STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075419	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwoods of Farmington	416 Colt Highway Farmington, CT 06032

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure food was labeled appropriately and temperatures completed prior to serving. The findings include:A tour of the kitchen on 7/24/25 at 10:15 AM with the Food Service Director identified a bottle of thousand island dressing that was half filled with a date of 12/31/24 located in the reach in refrigerator. Interview on 7/24/25 at 10:20 AM with the Food Service Director identified opened condiments such as salad dressing should be used within 3 months of opening and then discarded. Observation of the walk-in freezer on 7/24/25 at 10:30 AM identified a frozen apple pie in saran seal with no open date or expiration date. Interview on 7/24/25 at 10:35 Am with the Food Service Director identified she could not locate the open date or expiration date but believed it was from a recent event. Review of the food temperature log on 7/24/25 at 10:40 AM identified no record of food temperature completed on the following days/meals: On 6/1/25, 6/2/25, 6/3/25, 6/4/25, 6/7/25, the dinner meal temperatures were not completed. On 6/24/25(lunch), on 6/28/25(breakfast, lunch and dinner), on 6/29/25, 6/30/25, and 7/3/35, the temperatures were not completed for the breakfast and lunch meals. On 7/4/25, the temperatures were not complete for breakfast lunch or dinner and on 7/15/25 they were not complete for the dinner meal. Interview on 7/31/25 at 11:15 AM with Dietary Aide #1 identified that she always has to remind [NAME] #1 to complete the food temperatures and log the results, and it seems to be missing on the days in which that staff member works. Interview on 7/31/25 at 11:25 AM with the Food Service Director identified that she speaks about the taking and logging of the food temperatures; however, there have not been any recent in-service training on completing this. She does however agree with Dietary Aide #1 that there does seem to be one specific cook who does not log the temperatures however she had not spoken about it yet to the [NAME] as the [NAME] had been out sick during the survey period. The importance of taking the temperature of the food served to the residents would be to ensure that the food is being served at a safe temperature. [NAME] #1 was out sick for the duration of the survey and was not able to be interviewed. The Marking policy directed that food marking systems are in place to reduce foodborne illness. Salad dressing from the date manufactured should be used within 4 months of opening. The Food Temperature for Tray line policy directed all foods placed in tray line for service are safe for resident consumption. All foods should be brought to the appropriate temperature in the cooking vessel before placing them in the steam table no sooner than 30 minutes prior to service and recorded on the Cooks Temp Log.

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

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

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of facility policies and procedures and interviews for the facility reviewed for Administration, the facility administration failed to ensure that all contracted staff who provide direct or indirect care to residents met the training requirements or were provided the mandatory training as outlined in the facility assessment and per regulatory requirements prior to, and while providing ongoing services in the facility. The findings included: Review of the facility assessment dated [DATE] identified under the training plan section indicated a training mechanism for mandatory training of new and existing employees, contracted individuals, and volunteers, in all of the following required areas:Effective communicationResident RightsAbuse, Neglect, and Exploitation Quality Assurance and Performance ImprovementInfection ControlCompliance and EthicsNurse aide competencyBehavioral healthNon-pharmacological interventionsDementia CareOn 8/25/25 at 10:10 AM a request was made to the facility for the education and training documentation listed in the facility assessment training plan for contracted staff. Although the facility was able to provide education and training for two contracted agencies that provided nursing and nurse aide staffing, they failed to provide any documentation of education or training for other contracted agencies who provided direct and indirect care to facility residents. Interview on 8/25/2025 10:10 AM with the Administrator and Assistant Director of Nursing (ADNS) identified the facility obtained contractual services for podiatry, ophthalmology, audiology, wound care, psychiatry, nursing services, provider services, Hospice, laboratory, pharmacy and radiology services. The Administrator indicated that contractual agency nurses and nurse aide staff are the only contractual staff who received training, prior and ongoing, as listed in the facility assessment. The trainings are maintained by the contracted staffing agencies for the nurses and NAs. If the required training is not completed, the nurses and nurse aide agency staff are not able to pick up shifts to work at the facility. The Administrator further identified that the contract staff, such as providers, in the building are instructed to follow direction of the facility staff in the event of an emergency. Interview on 8/25/25 at 12:01 PM with the medical director identified he started working at the facility a little over a year ago and was not aware that he or contracted staff had to provide, or should have received education on communication, resident rights, abuse, neglect, and exploitation, QAPI, infection control, behavioral health or compliance and ethics from the facility. The medical director identified that he has to complete ongoing education to renew his licensure and was never asked to provide proof of continued education to the facility. The medical director indicated that he received a general orientation of the building and was introduced to staff.Interview on 8/26/25 at 10:46 AM with the Administrator and the DNS identified that they were part of the governing body along with the owners of the facility and the medical director and were not aware that contracted providers were to receive mandatory education to include communication, resident rights, abuse, neglect, and exploitation, QAPI, infection control, behavioral health or compliance and ethics, by the facility or that the facility should maintain records of education for the contracted providers on the related topics. The DNS and the administrator indicated that those topics were expected of each practitioner to have knowledge and education as the facility only offered specific general orientation to the facility to include touring of the building, where the restrooms were, who was in charge and contact information for supervisors and administration. The administrator indicated that the contractual staff was not listed in the training plan and that no staff at the facility follows up or verifies education and training requirements for the contracted providers with exception of the nursing and nurse aide staffing agencies and volunteers. The administrator identified the facility only tracks credentials of the contracted providers.Interview on 8/26/25 at 11:45 AM with the administrator and the DNS identified they were part of the development and updating the facility assessment annually as part of the governing body. The administrator identified that she reads the assessment over and makes changes as the needs arise. The administrator then reviewed the training (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan section in the facility assessment then identifying that the training plan did outline that the facility would provide mandatory education to contracted individuals and indicated the facility administration must have overlooked that. The administrator identified that the facility assessment did not address the length, frequency or mechanism of training for the contracted individuals and volunteers providing direct and indirect services to the facility residents but indicated that the volunteers received orientation and annual education if they were in the facility for that length of time even though it was not mentioned in the facility assessment.The facility assessment dated [DATE] identified under the training plan section that training had a described length, frequency and a training mechanism for mandatory training of new and existing employees, contracted individuals, and volunteers, in all of the following required areas:Effective communicationResident RightsAbuse, Neglect, and ExploitationQuality Assurance and Performance ImprovementInfection ControlCompliance and EthicsNurse aide competency Behavioral healthNon-pharmacological interventionsDementia CareAlthough the required areas listed above outlined length, frequency and training mechanism for new and existing employees, the facility assessment failed to outline the same parameters for contracted individuals and volunteers.

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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. Based on observations, clinical record review, review of facility documentation, review of facility policy/procedures and interviews for 22 residents (Residents #3, #4, #6, #16, #17, #24, #29, #33, #37, #42, #47, #49, #52, #84, #85, #90, #94, #127, #128, #140, #145 and #146) who received podiatric care from one Podiatrist, the facility failed to ensure a contracted Podiatrist maintained standard precautions, and failed to ensure the podiatry medical equipment was cleaned and disinfected after each resident and prior to use on another resident to prevent cross-contamination and spread of infection. The findings include:Observations on 7/24/25 at 11:40 AM identified the Podiatrist exited Resident #146's room, and was wearing latex gloves, he proceeded to push a cart down the corridor. The cart contained a pair of soiled latex gloves, a small pile of unused gloves, a clear plastic container that contained about a fourth of an inch of bluish colored liquid, the container had a paper towel that covered the bottom of the container, and the container held three metal clipping tools. Two of the clipping tools contained white debris and appeared visibly soiled. The heads of the clipping tools rested in the liquid with the handles resting on the side of the container, also located on the cart was a rotary tool (used for removing dead tissue from nails and skin) and a box that had four different heads that appeared white in color and unused. The head of the rotary tool (sanding tip) appeared off white and used. The cart did not contain hand sanitizer. The observation of the plastic container with fluid also identified there were 3 drops of a red substance on the paper towel that the Podiatrist, when asked, denied were blood. The Podiatrist entered Resident #85's room (Resident #85 had a sign on the door that identified that it was an enhanced barrier precaution room, which indicates that gloves and a gown must be worn for resident care) and spoke briefly with the resident then exited the room and proceeded to Resident #94's room. Once in the room the Podiatrist closed the door and the use of the rotary tool the use of the rotary and clipping tools could be heard from the corridor.At 11:50 AM the Podiatrist exited Resident #94's room with gloves on and entered Resident #85's room. The cart now contained two pairs of soiled gloves on the bottom shelf of the cart. He went into Resident #85's room without changing gloves or performing hand hygiene. The same tools were in the clear plastic container with handles resting on the side of the container and the very tip of the tool in the liquid. There were no gloves observed in the garbage can in the bathroom of Resident #94's room.At 12:00 PM the Podiatrist exited Resident #85's room with gloves on, two pair of gloves remained on the bottom of the cart. The Podiatrist had not donned a gown or performed hand hygiene prior to entering or exiting the room. He then proceeded down the corridor toward the nursing station and was using his phone. At 12:08 PM he entered Resident #37's room. The running of the rotary tool and the sound of the clipping tools could be heard from outside of the room. When the podiatrist exited the room, with gloves in place, was on his phone and two pairs of soiled gloves remained on the bottom shelf of the cart he was utilizing.The affected residents are listed below:Resident #3's diagnoses included Type 2 diabetes mellitus with diabetic chronic kidney disease, dementia, and polyneuropathy.Podiatry consult notes dated 7/24/25 identified Resident #3 had five nails on the right foot and thee nails on the left foot that were dystrophic (misshapen, discolored or thickened), long, brittle, discolored, had fungal odor, pain on palpation and subungual (nail bed) debris with treatment rendered as all normal non dystrophic nails were aseptically (in a manner that is free from contamination by harmful microorganism) trimmed and reduced in length, any benign hyperkeratotic (skin thickening) lesions were cut and pared, and onychomycosis (fungal infection) toenails were aseptically and significantly debrided (removal of thickened, brittle or infected material) and reduced in thickness bulk and length using both manual and mechanical means.Resident #4's diagnoses included chronic viral infection, and idiopathic gout. Podiatry consult note dated 7/24/25 identified Resident #4 had thick painful toenails and calluses on the feet and indicated all nails on the right foot and the 1st nail on the left foot were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated 6 onychomycosis toenails were aseptically and significantly reduced and debrided in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thickness, bulk and length using both manual and mechanical means.Resident #6's diagnoses included Type 1 diabetes mellitus, and Waldenstrom Macroglobulinemia (cancer of the blood cells).Resident #16's diagnoses included Type II diabetes mellitus with other diabetic kidney complications and diabetic peripheral angiopathy without gangrene and dementia.Podiatry note dated 7/24/25 identified Resident #16 had a 5th toe amputation secondary to bone infection and chronic thick toenails. The note indicated all nails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and identified 10 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #17's diagnoses included dementia, type 2 diabetes mellitus and peripheral vascular disease.Podiatry treatment note dated 7/24/25 identified Resident #17 had a high risk for infections, amputations and ulcerations due to comorbidities and identified 6 thick toenails. The note indicated 6 toenails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and identified 4 normal/non dystrophic nails were aseptically trimmed and reduced in length and 6 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #24's diagnoses included dementia, and candidiasis unspecified (fungal infection caused by yeast).Podiatry visit note dated 7/24/25 identified Resident #24 had 10 moderately painful toenails and indicated all toenails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris with treatment to 10 onychomycosis toenails aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #24 had marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plat but indicated Resident #24 was not a candidate for oral therapy after review of medications and recommended over-the-counter antifungal topicals.Resident #29's diagnoses included immunodeficiency, and idiopathic chronic gout.Podiatry visit note dated 7/24/25 identified Resident #29 had idiopathic peripheral neuropathy and was at a high risk for infections, amputations and ulcerations and indicated the presence of 2 bilateral hallux (big toe) thick toenails and eight elongated toenails in need of debridement. The note further identified bilateral hallux nails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated 8 normal/non dystrophic nails were aseptically trimmed and reduced in length and 2 bilateral hallux onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #33's diagnoses included type 2 diabetes mellitus, and polyneuropathies. Podiatry visit note dated 7/24/25 identified Resident #33 was seen regarding a stage two hemorrhagic blister/decubitus to the posterior left heel and indicated all 10 toenails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris but indicated the only care provided was assessment of the posterior left heel area with no debridement of the nails.Resident # 37's diagnoses included type 2 diabetes mellitus, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.Podiatry visit note dated 7/24/25 identified Resident #37 had a high risk for infections, amputations and ulcerations and indicated 6 toenails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris. The note identified treatment to 4 normal/non dystrophic nails aseptically trimmed and reduced in length and 6 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #42's diagnoses included vascular dementia, and chronic kidney failure.Podiatry visit note dated 7/24/25 identified Resident #42 had 6 toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered on 6 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #42 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after review of medications but recommended over the counter antifungal topicals.Resident #47's diagnoses included sepsis unspecified organism, localized edema and encephalopathy.Podiatry visit note dated 7/24/25 identified Resident #47 had 10 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered as 10 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #47 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy but recommended over the counter antifungal topicals.Resident #49's diagnoses included type 2 diabetes mellitus, atherosclerotic heart disease of native coronary artery without angina pectoris, and peripheral vascular disease.Podiatry visit note dated 7/24/25 identified Resident #49 had a high risk for infections, amputations and ulcerations, had 7 thick toenails and 1 right hallux callous and indicated 7 toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris. The note identified treatment to 3 normal/non dystrophic nails were aseptically trimmed and reduced in length, 1 hallux distal toe benign hyperkeratotic lesions were cut and pared, and 7 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #52's diagnoses included history of methicillin resistant staphylococcus aureus infection (MRSA), localized edema, heart failure and chronic kidney disease.Podiatry visit note dated 7/24/25 identified Resident #52 had a high risk for infections, amputations and ulcerations and indicated bilateral hallux were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris. The note further identified treatment to 8 normal/non dystrophic nails were aseptically trimmed and reduced in length and bilateral hallux onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #84's diagnoses included vascular dementia and an immunodeficiency virus infection.Podiatry visit notes dated 7/24/25 identified Resident #84 had 10 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #84 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and that the resident was not a candidate for oral therapy but recommended over the counter antifungal topicals and use OTC topical antifungal spray in all shoes.Resident #85's diagnoses included vascular dementia, and acute kidney failure.Podiatry visit note dated 7/24/25 identified Resident #85 had 10 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #85 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy but recommended over the counter antifungal topicals and use of an OTC topical antifungal spray in all shoes.Resident #90's diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and adult failure to thrive.Podiatry visit note dated 7/24/25 identified Resident #90 had 9 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 9 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, and length using both manual and mechanical means. The note further identified Resident #90 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy but recommended over the counter antifungal topicals and use of OTC (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	topical antifungal spray in all shoes.Resident # 94's diagnoses included Alzheimer's disease, immunodeficiency due to conditions classified elsewhere, and acquired absence of left great toe.Podiatry visit note dated 7/24/25 identified Resident #94 was at risk for amputations, infections and ulcerations with 8 thick painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 8 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #127's diagnoses included Alzheimer's disease, and difficulty in walking.Podiatry visit note dated 7/24/25 identified Resident #127 had 10 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #127 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy but recommended over the counter antifungal topicals and OTC topical antifungal spray in all shoes.Resident #128's diagnoses included peripheral vascular disease, and dementia.Podiatry visit note dated 7/24/25 identified Resident #128 had 10 moderately aching painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly reduced and debrided in thickness, bulk and length using both manual and mechanical means. The note further identified Resident #128 had marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and was not a candidate for oral therapy but recommended over the counter antifungal topicals and OTC topical antifungal spray in all shoes.Resident #140's diagnoses included dementia, type 2 diabetes mellitus and resistance to multiple antibiotics and extended spectrum beta lactamase (ESBL) resistance.Podiatry visit note dated 7/24/25 identified Resident #140 had a high risk for infections, amputations and ulcerations with 9 toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 1 normal/non dystrophic nails were aseptically trimmed and reduced in length and 9 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #145's diagnoses included vascular dementia, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.Podiatry visit note dated 7/24/25 identified Resident #145 was a high risk for amputations, infections and ulcerations and all toenails were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Resident #146's diagnoses included chronic venous hypertension (idiopathic) with ulcer and inflammation of bilateral lower extremity, and pressure induced deep tissue damage of left heel.Podiatry visit dated 7/24/25 identified Resident #146 was a high risk for amputations, infections and ulcerations with 10 thick painful toenails that were dystrophic, long, brittle, discolored, had fungal odor, pain on palpation and subungual debris and indicated treatment rendered to 10 onychomycosis toenails were aseptically and significantly debrided and reduced in thickness, bulk and length using both manual and mechanical means.Interview on 7/24/25 at 12:09 PM with APRN #1 identified that both she and the Podiatrist are contracted staff at the facility and are expected to follow infection prevention guidelines. When asked about the guidelines she was aware of, APRN #1 answered with the question; you mean like changing gloves and hand hygiene in between patients, after which she exited the unit.Interview on 7/24/25 at 12:16 PM with the Podiatrist identified that he is aware that he should be changing gloves between residents but identified that he had not changed his gloves or washed his hands after providing care. He further identified that between non-infectious residents that do not have visible blood or pus, there is no requirement for cleaning nail equipment nor was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there any required dwell time for the equipment in a sanitizing solution prior to using the equipment on another resident. Additionally, he identified that the rotary tool used was not changed or cleaned and does not need to be cleaned unless there is visible contamination which only requires that it be wiped with a piece of dry gauze and when an inquiry was made about the possible spread of fungus, the Podiatrist stated all toenails have fungus. He acknowledged that prior to being on the unit where the observations were made, he had already provided care to about 20 residents. Interview on 7/24/25 at 1:00 PM with the Administrator and DNS identified that any contracted staff are required to maintain infection prevention standards while in the facility. The DNS indicated that contract staff have training from the company that hires them and are required to sign an agreement that they will follow infection prevention protocols when they go to facilities. The Administrator identified that the facility has cameras that reset within 24 hours and would check the availability of the footage for viewing.Interview on 7/28/25 at 12:46 PM with APRN #1 identified that she observed the Podiatrist leave one resident room and wheel himself across the hallway while seated on a stool. She noted that she did not know if the Podiatrist had performed hand hygiene and/or changed his gloves prior to entering the room, but noticed he exited a resident with gloves on. APRN #1 identified that after observing the above, she notified the Administrator about the Podiatrist's infection control practices.Interview on 7/29/25 at 10:00 AM with the DNS identified that contract staff sign the contract that the facility has with the contract agency (the Podiatrist office) and they agree to abide by infection prevention protocols. The facility does not provide education or training for the contracted staff. The DNS further indicated she spoke with the podiatry office and reported the incident. Interview on 7/29/25 at 10:31AM with the Chief Executive Officer of the contracted company providing podiatric services to facility residents (Person #5) identified that the expectation of providers who provide care to residents in the nursing home is to follow OSHA (Occupational Safety and Health Administration) and CDC (Centers for Disease Control) guidelines. Person #5 indicated that providers should remove their gloves between residents and perform hand hygiene and don a clean pair of gloves prior to providing care to the next resident. Person #5 identified all Podiatrists have an OSHA certification but that the company does not have any of the Podiatrist's trainings or certifications but offered to send the Podiatrist's resume as proof of experience. In addition, Person #5 identified the company confirms experience and references and check for an active license and proof of malpractice insurance. Person #5 indicated Podiatrists are supplied with a disinfection tray for disinfecting equipment and described a rectangular shaped compartment that has a tray on the inside and indicated the instruments should be fully submerged and the instruments should be rotated between patients. Person #5 identified the company supplies Sani wipes for the rotary tool and as long as there is no pus or blood on the tools they can just be wiped with the Sani wipes and indicated that she was unsure if wiping the head of the rotary tool with dry gauze was an effective cleaning practice.Review of the CDC guidelines for infection prevention for outpatient podiatry settings identified that hand hygiene should be performed before and after removing personal protective equipment (PPE) and that PPE should be removed before exiting the patient environment. Additionally, the guidance indicates that reusable medical devices (cuticle and nail nippers, forceps) should be cleaned and reprocessed prior to use on another patient, visually inspect reusable medical devices for residual soil prior to disinfection or sterilization, use enzymatic cleaner or detergent and discard according to manufacturer instructions and disinfect devices for the appropriate length of time, at the appropriate temperature and appropriately rinsed after high level disinfection (HLD), all as specified by manufacturer instructions.Interview on 7/29/25 at 5:20 PM with the Administrator and the DNS identified that when the concern with the Podiatrist was brought to her attention, she had the Infection Preventionist ask the Podiatrist to leave the facility, and the Administrator contacted the podiatry company. Review of the podiatry summary with the DNS confirmed that the Podiatrist provided podiatric services to twenty-five residents. She further noted that she was unaware that the podiatrist provided care to a resident with a diagnoses of Hepatitis C, and a resident with an active (continued on next page)

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	075419	A. Building B. Wing	08/26/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fungal infection who was not a candidate for oral medications. She further noted that the Podiatrist should have worn PPE (gown) when providing care to residents with enhanced barrier precautions in place.Interview on 7/30/25 at 9:32 AM with the Infection Preventionist (LPN#1), and the ADNS identified that general precautions for care and hygiene was that any contact would be to perform hand hygiene and use gloves. LPN #1 indicated that any equipment being used should be cleaned before and after care and that gowns and gloves should be worn with direct contact in the EBP rooms. LPN #1 indicated that when she was notified on 7/24/25 of the concern with the Podiatrist, he had already left the building for the day. The ADNS identified that the residents seen by the Podiatrist were being monitored and that the Podiatrist was not returning to the facility in the future. LPN #1 identified that changing gloves, hand hygiene and cleaning equipment was the standard practice in place to prevent the spread of organisms between residents.The hand hygiene policy identified that hands should be cleansed before and after resident care, after contact with any blood or body fluids and after handling any contaminated items. Additionally, the policy directed use of the alcohol hand sanitizer after contact with intact skin, after removing gloves, before entering and exiting resident rooms.The Infection Prevention Program identified that enhanced barrier precautions (EBP) require the use of gown and gloves for certain residents during specific high-contact resident care activities which include the provision of hygienic care. The policy further noted that resident's on EBP with have signage posted on the door or wall outside of the resident room.Facility policy for diabetic foot care identified the service of a Podiatrist is utilized for diabetic residents who have calluses, thickened toenails or pressure areas.The provider policy for sterilization/high-level disinfection identified a specific disinfectant to be used for the immersion disinfection of reusable instruments. The policy identified for non-soiled instruments, or instruments with no pus or blood, the instruments should be fully submerged in the disinfectant, the instruments should be rotated between patients and that soiled instruments must be removed from rotation.The provider policy for cleaning, disinfection, sterilization and procedure identified that all reusable instruments, equipment and used surfaces will be decontaminated, disinfected or sterilized prior to use on a patient. The policy indicated that all personnel/staff will follow the hand hygiene policy. The policy identified the cleaning of non-critical patient care items, or all non-disposable patient care equipment shall be cleaned the same regardless of the patient's infection status. The policy indicated the exam/treatment rooms of patients with MDROs, the amount of non-disposable equipment taken into the room shall be limited as much as feasible and identified the items will be cleaned and disinfected using a low to intermediate level disinfectant before taking them out of the room.

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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** Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 1 of 4 sampled residents (Resident #113) reviewed for pressure ulcers, the facility failed to ensure an assessment was completed upon identification of a pressure ulcer. The findings include:Resident #113 was admitted to the facility on [DATE] with diagnoses that included lack of coordination, type 2 diabetes mellitus with chronic kidney disease, and dementia. The care plan dated 7/9/25 identified Resident #113 was at risk for skin breakdown related to anticoagulant use with interventions that included: administer pressure relieving devices as ordered, apply house lotion as needed, apply treatments as ordered, dietary consult as needed, turn and reposition per facility policy, weekly skin checks by licensed nurse.The admission assessment dated [DATE] identified a new skin issue on the buttocks, denuded (the loss of the outermost layer of skin) skin wound measurements not documented. Review of Braden Assessment from 7/9/25 identified a score of 18 indicating a mild risk for skin impairment. Physician's order dated 7/9/25 directed coccyx apply barrier cream twice daily and after incontinent care as needed for redness after incontinent care.The admission MDS assessment dated [DATE] identified Resident #113 was cognitively intact, had no behaviors, required supervision with bed mobility, substantial/maximal assistance with transfers, partial/moderate to substantial assistance with dressing and partial/moderate assistance with personal hygiene. The assessment further identified that the resident utilized a walker and wheelchair for mobility and was at risk for pressure ulcers however had zero pressure ulcers. The assessment further identified the resident utilized a pressure reducing device on chair, and pressure-reducing device on bed.Physician's order dated 7/9/25 directed body audit weekly on shower days every evening shift every Wednesday update MD/APRN if new skin issues noted. Physician's orders dated 7/14/25 directed to cleanse the coccyx wound with warm soapy water, pat dry. Apply house barrier cream every shift and as needed for redness if soiled or saturated for moisture associated skin damage (MASD). Physician's order dated 7/16/25 directed: air mattress check for placement and proper settings every shift between 145-155 for coccyx wound.Physician's order dated 7/16/25 directed: coccyx cleanse with warm soapy water, pat dry. Apply calcium alginate followed by dry clean The nurse's noted dated 7/16/25 at 2:17 PM identified Resident #113 had a skin injury to the coccyx and was seen by the wound nurse, the APRN was notified, and the resident had an air mattress in place and functioning. Review of Pressure Ulcer List provided by the facility identified Resident #113 had a facility acquired Stage 3 pressure ulcer to the buttocks that started on 7/16/25.Review of Wound Physician/Provider notes identified the first assessment of the wound was on 7/22/25 by the Wound MD who staged it at a Stage 3 Coccyx pressure wound measuring 1.1 cm x 0.6cm x 0.2cm. Interview on 7/31/25 at 2:00 PM with Wound nurse/Infection Control LPN#1 identified she was made aware of the pressure wound on 7/16/25 when therapy was with Resident #113 in the bathroom. Therapy called the Wound Nurse to come look at the wound where she identified there was a wound on the Coccyx. No measurements were made at the time of identification due to the fact the resident was soiled; however, she did not return after the resident was cleaned up to make the initial wound measurements. She notified the APRN of the area and received an initial order for the mattress and treatment to be started and put the resident on the to be seen wound MD list for the following week. LPN#1 identified that wounds should be assessed upon identification and that is usually done by the RN/supervisor however when she was made aware she notified the APRN not the supervisor. Once the patient would be seen by the wound MD they would be responsible for the staging of the wound. The air mattress also was not started until the wound started on 7/16/25 due to the fact they don't typically put an air mattress in place for residents unless they are low in their weight or hospice. LPN#1's oversight is by the ADON. Review of skin observation by LPN#2 on 7/16/25 identified Resident #113 refused. Review of twenty-four-hour report for 7/16/25 and 7/17/25 failed to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identify an alteration in Resident #113's skin. Interview on 7/31/25 at 2:00 PM with Resident #113 identified she/he has not refused her/his bottom being seen by anyone since she/he been admitted . Interview on 7/31/25 at 2:25 PM with the DON identified an assessment should be completed upon the identification of a new pressure wound or change in skin. Interview on 7/31/25 at 2:35 PM with the ADON identified her job is to co-sign what is done by the wound nurse/infection control LPN# 1 and does rounding sometimes with the wound physician. Once a wound is identified an assessment should be completely immediately and then weekly going forward unless it is being followed by the wound clinic. The wound nurse does the tracking of the wounds in house and her job is to audit what she is doing and sign off on it. She was never requested to assess Resident #113 on 7/16/25 when the pressure area was identified and does not recall when she was initially notified of the area. Interview on 7/31/25 at 2:40 PM with APRN#1 identified she does order treatments when notified of a change in skin and will look at it if she is made aware of it while in the building, otherwise the wound physician is the one who is managing the orders/treatment and sees the wounds. If she does see the wound and was in house when notified she would put an assessment note in the medical record. Observation on 7/31/25 at 3:10 PM identified a healing pressure ulcer on the coccyx dark pink in color covered by a dry dressing with granulation noted. Review of Pressure Ulcers Skin Breakdown policy directed the nursing staff, and practitioner will assess and document an individual's significant risk for developing pressure ulcers and examine skin for evidence of pressure ulcers and other skin conditions. Review of the body audit policy directed any change in skin will be reported to the charge nurse or supervisor. Newly identified areas will be investigated and documented. Documentation will include measurements, and details of the wound and or skin change.

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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** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of six sampled residents (Resident #53) reviewed for accidents, the facility failed to supervise a resident who exhibited wandering behaviors and was at risk for elopement. The findings include:Resident # 53's diagnoses included dementia, anxiety, depression, adjustment disorder, restlessness and agitation.The elopement evaluation dated 4/28/25 identified Resident # 53 was at risk for elopement.The care plan dated 5/27/25 identified Resident #53 was at risk for wandering and elopement with interventions that included: clearly identify the resident's room and bathroom, engage the resident in activity, and re-direct when noted self-propelling in the wheelchair outside the unit, supervision with wheelchair mobility. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #53 had moderate cognitive impairment, required supervision with wheelchair mobility and had not displayed wandering behavior within the past seven days. The note written by RN #1 dated 7/26/25 at 9:32 PM identified that she received a call from a visitor who had assisted Resident #53 from outside the front door back inside the facility. RN #1 identified that Resident #53 was sitting calmly in the lobby when she arrived. In addition, RN #1 identified that a wander guard (alarm) was applied to his/her wheelchair, and the resident was placed on visual checks to be conducted every 15 minutes. The revised RCP dated 7/26/25 identified Resident #53 had a wander guard placed on the wheel chair, check function of the wander guard every night, check the placement of the wander guard on the wheel chair every shift, and check resident every 15 minutes.Review of the timeline of Resident #53's elopement on 7/26/25 via recorded camera footage with the DNS on 7/30/25 at 1:45 PM identified the following:At 7:51 PM; Resident #53 was seated in his/her wheelchair in the front lobby and pushed the bar to open the front door, there were no other staff or residents in the lobby at the time. At 7:54 PM; Resident #53 was able to push the first set of doors open (there are two doors to access the lobby from outside and vice versa. At 7:57 PM; Resident #53 was able to exit the second door leading outside. The camera footage showed Resident #53 self-propelling his/her wheelchair toward the right side of the building. At 7:58 PM; Resident #53 was outside of the viewing capacity of the camera.At 8:02 PM; a female visitor was seen walking out of the facility.At 8:04 PM; Resident #53 was brought back to the front lobby by the female visitor. Interview with RN #1 on 7/29/25 at 9:45 AM identified that she received a phone call from a visitor on 7/26/25 and the visitor conveyed Resident #53 was sitting alone in a wheel chair outside near the front door. She also identified that it was between 7:30 PM to 8:00 PM when she received the call. She identified that the front door was already locked because the receptionist leaves at 6:00 pm and locks the front the door. She also identified that visitors and/or residents could go out the front door by pressing the disabled button to open the front door. She identified that Resident #53 was already inside the front lobby when she came down and identified that Resident #53 was calm and cooperative at that time. She identified that Resident #53 was able to self-propel independently while sitting in the wheelchair and only required supervision. She identified that Resident #53 did not have a wanderguard in place at the time and was not sure whether Resident # 53 should have had a wanderguard at that time. She identified that Resident #53 had cognitive impairments and should not be alone outside the facility without staff supervision. Interview with Person #1 on 7/29/25 at 12:10 PM identified he/she received a call from RN #1 on 7/26/25 who conveyed Resident #53 had exited the facility through the front door and was observed sitting alone outside. She identified that Resident #53 had dementia and should be supervised at all times. Interview with the ADNS on 7/30/25 at 11:45 AM identified that all residents are assessed for elopement risk upon admission, re-admission, quarterly, and/or change of condition. When the resident assessment indicates at risk for elopement, a wanderguard is placed on the resident. She identified that Resident #53's elopement risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment on 4/28/25 indicated he/she was at risk for elopement. She identified that the delivery door and the front door were both equipped with a wanderguard alarm system and when activated, it will be heard at the first-floor nursing station. She identified that Resident #53 had a history or attempt to leave the facility, and a wanderguard was used with Resident #53. She identified that Resident #53's responsible party had removed the wanderguard from the resident and would like to place the wander guard alarm on the wheel chair. She could not identify why Resident #53 did not have a wanderguard alarm on the wheel chair. Interview with the DNS on 7/30/25 at 1:15 PM identified that all residents who are at risk for elopement will have a wanderguard placed unless a resident resides on the secured dementia unit. She identified that Resident #53 was identified at risk for elopement on 4/28/25 but did not have a wanderguard in place because even though Resident #53 was at risk for elopement, he/she did not have a current episode of elopement or recent attempt to elope from the facility. She identified that the wanderguard was removed by a family member and Resident #53 wandered within the facility and had never verbalized wanting to go home and/or to go out the facility. She identified that Resident # 53 did not have attempt to leave the facility since the wander guard had been removed. She identified that she had received a call from the nursing staff that Resident #53 was noted outside the facility on 7/26/25 and she had reviewed the facility camera and identified that Resident #53 was outside the facility for a total of 7 minutes. She identified that she did not report the elopement to the state agency because she did not consider the incident an elopement. She also identified that she was not sure whether the nursing staff was aware that Resident #53 was sitting alone in the lobby at that time but, she identified in the facility camera that there was no staff in the lobby when Resident #53 exited the facility.The facility Elopement policy identified that all residents will be assessed for elopement risk upon admission, re-admission, quarterly, or upon a significant change in condition and for those who display new behavior or attempts to elope. The elopement at risk assessment identified resident risk factors such as previous attempt at elopement, dementia diagnosis, cognitive impairment, and making repeated statements that infer dissatisfaction with facility placement. Any residents who are at risk for elopement will have an individualized comprehensive care plan developed.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one of five sampled residents (Resident #25) reviewed for vaccinations, the facility failed to offer or provide the pneumococcal #20 vaccination. The findings include: Review of the Infection Preventionist's (LPN #1) vaccine line list identified Resident #25 received the pneumococcal #23 on 10/31/20. There were no other noted pneumococcal vaccines listed as administered.A physician's order dated 12/24/24 directed to administer the pneumococcal vaccine. Resident #25's Pneumonia Vaccine Education Documentation Form, indicated the resident elected and agreed to receive the pneumococcal vaccine PVC #20, dated 12/29/24. A physician's order dated 1/21/25, directed to administer the Prevnar #20 intramuscular suspension prefilled syringe 0.5ml, inject 0.5ml intramuscularly as needed for vaccine. Resident #25 was readmitted (original admit date was 12/24/24) to the facility in March of 2025 and had diagnoses that included a history of MRSA (methicillin resistant staphylococcus aureus-multi-drug-resistant bacteria), chronic kidney disease and bipolar disorder. A physician's order dated 3/19/25 directed to administer the pneumococcal vaccine. The quarterly MDS assessment dated [DATE] identified Resident #25 was moderately cognitively impaired, had no behaviors, and indicated the pneumococcal vaccine was offered and declined. The significant change in status MDS assessment dated [DATE], identified Resident #25 was moderately cognitively impaired, had no behaviors and indicated Resident #25's pneumococcal vaccination was up to date.Interview on 7/29/25 at 11:18 AM with the ADNS and IP, indicated the IP was doing catch up had been the IP nurse at the facility for about a year now. The admission consent forms are utilized indefinitely, no additional consents for vaccinations are required. The residents on the short-term units are reviewed for vaccinations first/ASAP, as their stay at the facility is shorter. The facility does not have all the vaccinations in house. They are ordered resident specific. The only two vaccinations kept in house are the Flu and Covid vaccinations during those seasons. According to the ADNS, the consent forms provided upon admission, for vaccinations and care, have to be signed by the resident or resident's designated person. No additional signature was required. All consents should be signed. No care or vaccinations should ever be administered without consent or signatures. Interview on 7/31/25 at 10:39 AM with the ADNS and IP indicated the facility had been using a different electronic medical record system (EMR) last year and the change occurred around February of 2024. The ADNS then proceeded to review the immunization records in the older EMR and was able to provide further information regarding the other selected resident's vaccination statuses. The new search did not find any offering or documentation regarding Resident #25 being offered the pneumococcal #20 or declining it. According to the CDC Pneumococcal Vaccine timing recommendations (prior vaccines-complete pneumococcal vaccine schedules) for adults over [AGE] years of age, Resident #25 was eligible for the #20 pneumococcal vaccination 1 year after receiving the pneumococcal #23.Review of the Vaccine Administration Guidelines policy, directed, that residents are offered the pneumococcal vaccination. The resident or responsible party signs an informed consent, which documents education on the risks/benefits, of the vaccination and the licensed nurse will document education was provided, manufacturer of the vaccine, lot number, lot expiration date and date and site of administration. It also indicated the infection preventionist nurse to maintain a current list of residents who have received the pneumovax.

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F 0940 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of facility policies and procedures and interviews for the facility reviewed for training requirements, the facility failed to ensure that an effective training program was developed, implemented, and maintained for all individuals providing services under a contractual arrangements met the multiple training topic requirements prior to, and while providing ongoing services in the facility according to the facility assessment and regulatory guidance. The findings included:On 8/25/25 at 10:10 AM a request was made to the facility for the education/training documentation to include communication training, resident rights training, Abuse, neglect, and exploitation training, QAPI training, Infection control program training, Compliance and ethics training, nurse aide training, and behavioral health training for all individuals providing direct and indirect services under a contractual arrangements to facility residents. The facility was only able to provide education and training documentation for the mentioned topics for two contracted agencies that provided nursing and nurse aide staffing, but failed to provide any documentation of education or training for other contracted agencies who provided direct and indirect care to facility residents. Interview on 8/25/2025 10:10 AM with the Administrator and Assistant Director of Nursing (ADNS) identified the facility obtained contractual services for podiatry, ophthalmology, audiology, wound care, psychiatry, nursing services, provider services, Hospice, laboratory, pharmacy and radiology services. The Administrator indicated that contractual agency nurses and nurse aide staff are the only contractual staff who received training, prior and ongoing, as listed in the facility assessment. The trainings are maintained by the contracted staffing agencies for the nurses and NAs. If the required training is not completed, the nurses and nurse aide agency staff are not able to pick up shifts to work at the facility. The Administrator further identified that the contract staff, such as providers, in the building are instructed to follow direction of the facility staff in the event of an emergency. Interview on 8/25/25 at 12:01 PM with the medical director identified he started working at the facility a little over a year ago and was not aware that he or contracted staff had to provide, or should have received education on communication, resident rights, abuse, neglect, and exploitation, QAPI, infection control, behavioral health or compliance and ethics from the facility. The medical director identified that he has to complete ongoing education to renew his licensure and was never asked to provide proof of continued education to the facility. The medical director indicated that he received a general orientation of the building and was introduced to staff. Interview on 8/25/25 at 2:15 PM with APRN#2 identified she is a contracted provider and had not received any education or training specific to the facility from the facility. APRN#2 indicated she was not directed to provide the facility with any education or training related to behavioral health, abuse, neglect and exploitation, resident rights, infection control, QAPI, emergency procedures and indicated she had long term care experience and had knowledge of these topics.Interview on 8/26/25 at 10:46 AM with the Administrator and the DNS identified they were not aware that contracted providers were to receive mandatory education to include communication, resident rights, abuse, neglect, and exploitation, QAPI, infection control, behavioral health or compliance and ethics, by the facility or that the facility should maintain records of education for the contracted providers on the related topics prior to and while independently providing services in the facility. The DNS and the Administrator indicated that each practitioner was expected to have knowledge of and be educated in those topics as the facility only offered specific general orientation to the facility to include touring of the building, where the restrooms were, who was in charge and contact information for supervisors and administration. The administrator indicated that the contractual staff was not listed in the training plan and that no staff at the facility follows up or verifies education and training requirements for the contracted providers with exception of the nursing and nurse aide staffing agencies and volunteers. The Administrator (continued on next page)

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F 0940 Level of Harm - Potential for minimal harm Residents Affected - Many	indicated there was not a facility staff member responsible for providing education to contracted provider staff. The administrator identified the facility only tracks credentials of the contracted providers.Interview on 8/26/25 at 11:45 AM with the administrator and the DNS identified they were part of the development and updating the facility assessment annually as part of the governing body. The administrator identified that she reads the assessment over and makes changes as the needs arise. The administrator then reviewed the training plan section in the facility assessment then identifying that the training plan did outline that the facility would provide mandatory education to contracted individuals and indicated the facility administration must have overlooked that. The facility assessment dated [DATE] identified under the training plan section that training had a described length, frequency and a training mechanism for mandatory training of new and existing employees, contracted individuals, and volunteers, in all of the following required areas:a. Effective communicationb. Resident Rightsc. Abuse, Neglect, and Exploitationd. Quality Assurance and Performance Improvemente. Infection Controlf. Compliance and Ethicsg. Nurse aide competencyh. Behavioral healthi. Non-pharmacological interventionsj. Dementia CareAlthough the required areas listed above outlined length, frequency and training mechanism for new and existing employees, the facility assessment failed to outline the same parameters for contracted individuals and volunteers. In an interview with the Administrator on 8/26/25 at 11:45 AM identified the facility assessment did not address the length, frequency or mechanism of training for the contracted individuals and volunteers providing direct and indirect services to the facility residents but indicated it was a facility practice to provide the volunteers mandatory training education with orientation and annual education if they were in the facility for that length of time even though it was not mentioned in the facility assessment.Facility education policy identified the facility must develop, implement, and maintain an effective training program for all new and existing staff and volunteers. A facility must determine the amount and types of training necessary based on a facility assessment. Education will be provided to all staff and volunteers as required by state regulation for skilled nursing ability and special care dementia unit. Additional or interim education provided as needed based on facility need, customer feedback, QAPI projects, outcome data, observation, surveillance and any deficient practices identified. Additional in services will be provided for any new facility initiatives or quality improvement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075419	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwoods of Farmington	416 Colt Highway Farmington, CT 06032

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 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews for one of five sampled residents (Resident #6) reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to obtain and complete the PASARR level II screen after the resident received a qualifying diagnosis. The findings include: Resident #6's diagnoses included paranoid schizophrenia, bipolar disorder, depression, and obsessive-compulsive disorder. The quarterly MDS assessment dated [DATE] identified Resident #6 had intact cognition and required extensive assistance for bed mobility, transfers, toileting and hygiene. Interview with SW #1 on 7/31/25 at 9:45 AM identified that the social workers are responsible for submitting requests for a Level II PASARR screening when there is a qualifying diagnosis that was not known when the resident was admitted to the facility. She identified that Resident #6 had new diagnoses of paranoid schizophrenia and bipolar disorder on 1/25/22, which would require a PASARR level II screening to be completed. She identified that she was not employed by the facility at the time the new psychiatric diagnoses were made. SW #1 could not identify why there was no PASARR level II screen completed for Resident #6. She further identified that she audited all long-term residents' medical diagnoses to ensure all residents who had qualifying psychiatric diagnoses had an appropriate PASARR level II screening and assessment completed. She further noted that she was in the process of submitting a PASARR level II screening for Resident #6. Although requested, a facility PASARR level II screen policy was not provided.