaluation and Safety Screen dated 8/13/24 was inaccurate. Resident #51 was always a smoker and never quit smoking during his/her admission to the facility. The DNS indicated that a nurse working the 11:00 PM to 7:00 AM shift, who did not know Resident #51 was a smoker, completed the 8/13/24 Smoking Evaluation and Safety Screen. Subsequent to surveyor inquiry, a current and accurate Smoking Evaluation and Safety Screen was completed on 9/24/24. Review of the smoking policy directed, in part, residents who smoke will be evaluated for their ability to smoke upon admission, quarterly and as dictated by any significant change in condition, to ensure that they continue to be capable of smoking and use of smoking materials without presenting a danger to themselves or others. The need for assistive and/or safety devices will be identified and noted in the residents individualized care plan. 3. An observation made during the initial tour on 9/19/24 at 1:42 PM identified that the main courtyard gazebo was damaged and was observed to have splintered wood with exposed nails, missing wood panels along the railings, and a board was lying in the walkway that extends around the gazebo. Also observed in the main courtyard was a resident, alone, near the gazebo. An interview on 9/26/24 at 11:57 AM with the Director of Nursing (DNS) identified that all residents in the facility, excluding A-wing residents, have access to the main courtyard and can utilize the gazebo. An interview on 9/26/24 at 1:51 PM with the Maintenance Director and Maintenance Person #1 identified that the gazebo was damage (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ed for approximately 2 weeks. Subsequent to the State Agencies Building, Fire, Safety Inspectors visit on 9/19/24, the gazebo was repaired on 9/25/24. 50179

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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** 48950 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #23 and Resident #29) reviewed for respiratory care and treatment, the facility failed to change oxygen tubing per physician order and failed to date and label oxygen tubing. The findings include: 1. Resident #23's diagnoses included chronic obstructive pulmonary disease, heart failure, and diabetes. A physician's order dated 8/12/24 directed to change oxygen tubing every Tuesday on the 11:00 PM to 7:00 AM shift. The Resident Care Plan (RCP) dated 8/13/24 identified Resident #23 had a diagnosis of chronic obstructive pulmonary disease and included interventions to administer oxygen, monitor oxygen saturation, and provide nebulizer treatments as ordered. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #23 was severely cognitively impaired, required set up assistance for eating, was dependent for toileting, transfers, and bathing, and required maximal assistance for hygiene. The MDS also identified Resident #23 was short of breath while lying flat and received oxygen therapy. Review of the Treatment Administration Record (TAR) included documentation that Resident #23's oxygen tubing was last changed on 9/17/24. An observation on 9/19/24 at 11:57 AM identified the oxygen tubing was dated 9/11/24 (and not 9/17/24 as the TAR indicated). An interview on 9/23/24 at 10:15 AM with RN #2 identified Resident #23's oxygen tubing was still labeled 9/11/24 and that, according to the facility policy, the oxygen tubing should be changed every Tuesday on the 11:00 PM to 7:00 AM shift. RN #2 indicated the oxygen tubing should have been changed on Tuesday 9/17/24 and could not speak to why the tubing was not changed. Subsequent to surveyor inquiry, Resident #23's oxygen tubing was changed. 2. Resident #29 's diagnoses included heart failure, pneumonia and septicemia. A physician's order dated 6/29/24 directed to provide oxygen via nasal cannula at 2 liters/minute daily at bedtime and to change oxygen tubing every Tuesday on the 11:00 PM to 7:00 AM shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #29 was cognitively intact and required extensive assistance with bed mobility and transfers and limited assistance with toileting. The MDS further identified Resident #29 utilized oxygen therapy. The Resident Care Plan dated 7/17/24 identified a diagnosis of bacterial pneumonia with interventions that included to provide oxygen as directed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 9/1/24 to 9/30/24 Treatment Administration Record (TAR) identified an order to change oxygen tubing every Tuesday on the 11:00 PM to 7:00 AM shift and was signed off as completed on 9/17/24. Interview on 9/19/24 at 11:25 AM with Resident #29 identified that he/she used the bedside oxygen concentrator daily at bedtime and wore the oxygen tubing overnight. Observations on 9/19/24 at 11:30 AM and 9/23/24 at 10:15 AM identified the oxygen tubing connected to Resident #29's bedside oxygen concentrator lacked a label and date of when it was changed. Interview and observation with RN #2 on 9/23/24 at 10:20 AM identified Resident #29's oxygen tubing was not labeled or dated. RN #2 identified changing the oxygen tubing was the responsibility of nurses working the 11:00 PM to 7:00 AM shift on Tuesdays. RN #2 further identified she did not know the reason the oxygen tubing was not labeled or dated and that she would change the tubing and apply a label and date. Subsequent to surveyor inquiry, an observation on 9/23/24 at 11:40 AM identified the oxygen tubing was changed and labeled 9/23/24 by RN #2. Review of the facility policy, Oxygen Administration Nasal Cannula, dated 11/2020, directed to replace and date cannula and tubing weekly or when visibly soiled or damaged. 50249

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on review of facility documentation and interviews, the facility failed to maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver but continued to perform glucoscan testing. The findings include: During an interview and facility documentation review with the Administrator on [DATE] at 10:30 AM, the Administrator identified the CLIA certificate of waiver expired on [DATE]. The Administrator indicated the certificate was renewed and she was waiting to receive the new certificate from the State Agency (SA). The Administrator further identified there was email correspondence with the SA regarding the certificate renewal. During an interview with the Administrator on [DATE] at 10:00 AM, the Administrator provided the email correspondence which identified the Administrator contacted the SA on [DATE] and the CLIA certificate of waiver expired on [DATE] due to non-payment. The Administrator identified the facility had an expired CLIA certificate of waiver for 23 days (from [DATE] to [DATE]) and full payment for the renewal of the CLIA certificate of waiver was issued by the facility, to the SA, on [DATE] (subsequent to the re-certification survey start date of [DATE]). An interview with the SA laboratory section on [DATE] at 11:48 AM identified the facility had not issued a CLIA certificate of waiver from [DATE] to [DATE] due to lack of payment. Interview with the Administrator and DNS on [DATE] at 2:00 PM identified they were not aware that the CLIA certificate of waiver was expired. The Administrator indicated that once she was informed by the surveyor on [DATE] that the certificate was expired, she contacted the SA via email on [DATE]. Review of the facility documentation identified that, between [DATE] and [DATE], 22 residents had daily, weekly or monthly physician's orders for blood glucose testing by glucometer, and 3 residents had physicians orders for nasal swab testing for COVID-19, completed at the facility, without the required CLIA certificate of waiver. The Administrator and DNS indicated the facility was out of compliance from [DATE] to [DATE].

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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** 19953 Based on observation, staff interview and policy review, the facility failed to ensure food was dated when opened/identified an expiration date, practice proper handwashing, failed to ensure dishwashing temperatures were consistently monitored. The findings include: On [DATE] at 10:25 AM, tour of the Dietary department with the Director of Dining Services identified the following: 1a. a 50 pound (lb) plastic storage bin, (which was almost full) of loose flour identified the flour was placed in the bin on [DATE], but lacked an expiration date. b. a 50 lb plastic storage bin approximately ,d+[DATE] full, contained thick it was dated [DATE], but lacked an expiration date. c. the walk in freezer contained a blue plastic garbage baggie of peas (approximately ,d+[DATE] full) which was not dated when opened and did not contain an expiration date. A blue baggie was knotted which contained 5 trays with 6 manicotti in each tray, which was removed from the cardboard box, lacking a date when opened or an expiration date. d. a 15 lb bag (approximately ,d+[DATE] full) of breakfast sausage links, located in the cook's refrigerator was noted to be opened and dated [DATE], but lacked an expiration date. Interview with the Director of Dining Services at that time identified that she doesn't usually include an expiration date on dry storage, but could not ascertain when the product expired. 2. On [DATE] at 11:51 AM observation of of Dietary Aide (DA) #1 identified she removed the cover of a plastic garbage container by touching the underside of the lid and threw away contents from a metal pan (celery and skins of an onion) with ungloved hands. She was then observed to wipe her hands on a pot holder, remove a metal tray of stuffed peppers from the oven, peel back the foil, touch the metal section of a thermometer, and temp the stuffed peppers with the thermometer without the benefit of performing hand hygiene after touching the lid to the garbage container. Interview with DA #1 at that time identified that she did not know the reason she did not wash her hands after touching the garbage cover, but stated I should have done that. Interview with the Director of Dining Services identified DA #1 should have washed her hands after touching the inside of the garbage cover and then handing the thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the Dishwashing Temperature Log with the Director of Dining Services on [DATE] at 9:27 AM identified that dishwashing temperatures were not consistently completed as follows: [DATE] lunch dishwashing/rinse temperatures, [DATE] breakfast and lunch washing/rinse temperatures, [DATE] lunch washing/rinse temperatures, [DATE] breakfast and lunch dishwashing/rinse temperatures, [DATE] breakfast and lunch dishwashing/rinse temperatures, [DATE] supper dishwashing/rinse temperatures, [DATE] lunch dishwashing/rinse temperatures, [DATE] breakfast and lunch dishwashing/rinse temperatures and [DATE] breakfast and lunch wash/rinse temperatures and [DATE] supper wash/rinse temperatures were not completed. Interview with the Director of Dining Services at that time identified when the cooks come in, they run the dishwasher and document the temperatures after breakfast, lunch and supper. Additionally, she identified although she reviews the logs for completeness, she did not know the reason she did not notice the logs were incomplete. Facility policy for Dishmachine Temperatures identified the Director of Dining Services or designee will be responsible for the monitoring and documentation of wash/rinse temperatures a minimum of 3 times daily (breakfast, lunch and supper), prior to washing and sanitizing dishes after each meal.