STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075416	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Candlewood Valley Health & Rehabilitation Center	30 Park Lane East New Milford, CT 06776

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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** 48792 Based on review of the clinical records, facility documentation, facility policy and interviews for 2 of 2 residents (Residents #23 and #30) reviewed for Resident Rights, the facility failed to ensure residents were treated with dignity by a nurse aide. The findings include: 1. Resident #23's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), emphysema, and chronic respiratory failure. The Resident Care Plan dated 5/16/24 identified the resident required supervision and assistance with Activities of Daily Living (ADL). Interventions included assisting the resident with ADL daily for optimal independence. The social services note dated 5/31/24 at 1:55 PM written by (Social Worker) SW #3, identified the resident as alert and oriented and able to make his/her needs known. Additionally, the note indicated Resident #23 did not have any roommate or behavioral issues. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 as cognitively intact and required partial assistance with showering, set up or clean up assistance with toileting and dressing. A physician's order dated 6/1/24 directed to assist and/or provide supervision with ADL. A Record of Grievance/Concern note dated 6/2/24 written by Registered (RN #2), (after surveyor inquiry) identified Resident #23 voiced concerns of a Nurse Aide (NA #1) tone of how she responded to her/him. In an interview with Resident #23 on 6/3/24 at 10:00 AM, NA #1 raised her voice to Resident # 23 on Sunday (6/2/24). Resident #30 had to go to the bathroom and NA #1 told her/him she/he had to wait as NA#1 was clearing trays. After about 10 minutes NA #1 did not come back to assist Resident #30, therefore Resident #23 asked NA #1 to assist Resident #30 and NA#1 raised her voice and told Resident # 23 she was busy and would help when she could. NA #1 stated she reported the incident to the nursing supervisor (RN #2). (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/3/24 at 12:20 PM with RN #2(nursing supervisor), identified she spoke with Resident #23 who stated that s/he did not like the tone of voice NA #1 used. RN #2 stated the incident was a customer service issue. Resident #23 was given the choice to continue to allow NA #1 to provide care to Resident # 23 or to have NA #1 removed. Resident #23 stated s/he did not care either way. When asked if RN #2 documented any of the investigation, she responded no. When she was asked if she followed facility policy, RN # 2 stated she followed facility policy for complaint investigations and wrote up the incident as a grievance. RN #2 also stated she misunderstood the surveyor's original question about documenting the complaint. After the surveyor inquiry a record of grievance was given to the surveyor, there was no investigation attached and the document was not signed. 2. Resident #30's diagnosis included weakness, hemiplegia, and hemiparesis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #30 as cognitively intact and required total assistance with toileting, maximal assistance with hygiene and lower body dressing. The Resident Care Plan dated 5/30/24 identified the resident required assistance with activities of daily living and has decreased physical functioning. Interventions included assisting with activities of daily living daily for optimal independence. A physician's order dated 6/1/24 identified maximum assistance required for hygiene, toileting, and bed mobility. Resident # 30 was non ambulatory. In an interview with DNS on 6/3/24 at 12:30 PM identified her expectation would be that when a resident requires help with toileting, she would expect that would be a priority before clearing trays. The DNS further stated social services did not see the resident as she was not in the building on the day of the incident and would see the resident on 6/3/24. In an interview with Resident #30 on 06/04/24 10:00 AM identified that over the weekend, possibly Sunday (6/2/23), Resident # 30 had to go to the bathroom and asked NA #1 to take her/him. NA #1 told Resident # 30 s/he would have to wait as she was busy clearing trays. She asked a second time approximately 10 minutes later and NA #1 said s/he had to wait. Resident #23 spoke up and told NA #1 that s/he was going to report NA #1 and at that point, NA #1 assisted Resident # 30 to the bathroom. In an interview with NA #1 on 6/6/24 at 9:00 AM identified on Sunday 6/2/24 she was feeding residents and came out of the dining room to get some sugar. Resident #30 asked her for help to go to the bathroom. NA #1 stated she told Resident # 30 she would assist as soon as she was done feeding. NA #1 went back to feed, she also told Resident #30 that she could ask another nurse aide or nurse to help her/him. When she was putting the trays back on the cart Resident #23 started yelling at her. NA #1 took Resident #30 to the bathroom at that time. NA #1 stated it was about 15 minutes after the resident's initial request to take her/him to the bathroom. When asked if she told another NA or nurse to assist Resident #30, she said no because the resident could speak for him/herself, and she told Resident #30 to ask someone else. Review of the Grievance policy dated 3/15/22 notes in part, the facility will complete a prompt, thorough investigation of all grievances and/or concerns filed with the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Employee Code of Conduct, undated, directed in part, Employees shall: Treat all residents with care, courtesy, and respect. Based on review of the clinical records, facility documentation, facility policy and interviews for 2 of 2 residents (Residents #23 and #30) reviewed for Resident Rights, the facility failed to ensure residents were treated with dignity by a nurse aide. The findings include: 1. Resident #23's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), emphysema, and chronic respiratory failure. The Resident Care Plan dated 5/16/24 identified the resident required supervision and assistance with Activities of Daily Living (ADL). Interventions included assisting the resident with ADL daily for optimal independence. The social services note dated 5/31/24 at 1:55 PM written by (Social Worker) SW #3, identified the resident as alert and oriented and able to make his/her needs known. Additionally, the note indicated Resident #23 did not have any roommate or behavioral issues. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 as cognitively intact and required partial assistance with showering, set up or clean up assistance with toileting and dressing. A physician's order dated 6/1/24 directed to assist and/or provide supervision with ADL. A Record of Grievance/Concern note dated 6/2/24 written by Registered (RN #2), (after surveyor inquiry) identified Resident #23 voiced concerns of a Nurse Aide (NA #1) tone of how she responded to her/him. In an interview with Resident #23 on 6/3/24 at 10:00 AM, NA #1 raised her voice to Resident # 23 on Sunday (6/2/24). Resident #30 had to go to the bathroom and NA #1 told her/him she/he had to wait as NA#1 was clearing trays. After about 10 minutes NA #1 did not come back to assist Resident #30, therefore Resident #23 asked NA #1 to assist Resident #30 and NA#1 raised her voice and told Resident # 23 she was busy and would help when she could. NA #1 stated she reported the incident to the nursing supervisor (RN #2). In an interview on 6/3/24 at 12:20 PM with RN #2(nursing supervisor), identified she spoke with Resident #23 who stated that s/he did not like the tone of voice NA #1 used. RN #2 stated the incident was a customer service issue. Resident #23 was given the choice to continue to allow NA #1 to provide care to Resident # 23 or to have NA #1 removed. Resident #23 stated s/he did not care either way. When asked if RN #2 documented any of the investigation, she responded no. When she was asked if she followed facility policy, RN # 2 stated she followed facility policy for complaint investigations and wrote up the incident as a grievance. RN #2 also stated she misunderstood the surveyor's original question about documenting the complaint. After the surveyor inquiry a record of grievance was given to the surveyor, there was no investigation attached and the document was not signed. 2. Resident #30's diagnosis included weakness, hemiplegia, and hemiparesis. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set assessment dated [DATE] identified Resident #30 as cognitively intact and required total assistance with toileting, maximal assistance with hygiene and lower body dressing. The Resident Care Plan dated 5/30/24 identified the resident required assistance with activities of daily living and has decreased physical functioning. Interventions included assisting with activities of daily living daily for optimal independence. A physician's order dated 6/1/24 identified maximum assistance required for hygiene, toileting, and bed mobility. Resident # 30 was non ambulatory. In an interview with DNS on 6/3/24 at 12:30 PM identified her expectation would be that when a resident requires help with toileting, she would expect that would be a priority before clearing trays. The DNS further stated social services did not see the resident as she was not in the building on the day of the incident and would see the resident on 6/3/24. In an interview with Resident #30 on 06/04/24 10:00 AM identified that over the weekend, possibly Sunday (6/2/23), Resident # 30 had to go to the bathroom and asked NA #1 to take her/him. NA #1 told Resident # 30 s/he would have to wait as she was busy clearing trays. She asked a second time approximately 10 minutes later and NA #1 said s/he had to wait. Resident #23 spoke up and told NA #1 that s/he was going to report NA #1 and at that point, NA #1 assisted Resident # 30 to the bathroom. In an interview with NA #1 on 6/6/24 at 9:00 AM identified on Sunday 6/2/24 she was feeding residents and came out of the dining room to get some sugar. Resident #30 asked her for help to go to the bathroom. NA #1 stated she told Resident # 30 she would assist as soon as she was done feeding. NA #1 went back to feed, she also told Resident #30 that she could ask another nurse aide or nurse to help her/him. When she was putting the trays back on the cart Resident #23 started yelling at her. NA #1 took Resident #30 to the bathroom at that time. NA #1 stated it was about 15 minutes after the resident's initial request to take her/him to the bathroom. When asked if she told another NA or nurse to assist Resident #30, she said no because the resident could speak for him/herself, and she told Resident #30 to ask someone else. Review of the Grievance policy dated 3/15/22 notes in part, the facility will complete a prompt, thorough investigation of all grievances and/or concerns filed with the facility. Review of the Employee Code of Conduct, undated, directed in part, Employees shall: Treat all residents with care, courtesy, and respect.

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F 0573 Level of Harm - Potential for minimal harm Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on clinical record review, review of facility policy and staff interviews for 1 of 3 sampled residents (Resident #432) reviewed for abuse, the facility failed to provide copies of the resident's medical record within 48 hours. The findings include: Resident #432 was admitted to the facility on [DATE]. The resident's diagnoses included metabolic encephalopathy, essential hypertension, muscle weakness, hypothyroidism, and dysphagia. A Minimum Data Set (MDS) assessment dated [DATE] identified Resident 432 as cognitively impaired and required substantial/maximal assistance with toileting, bathing, lower body dressing, and bed to chair transfer. The Resident Care Plan (RCP) dated 11/29/23 identified Resident #432 had cognitive loss/dementia, resident has decreased physical functioning and requires assistance with activities of daily living (ADL). Interventions include assisting with Activities of Daily Living (ADL) for optimal independence, and resident will ensure the resident makes daily choice or preference regarding his/her life. The clinical record review identified the resident's family member (Person # 5) was Resident #432 emergency contact. The social worker progress note 11/27/2023 identified Person # 5 wanted a copy of Resident #432 discharge paperwork and the Social Worker (SW) told Person # 5 that they could not provide the paperwork and Person # 5 would need to go to the discharge acute care facility to get a release of the discharge paperwork. Interview with Social Worker (SW) #1 on 6/7/24 at 12:58 PM identified Resident #432 emergency contact (Person # 5) wanted a copy of the medical record from discharge acute care facility and not the discharge paperwork from the facility and that the statement was written in error in her note. SW #1 also indicated the policy of the facility directs that any medical records outside the facility the family or resident would have to go to outside facility to obtain the records. SW #1 further stated that discharge paperwork from the acute care facility but be in the resident's medical record but would not be part of the medical record. Interview with Person #2 on 6/7/24 at 1:31 PM from medical records identified she could not remember if she receives a request from anyone asking to make copies of Resident #432's medical record and could not find any email or documentation asking her to make copies. Review of facility policy for Access to Medical Records identified the resident or legal representative has the right upon written or oral request to access all records pertaining to themselves. The resident/ legal representative also has the right to purchase copies of his or her records and the facility has up to two working days after the initial request to provide these photocopies.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #427) reviewed for change of condition, the facility failed to notify the physician of a change in status for a resident exhibiting reoccurring symptoms in a timely manner. The findings include: Resident #427's diagnoses included acute kidney failure and duodenitis (inflammation of the first section of the small intestine) without bleeding. The hospital discharge documentation dated 5/30/24 identified Resident #427 was admitted and treated for acute kidney injury and duodenitis. Resident #427's abdomen was soft, non-distended, non-tender with normal bowel sounds, no documented diarrhea and noted the resident was stable for discharge to short term rehabilitation. The Nursing Admission assessment dated [DATE] identified Resident #427 as alert and oriented to person, place, and time, had a distended abdomen, with no problems with digestion and no documented diarrhea. The (baseline) Resident care Plan dated 5/30/24 identified Resident #427 was less mobile which may cause irregularities in bowel movements and constipation and decreased activity of daily living functioning. Interventions directed monitor bowel activity daily and transfer using a mechanical lift. The Advanced Practice Registered Nurse, APRN communication book dated 6/1/24 identified Resident #427 was requesting Imodium (medication that treats diarrhea) and Simethicone (medication that treats abdominal gas) for loose stool. A nursing progress note dated 6/2/24 at 10:29 AM written by Licensed Practical Nurse, LPN #6 identified Resident #427 had two episodes of diarrhea previously that morning. Vital signs were stable. A review of the nursing, medical progress notes or physician orders dated 6/1/24 and 6/2/24 did not include documentation of how the change of condition was addressed. A nurse's note dated 6/3/24 at 11:00 AM (edited 6/4/24 at 8:27 AM) identified the Advanced Practice Registered Nurse (APRN) was notified of the resident's loose stool with no new orders. An interview with Resident #427 on 6/03/24 at 12:25 PM identified s/he had eaten shrimp over the weekend for lunch and began experiencing symptoms of gastric upset and then diarrhea. Resident #427 reported to staff that no one came to see h/her. Resident #427 identified s/he had additional diarrhea earlier in the shift but no medical staff had evaluated h/her condition. An interview with Licensed Practical Nurse (LPN #2) on 6/3/24 at 12 40 PM identified she was responsible for infection control and the tracking of resident illnesses. LPN #1 identified there had been no reports of a resident with loose stool that had been reported to her over the weekend and previous to surveyor inquiry. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/3/24 at 12:44 PM with LPN #6 identified Resident #427 had diarrhea beginning over the weekend and someone had already place the information in the (APRN communication) book. Subsequent interviews with LPN #6 on 6/3/24 at 2:52 PM and on 6/07/24 at 9:43 AM identified she was the assigned nurse during the 7:00 AM to 3:00 PM shift on 6/2/24 when Resident #427 had episodes of diarrhea. LPN #6 further identified she did not report the change of condition to a nursing supervisor or physician because it was previously documented in the APRN communication book, and Resident #427 reported the diarrhea was due to food, so she did not feel it needed to be reported. The nursing progress note dated 6/03/2024 at 7:18 PM identified nursing staff spoke to the physician and obtained a new order for loperamide 2 Milligrams (MG) (4) times daily as needed for loose stool as per resident request. An interview with Registered Nurse, RN #2 on 6/05/24 at 2:58 PM identified she was the assigned Nursing Supervisor 7:00 AM to 3:00 PM on 6/1/24 and 6/2/24 and there were no reports that Resident #427 had loose stool. RN #2 identified the change of condition should have been. An interview with the Director of Nursing Services on 6/5/24 at 3:30PM identified she would expect nursing staff to notify the physician of any change of condition should be reported. An interview with LPN #7 on 6/6/24 at 4:23 PM identified she was the assigned nurse on 6/1/23 during the 7:00 AM -3:00 PM shift on 6/1/24 when Resident #427 had an episode of diarrhea. LPN #7 identified it was change of shift she asked the oncoming nurse, LPN #8 to notify the nursing supervisor and physician. An interview with the Medical Director on 6/07/24 at 12:02 PM identified he believed he was notified of the initial episode of diarrhea over the weekend. The Medical Director gave instructions to monitor for further loose stool at the time with no other instruction. The Medical Director further identified he was not notified of any recurrent episodes of diarrhea previous to 6/3/24. The Medical Director also indicated he would expect to be notified when Resident #427 experienced continued diarrhea. Although attempted, efforts to interview LPN #8 were unsuccessful. A review of the facility policy for Significant Change in Status no date) directed that when there is a significant change in status, the unit nurse will be notified, obtain resident data as applicable to signs and symptoms and report to the Nursing Supervisor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37721 Based on observations, facility documentation and facility policy and interviews, the facility failed to ensure the environment was maintained in a safe secured manner on a locked unit for residents with special needs. The findings include: An observation of the facility memory care unit with the Director of Nursing Services and Assistant Director of Nursing Services on 6/06/24 at 12:35 PM identified the following: 1. One door labeled identified as the 'Soiled Utility' was unable to be fully closed, latched, and locked. 2. One door labeled 'Supply Room' was unable to be fully closed, latched, and locked. 3. One door labeled 'Clean Utility' was unable to be fully closed, latched, and locked. 4. The door identified as 'Shower' was not locked. There were no accessible sharps or hazardous material in all the rooms and no residents in the immediate area. An interview with the Director of Nursing Services on 6/06/24 at 12:35 PM identified the doors should be remain securely locked on the memory care unit. An interview with the Director of Maintenance on 6/07/24 at 8:59 AM identified moisture would prevent the doors from fully closing and latching all the way. The Director of Maintenance further identified he was not previously aware the doors were required to be locked and had since arranged for new locks and doors for replacement beginning later that morning. Although requested, a facility policy for ensuring a safe and secure environment was not provided.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record reviews, facility documentation, review of policy and staff interviews, for 1 of 2 resident reviewed for abuse (Resident #48), the facility failed to keep Resident #48 free from abuse during a witnessed resident-to-resident altercation. The findings include: 1. Resident #48's diagnoses including Alzheimer' disease and insomnia. A quarterly MDS assessment dated [DATE] identified Resident #48 as severely cognitively impaired and independent with eating and ambulation. Additionally, the MDS indicated that the resident did not experience any wandering or behaviors exhibited towards self or others. 2. Resident #75's diagnosis that included Alzheimer's disease and cognitive communication deficit. The quarterly MDS assessment dated [DATE] indicated Resident #75 had severe cognitive impairment and had not exhibited behaviors directed towards self or others. A facility Incident Report dated 4/30/2022 identified Resident #48 was struck in the chest by another resident (Resident # 75). The Incident Report indicated Resident # 48 was visited by Person # 6 s/he witnessed Resident #75 hit Resident #48. Additionally, Resident #75 was heard by staff speaking profanities towards another resident. The facility Incident Report further indicated that the supervisor, physician, and police were called. A nursing progress note by LPN #4 dated 4/30/2022 identified Resident # 48 was walking in the hallway with Person # 6. When they walked past Resident #75, Resident #75 struck Resident #48, hitting him/her in the upper left chest. Additionally, Resident #75 yelled profanities at Resident #48. A nursing progress note dated 4/30/2022 indicated that Residents #48 and #75 were separated and removed from the situation. Resident #75 was placed on a 1:1 observation and sent to the hospital for evaluation. On 6/5/2024, an interview with LPN #9 at 1:14 PM indicated Resident #75 did not have previous instances of aggression towards other residents and the resident preferred to stay in his/her room, although the resident used the lounge at times. LPN #9 also indicated Resident #75 would come out of their room to pick up and drop off their meal tray. On 6/6/2024 at 8:15 AM, an interview with LPN#4 indicated she was the nurse assigned to Resident #48 at the time of the resident-to-resident altercation. LPN #4 indicated she witnessed the incident, and the altercation was unprovoked. Additionally, LPN #4 indicated there was no indication that either Resident #48 or Resident #75 were upset or agitated prior to the incident occurring. The facility policy for abuse defines resident-to-resident altercation as a physical or verbal act between two residents with or without resulting in injury. The facility policy indicated that for cognitively impaired residents, the resident must be able to possess intent to harm.

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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** 48880 Based on clinical record review, observation and staff interviews for 1 of 1 resident reviewed for accidents (Resident #48), the facility failed to ensure the resident was administered medications as prescribed by the physician and within accordance to professional practice . The findings include: Resident #48's diagnoses including Alzheimer' disease and insomnia. The quarterly MDS assessment dated [DATE] indicated Resident #48 had severe cognitive impairment and was independent with eating and ambulation. The resident required partial or moderate assistance with personal hygiene and dressing. Additionally, the quarterly MDS indicated Resident #48 did not have any swallowing disorders. A care plan dated 5/8/2024 indicated the resident was at risk for aspiration related to dysphagia, advanced dementia, and requiring a ground diet consistency. Interventions included reporting signs of aspiration, keeping the head of the bed elevated during meals, and speech therapy as needed. The care plan also indicated Resident #48 was on psychotropic medication for psychotic disorder, depression, obsessive-compulsive disorder, and insomnia. Interventions included giving medications as ordered and observing the resident's behaviors, mood, mental status, and sleep. The physician's orders dated 5/1/2024 through 5/31/2024 identified directed to administer Melatonin (a medication for sleep) 10 milligrams (mg) daily at bedtime, paroxetine (a medication for obsessive-compulsive disorder) 40mg daily at bedtime, donepezil (a medication for Alzheimer's disease) 20mg daily at bedtime, quetiapine (an antipsychotic medication) 100mg daily at bedtime, and memantine (a medication for Alzheimer's disease) 20mg daily at bedtime. On 6/4/2024 at 11:26 AM, an interview with Person # 6 identified s/he found pills in the bottom drawer of Resident # 48's nightstand. Person # 6 indicated s/he notified and showed the pills to the ADNS. On 6/5/2024 at 3:17 PM, an interview and record review with the ADNS identified on 5/24/2024, Person # 6 showed her five pills s/he had found in the resident's bedside drawer. The ADNS indicated the facility performed an internal investigation and found the pills were medications the resident regularly took in the evening. The ADNS indicated she was able to identify the pills by their appearance and the numbers imprinted on the pills and the medications were Melatonin, paroxetine, donepezil, quetiapine, and memantine. The ADNS also indicated there was no medication cup found in the room and that the pills were rough around the edges. The ADNS further indicated the resident may have had the pills in his/her mouth and may have spit them out. The ADNS indicated after the incident, education on oral checks was performed. The ADNS further indicated that ensuring cognitively impaired residents take their medications completely as part of the standard of practice and this has become part of Resident #48's specific care. After surveyor inquiry, the ADNS indicated she would be initiating a care plan for oral checks during medication administration for Resident #48. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/2024 at 3:36 PM, an interview with LPN #3 indicated Resident #48 had no problems swallowing pills whole. LPN#3 also indicated that the training in a memory care unit is to ensure residents swallow their medications since sometimes residents may keep the medications in their mouth even after swallowing the water. LPN#3 indicated checking if a resident swallowed their medications properly was not a new practice and she had learned the standard of practice while receiving her nursing education. On 6/6/24 at 8:15 AM, an observation of the medication pass of LPN #4 was performed on the same unit as Resident #48. Observation identified LPN #4 performed an oral check of Resident # 48 during the medication pass. An interview with LPN #4 indicated she did not participate in the oral-checks in-service held by the facility on 5/24/2024 because she was on leave at the time. Additionally, LPN #4 indicated that ensuring residents in the memory care unit swallowed their medications was a standard of practice that she learned while still receiving her nursing education. A staff development in-service attendance record dated 5/24/2024 identified eight staff members received education on oral checks for Resident #48.

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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** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #427) reviewed for change of condition, the facility failed to ensure a nursing assessment was completed for resident with experiencing new onset of symptoms. The findings include: Resident #427's diagnoses included acute kidney failure and duodenitis (inflammation of the first section of the small intestine) without bleeding. a. The hospital discharge documentation dated 5/30/24 identified Resident #427 was admitted and treated for acute kidney injury and duodenitis. Resident #427's abdomen was soft, non-distended, non-tender with normal bowel sounds, no documented diarrhea and noted the resident was stable for discharge to short term rehabilitation. The Nursing Admission assessment dated [DATE] identified Resident #427 as alert and oriented to person, place, and time, had a distended abdomen, with no problems with digestion and no documented diarrhea. The (baseline) Resident care Plan dated 5/30/24 identified Resident #427 was less mobile which may cause irregularities in bowel movements and constipation and decreased activity of daily living functioning. Interventions directed monitor bowel activity daily and transfer using a mechanical lift. The Advanced Practice Registered Nurse, APRN communication book dated 6/1/24 identified Resident #427 was requesting Imodium (medication that treats diarrhea) and Simethicone (medication that treats abdominal gas) for loose stool. A nursing progress note dated 6/2/24 at 10:29 AM written by Licensed Practical Nurse, LPN #6 identified Resident #427 had two episodes of diarrhea previously that morning. Vital signs were stable. A review of the nursing, medical progress notes or physician orders dated 6/1/24 and 6/2/24 did not include documentation of how the change of condition was addressed. A nurse's note dated 6/3/24 at 11:00 AM (edited 6/4/24 at 8:27 AM) identified the Advanced Practice Registered Nurse (APRN) was notified of the resident's loose stool with no new orders. An interview with Resident #427 on 6/03/24 at 12:25 PM identified s/he had eaten shrimp over the weekend for lunch and began experiencing symptoms of gastric upset and then diarrhea. Resident #427 reported to staff that no one came to see h/her. Resident #427 identified s/he had additional diarrhea earlier in the shift but no medical staff had evaluated h/her condition. An interview with Licensed Practical Nurse (LPN #2) on 6/3/24 at 12 40 PM identified she was responsible for infection control and the tracking of resident illnesses. LPN #1 identified there had been no reports of a resident with loose stool that had been reported to her over the weekend and previous to surveyor inquiry. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/3/24 at 12:44 PM with LPN #6 identified Resident #427 had diarrhea beginning over the weekend and someone had already place the information in the (APRN communication) book. Subsequent interviews with LPN #6 on 6/3/24 at 2:52 PM and on 6/07/24 at 9:43 AM identified she was the assigned nurse during the 7:00 AM to 3:00 PM shift on 6/2/24 when Resident #427 had episodes of diarrhea. LPN #6 further identified she did not report the change of condition to a nursing supervisor or physician because it was previously documented in the APRN communication book, and Resident #427 reported the diarrhea was due to food, so she did not feel it needed to be reported. The nursing progress note dated 6/03/2024 at 7:18 PM identified nursing staff spoke to the physician and obtained a new order for loperamide 2 Milligrams (MG) (4) times daily as needed for loose stool as per resident request. An interview with Registered Nurse, RN #2 on 6/05/24 at 2:58 PM identified she was the assigned Nursing Supervisor 7:00 AM to 3:00 PM on 6/1/24 and 6/2/24 and there were no reports that Resident #427 had loose stool. RN #2 identified a nursing assessment should have been completed. An interview with the Director of Nursing on 6/5/24 at 3:30PM identified she would expect nursing staff to notify the nursing supervisor of any change of condition so an assessment can be completed. An interview with LPN #7 on 6/6/24 at 4:23 PM identified she was the assigned nurse on 6/1/23 during the 7:00 AM -3:00 PM shift on 6/1/24 when Resident #427 had an episode of diarrhea. LPN #7 identified it was change of shift she asked the oncoming nurse, LPN #8 to notify the nursing supervisor and physician. Although attempted, efforts to interview LPN #8 were unsuccessful. b. The nursing progress note dated 6/1/24 at 4:55 AM identified Resident #427 had an episode of epistaxis (nosebleed) from the right nares. Resident # 427 was resting in bed with the call bell with in reach. The 24 Hour Shift to Shift Report dated 6/1/24 identified Resident #427 had a nosebleed that was relieved with pressure. A review of the clinical record did not identify a documented nursing assessment. An interview with the Director of Nursing Services on 6/5/24 at 3:30PM identified she would expect nursing staff to notify the nursing supervisor of any change of condition and that an assessment be completed. An interview with Licensed Practical Nurse, PN #7 on 6/6/24 at 4:23 PM identified she worked the 11:00 PM to 7: 00 AM shift on 6/1/24 when Resident #427 experienced a nosebleed. LPN #7 identified she did not notify nursing supervisor of the change of condition as it was a onetime episode. Although requested, a policy for RN assessments was not provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, facility documentation, facility policy review and interviews for 1 of 3 sampled residents (Resident #103) reviewed for pressure ulcers, the facility failed to reassess the nutritional status and needs of a resident with newly identified wound(s). The findings include: Resident #103's diagnoses that included type II diabetes mellitus, obstructive sleep apnea and malignant neoplasm of the urethra/ bladder. The readmission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #103 was cognitively intact, required partial assist with bed mobility, total (2 person) assist with transfers, was at risk for the development of pressure ulcers and had one or more unhealed pressure ulcers. The Resident Care Plan dated 4/17/24 identified Resident #103 was at risk for impaired skin integrity related to impaired mobility and at nutritional risk due to malnutrition/terminal cancer. Interventions directed to implement the facility skin care protocol to include turning/positioning, incontinent care, weekly skin checks provide diet as ordered and refer to the dietitian as ordered. The nursing progress note dated 4/19/24 identified a sacral wound was noted as healed. The Wound Tracking Tool dated 4/26/24 identified a new pressure wound on the left ankle and sacrum with new orders that directed for Santyl ointment daily. A nutritional progress note dated 4/29/24 at 10:50 AM identified an unstageable pressure injuries and deep tissue injury to the (left) heel. Resident #103 receiving palliative care. Recommendations included continuing to try and encourage good intake while providing additional food tray items for added nutrition support. Food preferences were up to date. Continuing with the plan of care. Registered Dietitian following. A subsequent nutritional progress note dated 5/22/2024 at 11:12 AM identified Resident #103 was receiving comfort measures and presenting with a worsening wound. Liquid protein 30cc twice daily was added to help aid in wound healing. Facility Weekly Wound tracking dated 5/24/24 identified a newly open wound on the right hip. Subsequent Facility Weekly Wound tracking dated 5/31/24 identified a newly open wound on the right knee. However, a review of the clinical record did not identify a reassessment of Resident #103's nutritional status following the development of the new wound(s). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and clinical record review with the Dietitian on 6/05/24 at 12:16 PM identified wounds were discussed weekly with the interdisciplinary team and he would follow up for any new wounds to evaluate a resident's current nutritional status and determine if there were any further needs. The Dietitian could also be reached by email or text for any new issues that required attention outside of wound rounds. The Dietitian further identified he was unaware of Resident #103's new wound(s) and although he would have not likely have made any further recommendations, he would have completed an assessment of Resident #103's nutritional needs and documented any further recommendations. An interview with the Director of Nursing Services, DNS on 6/05/24 at 12:44 PM identified that wounds were discussed weekly with the interdisciplinary team including the Dietitian. The DNS identified she would expect the dietitian to evaluate a resident's nutritional needs immediately following the identification of a newly identified wound. Further interview and wound round review identified the Dietitian had signed into the meeting dated 5/29/24 as present when Resident #103's newly identified wound was discussed. A review of the facility policy for Pressure Injury Prevention and Management dated 11/1/2017 directed that residents assessed at high risk for pressure injuries or who have pressure injuries are provided interventions to prevent or treat current pressure injuries. A plan of care is developed by the interdisciplinary team (including the dietitian), based on the residents assessed need. Pressure injuries are assessed weekly, and the plan of care revised if clinically necessary.

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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** 37721 Based on clinical record reviews, observations, facility policy and interviews for 2 of 3 sampled residents (Resident #71 and Resident #103) reviewed for respiratory care, the facility failed to ensure respiratory equipment was stored and maintained in accordance with standards of practice. The findings include: 1. Resident #71's diagnoses included chronic obstructive pulmonary disease and essential hypertension. The quarterly Minimum Data (MDS) assessment dated [DATE] identified Resident #71 as moderately cognitively impaired and partial to moderate assist with activities of daily living. The Resident Care Plan (RCP) dated 3/21/24 identified Resident #71 had a respiratory therapy care plan with interventions that directed to administer nebulizer treatments as directed and observe for side effects. A physician's order dated 6/3/24 directed budesonide suspension for nebulizer 0.5mg/2ml via inhalation twice daily at 9:00 AM and 5:00 PM and Ipratropium-albuterol solution for nebulization 0.5mg/2.5mg base four times daily at 8:00 AM, 1:00 PM, 4:00 PM and 8:00 PM. An observation with the Director of Nursing Services, DNS on 6/04/24 at 8: 50 AM identified a nebulizing mouthpiece at Resident #71's bedside laying directly in top on the nebulizing equipment without the benefit of a cover. An interview with the DNS on 6/04/24 at 8: 50 AM identified all respiratory equipment should be stored in a bag when not in use. An interview with Registered Nurse, RN #3 on 6/4/24 8:54 AM identified all nebulizing wells should be rinsed and placed in a storage bag after use. RN #3 identified she had administered a nebulizing medication previously that morning and observed Resident #71's mouthpiece was found uncovered. RN #3 identified the mouthpiece was changed out the evening prior and should have been stored in a bag. RN #3 further identified she did not store the nebulizing mouthpiece in a bag after use as an oversight. 2. Resident #103's diagnoses that included obstructive sleep apnea. The physician's orders dated 5/6/24 directed CPAP pressure daily, place prior to sleep at 8:30 PM. Remove in the morning and oxygen as needed to maintain sats above 92%. The quarterly MDS assessment dated [DATE] identified Resident #103 was cognitively intact and required extensive assist with ADL skills. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP dated 5/30/24 identified Resident #103 was at risk for alteration in respiration secondary to obstructive sleep apnea. Interventions directed to use continuous positive airway pressure, Continuous Positive Airway Presssure (CPAP) a device used to prevent breathing interruptions for those with sleep apnea.) a. An observation on 6/03/24 at 11:37 AM identified Resident laying in bed with the head of bed up approximately 60-80 degrees, requesting assistance to have the call light moved closer which was adjacent to h/her approximately 4 inches from reach. The CPAP machine was observed on the bedside and approximately 2 ft behind Resident #103's right side (due to the head of bead being in a higher position, and with the CPAP mask placed on top without the benefit of a cover. An interview with Resident #103 on 6/03/24 at 11:32 AM identified s/he had been using the CPAP during the night, oxygen during the day and was requesting oxygen to be initiated. Licensed Practical Nurse, LPN #6 was notified. An interview with Nurse Aide, #5 on 6/3/24 at 11:37 AM identified aides were permitted to store respiratory equipment when not in use. NA #5 identified the mask should have been stored in a bag when not in use. An interview with the Director of Nursing, DNS on 6/04/24 at 8: 50 AM identified that all respiratory equipment should be stored in a bag when not in use. A subsequent interview with NA #5 on 6/05/24 at 10:17 AM identified at approximately 8:00 AM Resident #103 she served Resident #103 h/her breakfast, the CPAP was in use by Resident #103. NA #5 returned a short time later and observed the mask off, presumably by Resident #103. NA #5 was unable to explain why the mask was not stored at the time she observed the mask no longer in use. Although requested, a policy for the storage of CPAP equipment was not provided. b An observation on 6/03/24 at 11:32 AM identified oxygen tubing placed on top of a oxygen concentrator (oxygen delivery device), labeled 5/2/24 and without the benefit of a storage bag. An interview with Resident #103 on 6/03/24 at 11:32 AM identified s/he had been using the CPAP during the night, oxygen during the day and was requesting oxygen to be initiated. Licensed Practical Nurse, LPN #6 was notified. An observation and interview with Licensed Practical Nurse, LPN #6 on 6/03/24 at 11:37 AM identified the oxygen tubing should have had a current date within the week. An interview with the Director of Nursing Services, DNS on 6/04/24 at 2:05 PM identified that all respiratory equipment should be stored in a bag when not in use and that oxygen tubing should be changed weekly and labeled with a date. A review of the facility policy (no date) for Storage Guidelines for oxygen tubing directed that tubing shall be labeled with the date opened. When not in use, tubing should be safely secured with the nose/mouthpiece in a bag and changed weekly or sooner if visibly soiled.

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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** 49100 Based on review of the clinical record, review of facility policy and staff interviews for 1 of 5 resident (Resident #430) reviewed for Unnecessary Medication, the facility failed to ensure a psychotropic medication was re-evaluated for use. The findings include: Resident #430 's diagnoses included anxiety disorder, Major Depressive Disorder, and vascular dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #430 was (cognitive impaired) and required maximal assistance with eating and dressing and dependent with mobility. A physician's order dated [DATE] directed to give Lorazepam Intensol - Schedule IV concentrate; 2 mg/mL; amt: 0.5 mg (0.25 ml); oral Special Instructions: give every 4 hours and when needed (PRN) for restlessness/agitation Every 4 Hours - PRN PRN 1, PRN 2, PRN 3, PRN 4, PRN 5, PRN 6 End date indicates open ended Additionally notes indicates behavioral monitoring. A nurses note dated [DATE] at 11:04 AM indicated Resident #430 PRN Lorazepam and Haldol (Anti-psychotic) had expired and orders for each medication was recommended. A nurse's note dated [DATE] at 2:58PM identified Resident was grabbing at staff and mumbling during care, getting agitated, making it difficult to assist with AM care, PRN lorazepam given with effect. A revision of Medication Admission Records indicated Resident #430 only received the PRN Lorazepam medication on [DATE]. The RCP dated [DATE] identified Resident has behavioral issues. Interventions included providing emotional support, removing residents from common areas if disruptive and medication as ordered and to report any adverse reaction. The physician's progress notes dated [DATE] indicated a 30-day review of medication for residents. Resident #430 Behavioral flow reviewed from [DATE]- [DATE] and [DATE]-[DATE] indicated no change in behaviors. Interview with RN 5 on [DATE] at 11:10 am indicated PRN are ordered for 14 days and should be reevaluated. Interview with LPN # 4 [DATE] 10:48 AM indicated when psychotropic medications are ordered it also notes targeted behaviors and interventions. If behaviors are present staff are expected to document how many times behavior was present, cause of onset for the behavior and interventions used. LPN #4 also indicated if a resident is given PRN medication the APRN/ Medical Doctor (MD) communicates with the nurses the stop date and staff are expected to update the medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DNS [DATE] at 11:02 AM indicated the facility does not usually prescribe psychotropic medication as PRN. Review of APRN notes dated [DATE] and [DATE] indicated medication list consisted of Lorazepam, however, the notes did provide a rationale for continued PRN order for psychotropic medication. Request for documentation providing rationale for Resident #430 PRN Lorazepam medication was not provided. A review of the facility policy for Psychotropic Medication did not address requirements for medication use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100 Based on observations of the facility Medication Storage, facility policy reviewed and staff interviews for (4 of 7) medication carts, the facility failed to store and label medications to meet professional standards and within accordance to facility policy. The findings included: 1. Review of the medication cart on Elm Tree unit on [DATE] at 11:00 AM identified Resident #23 was prescribed Latanoprost .005% OPT SOLN (1 drop eye to be given at Bed). The directions directed that the medications be stored in the refrigerator upon opening and to discarded 6 weeks after opening (LPN) # 1 was unsure when the medication was opened). S/he also indicated the medication is stored in the top draw in the right back corner of the medication cart. The clinical record indicated the resident was last given the Latanoprost .005% optical solution on [DATE] at 7:59 PM. Interview with LPN#1 on [DATE] at 11:01AM indicated medications are expected to be stored according to directions and stated the last nurse who used the medication is responsible for placing the medications in proper storage area. 2. Review of medication cart on Apple Blossom Unit revealed Resident #80 Ventolin HFA (inhaler) 90 mcg medication was not labeled. Additionally, Resident #37 Albuterol sulfate 90 mcg 2 puff every 4 hours was not labeled with a date when the medication was opened. Interview with RN#3 on [DATE] at 11:45 AM identified s/he was unable to provide an explanation of why Resident #80 medication was not labeled. RN#3 indicated the pharmacy is responsible for ensuring that residents medications are labeled with the directions. S/he also indicated staff are expected to check orders before giving medication. RN#3 indicated medications are expected to have a date and time when medications are opened. 3. Observation of medication room on Dogwood unit revealed medication for Resident #38 medication (1.5 mg Trazadone expired on [DATE]). Interview with LPN #2 on [DATE] indicated the expectation is that medications are reviewed and discarded once expired. She also reported that the nurses are responsible for checking the dates on medications for expiration. The facility Storage of Medication policy notes all medication dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label. The policy also indicated the nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. Policy additionally directs medication requiring refrigeration to be kept in a refrigerator at appropriate temperatures.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 2 of 25 sampled residents (Resident #121 and Resident #52) reviewed for food preferences, the facility failed to ensure a resident preference for food choice was honored. The findings include: 1. Resident #121's diagnoses included diverticulitis, atherosclerosis, and alcohol abuse. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #121 as moderately cognitively impaired and independent with activities of daily living. The Resident Care Plan dated 4/10/24 identified Resident #121 utilized an antidepressant to manage anxiety. Interventions directed to take complaints seriously and, understand likes and dislikes. The physician's orders dated 6/2/24 directed regular low fiber diet. Resident #121's meal ticket identified Resident #121 Liked selective menus and Disliked cereal. An interview with Resident #121 on 6/3/24 at 12:04 PM identified the residents were served real eggs and hash browns once a week. Resident #121 expressed to staff (unsure who), that s/he would like it them more often. Resident #121 told the dietary staff but was told once weekly was the only time the food items were available. An interview with the Food Service Director (FSD) on 6/03/24 at 12:15 PM identified. Eggs and hash browns were served to residents once weekly. Resident #121 did say s/he wanted hash browns more often and eggs. The FSD identified she was unable to provide the eggs more often as the eggs need to be cooked and served immediately. Resident #121 was instead offered alternate choices such as a vegetable or cheese omelet which s/he was agreeable to. The FSD identified that she ensures that additional serving of hash browns was put aside for Resident #121 when prepared weekly. The FSD further identified that hash browns were served earlier that morning but would have to check with the Cook, who was responsible for the handling and storage of remaining food, if there was any leftover hash browns. An interview with the [NAME] on 6/3/24 at 12:25 PM identified all the remaining hash browns were used in a soup for another meal and was not provided any directive and was not made aware to set aside an additional serving of hash browns for any resident. An interview with the Director of Nursing Services, DNS on 6/5/24 at 12:35 PM identified she was aware Resident #121 had a lot of preferences. The DNS identified she would expect reasonable food preferences to be recognized. 2. Resident #52's diagnoses included Macular Degeneration, hypertension, and heart failure. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #52 was moderately cognitively impaired and required partial assistance with personal hygiene, maximum assistance with toileting and dressing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075416	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Candlewood Valley Health & Rehabilitation Center	30 Park Lane East New Milford, CT 06776

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan dated 5/2/24 identified the resident as being at risk for impaired nutrition secondary to advanced age, dementia, GERD, depression, and constipation. Interventions included providing food preferences. A Registered Dietician note dated 5/29/24 at 10:33 AM identified that there were no nutritional changes for the quarter and food preferences were up to date. A physician's order dated 6/1/24 directed to provide a regular diet with thin liquids. An interview and screening with Resident on 6/4/24 at 9:31 AM identified that he/she does not want mayonnaise on his/her sandwiches, but they keep putting it on. He/she has told dietary and writes it on the menu. Review of dietary slip with the lunch tray on 6/4/24 at 12:00 PM stated no mayonnaise. Interview with Kitchen Supervisor #1 on 6/5/24 at 1:55 PM identified she was aware that the resident has been served sandwiches with mayonnaise even though her/his meal ticket states that the resident does not like mayonnaise. Further she identified this had been a problem and this past Friday (5/31/24) the resident did get a sandwich with mayonnaise and as soon as Kitchen Supervisor #1 realized the error a new sandwich without mayonnaise was served. It was after the sandwich with mayonnaise was served to the resident that the error was identified. The Kitchen Supervisor #1 also stated they separate the sandwiches with mayonnaise from the sandwiches without but due to new staff, they get confused sometimes and the wrong sandwich goes out. Review of the Dietary Notice policy, undated, directed, in part, the dietary notice or slips are to provide effective communication of resident diet, preferences and food allergies on admission, re-admission, or when a diet change is necessary. Review of the Residents' [NAME] of Rights states that the resident has the right to make choices about aspects of your life that are significant to you. A review of the Resident [NAME] of Rights directed that a resident had the right to reasonable accommodation of individual needs, preferences, and choices about all aspects of life that are significant to that resident 48792

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on clinical record review, review of facility policy and staff interview for 1 of 3 sampled residents (Resident #432) reviewed for abuse, the facility failed to charge the appropriate amount for copies of Resident #432 medical records. The findings include: Resident #432 was admitted to the facility on [DATE]. The resident's diagnoses included metabolic encephalopathy, essential hypertension, muscle weakness, hypothyroidism, and dysphagia. A Minimum Data Set (MDS) assessment dated [DATE] identified Resident 432 as cognitively impaired and required substantial/maximal assistance with toileting, bathing, lower body dressing, and bed to chair transfer. The Resident Care Plan (RCP) dated 11/29/23 identified Resident #432 had cognitive loss/dementia, resident has decreased physical functioning and requires assistance with activities of daily living (ADL). Interventions include assisting with Activities of Daily Living (ADL) for optimal independence, and resident will ensure the resident makes daily choice or preference regarding his/her life. The clinical record review identified the resident's family member (Person # 5) was Resident #432 emergency contact. Review of the medical record invoice sheet identified Resident #432 paid by check and was charged 75 cents per page and charged 30 dollars for document retrieval for Resident # 432's medical record. Interview from Person #1 identified that it could take up to 10 days to process a request of medical records and that the facility charges 50 cents per page. Interview with Person #2 identified that they charge 60 cents per page for making copies of medical records but does not know the Connecticut general state statue on charging for copies of medical records. Interview with the Administrator identified residents or family should not be charged no more then 65 cents per page for copies of medical records and s/he did not know why Resident #432 was charged 75 cents per page and did not know why Resident #432 was charged 30 dollars for document retrieval. Review of facility policy for Access to Medical Records identified the resident/ legal representative also has the right to purchase copies of his/her records at a cost no greater than prevailing community rates.

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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. 48792 Based on observation of the environment, review of facility documentation, facility policy, and interviews, the facility failed to ensure laundry room vents and a smoke detector were free of debris. The findings include: 1. During a tour of the laundry area on 6/5/24 at 11:30 AM, 2 vents and a smoke detector were covered in gray debris. One vent was in the dirty laundry area and the second vent was in the clean laundry area near a folding table. The smoke detector was also located in the clean laundry area. Interview and observation with Laundry Supervisor #1 on 6/5/24 at 11:30 AM identified the vents should be cleaned monthly. He was also unsure when the last time the vents and smoke detector were cleaned. The Laundry Supervisor # 1 stated he would check the logs; he would have to get the logs because they were not in the laundry area. In an interview and observation with the Infection Preventionist (IP)/LPN #2 on 6/5/24 at 11:45 AM identified the vents should be cleaned weekly by the laundry aide and there are cleaning logs. She also stated she was unsure why the policy was not followed, and she was responsible for ensuring that policies are followed. A review of the Laundry Cleaning logs for May 2024 and June 2024 were reviewed with IP/LPN #2 on 6/6/24. As per the log the vents were cleaned 5/16/24, 5/27/24, and 5/29/24. The June log stated that the vents were cleaned today. There was no date. Logs were produced after surveyor inquiry. IP/LPN #2 could not identify the exact date the vents were cleaned in June 2024. Review of the Cleaning and Upkeep of Laundry Department Areas and Equipment dated 2 20/24, directed in part, vents were to be cleaned weekly by the laundry aide.