STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075420	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit at Plantsville Center for Health & Rehabili	261 Summit Street Plantsville, CT 06479

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, review of facility documentation, review of facility policies and procedures, and interviews, the facility failed to ensure that environmental rounds were conducted/completed monthly, the facility failed to ensure the monthly Infection Control Surveillance data collection reports were inclusive of all infections identified within the facility and the facility failed to identify a possible communicable disease/outbreak amongst residents and for 3 sampled residents (Residents #150, #46, #116) reviewed for dining, the facility failed to ensure infection control practices were followed in the dining room. The findings include: 1. Review of the infection control environmental round documentation for the period of January 2024 to August 2025 failed to identify the monthly environmental rounds that were completed for the months of January, February and March of 2024. Review of the environmental rounds provided by the facility with the Infection Preventionist (IP) Nurse (LPN #2) on 9/10/25 at 12: 23 PM identified the monthly environmental rounds were not completed for January to March of 2024. Interview with LPN #2 on 9/10/25 at 12: 23 PM identified she was unable to locate the months of January, February and March in 2024 in the binder. She identified the environment rounds are conducted monthly with the housekeeping director, the Infection Preventionist, Administrator, food service/dining, and Maintenance Director to complete a cumulative report. LPN #2 identified it was the responsibility of the previous IP nurse to ensure they were conducted as she had only started in the role of an IP at the facility in April 2024. Review of the Environmental Rounds policy identifies rounds will be conducted monthly by the Infection Prevention Committee and appropriate department heads and the environmental rounds tool checklist will be completed for each area of the building as it is surveyed. The committee, at a minimum, consists of the Administrator, Infection Control Nurse, Housekeeping supervisor, environmental/maintenance supervisor and food service supervisor. Review of the infection control program for the period of November 2024 to August 2025 failed to identify on the monthly infection surveillance reports any resident who had an infection and were not treated with an antibiotic. Interview and review of the facility documentation with the Infection Preventionist (IP) Nurse (LPN #2) on 9/10/25 at 12: 23 PM in the presence of the ADNS identified facility had a COVID-19 outbreak which occurred in April 2025 and none of the residents who were affected was identified on the April infection control surveillance report. LPN #2 identified she only tracks the residents who are treated with antibiotics on her reports. LPN #2 indicated if residents had any symptoms of an infection the nurse would document in the resident's individual chart, but she does not track those residents. LPN #2 identified in the past when she was using paper documentation, she would track residents who were treated with antiviral but since they went electronic, she had stopped. LPN #2 identified she (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was responsible for tracking all infections within the facility and document the infections. Interview with the DNS on 9/10/25 at 1:51PM in the presence of the Corporate Clinical Nurse (RN #3) identified she was unaware that the IP nurse was not tracking residents with respiratory symptoms or any other symptoms of infections that were not treated with an antibiotic. The DNS identified the IP should be tracking all infections in the facility not only the ones that are been treated with antibiotics. Review of the Infection Surveillance policy identifies the infection surveillance process includes data collection which is conducted by a trained infection preventionist either concurrently or retrospectively, based on the situation. The policy further identifies the source of the data: resident electronic health records, laboratory reports, incident and infection logs device utilization data. In addition, the policy identified infection to monitor includes ventilator-associated pneumonia, respiratory tract infections, urinary tract infections, bloodstream infections gastrointestinal infections and skin and soft tissue infections. Review of the facility monthly infection report for the month of July 2025 identified a total of 16 cases of facility acquired respiratory tract infections. The facility had a total of 5 units with 3 of the 5 units being affected, with one unit having a total of 9 cases. Review of the Infection Control Data Collection tool McGeer (criteria tool used to identify infections) of each identified case on the July 2025 monthly infection surveillance tracking identified the following: Resident #1 McGeer data collection dated 7/18/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #1 had symptoms of new/increased cough, new or changed in lung examination abnormalities, a chest x-ray which demonstrated pneumonia or the presence of a new infiltrate and leukocytosis with the infection/symptom beginning on 7/16/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #1 further identifies in the section which asked if the infection was reported to the local public health agency with a response of no, not reportable. Resident #26 McGeer data collection dated 7/10/25 identified was suspected of having a potential infection of lower tract infection. Resident #26 had symptoms of new/increased cough, and functional decline with the infection/symptom beginning on 7/7/25. The McGeer data collection for Resident #26 further identifies in the section which asked if the infection was reported to the local public health agency with a response of no, not reportable. Resident #39 McGeer data collection dated 7/18/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #39 had symptoms of new/increased cough, pleuritic chest pain, a chest x-ray which demonstrated pneumonia or the presence of a new infiltrate, leukocytosis, and acute functional decline with the infection/symptom beginning on 7/17/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #39 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #59 McGeer data collection dated 7/18/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #59 had symptoms of new/increased cough, new or increased sputum production, new or changed in lung examination abnormalities, a chest x-ray which (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	demonstrated pneumonia or the presence of a new infiltrate, acute change in mental status from baseline and acute functional decline with the infection/symptom beginning on 7/18/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #59 further identifies in the section which asked if the infection was reported to the local public health agency with a response of no, not reportable. Resident #67 McGeer data collection dated 7/2/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #67 had symptoms of new/increased cough, new or changed in lung examination abnormalities, a chest x-ray which demonstrated bilateral infiltrates with the infection/symptom beginning on 7/1/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #67 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #68 McGeer data collection dated 7/7/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #68 had symptoms of new/increased cough, new or increased sputum production, a chest x-ray which demonstrated atypical pneumonitis, and acute functional decline with the infection/symptom beginning on 7/2/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #68 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #82 McGeer data collection dated 7/29/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #82 had symptoms of new/increased cough, new or changed in lung examination abnormalities, a chest x-ray which demonstrated opacities in lung bases, and acute functional decline with the infection/symptom beginning on 7/28/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #82 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #85 McGeer data collection dated 7/21/25 identified he/she was suspected of having a potential infection of COVID-19. Resident #85 had symptoms acute functional decline with the infection/symptom beginning on 7/17/25 wherein resident went to the hospital on 7/17/25 and was diagnosed with COVID and returned to the facility in the evening. The McGeer data collection for Resident #85 further identifies in the section which asked if the infection was reported to the local public health agency with a response of yes. Resident #89 infection McGeer nurses note dated 7/15/25 identified he/she had a respiratory infection and had a dry cough. Resident #94 McGeer data collection dated 7/4/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #94 had symptoms of new/increased cough, new or increased sputum production, a chest x-ray which demonstrated bilateral infiltrates, and new or changed in lung examination abnormalities with the infection/symptom beginning on 7/3/25. The McGeer data collection for Resident #94 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #103 McGeer data collection dated 7/5/25 identified was suspected of having a potential infection of upper respiratory infection. Resident #103 had symptoms of stuffy nose or nasal congestion and dry cough with the infection/symptom beginning on 7/4/25 which met criteria. The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	McGeer data collection for Resident #103 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #109 McGeer data collection dated 7/18/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #109 had symptoms of new/increased cough, new or increased sputum production, new or changed in lung examination abnormalities, acute functional decline, leukocytosis, and a chest x-ray was done which demonstrated no acute disease process with the infection/symptom beginning on 7/15/25. The McGeer data collection for Resident #109 further identifies in the section which asked if the infection was reported to the local public health agency with a response of no, not reportable. Resident #120 McGeer data collection dated 7/10/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #120 had symptoms of new/increased cough, a chest x-ray which demonstrated faint right basal infiltrate, and acute functional decline with the infection/symptom beginning on 7/9/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #120 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Resident #151 McGeer data collection dated 7/6/25 identified he/she was suspected of having a potential infection of pneumonia. Resident #151 had symptoms of new/increased cough, new or increased sputum production, new or changed in lung examination abnormalities, pleuritic chest pain, a chest x-ray which demonstrated right middle lobe infiltrate, and acute functional decline with the infection/symptom beginning on 7/6/25 which met the criteria of pneumonia infection. The McGeer data collection for Resident #151 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Review of Resident #154's clinical records identified a nurse's note dated 7/6/25 at 2:21 PM by the ADNS identified Resident #154 had worsening cough this shift, audible inspiratory and expiratory wheeze throughout lung, positive for shortness of breath and productive cough with green sputum. The note further identified the resident had new order for a chest x-ray and labs to be completed as soon as possible, viral respiratory panel and monitor respiratory status. Resident #55 McGeer data collection dated 7/2/25 identified he/she was suspected of having a potential infection of the lower respiratory tract. Resident #155 had symptoms of new/increased cough, new/increase sputum production, new or changed in lung examination abnormalities, fever, and leukocytosis with the infection/symptom beginning on 7/1/25. The McGeer data collection for Resident #155 further identifies in the section which asked if the infection was reported to local public health agency with a response of no, not reportable. Review of the Trend and Track Healthcare Acquired Infection Rates/MDRO Variance Analysis report identified the rate of pneumonia infections in July/2025 was 2.05 and in June/2025 the rate was 1.64, showing an increase in the rate from the previous month. The report also identified an increase in lower respiratory tract/bronchitis infections July/2025 (1.59) than in June/2025 which had a rate of 1.17. A line list was requested for the increasing facility acquired respiratory tract infections in July/2025 but was not provided by the facility. The DNS identified she could not recall a line list was initiated at the time of the increase. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the Infection Preventionist (IP) (LPN #2) on 9/9/25 at 11:54 AM identified the facility had an increase rate of respiratory infections especially pneumonia in July 2025. However, she would not have reported/thought the pneumonia infections as an outbreak. The IP identified the increasing respiratory cases in July was out of the normal occurrence for respiratory illnesses, with a few cases starting in June 2025 but majority of the cases were in July/2025. Interview with LPN #2 and the ADNS on 9/10/25 at 12:23 PM identified a line list would have been started if the residents met the criteria of an outbreak. They were then asked what the facility criteria for outbreak is, which they reviewed the outbreak policy and responded based on the policy and reviewing of the documentation the facility did have an outbreak. The ADNS and LPN #2 identified the increase in respiratory illness was discussed during morning report and they decided to keep the resident on the unit, implement surgical mask usage on the units by staff, extra cleaning by housekeeping staff and provided education on hand hygiene to staff. LPN #2 and the ADNS indicated they treated the increase respiratory infections as an outbreak, however, did not consider this incident as an outbreak. LPN #2 identified testing for Legionnaires disease was not considered or completed with the increasing facility acquired pneumonia cases. The ADNS further indicated she was told yesterday she was responsible for overseeing the IP infection control responsibilities and not only just the wound portion of the IP's role. The ADNS and IP identified they could not recall if their regional staff who would provide guidance in determining if the facility was experiencing an outbreak was contacted during the increasing facility acquired respiratory tract illness. Interview with the DNS on 9/10/25 at 1:51PM in the presence of the Corporate Clinical Nurse (RN #3) identified when the increase in respiratory cases was discussed during morning report, she stopped communal activities but had not initiated a line list to be completed. The DNS identified they had no line list completed, and the facility had not reached out to their corporate IP for guidance during the time of the increase as to identify the facility had an outbreak. Review of the At-Risk Meetings dated 7/2/25 and 7/18/25 failed to identify the increase in cases of respiratory infections/illnesses. Review of the weekly Medical Director Rounds conducted identified on 7/2/25 indicated antibiotic use was reviewed; on 7/16/25 indicated infection control report was reviewed and on 7/23/25, indicated antibiotics report was reviewed. The rounds failed to indicate any discussion regarding a respiratory outbreak, increase in respiratory illnesses and measures implemented to reduce or prevent further cases. Review of the Outbreak management policy identified an outbreak is defined as three (3) or more cases of clinically significant, facility acquired infections caused by the same organism occurring in the same general area within a period of seven (7) das OR twice the average number of these infections per month observed for three (3) consecutive months OR two or more with nosocomial cases of non-aspiration pneumonia within a 10-day period will be reviewed as a potential outbreak, consider testing for Legionnaires. The policy further identified when a commonality of symptoms is evident among residents or staff who have other factors in common such as person, place, time or event, suspect an outbreak. In addition, the policy identifies to notify state and local health officials as required by public health codes or ordinances, report excess illnesses and new or unusual infections to public health agencies as soon as possible. 2. Observation on 9/3/25 at 11:45 AM identified Resident #150, 46 and 116 in the dining room awaiting lunch service. At 11:50 AM lunch service arrived from the dietary staff with two carts wheeled to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dining room. LPN#7 and NA#3 along with three other staff started to serve the residents in the dining room. Trays were unloaded from both carts. LPN#7 helped to push Resident#46 closer to the food and then started to cut the chicken sandwich in half placing one bare hand on the chicken sandwich to steady it while cutting with the other hand. NA#3 at the same time asked Resident #150 if she would like the bread buttered. NA#3 then proceeded to butter the bread holding the bread with her bare hand and buttering with the knife. Following the assistance given to Resident #150 NA#3 went back to the second dining storage cart and closed the door then returned to a different table where Resident #116 was seated. NA#3 then proceeded to butter Resident #116's bread handling the bread in her bare hand. Interview on 9/3/25 at 12:28 PM with LPN#7 identified that it was not a clean practice to touch the food with her bare hands as well as helping residents and that it could be an infection control issue and that she should have washed her hands before touching the food and probably should have worn gloves. Interview on 9/3/25 at 12:35 PM with NA#3 identified that she should not be touching the residents' food with her bare hands. She further noted that she should wash her hands before providing assistance with food. She further noted that she does not wear gloves in the dining room. Review of the Food Safety policy identified food, and food service supplies are procured, handled, prepared, stored, distributed, served, and disposed of in accordance with professional standards for food service safety (e.g., FDA food Code and CDC Food Safety guidance) to minimize the risk of and/or prevent contamination and foodborne illness.

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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. Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure expired medications were removed from the medication carts and not in use, failed to ensure multiple use vials were labelled upon opening to ensure they were discarded after 30 days. The findings include:Observation with LPN #5 on 9/8/25 at 11:53 AM identified the medication cart on the secured unit contained the following outdated medications: a bottle of aspirin 81mg with no expiration date a bottle of calcium 600 plus D5 mcg with an expiration date of 7/2025, there was a noted date of 8/31/25 that identified the bottle was opened on that date (post expiration date) 4 multi-use vials of Lidocaine 1% that were not marked with an opened date Interview on 9/8/25 at 12:12 PM with LPN #5 identified that the vials should be marked with the date opened. LPN#5 identified the facility had night shift staff delegated to check expiration dates but indicated that it was the responsibility of the nurse managing the medication cart to check expiration dates. Observation with LPN #7 on 9/8/25 at 12:37 PM identified the 1st floor medication cart contained an expired resident specific bubble pack of Meclizine 25mg tablets with an expiration date of 6/18/25. The bubble pack had 7 remaining tablets. Interview on 9/8/25 at 12:40 PM with LPN #7 identified that all nurses are responsible for removing expired medications from the medication cart. LPN#7 identified expired medications should be given to the supervisor and identified that she did not administer the medication and therefore did not check whether the medication was expired. Interview on 9/8/25 at 12:54 PM with the Nursing Supervisor (RN #2) identified that if something doesn't have an expiration date, it should not be put into circulation. RN#2 identified the multi-use vials should be labelled when opened and should be discarded 30 days from the opened date. RN#2 further noted there is a designated person to inspect the medication rooms on a weekly basis and remove the expired medications. Interview on 9/8/25 at 1:58 PM with the ADNS and DNS identified that all staff are required to check expiration dates and discard if needed. Additionally, the DNS indicated that if the medication is no longer prescribed, it should be removed from the medication cart. The facility policy for medication storage identified that prior to and after opening, all medications shall expire on the date specified by the manufacturer on the product label, unless the manufacturer has specifically indicated a shortened expiration once opened on the product label itself, and once expired should be removed from circulation.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical records, review of facility policy, review of facility documentation, and interviews for five of ten sampled residents (Resident #3, Resident #20, Resident #151, Resident #153, and Resident #154) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was assessed, offered/ and administered as requested by the resident upon/on admission. The findings include: 1. Resident #3 was admitted to the facility in May of 2025 and had diagnoses that included cerebral infarction, anemia and respiratory failure. The quarterly MDS assessment dated [DATE] identified Resident #3 had severely impaired cognition. The assessment further identified Resident #3 had not received the pneumococcal vaccine as it was not offered. Review of the clinical records for Resident #3 immunization consents and records failed to identify a consent/declination was obtained or a record of a documented vaccine was found in the resident record. Review of Resident #3 immunization consents and records with the Infection Preventionist (LPN #2) on 9/9/25 at 12:46 PM failed to identify that the pneumococcal vaccine was offered to the resident, or the resident had received the vaccine prior to admission. Interview with the Infection Preventionist (IP) (LPN #2) on 9/9/25 at 12:46 PM identified vaccine consent is obtained on admission by the admitting nurse or by herself when she is in the facility. LPN #2 identified she was responsible for reviewing the vaccine consent and added there were issues with the admission packets not having the vaccine paperwork included in the paperwork. The IP nurse (LPN#2) identified she did not have a tracking system in place to check resident vaccination status. Interview on with LPN #2 and the ADNS on 9/10/25 at 12:23 PM identified they had problems with residents' vaccination status and had conducted a whole house audit as there was a break the facility's process. The ADNS further identified consents were not obtained on admission as they were not included as a part of the admission process and they had added another nurse recently to assist the IP nurse to give her extra time to complete other tasks. A request for the audits that were completed and when the process had begun, however, they failed to provide such documentation of the audits and timeline as to when the break in the process had begun. Review of the Pneumococcal Vaccination policy identifies all residents admitted to this facility will be evaluated to determine if they have received pneumococcal vaccination. The facility will educate the resident/representative on the benefits of pneumococcal immunization, and offer administration unless immunization is medical contraindicated, the resident has already been immunized or resident and or responsible party declination. The policy further identifies the purpose of the pneumococcal vaccination is to ensure that the residents receive optimal protection against the pneumococcal infection. 2. Resident #20 was admitted to the facility in July of 2025 and had diagnoses that included Alzheimer's disease, type 2 diabetes mellitus, and interstitial pulmonary disease. The admission MDS assessment dated [DATE] identified Resident #20 had severely impaired cognition. Review of the Pneumococcal Vaccination Series (PCV/PPSV23) consent form identified Resident #20's responsible party gave the facility permission on 8/4/2025 to administer/complete the pneumococcal series as directed by the Center for Disease Control and Prevention (CDC) guidelines and my physician. Review of the clinical records for Resident #20 immunization consents and vaccination records failed to identify Resident #20 had received the pneumococcal vaccine as requested by the resident. Review of Resident #20's clinical records with the Infection Preventionist (LPN #2) on 9/9/25 at 11:54 AM indicated Resident #20 had received the Pneumovax 23 outside of the facility on 11/11/2019 but failed to identify that he/she had received any pneumococcal vaccines while at the facility to complete the pneumococcal series. In addition, the records did not contain any documentation that the resident had refused the vaccine while at the facility. Interview with the Infection Preventionist (IP) (LPN #2) on 9/9/25 at 11:54 AM identified the admitting nurse or if she is here at the facility would obtain vaccine consent. She indicated if the facility staff obtained the consent for the vaccine, they would place a copy in her mailbox or email her (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a copy. She identified she was responsible for reviewing the consent forms to identify the appropriate vaccine for resident and obtain the physician's order. LPN #2 was asked why Resident #20 did not received the vaccine when consented she responded that she don't have an answer. She was also asked if the vaccine was available at the pharmacy and responded that she had no information that the vaccine was not available. Interview with the DNS on 9/9/25 at 2:00 PM identified after vaccine consent is obtained for pneumococcal vaccine that she expects the vaccine it to be administered as soon as possible. Review of the Pneumococcal Vaccination policy identifies all residents admitted to this facility will be evaluated to determine if they have received pneumococcal vaccination. The facility will educate the resident/representative on the benefits of pneumococcal immunization, and offer administration unless immunization is medical contraindicated, the resident has already been immunized or resident and or responsible party declination. The policy further identifies the purpose of the pneumococcal vaccination is to ensure that the residents receive optimal protection against the pneumococcal infection. 3. Resident #151's diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, and acute respiratory distress. The significant change MDS assessment dated [DATE] identified Resident #151 had severely impaired cognition. The assessment further identified Resident #151 had not received the pneumococcal vaccine as it was not offered.Review of the Pneumococcal Vaccination Series (PCV/PPSV23) consent form identified Resident #151's gave the facility permission on 6/2/2025 to administer/complete the pneumococcal series as directed by the Center for Disease Control and Prevention (CDC)guidelines and my physician. Review of the clinical records for Resident #151 immunization consents and vaccination records failed to identify Resident #151 had received the pneumococcal vaccine as requested by the resident. Review of Resident #151's clinical records with the Infection Preventionist (LPN #2) and the ADNS on 9/10/25 at 12:23 PM failed to identify that he/she had received any pneumococcal vaccines while at the facility to complete the pneumococcal series nor did the records contain any documentation that the resident had refused the vaccine or was unable to receive the vaccine or had received the vaccine historical. Interview with the DNS on 9/9/25 at 2:00 PM identified after vaccine consent is obtained for pneumococcal vaccine that she expects the vaccine it to be administered as soon as possible. Interview on with LPN #2 and the ADNS on 9/10/25 at 12:23 PM identified they had problems with residents' vaccination status and had conducted a whole house audit as there was a break the facility's process. The ADNS further identified consents were not obtained on admission as they were not included as a part of the admission process and they had added another nurse recently to assist the IP nurse to give her extra time to complete other tasks. A request for the audits that were completed and when the process had begun, however, they failed to provide such documentation of the audits and timeline as to when the break in the process had begun. The IP nurse indicated Resident #151 was unable to receive the vaccine as he/she was ill, however, failed to provide any documentation in the clinical records which indicated why the pneumococcal vaccine was not administered as requested by the resident. Review of the Pneumococcal Vaccination policy identifies all residents admitted to this facility will be evaluated to determine if they have received pneumococcal vaccination. The facility will educate the resident/representative on the benefits of pneumococcal immunization, and offer administration unless immunization is medical contraindicated, the resident has already been immunized or resident and or responsible party declination. The policy further identifies the purpose of the pneumococcal vaccination is to ensure that the residents receive optimal protection against the pneumococcal infection. 4. Resident#153 was admitted to the facility in March of 2025 and had diagnoses that included chronic obstructive pulmonary disease, pneumonia, and muscle weakness. The quarterly MDS dated [DATE] identified Resident #153 had severely impaired cognition, an active diagnosis of a cardiorespiratory condition, had not received the pneumococcal vaccine. Review of the medical record for Resident#153 immunization consents and records failed to identify a consent/declination was obtained or a record of a documented vaccine was found in the resident record. The documented cause of death as primary on the death certificate (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was listed Pneumonia. The review of the Resident#153 vaccination record with the Infection Preventionist (LPN#2) on 9/9/25 at 12:50PM failed to identify that the pneumococcal vaccine was offered to the resident, or the resident had received the vaccine prior to admission. The IP nurse (LPN#2) identified she did not have a tracking system in place to check/track resident vaccination status. Interview with the Infection Preventionist (IP) (LPN #2) on 9/9/25 at 12:46 PM identified vaccine consent is obtained on admission by the admitting nurse or by herself when she is in the facility. LPN #2 identified she was responsible for reviewing the vaccine consent and added there were issues with the admission packets not having the vaccine paperwork included in the paperwork. The IP nurse (LPN#2) identified she did not have a tracking system in place to check resident vaccination status. Interview on with LPN #2 and the ADNS on 9/10/25 at 12:23 PM identified they had problems with residents' vaccination status and had conducted a whole house audit as there was a break the facility's process. The ADNS further identified consents were not obtained on admission as they were not included as a part of the admission process and they had added another nurse recently to assist the IP nurse to give her extra time to complete other tasks. A request for the audits that were completed and when the process had begun, however, they failed to provide such documentation of the audits and timeline as to when the break in the process had begun. Interview with the DNS on 9/9/25 at 2:00 PM identified after vaccine consent is obtained for pneumococcal vaccine that she expects the vaccine it to be administered as soon as possible. Review of the Pneumococcal Vaccination policy identifies all residents admitted to this facility will be evaluated to determine if they have received pneumococcal vaccination. The facility will educate the resident/representative on the benefits of pneumococcal immunization, and offer administration unless immunization is medical contraindicated, the resident has already been immunized or resident and or responsible party declination. The policy further identifies the purpose of the pneumococcal vaccination is to ensure that the residents receive optimal protection against the pneumococcal infection. 5. Resident #154's diagnoses included hypertension, asthma, and diastolic congestive heart failure. The annual MDS assessment dated [DATE] identified Resident #154 was cognitively intact. The assessment further identified Resident #154 had not received the pneumococcal vaccine as it was not offered. Review of the Pneumococcal Vaccination Series (PCV/PPSV23) consent form identified Resident #154's gave the facility permission on 7/19/2025 to administer/complete the pneumococcal series as directed by the Center for Disease Control and Prevention (CDC)guidelines and my physician. Review of the clinical records for Resident #154 immunization consents and vaccination records failed to identify Resident #154 had received the pneumococcal vaccine as requested by the resident. Review of Resident #154's clinical records with the Infection Preventionist (LPN #2) on 9/9/25 at 11:54 AM indicated Resident #154 had received the Pneumovax 23 outside of the facility on 9/16/2019 but failed to identify that he/she had received any pneumococcal vaccines while at the facility to complete the pneumococcal series. In addition, the records did not contain any documentation that the resident had refused the vaccine while at the facility. Interview with the DNS on 9/9/25 at 2:00 PM identified after vaccine consent is obtained for pneumococcal vaccine that she expects the vaccine it to be administered as soon as possible. Interview on with LPN #2 and the ADNS on 9/10/25 at 12:23 PM identified they had problems with residents' vaccination status and had conducted a whole house audit as there was a break the facility's process. The ADNS further identified consents were not obtained on admission as they were not included as a part of the admission process and they had added another nurse recently to assist the IP nurse to give her extra time to complete other tasks. A request for the audits that were completed and when the process had begun, however, they failed to provide such documentation of the audits and timeline as to when the break in the process had begun.Review of the Pneumococcal Vaccination policy identifies all residents admitted to this facility will be evaluated to determine if they have received pneumococcal vaccination. The facility will educate the resident/representative on the benefits of pneumococcal immunization, and offer administration unless immunization is medical contraindicated, the resident (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy/procedures and interviews for the one sampled resident (Resident #20) reviewed for Advanced Directives, the facility failed to ensure the physician's orders accurately reflected the resident's code status of do not resuscitate. The findings included:Resident #20 was admitted to the facility [DATE]. Diagnoses included Alzheimer's disease, and Type 2 diabetes mellitus with hyperglycemia. The hospital Discharge summary dated [DATE] identified a code status of full code (a full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive including cardiopulmonary resuscitation (CPR)). The physician's orders dated [DATE] did not direct a code status for Resident #20. The care plan dated [DATE] identified Resident #20 had an advanced directive of cardio pulmonary resuscitation with interventions to honor the advanced directives as directed by resident/responsible party for guidance. The APRN progress notes dated 7/23, 7/28, 7/30, 7/31, 8/1, 8/5, 8/13, 8/14, 8/19, 8/21, 8/22, 9/2 and [DATE] identified Resident #20's code status was full code. The admission MDS assessment dated [DATE] identified Resident #20 had severely impaired cognition and utilized a walker for mobility. Review of the clinical record identified an advanced directive form dated/signed on [DATE] by the resident's responsible party, and the DNS that directed a code status of do not administer cardiopulmonary resuscitation (DNR), artificial respiration, artificial nutrition, IV hydration or hospitalization. The care plan meeting notes dated [DATE] identified Resident #20 as a full code. Interview on [DATE] at 10:53 AM with Person #1 (responsible party and emergency contact for Resident #20), who signed the advanced directive identified the directive choice was DNR/DNI (do not intubate). Interview on 9/ 9/2025 at 6:31 AM with LPN#4 identified after verification in the computer that Resident #20's code status was designated as full code (provide CPR if needed). Interview on [DATE] at 6:36 AM with the DNS identified that she was the witness signature on Resident #20's advance directive. The DNS indicated that the paperwork, once completed, is given to the nursing supervisors to enter into the care plan and place an order. The DNS identified that in the event of a need for CPR she would expect the staff to check the medical record, and the electronic health record (EHR). The DNS verified in the computer that Resident #20 was listed as a full code. Interview on [DATE] at 11:13 AM SW#1 identified that social work may reach out to the family if there is a delay, but that nursing takes care of the advance directives. The facility policy for Advanced care planning code status identified that orders not to attempt cardiopulmonary resuscitation of a resident will be in writing, after consent had been obtained. The policy identified that at admission the facility will check code status with the transferring agency and will be valid until the facility can verify and obtain its own record of the residents/family/surrogate/designated representative's wishes regarding CPR but in no event shall the order be valid for more than 48 hours. The policy indicated that a physician's order must be written to reflect the choice of choosing to resuscitate or not to resuscitate.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of clinical records, review of facility policy/procedures and interviews for 1 of 2 sampled residents (Residents #101) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the MDS accurately reflected the residents' status. The findings include: Resident # 101's diagnoses included bipolar disorder, anxiety, and insomnia.The PASRR level II screening dated 8/5/2015 identified Resident #101 had a positive level II PASRR.The annual MDS assessments dated 4/27/24 and 4/8/25 identified Resident #101 had intact cognition, no behaviors, was dependent on staff assistance for dressing, personal hygiene, and transfers. The assessment further identified Resident #101 had active psychiatric mood disorder of anxiety and bipolar disorder. The assessment further reflected that the resident did not have a positive level 2 PASRR. The assessment failed to reflect the resident's accurate status. The Resident Care Plan (RCP) dated 3/16/25 identified Resident #101 had a behavior problem related to extreme fear and bipolar disorder. Care plan interventions directed to administer medication as physician orders, anticipate and meet resident's need, assessed resident behavior episode and attempt to determine the underlying cause, and explained all procedures to the resident before starting a procedure.Interview with the Social Worker (SW#1) on 9/8/25 at 11:21 AM identified she was responsible for completing the PASSR section of the MDS assessment and when a resident is has a positive level II assessment, she enters the information on the MDS. After reviewing Resident #101's annual MDS assessments she noted that they should have been coded to reflect the positive level II assessment status. Although requested, a policy for accuracy of MDS coding was not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for one of five sampled residents (Resident #110) reviewed for unnecessary medication, the facility failed to ensure the care plan included interventions to address the possible side effects and the monitoring that should accompany the use of anticoagulant medication. The findings include: Resident #110's diagnoses included major depressive disorder, anxiety disorder, hypertensive heart disease, and spastic diplegic cerebral palsy. The quarterly MDS assessments dated 7/14/25 identified Resident #110 had intact cognition, required supervision or touching assistance with eating. The physician's orders for the month of July 2025 directed Xarelto (anticoagulant) 20 milligrams (mg) one tablet by mouth at bedtime for deep vein thrombosis (DVT). Interview and clinical record review with the MDS Coordinator Director (RN #4) on 9/8/25 at 11:05 AM identified Resident #110 is taking an anticoagulant medication, and his/her current care plan did not include a care plan that addressed the use of anticoagulant medication. RN #4 identified the resident had a care plan for anticoagulant therapy that was resolved on 7/22/25 when the care plan was reviewed and revised. She identified the focused area should not have been resolved as the resident is still on the medication. Further she noted the care plan should include educating the resident on and reporting of any bleeding and for staff to monitor sign/symptoms of bleeding. She identified it was the responsibility of the person who reviews the care plan to ensure the resident had the appropriate care plans. Interview with Care Plan Coordinator (LPN #6) in the presence of the ADNS on 9/8/25 at 12:00 PM identified she was responsible for updating and revising care plans. She further identified she had not resolved the anticoagulant care plan as the resident was still taking the medication. LPN #6 identified the facility was in the process of switching care plans to the new company's care plan, however, she would have added the new company's care prior to removing the old care plan. LPN #6 and the ADNS identified the resident care plan should have reflected the use of the anticoagulant medication with the inclusion to monitor for bleeding. Subsequent to surveyor's inquiry a care plan for potential for untoward effects due to anticoagulant therapy dated 9/8/25 was developed and implemented with interventions that included administer medication as ordered by the physician and monitor for signs/symptoms of abnormal bruising or bleeding, and report side effects of anticoagulant therapy to the nurse including coffee ground emesis, melena, hematuria, bleeding gums, petechial, easy bruising, shortness of breath and change in level of consciousness. The Baseline and Comprehensive Person Centered Care Plan policy identified the interdisciplinary team utilizes the comprehensive person-centered care plan to address resident's strength, needs, and/or problems as identified. The policy also identified that the care plan is periodically reviewed and revised based upon any changes in status.

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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. Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Residents #110) reviewed for pressure ulcer/injury, the facility failed to ensure the alternating pressure relief mattress was in place as ordered and set to the ordered weight. The findings include: Resident #110's diagnoses included major depressive disorder, anxiety disorder, hypertensive heart disease, and spastic diplegic cerebral palsy. The quarterly MDS assessments dated 7/14/25 identified Resident #110 had intact cognition, no behaviors, was dependent on staff for transfers, personal hygiene and toileting hygiene, required substantial to maximal assistance with upper body dressing, was non ambulatory and utilized a wheelchair for mobility. The MDS further identified Resident #110 was at risk for developing pressure ulcers/injury, had no current skin impairments, and utilized a pressure reducing device in a chair, and bed. The care plan dated 7/22/25 identified Resident #110 had a potential for skin breakdown related to impaired mobility with interventions that included offload heels while in bed, and pressure redistribution mattress. The care plan entry dated 8/12/25 identified resident had a deep tissue injury (DTI) to the right heel with interventions that included air mattress set at alternating 200 per current weight and heel lift boots. The physician's order dated 8/13/25 directed to check function and setting of air mattress, set at 200 every shift. A review of Resident #110's clinical record identified Resident #110's weight was noted as 181 pounds on 8/2/25. The wound physician's note dated 8/28/25 identified Resident #110 had a deep tissue injury with persistent non-blanchable deep red, maroon or purple discoloration to the right medial heel that was noted to be not healed, the measurements were noted as 1.7 centimeters (cm) in length by 2.1 cm in width with no measurable depth and no drainage or odor noted. The note further identified orders for off-loading and facility pressure injury prevention protocol. Observation on 9/3/25 at 11:00 AM identified Resident #110 in bed positioned on his/her side facing the door. The resident was lying on a regular mattress and did not have an alternating air pressure mattress in place. Observation on 9/8/25 at 8:56 AM identified Resident #110 in bed positioned on his/her back with the alternating pressure mattress with the weight set at 325 pounds. A review of the air mattress audit completed on 9/3/25 identified Resident #110 had an air mattress set to 200 pounds. A review of the medication administration record/treatment administration record (MAR/TAR) for September 2025 identified LPN#3 signed off on 9/4/25, 9/5/25 and 9/8/25 at 7:21 AM for the checking of the mattress setting (day shift) and LPN#8 signed off on 9/3/25. Interview with the Charge Nurse (LPN #3) on 9/8/25 at 10:41 AM identified she signed off in the MAR/TAR that she had checked the air mattress setting at 7:21 AM on all the identified days; however, she identified that she had not checked the mattress at that time. LPN #3 identified that signing off the MAR/TAR means that the order was being followed but acknowledged that she had not physically checked the mattress to ensure the mattress was in place and the setting was correct. Interview with the Wound Nurse (LPN #2) on 9/8/25 at 11:28 AM identified Resident #110 was placed on an alternating pressure mattress that utilized a pump on 8/13/25 when the DTI to the right heel was identified. She identified that if the mattress was set to 325 pounds, it would be too hard and could potentially cause skin issues. Interview with the Director of Housekeeping and Housekeeper #1 on 9/8/25 at 12:55 PM identified the housekeeping department is responsible for changing the resident's mattresses. The Director of Housekeeping identified he was notified by the IP nurse on 8/12/25 to provide Resident #110 with an alternating pressure mattress which he did, and within the next 2 days he was told to change the mattress back to the resident regular mattress, which he also did. He identified during the week of 9/1/25, he could not identify the exact date when the IP nurse told him to change Resident #110 regular mattress back to the alternating air pressure mattress which was done on 9/5/25. He identified the IP/nurse would set the settings. Interview with LPN #2 on 9/8/25 at 2:00 PM identified she had completed the air mattress audit at 7:00 AM as soon as she came in and Resident #110 air mattress was set to 200. Interview (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with NA #1 and NA #2 on 9/8/25 at 2:21 PM identified Resident #110 mattress was changed on Friday (9/5/25) to the alternating mattress and prior to that, the resident had a regular mattress. Interview with LPN #8 on 9/8/25 identified Resident #110's mattress was changed on Friday (9/5/25) to the alternating air loss mattress. She indicated she worked on 9/3/25 and did sign off the MAR/TAR but could not recall if the mattress was there when she signed off the MAR/TAR. Interview with the ADNS (oversees wounds care in the facility) on 9/10/25 at 8:39 AM identified Resident #110 was on an alternative air mattress as preventative measure for pressure injuries. She identified if the resident was not utilizing the air mattress as ordered or if the setting was incorrect, it will put the resident at risk for skin breakdown and worsening of the DTI as at times Resident #110 spends most of the day in bed. Review of the Pressure Injury Prevention Program - Pressure Injury Prevention Support Surfaces protocol policy under the guidelines for use of support surfaces identified that use of support surfaces will be based on the interdisciplinary team recommendation, the surface will be placed on the bed by housekeeping/maintenance and/or vendor. The support surface will be secured properly to the bed frame, the correct setting will be set by the nurse based on resident's weight or comfort level, and monitoring of the support surface inflation will be done by the nurse every shift and documented on the TAR.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and interviews for one of four sampled residents (Resident #95) reviewed for nutrition, the facility failed to ensure that the dietician completed a quarterly assessment for a resident with weight loss. The findings include:Resident #95's with diagnoses that included Alzheimer's disease, dysphagia, hypertension, and GERD (Gastro-Esophageal Reflux Disease).The Dietician's progress note dated 3/12/25 identified Resident #95 had 15 percent weight loss and a current weight of 148 pounds. The Resident Care Plan (RCP) dated 3/14/25 identified Resident #95 was at risk for malnutrition related to Alzheimer's disease, dysphagia, and mechanically altered diet. Care plan interventions directed resident to have sufficient time to eat, diet as prescribe, encourage and monitor resident intake throughout the day, provide feeding assistance as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #95 had severe cognitive impairment, required limited assistance with eating and had an unplanned weight loss and was on a mechanically altered diet.The physician's order dated 5/7/25 directed to give regular diet with minced and moist texture, thin liquid consistency, no rice and keep resident seated upright for all meals and 30 minutes after eating.The quarterly MDS assessment dated [DATE] identified Resident #95 had severe cognitive impairment, required limited assistance with eating, did not have weight loss within the past 3 months, and was on a mechanically altered diet.Review of Dietician progress notes and/or nutritional evaluation from 3/13/25 to 6/14/25 failed to identify that Resident #95 nutritional status was evaluated on a quarterly basis following the last assessment dated [DATE] where it was noted that the resident had experienced a weight loss. Interview with the Dietician on 9/8/25 at 11:00 AM identified that she is responsible for assessing the residents' nutritional status. She identified that she completes assessments on admission, quarterly, and/or when there is a significant change in the resident nutritional status. She further identified that she documents either in the nutritional evaluation form and/or a progress note. In addition, her nutritional evaluation includes medical diagnoses, review of the current diet and changes in texture, review of the resident preferences, review of the average meal intake and review of the current medications. Further, the Dietician could not produce her quarterly nutritional assessment and/or progress notes from 3/13/25 to 6/14/25 for Resident #95. The Culinary and Nutrition policy identified that the nutritional status of the residents will be assessed on admission, quarterly, annually, and/or when a significant change occurred or more frequently as deemed necessary by the interdisciplinary team.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, review of facility policy, facility documentation, and interview for one of six residents (Resident #3) reviewed for immunizations, the facility to ensure that the COVID-19 booster vaccine was offered on admission to the resident. The findings include:Resident #3 was admitted to the facility in May of 2025 and had diagnoses that included cerebral infarction, anemia and respiratory failure. The quarterly MDS assessment dated [DATE] identified Resident #3 had severely impaired cognition. The assessment further identified Resident #3 was not up to date with the COVID-19 vaccination. Review of Resident #3 clinical records on 9/9/25 failed to identify that he/she received the COVID-19 booster for the 2024-2025 vaccination historically or any documentation the resident had received/refused the vaccine at the facility. Interview with the Infection Preventionist (IP) (LPN #2) on 9/9/25 at 12:46 PM identified vaccine consent is obtained on admission by the admitting nurse or by herself when she is in the facility. LPN #2 identified she was responsible for reviewing the vaccine consent and has identified there was an issue with the admission packets not having the vaccine paperwork included in the paperwork. The IP nurse (LPN#2) identified she did not have a tracking system in place to check resident vaccination status. Review of Resident #3's immunization consents and records with the DNS on 9/10/25 at 3:00 PM failed to identify that COVID-19 booster vaccine was offered to the resident. In an interview with the DNS on 9/10/25 at 3:00 PM identified she was unable to locate a consent form for the COVID-19 booster vaccine for Resident #3, and if it was not there, then it was not offered, which should have been done on admission. Review of the Infection Prevention and Control Program in the Immunizations for Resident section of the policy identifies the facility will educate and offer the COVID-19 vaccine to all eligible residents as per recommendations of the ACIP/CDC. The policy further identified vaccines are offered by the facility or through an arrangement with a pharmacy partner, local health department or other appropriate health entity and any new vaccine information will be dispersed as they become available.