STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075423	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis Place	111 Westcott Rd Danielson, CT 06239

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47402 Based on clinical record review, review of facility policy, and interviews for three of fifteen sampled resident (Resident #41, Resident #76, and Resident #126) reviewed for dining, the facility failed to ensure a dignified dining experience. The findings include: Observation on 8/14/24 at 8:30 AM on the 2West unit identified nurses' aides going in and out of resident rooms providing care, carrying bags of dirty linens, the charge nurse was passing medications, and some residents were positioned in the entryway to their rooms. Residents #41 and #76 were seated in wheelchairs and positioned in the hallway outside of their rooms and were feeding themselves breakfast. A third resident, Resident #126 was being fed breakfast by a nurse aide. Other residents in the hallway appeared to be watching the residents while they ate. Interview with NA #3 on 8/14/24 at 8:50 AM identified that during breakfast, the residents that are supervised or fed are placed in the hallway, so they can multi-task and supervise or respond to other residents rather than bringing all the residents into the small dining area on the unit. NA#3 further identified that at lunch time they bring the residents that need assistance or supervision into the small dining area on the unit. Interview with the Dietician on 8/14/24 at 8:55 AM identified that the small dining areas on the units were utilized recently for individuals who needed supervision or assistance with eating. The Dietician also identified that she had seen the residents eating on the unit and did not believe that it was dining in a dignified manner. There had already been discussions regarding having the residents eating in the hallway and it should not have been happening. Interview with the DNS on 8/15/24 at 9:40 AM identified that residents should not be fed in the hallway on the units and the satellite dining areas on the units are a better option than the hallway. She further noted that being in the hallway could pose a safety issue to other residents if there are spills or food grabbed from other residents. Additionally, the DNS identified the residents should be taken to the satellite dining area or kept in their rooms during meals. The Meal Service Policy identified that the facility provides a dining experience that is conducive to meal acceptance, which includes a quiet, pleasant room, positive staff attitudes and attractive meal presentation. Residents will be assisted to the dining room as needed by the nursing staff. Positioning and assistance at mealtime will be appropriate for the resident's needs and is the responsibility of the nursing staff. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident rights of the facility identified that the facility must care for residents in a manner that enhances their quality of life and treat them with dignity and respect in full recognition of their individuality.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observation, review of facility documentation, and interviews, the facility failed to ensure the residents had the opportunity to experience their choice of in-person community dining. The findings include: During the resident council meeting with the residents on 8/12/24, it was identified that the residents had previously brought up the concern during their resident council meetings that there was no in person dining in the main dining rooms. They identified that it had been approximately a year since they'd had in person dining and that the concern had been raised several times in resident council, however they still did not have in person dining in place. Review of the Resident Council meeting minutes dated 6/27/24 identified the food service director spoke about the plans for the dietary department including satellite dining and main dining. Recreation spoke about the action plan for resident dining. Review of the Resident Council meeting minutes dated 7/25/24 identified dietary spoke about the action plan on the dining room and finalizing the new list of who is eating in the dining area and what that looked like. Observation of lunch service on 8/12/24 at 12:45 PM identified residents in their rooms eating lunch on the 2West unit. Some residents who were being assisted to eat were in a small dining space located on the 2West unit. Interview with Resident #36 on 8/12/24 at 10:45 AM identified Resident Council has talked about wanting to open up the main dining room on countless occasions and they still do not have in-person dining going on in the main dining rooms. It really would be great to be able to sit at a table of people and interact with them while you eat. The socialization is something that a lot of people want to have back in place. Interview with Resident #103 on 8/12/24 at 10:50 AM identified that this issue has been brought up several times during resident council and that it would be wonderful to sit and chat and interact with others while you eat. Resident #103 identified that it hasn't been done for a very long time and they really missed it. Interview with NA#1, and NA#2 on 8/13/24 at 12:10 PM identified that the dining rooms had not been open since the previous year and that the satellite dining areas on the units were utilized for residents who needed assistance or supervision with eating and that residents who were independent stayed in their rooms to eat. Interview with the Dietician on 8/14/24 at 8:55 AM identified that, the main dining room had been closed for some time, however they had just opened the satellite dining areas for people who needed supervision or assistance with eating. She further identified that; although, she knows there could have been a negative impact on the residents from the dining areas being closed for that long of a period of time, she hasn't seen any negative impact on the residents and that if there were any changes identified the resident may be moved to the supervised dining area on the unit. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Manager on 8/14/24 at 9:00 AM identified the main dining rooms had been closed for some time however he started in his position in July of 2024 and as of August they had been working on making a seating chart and finding out who wanted to eat in the dining rooms. He further identified there were many moving parts as once the seating chart was made then they needed to ensure the trays were arranged in the kitchen carts and the tickets updated. He noted that 27 residents had made it known that they wanted to eat in the main dining room and that he really wanted in person dining to occur. Interview with RN#4 on 8/14/24 at 2:08 PM identified she worked on getting the units open back in June of 2024, and they were working on the plan for the main dining areas to open and that they were hoping to open them this week. Interview with the Administrator on 8/14/24 at 3:10 PM identified that the dining rooms had been closed for a period of time, he started in September of 2023, and they have basically been closed since then. He identified that not only were they closed due to the outbreaks of illness throughout the facility, but staffing has been a consistent issue in the dietary department. With the illnesses and with kitchen staffing between the two issues the stars never aligned for the dining rooms to open. The Administrator further identified; it was brought up in June 2024 at a resident council meeting he attended that the residents wanted the main dining room open to in-person dining for meals and noted things were in the works such as seating arrangements but that there were many moving parts to making it happen. Interview with the Director of Nursing on 8/15/24 at 9:30 AM identified that she has been in outbreak mode from 8/23/23 to 6/10/24 then on 7/11/24 to present was the next COVID outbreak. If there is an outbreak on a unit, they would not have dining in the main dining rooms and isolate the unit to stop the spread of infection such as COVID. This would limit activities as well to just being done on the unit and residents would not be able to participate in group activities. However, during these times not all units were affected throughout the whole outbreak. There were breaks in time in which some units were not affected. The most recent COVID outbreak that started on 7/11/24 did not affect unit 2East or 2West. The previous wave of COVID affected Unit 1 and 2East and 2West however did not affect Unit #3. Unit #1 and #2 were clear from their 14-day period as of 5/21/24. Dining in the main dining areas had not been done since the 8/23/23 outbreak. Interview with Recreation on 8/15/24 at 2:00 PM identified that in person recreation activities have been occurring in the building. At times due to COVID they have had to limit the activities to the units, but most recently they have been doing in person activities, such as entertainment the previous day in the large group setting in the Dining room [ROOM NUMBER]. Although a policy for Resident Council/Committees was requested none was provided. Review of the Outbreak of Communicable disease policy reviewed April 2024 directed an outbreak of most communicable disease can be defined as one of the following: One case of an infection that is highly communicable, trends that are 10 percent or more above the historical rate of infection for the facility; or occurrence of three or more cases of the same infection over a specified period of time and in a defined area. The infection preventionist and Director of Nursing will discontinue group activities as indicated. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Meal service policy directed it is the policy of the facility to provide a dining experience that is conducive to meal acceptance, residents will be interviewed at the time of admission and thereafter as needed as to their preference to eat in the dining room or their room. The resident's eating preference will be obtained and entered into their resident profile so that their preference will print on the tray cards. Residents will be assisted to the dining room as needed by the nursing staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based clinical record review, review of facility policy and interviews for one sampled resident (Resident #122) who had a change in condition, the facility failed to ensure the physician was notified when the resident experienced a change in condition. The findings included: Resident #122 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, essential hypertension, acute cystitis without hematuria, acute respiratory failure with hypoxia, and pleural effusion. Physician's orders dated 7/28/2024 identified Resident #122 had a code status of full code (which means that in the event the heart stops cardiopulmonary resuscitation will be performed), resident care plan as outlined, Ondansetron HCL (antiemetic) tablet 8 mg give 1 tablet by mouth every 6 hours as needed for nausea and vomiting. The admission MDS assessment dated [DATE] identified Resident #122 had intact cognition, was dependent with toileting hygiene, lower body dressing and personal hygiene, required substantial/maximal assistance with position changes from sitting to lying or lying to sitting and from the side of the bed, and partial/moderate assistance to roll left and right. Physician's progress note dated 8/4/2024 at 12:18 PM identified Resident #122's lungs were clear to auscultation. The Wound Physician's progress note dated 8/6/2024 at 5:04 PM identified Resident #122's respiratory effort was within normal limits. RN #11's progress note dated 8/11/2024 at 4:00 AM identified Resident #122 slept well, had no complaints, fluids encouraged. Vital signs stable. Call bell in reach. RN #10's progress note dated 8/11/2024 at 10:02 PM identified Resident #122 vomited a small amount after dinner and sounded congested this shift, message left for APRN, not respiratory distress, short of breath, oxygen saturation 93% on room air, will continue to monitor. Vital signs: temperature; 98.4, pulse, 92: respirations, 20: blood pressure, 152/84. Interview with Resident #122's family members on 8/12/24 at 12:19 PM identified Resident#122 has chronic kidney issues, and was currently experiencing confusion, nausea, and vomiting. They further identified he/she was seen by the APRN this morning after they relayed their concerns about the lack of care Resident #122 had received over the weekend and demanded he/she be seen. They identified that the resident had vomited and choked yesterday (Sunday). The resident's family member identified that they had shouted loudly for assistance and rang the call bell which was responded to by a nurse aide who told them a nurse was coming. The family member indicated that someone came in to give the morning pill and that the nurse didn't come in until after change of shift, who was not the night nurse but the day shift nurse and denied having been told of the resident's coughing/choking episode. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the APRN on 8/12/2024 at 1:10 PM identified she saw Resident #122 after she was asked by the facility to see the resident. Resident #122 is seen by a different provider. The APRN identified the resident was reported by family to have vomited and may have choked while vomiting on Sunday morning. She further noted that in the event that this occurred, the situation was not handled appropriately. The APRN identified her concern for aspiration and would have expected a provider/physician to be notified when the vomiting/choking had occurred. Further, she noted that there were providers on call to handle weekend concerns and they should not have waited for 24 hours to have the resident assessed/seen or to notify the provider/physician. The APRN's progress note dated 8/12/2024 identified Resident #122 had a few vomiting episodes on 8/11/2024 and reported feeling weak and similar to when hospitalized prior. Systems review identified resident had cough with slight shortness of breath and lung sounds were coarse rhonchi with wheezing throughout. Physician's orders dated 8/12/2024 identified change in condition monitoring related to nausea and mildly increased confusion. Additional medications after APRN assessment Budesonide suspension 0.25 mg/2 ml inhale orally every 6 hours for abnormal lung sounds. Ciprofloxacin HCL oral tablet 500mg give 1 tablet by mouth two times a day for urinary tract infection. Guaifenesin ER tablet extended release 12-hour 600 mg give 1 tablet by mouth every 12 hours for congestion. Interview with RN #9 on 8/13/24 at 9:50 AM identified that if a resident experiences a new onset of vomiting and choking, it should be considered a change in condition. RN #9 identified that staff should notify the nursing supervisor and the nursing supervisor should assess the resident and if needed, call the provider. Interview with NA #8 on 8/13/2024 at 1:30 PM identified NA #8 worked the Saturday evening into Sunday morning shift (10p-6am) and that on Sunday morning at the end of her shift she was providing care to another resident with the help of NA #9 when they heard someone shouting for help. NA #9 left the room to check on the shouting and then came back in to finish care with NA #8. NA #9 relayed to NA #8 that Resident #122's spouse was the person shouting and that Resident #122 was spitting up and that NA #9 indicated to NA #8 that the nurse was notified. NA #8 identified the nurse as RN #11. NA #8 stated she was cleaning up as her shift was ending (possibly about 5:55) and she needed to go home and didn't respond to the shouting. Interview with LPN #11 on 8/14/2024 at 9:35 AM Identified she was the nurse for the day shift on Sunday 7a-3p who took report from RN #11 (the off going nurse). She identified she took the blood sugar at 7:30 AM and identified the resident was given Zofran on the night shift. She stated the resident and Family Member informed her of the vomiting and the resident conveyed he/she was feeling better with the Zofran. LPN #11 identified that if Resident #122 was actively vomiting she would have held the medication and notified a supervisor. She further identified Resident #122's vitals were within normal limits and he/she offered no complaints throughout the entire shift. Interview with RN #10 on 8/14/2024 at 11:16 AM identified he had worked Sunday evening shift, 3p-11pm and had worked at the facility for 6 years. RN #10 identified it was reported to him that the resident vomited during the morning shift at 6:30-7a possibly. He identified the resident was receiving Zofran, so the vomiting was not a new occurrence. RN #10 identified that in the event the resident had choked on the vomit, this would have been a change. When the resident vomited during the evening shift, a note was left by RN #10 for the covering provider to see the resident in the morning. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #122's Family Member on 8/14/24 at 1:11 PM identified that at the time of the incident the resident had vomited while lying flat and choked and was not able to sit up unassisted. He/she identified that no one came in, but the resident was able to clear the items and RN #11 was the nurse at the time who later came in and gave the resident a pill. Interview with NA #9 on 8/15/2024 at 7:11 AM identified that while providing care to a resident with NA #8 she heard someone screaming and left the room to see who was yelling. She identified that Resident #122's Family Member was shouting about the resident vomiting. She further identified that she notified RN #11 that Resident #122 was throwing up and coughing. Interview with RN #11 on 8/15/2024 at 7:41 AM identified she administered a pill to the resident at midnight and then another pill in the morning around 6:00 AM. RN #11 denied knowing that Resident #122 had vomited and denied being told that the resident had vomited or choked or coughed. RN #11 indicated that a NA had put antifungal powder on the resident's groin on Saturday evening shift and that the resident might have reported a cough at midnight related to having breathed in the powder. RN #11 did identify another NA reported that Resident #122's Family Member appeared upset about something, but he/she had not followed up. Interview with the DNS on 8/15/24 at 9:47 AM identified that if a resident had vomited and was choking or coughing after vomiting the expectation would be that an assessment of some sort was completed with bowel sounds at a minimum. Given the report of the resident choking, I would expect lung sounds, but there should have been something reported to the supervisor and an assessment completed. The facility policy for Change in a Resident's Condition or Status identified the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition or the need to alter the resident medical treatment significantly. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46046 Based on observations and interviews the facility failed to ensure an outdoor concrete patio (smoking area) was safe and free of accident hazards. The findings include: Observation of the smoking area on the unit three patio on 8/15/24 at 10:00 AM noted that the concrete patio contained multiple holes causing the surface to be uneven. After observing the unit three patio with the Administrator on 8/15/2024 at 10:15 AM, the Administrator identified that staff and Residents utilize the patio for smoking, and noted he was unaware of the status of the patio. The Administrator further indicated it was a safety issue and would be fixed that day. An interview with the Maintenance Director on 8/15/24 at 10:45 AM indicated he had been aware of the condition of the patio since 8/8/24 but had not notified the Administrator or the DNS. The Maintenance Director further indicated he had been busy and had planned to get the supplies to make the repairs. On 8/15/24 at 10:48 AM the Administrator was made aware that the Maintenance Director had known of the condition of the patio since 8/8/24. An observation on 8/15/24 at 11:10 AM noted a sign on the porch door and caution tape across the porch exit. An interview with the Administrator on 8/15/24 at 11:13 AM indicated the porch was closed off, a blast fax sent to all employees that it was closed until further notice and recreation would inform all residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #133) reviewed for missing property, the facility failed to follow up on a resident reported concern related to missing items in a timely manner. The findings include. Resident #133's diagnoses included dementia and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #133 had severe cognitive impairment and required one to two person assist with activities of daily living (ADL). The Resident Care Plan dated 5/5/24 identified Resident #133 had decreased cognition related to dementia and an ADL deficit. Interventions directed to provide safety measures in all activities and provide assistance with ADL care as needed. An interview with Person #2 on 8/11/24 at 12:20 PM identified that Resident #133's prescription glasses were reported missing to Corporate Admission Staff #1 about a month prior and was told the matter would be investigated and every time the status of the glasses has been inquired about, Person #2 was told they were not found. Further, there had been no follow-up to discuss future action. A review of nursing progress notes dated 7/1/24 through 8/10/24 did not include documentation concerning missing items. A review of social service progress notes dated 7/1/24 through 8/10/24 did not include documentation for any missing items. An interview with the Director of Social Services on 8/13/24 at 10:14 AM identified that for reports of missing property, he would be responsible for interviewing the resident/family, conducting a room search, and if necessary, refer to other disciplines such as nursing, housekeeping and laundry to attempt to locate the missing item. If the missing item is not located, the item would be replaced, or reimbursement provided based on resident/family preference, which would be determined that day. The Director of Social Services further identified it was just reported to him one hour earlier on 8/13/24 that Resident #133 had a pair of missing glasses along with other missing items. It was the first time he had learned of the missing items and had not been previously notified. An interview and facility documentation review with Corporate Admissions Staff #1 on 8/13/24 at 10:24 AM identified it was reported by Person #2 that Resident #133 had missing items that included a pair of prescription glasses. Corporate Admissions Staff #1 generated an electronic communication dated 7/19/24 to administrative staff that included the Director of Social Services to notify him of the missing item(s). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent interview and (handwritten) clinical record review with the Director of Social Services on 8/13/24 at 10:30 AM identified on 7/22/24, he did refer the matter to Transportation Staff #1 who was responsible for scheduling community provider specialty services for replacement. The Director of Social Services identified he did follow up with Resident #133 several times and offered cheater glasses but that s/he declined and likely could not recall. The Director of Social Services did not follow up with Person #2 regarding the missing item and should have. An interview with the Director of Nursing (DNS) on 8/13/24 at 11:08 AM identified the report of the missing item(s) should have been responded to and replaced if not found at the time it was reported. An interview and facility documentation review with Transportation Staff #1 on 8/15/24 at 11:40 AM identified she was responsible for scheduling community provider specialty services. Transportation Staff #1 was contacted by the Director of Social Services to schedule Resident #133 for glasses; however, it was not communicated that the glasses were just a replacement for a lost pair rather than a full exam. Transportation Staff #1 did schedule Resident #133 for glasses but was informed by the provider Resident #133 would not be able to be seen sooner than 9/2024, subsequent to surveyor inquiry, Transportation Staff #1 better understood the glasses were for replacement only and not a new prescription therefore could be replaced much sooner. Transportation Staff #1 identified the Director of Social Services never followed up with her to find out the status of the glasses, otherwise the matter could have been clarified. A review of the policy for Reported Losses/ Missing Items directed the facility to actively investigate and mitigate occurrences of lost or missing items of value. [NAME] an item is reported missing, the Nursing Supervisor will be notified, and a Missing Item Report completed. The Nursing Supervisor will conduct an initial investigation and the loss reported to DNS, ADNS social services and Administrator. An investigation will be conducted in conjunction with the local police department if indicated.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and interviews for 2 of 2 sampled residents (#40 and #134) reviewed for assessments, the facility failed to ensure staff submitted discharge assessments to the state and federal agencies timely. The findings include. Resident #40 was admitted on [DATE], the admission Minimum Data Set Assessment (MDS) was dated 2/28/2024 and Resident #40 passed away at the facility on 5/4/2024. An interview and record review on 8/14/2024 at 12:05 PM with RN#2, 1 of 2 MDS coordinators, indicated Resident #40's Death in Facility Minimum Data Set (MDS) dated [DATE] was completed but never sent to the state and federal agencies. RN #2 further indicated the submission information section on the MDS should have been changed to Submit to CMS (Centers for Medicare and Medicaid Services), but it was set to do not submit which needs to be manually changed by the user and would do so now and send the MDS to the agencies (110 days late). Resident #134 was readmitted to the facility on [DATE] with a quarterly MDS completed on 4/8/2024. Resident #134 was discharged from the facility on 5/31/2024. On 8/14/24 12:07 PM an interview and record review with RN #2 indicated Resident #134's Discharge MDS dated [DATE] was submitted on 8/12/2024 was submitted late (76 days late). RN #2 further indicated the MDS should have been submitted within 14 days of completion and must have been overlooked The Resident Assessment Instrument (RAI) manual dated 10/1/2024 indicated in part, the Death in Facility and Discharge MDS must be transmitted to the agencies within 14 days of the event date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, review of facility policy and interviews for one of three sampled residents (Resident #6) reviewed for respiratory care, the facility failed to develop and implement a comprehensive care plan for a resident utilizing oxygen therapy and for one of four sampled residents (Resident #138) reviewed for accidents, the facility failed to revise the comprehensive care plan to ensure safe food consumption for a resident who was repeatedly provided unsafe food items with a known swallowing disorder. The findings include: 1. Resident #6's diagnoses included chronic obstructive pulmonary disease (COPD), metabolic encephalopathy, and muscle wasting and atrophy. The quarterly MDS assessment dated [DATE] identified Resident #6 was cognitively intact, was totally dependent on staff for toileting, transfers, and personal hygiene. It further identified Resident #6 had shortness of breath or trouble breathing when lying flat and required oxygen therapy. The resident care plan (RCP) dated 7/20/24 did not address Resident #6's use of oxygen or interventions related to the use of oxygen therapy. Review of the physician's orders for the month of August/2024 failed to identify an order for the use of oxygen therapy. Observation on 8/12/24 at 2:35 PM identified Resident #6 was lying in bed wearing a nasal cannula connected to an oxygen concentrator set at 3 liters per minute (LPM). Interview with the Nursing Supervisor (RN #1) on 8/13/24 at 11:34 AM identified that a care plan should be developed and implemented for a resident utilizing oxygen. RN #1 was asked who was responsible for developing the care plan and she indicated that the nurses on the unit develop care plans for falls, and skin, but the MDS Coordinator does all other care plans. Interview with the MDS Coordinator (LPN #8) on 8/13/24 at 11:42 AM identified that the care plan dated 7/20/24 failed to identify Resident #6 had a care plan developed and implemented for oxygen therapy. LPN #8 identified that it was her responsibility to review Resident #6's care plans after completing the MDS to ensure that all areas of the resident's care were included in the plan of care. LPN #8 identified if the oxygen care plan was included it would have had interventions such as monitor for sign or symptoms of respiratory distress and report to MD, pulse oximetry, and oxygen as ordered. Subsequent to surveyor's inquiry Resident #6's care plan was updated (8/13/24) to reflect the focus area of oxygen therapy related to COPD with interventions that included monitor for sign or symptoms of respiratory distress and report to MD, respirations, pulse oximetry, accessory muscle usage, oxygen settings via nasal prongs/mask at 1-3 liters continuously and promote lung expansion and improve air exchange by positioning with proper body alignment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 8/14/24 at 3:18 PM identified that the nurses on the unit would develop and implement care plans but it was the MDS nurse's responsibility for the overall care plan to ensure that it was completed. The DNS indicated that if the resident was on oxygen a care plan should be included in the resident's plan of care. Review of the Care Plans, Comprehensive Person-Centered policy identified that the facility is to develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed. It further identified that the comprehensive person-centered care plan will incorporate identified problem areas and their causes and develop interventions that are targeted and meaningful to the resident. Additionally, the policy identified that assessments of residents are ongoing, and the care plans are to be revised as information about the resident's condition changes. 2. Resident #138 had diagnoses that included hemiplegia/hemiparesis (weakness and paralysis) following a cerebral infarction (stroke) affecting the left non-dominant side and dysphagia (swallowing disorder). The Admission MDS assessment dated [DATE] identified Resident #138 had moderate cognitive impairment, mobility impairment to one side of the body, and required partial to total assist with eating. The resident care plan (RCP) dated 7/31/24 identified an alteration in nutrition related to being on an altered textured diet related to dysphagia. Interventions directed to explain and reinforce the importance of maintaining the diet as ordered, comply with nutrition recommendations and provide set up/assistance as indicated. An observation on 8/11/24 at 1:17 PM identified Resident #138 with a plate of ground/minced in appearance food plated in front of him/her, holding a broken off chocolate covered wafer like cookie in his/her right hand and chewing. Person #3 was noted at bedside. An interview with LPN #5 on 8/11/24 at 1:17 PM identified Resident #138 was not approved to eat the cookie and proceeded into Resident #138's room to intervene. An interview and clinical record review with the (acting) Director of Rehabilitation on 8/13/24 at 12:58 PM identified Resident #138 was prescribed a minced/ground diet due to dysphagia with no exceptions, was currently receiving therapy related to poor attention, wet vocal quality and the need for continuous cueing for bolus (food) retrieval. Resident #138 required total supervision with meals. The Director of Rehabilitation was not aware Resident #138 was being provided unsafe food items but further noted that on 8/9/24, the caregiver was provided education on offering the resident smaller bites. A subsequent observation on 8/13/24 at 1:44 PM identified Person #3 offering Resident #138 a donut. LPN #10 was notified and immediately intervened. An interview with LPN #10 on 8/13/24 at 1:55 PM identified RN #7 reported that Resident #138 was provided unsafe food items, and this was the first occasion where LPN #10 made a direct observation. Person #3 was subsequently provided education on the provision of unsafe food items. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DNS on 8/14/24 at 9:51 AM identified the care plan could have been more specific to include the provision of unsafe food items with interventions that reduced the risk of an accident hazard. An interview with RN #8 on 8/14/24 at 10:45 AM identified she was the assigned RN supervisor for the 7:00 AM to 3:00 PM shift. RN #8 identified she was notified, believing it was some time the preceding week that [NAME] #3 was feeding unsafe food items to Resident #138. RN #8 provided education to Person #3 at that time. RN #8 identified that she was notified a second time on 8/11/24 that Resident #138 was again being provided unsafe food items. RN #8 was given a list of approved food items from speech therapy. RN #8 identified she was, in part, responsible for updating the care plan and did not. RN #8 further identified she should have updated the care plan with interventions to reduce the accident risk when the concern was first identified and education unsuccessful. An interview with RN #7 on 8/14/24 at 10:39 AM identified she had made at least two observations within the previous two weeks prior to 8/11/24 where on one occasion, she observed Person #2 feeding cream pie to Resident #138 and on another occasion, a donut. RN #7 reported both incidences to RN #8. RN #7 further identified that she educated Person #3 and completed a referral to speech therapy. An interview with (interim) the Speech Therapist, SLP #1 on 8/14/24 at 1:46 PM identified Resident #138 was prescribed a minced ground moist diet since readmission in 4/2024. Formed foods such as cookies were not permitted. SLP #1 became aware the preceding week when Person #2 complained that snacks were removed from Resident #138's room that were not appropriate. SLP #1 identified that snacks should not have been in Resident #138's room in the first place and that staff were not checking. SLP #1 provided education to Person #3 and Resident#138 about the risks of eating unsafe food items. SLP #1 identified there needed be increased in servicing around monitoring for safe food items. SLP #1 further identified that the provision of unsafe food items placed Resident #138 at risk for aspiration and choking and the continued provision of unsafe foods was placing Resident #138's life at risk. The RCP failed to identify Resident #138 was repeatedly being provided unsafe food items, failed to include interventions for safe food consumption and monitoring after Resident #138 was repeatedly provided unsafe food items when attempts to educate were unsuccessful. A review of the facility policy for Care Plans dated 12/2016 directed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet a resident's physical, psychological and functional needs is developed and implemented for each resident. Care plans are revised as information about the resident and resident condition changes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of clinical records, review of facility policy and interviews for one of three sampled residents (Resident #157) reviewed for accidents, the facility failed to ensure that a medication was not left at the resident's bedside for a resident who is without an order or assessment of self-administration. The findings include: Resident #157's diagnoses included prosthesis, elevated white blood cell, methicillin resistant staphylococcus aureus (MRSA). The admission MDS assessment dated [DATE] identified Resident #157 had moderate cognitive impairment, was dependent on staff for toileting hygiene, lower body dressing and transfers. The care plan dated 6/28/24 identified Resident #157 had decreased cognition related to short-term and/or long-term memory deficits with interventions that included: provide safety measures, close supervision, provide safety in all activities, reorientation to person, place and time as needed and offer simple choices. Observation on 8/11/24 at 11:20 AM identified Resident #157 lying in bed with the over bed table positioned on the left side of the bed with the following items on top of the table: a glass of milk, another glass half filled with orange juice, an empty milk and orange juice carton, and a medication cup containing 30 milliliters (ml) of a reddish colored liquid. Resident #157 identified that the nurse who gave the medication would know more about what was inside of the medication cup as he/she had not taken any protein with his/her morning medication. Interview with the Charge Nurse (LPN #1) on 8/11/24 at 11:23 AM identified that the reddish liquid in the medication cup was liquid protein, which she had given Resident #157 along with his/her morning medication. Review of the physician's order for the month of August/2024 identified an order directing Liquid protein supplement 30ml once daily by mouth. Review of Resident #157's clinical records failed to identify a physician's order for self-administration and failed to identify a completed self-administration assessment. Review of laboratory result dated 7/29/24 identified Resident #157's total protein level was 5.3 which is low based on the normal reference range of 6.4 to 8.3, and albumin level was 3.1 which is low based on the normal reference range of 3. To 5.0. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 8/11/24 at 11:45 AM identified she was responsible for administering medication to Resident #157 and that she had probably left the medication behind on the overbed table when she was taking up the other mediations in which the resident had refused. LPN #1 was asked if she had signed off the medication in the medication administration record (MAR), which she identified that she had signed it off, which indicates that the medication/supplement was administered as ordered. LPN #1 further identified that she should be present when administering medication to ensure that the resident takes the medication before signing the MAR. She also identified that Resident #157 did not have an order for self-administration. Interview with the DNS on 8/14/24 at 3:18 PM identified that medication should not be left at the bedside and if medication was left at the bedside a self-administration assessment would need to be completed prior. The DNS also indicated the nurse should be present and ensure that the resident takes the medication, as it is a part of medication administration. Interview with the Dietician on 8/15/24 at 1:55 PM identified that Resident #157 was placed on liquid protein supplement due to his/her wound to promote healing and to provide a boost to the resident. The Dietician identified that if Resident #157 was not taking the liquid protein supplement daily it would delay the wound healing process. Review of the Administration Procedures for all Medications policy identified that medications would be administered in a safe and effective manner. The policy further identified that after administration, return to the cart, and document administration in the MAR.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #138) reviewed for range of motion, the facility failed to ensure adaptive device(s) for limited mobility were applied according to physician's orders. The findings include. Resident #138 had diagnoses that included hemiplegia and hemiparesis (weakness and paralysis) following a cerebral infarction (stroke) affecting the left non-dominant side. The admission MDS assessment dated [DATE] identified Resident #138 had moderate cognitive impairment, mobility impairment to one side of the body and was dependent with bed mobility transfers and dressing. The Resident Care Plan dated 7/31/24 identified Resident #138 had left hand/elbow splints secondary to hemiparesis for contracture prevention. Interventions directed to apply splints as ordered, check skin before/after use and report changes. The physician's order dated 7/2/24 directed left elbow splint to be applied after lunch and removed with care on the evening shift daily. The physician's order dated 7/3/24 directed a splint application and wear schedule to the left hand on with morning care and to be removed with rounds after lunch daily. An observation on 8/12/24 at 11:27 AM identified there was no left-hand splint applied to the left hand. A subsequent observation on 8/13/24 after lunch at 12:58 PM with LPN #10 identified there was no left elbow splint applied to the left arm. An interview with NA #6 on 8/13/24 at 1:44 PM identified she was responsible for applying adaptive devices and was aware Resident #138 was to have the splints applied; however, she heard from another NA that Resident #138 was not wearing the splints because of skin integrity issues. NA #6 further identified she had not verified this information with the nurse. An interview and observation of Resident #138's skin with LPN #10 on 8/13/24 at 1:55 PM identified no skin integrity issues to the left hand/arm area and that it was not reported to her that the splints were being held due to skin integrity issues. An interview with the Director of Nursing on 8/14/24 at 9:28 AM identified she would expect staff to be following Resident #138's splinting schedule according to physician's orders. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Splinting directed that the licensed Nurse, Occupational Therapist/Physical Therapist will evaluate the need for a splint and a splinting program will be developed based on individual needs. The splinting program will be carried out daily with frequency determined by needs. Any skin redness/issues are to be reported by the nurse and Refusals are documented.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 46046 Based on observations, review of the clinical record, review of facility policy and interview for one sampled resident (Resident #312) receiving intravenous (IV) antibiotics, the facility failed to ensure old IV sites were removed and failed to ensure physician orders addressed flushing of the IV site. The findings include. Resident # 312's diagnoses included multiple pressure ulcers including the sacral region. A physician's order dated 8/5/2024 at 1:59 PM directed to administer Vancomycin HCL intravenous solution 500 mg /ml, use 500 mg intravenously every 12 hours for wound infection. The IV Nurse documentation dated 8/9/2024 at 3:03 PM identified that a peripheral IV line was placed in the right lower forearm. Observation with RN #1 on 8/11/2024 at 12:21 PM identified Resident #312 in bed appearing to be asleep with peripheral intravenous lines in each forearm. The peripheral IV line in the left arm was dated 8/5/2024 (6 days old) and appeared to have blood under the dressing. The peripheral IV line in the right arm was dated 8/9/2024. Interview with RN #1 at the time of the observation identified that the IV line dated 8/5/2024 should have been removed when the new IV line was placed in the right arm. She further identified that the order should have been obtained to discontinue the line when the order for the new IV line was obtained. Additionally, she noted that orders should have been obtained for flushes of the IV site, and monitoring of the site. The Facility policy labeled Removal of a Peripheral IV (Over the Needle, Peripheral Short) Catheter indicated in part the replacement of a peripheral IV catheter in an adult would be no more than 72-96 hours unless contamination or complication. The facility policy labeled peripheral IV Catheter flushing indicated in part a peripheral catheter used for intermittent infusion would be flushed at least every 12 hours. The facility policy labeled 7.0 IV therapy indicated in part Nurses who have successfully completed an educational course and demonstrations on how to monitor IV sites including appropriate documentation, care for the venipuncture site including documentation and administering IV fluids into existing lines could provide effective administration of infusion therapy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, review of facility policy and interviews for two of three sampled residents (Resident #6 and #140) reviewed for respiratory care, the facility failed to ensure a physician's order was in place directing the use of oxygen therapy for a resident utilizing oxygen and failed to ensure respiratory equipment was changed according to physician orders. The findings include: 1. Resident #6's diagnoses included chronic obstructive pulmonary disease (COPD), metabolic encephalopathy, and muscle wasting and atrophy. The quarterly MDS assessment dated [DATE] identified Resident #6 was cognitively intact, was totally dependent on staff for toileting, transfers, and personal hygiene. It further identified Resident #6 had shortness of breath or trouble breathing when lying flat and required oxygen therapy. Observation on 8/11/24 at 11:19 AM identified Resident #6 lying in bed wearing a nasal cannula connected to an oxygen concentrator set at a flow rate of 3 liters per minute (LPM). Observation on 8/12/24 at 2:35 PM with the Charge Nurse (LPN#6) identified Resident #6 was lying in bed wearing a nasal cannula connected to the oxygen concentrator set at 3 Liters/minute (LPM). Review of the physician's orders for the month of August/2024 failed to identify an order for the continuous or as needed use of oxygen therapy. Interview with LPN #6 on 8/12/24 at 2:35 PM identified that a physician order should be in the resident's record directing the utilization of oxygen therapy when a resident is receiving oxygen therapy; however, when LPN #6 reviewed the physician's order for August 2024, the records failed to identify a physician's order directing the use of oxygen for Resident #6. LPN #6 indicated that the reason Resident #6 did not have an order was because he/she goes to the hospital frequently. Interview with the Nursing Supervisor (RN #1) on 8/12/24 at 2:40 PM identified there was not a physician's order present directing the use of oxygen in Resident #6's electronic medical record in the physician's order section as the order was discontinued on 8/6/2024. RN #1 identified that an order for oxygen usage was written in Resident #6's Hospital Discharge Instructions (W-10) dated 8/6/24 for oxygen 2 -4 LPM as needed. RN #1 indicated that it would be the admitting nurse's responsibility to add the orders to the resident's records. Interview with the Nursing Supervisor (RN #9) on 8/12/24 at 2:45 PM identified that she was the admitting nurse and was responsible for reviewing the hospital discharge summary and inputting the orders in the resident's record. She indicated that the resident does utilize oxygen. RN #9 identified that the order for oxygen therapy was not in the physician's order because she had missed it and did not click off the oxygen orders in the computer when the resident was readmitted to the facility. Interview with the DNS on 8/14/24 at 3:18 PM identified that a physician's order should be in place for a resident utilizing oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Oxygen Administration policy identified that the nurse should verify that there is a physician's order for administering oxygen. 2. Resident #140 had a diagnosis that included a history of acute respiratory failure with hypoxia. The quarterly MDS assessment dated [DATE] identified Resident #140 had intact cognition and required assist of one with activities of daily living (ADL). The Resident Care Plan dated 7/3/24 identified Resident #13 had decreased cognition and a self-care performance deficit. Interventions directed to observe ability to perform ADL's adequately and safely. Physician's orders dated 8/1/24 directed oxygen at 2 liters per minute as needed for oxygen saturation less than 90% and oxygen tubing changes weekly. An observation on 8/12/24 at 9:46 AM identified Resident #140 ambulating out of his/her room with a rolling walker containing a portable oxygen tank. The tape adhered to the tubing was dated 6/5/24. An interview with Resident #140 on 8/12/24 at 9:46 AM identified he/she used oxygen daily. An observation and interview with LPN #7 on 8/11/24 at 10:09 AM identified the oxygen tubing should have been changed weekly. An interview with the DNS on 8/13/24 at 11:08 AM identified she expects oxygen tubing to be changed weekly according to physician orders. Although requested, a policy for care of respiratory equipment was not provided. 47900

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on review of the clinical record and interviews for one sampled resident (Resident #57) receiving insulin, the facility failed to ensure that physician orders for blood sugar monitoring/parameters were congruent with the administration of the morning dose of insulin. The findings include. Resident #57 had a diagnosis of diabetes A physician's order dated 4/24/24 directed to administer Tresiba Flex touch solution 100 units/ml pen injector, 24 units subcutaneously in the AM and to 21 units subcutaneously in the PM. A physician's order dated 6/13/24 directed to hold Tresiba if blood sugar is less than 90 every day and evening shift for diabetes. The annual MDS assessment dated [DATE] identified Resident #57 had severe cognitive impairment, could feed self with supervision, and received insulin daily. The care plan dated 7/18/24 indicated Resident #57 was an insulin dependent diabetic with interventions that included: administer insulin and blood sugar checks as ordered and staff to provide diet as ordered. Interview on 8/13/24 at 8:50 AM with LPN #8 indicated Resident #57 was a brittle diabetic and had a low blood sugar at 8:30 AM, the RN supervisor (RN #3) was notified, and the hypoglycemic protocol was followed with elevation of blood sugar to a normal level. Interview and record review on 8/13/24 at 10:30 AM with RN #3 identified that the 4/24/24 order to administer Tresiba was ordered to be given in the AM was scheduled to be given at 6:00 AM. A separate order dated 6/13/2024, directed to hold the Tresiba if the blood sugar level was below 90 was scheduled for the AM on the 7-3 shift, after the Tresiba was actually given at 6:00 AM. No blood sugar was scheduled to be performed at 6:00 AM prior to administering the Tresiba but a blood sugar was scheduled for 7:30 AM (an hour and half after the Tresiba was given at 6:00AM without the benefit of checking the blood sugar level to ensure it was within the physician's ordered parameter to be safely administered (64 days after the order to hold was written). RN #3 indicated she would contact the APRN for further orders. On 8/13/24 at 12:42 PM an interview with Pharmacist #1 indicated Tresiba would start working to lower a blood sugar level in about an hour and continues to be long acting over 24 hours. An interview with the DNS on 8/14/24 at 2:20 PM indicated the APRN writes the orders in the electronic system and the charge nurse notes the orders, third shift does a double check of new orders every night to ensure the orders are transcribed correctly onto the medication and/or treatment records. The DNS further indicated the staff involved will be reeducated. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy labeled Physician's orders-Oral, telephone and Written indicated in part all orders will include the name of the drug, dosage, form, route and length of time to be administered (stop date) the policy does not indicate how physician orders are double checked by nursing staff for accuracy of transcription to the medication and/or Treatment administration record. The facility failed to ensure that the blood sugars were monitored prior to the administration of morning dose of insulin.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37721 Based on observations, facility documentation review, facility policy and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner. The findings include: Observations during a tour of the kitchen on 8/11/24 at 10:05 AM with [NAME] #1 identified the following: The kitchen floor had an excessive amount of dried spillage brown/tan buildup under all counters and work prep areas in front of oven and back counter Dried white/tan/brown spillage along the side and front of ovens (4). 1/2 bag thawed mango loosely covered and placed on top of bin of pineapple also loosely covered. Leakage from the mango into the pineapple with the outside of bag directly making contact with the pineapple. 1/2 bag of opened mozzarella cheese balls with no date. 1/2 bag shredded of opened mozzarella cheese with no date. Three ceiling vent covers in the dishwashing station with moderate amount brown/grey matter buildup. Three red sanitizing buckets were stacked alongside the sink empty with cleaning supplies stored inside. The top of the Dishwasher with moderate amount of brown crumb-like debris. An interview with [NAME] #1 on 8/11/24 at 10:05 AM identified there were no set cleaning schedules for staff to follow and that staff were only responsible for cleaning immediate surface areas after use. All food items should have been dated and not stacked on top of each other. The cleaning of the ceiling vents was the responsibility of maintenance staff. [NAME] #1 further identified that although she had been switching food prep tasks on surface areas for breakfast and lunch, she did not use a sanitation solution and should have. Instead, [NAME] #1 used a towel with warm soapy water. An interview with the Director of Maintenance on 8/11/24 at 10:34 AM identified the kitchen staff were responsible for the cleaning of the ceiling vents covers in the dishwashing station. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Food Service Director, FSD on 8/11/24 at 11:05 AM identified he had been employed at the facility for one month and was responsible for overseeing staff in ensuring a clean and sanitary kitchen. The FSD was aware that the kitchen was not being maintained in a clean and sanitary manner, did not have any cleaning schedules that staff followed and was attempting to clean smaller areas of the kitchen at a time to address the issue. The FSD identified foods should be dated and not stacked to prevent leakage and that a sanitization bucket should have been set up and used to sanitize between food prep tasks. A review of the facility policy for Dietary Cleaning and Sanitation dated 8/2022 directed that the facility must maintain the sanitization of the kitchen through proper cleaning and sanitizing stationary food service equipment and food contact surfaces to minimize the growth of microorganisms that may result in food contamination. Although requested a policy on dating foods was not provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of clinical records, review of facility policy, review of facility documentation, and interviews during a review of the Infection Control Program, the facility failed to utilize personal protective equipment (PPE) when entering a transmission-based precaution resident's room and the facility failed to appropriately track and place a resident with a known MDRO on Enhanced Barrier Precautions (EBP). The findings include: Resident #127's diagnoses included pneumonia, acute kidney failure, and stroke. The admission MDS dated [DATE] identified Resident #127 had severely impaired cognition, dependent on care for toileting hygiene, personal hygiene, and transfers. The care plan date 8/13/24 identified Resident #127 had infection to left eye conjunctivitis with interventions that included precautions, intake and output every shift and temperature every shift. The physician's order dated 8/13/24 directed contact precaution secondary to conjunctivitis every shift for 7 days. Observation on 8/13/24 at 11:55 AM identified posted signage on the door frame of room [ROOM NUMBER] that identified the need for contact precaution which noted the need to perform hand hygiene before entering and before leaving the room, wear gloves when entering room or cubicle and when touching patient's skin, surfaces, or articles in close proximity, wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces with a red dot sticker on the back of the sign indicating room A by the door. LPN #7 stood in front of room [ROOM NUMBER] with her medication cart, performed hand hygiene, gathered the following supplies: clean gloves, glucometer, alcohol pad, gauze, lancet, testing stripe, Kleenex tissue, and a plastic cup. LPN #7 don cleaned gloves, and entered room [ROOM NUMBER]A by the door and placed all the supplies on the Kleenex tissue on top of the resident's overbed table. Interview with the Charge Nurse (LPN #7) on 8/13/24 at 11:55 PM identified that she had miss read the sign and thought that gloves were sufficient since she was not going to be in contact with the infected body site. LPN #7 then identified that she should have worn a gown along with the gloves based on the contact precaution sign. Subsequent to surveyor's inquiry LPN#7 performed hand hygiene, don clean gloves, gown and re-entered the room to perform the glucometer testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 8/14/24 at 12:38 PM identified posted signage on the door frame of room [ROOM NUMBER] that identified the need for contact precaution which noted the need to perform hand hygiene before entering and before leaving the room, wear gloves when entering room or cubicle and when touching patient's skin, surfaces, or articles in close proximity, wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces with a red dot sticker on the back of the sign indicating room A by the door. LPN #6 stood in front of room [ROOM NUMBER] with her medication cart as she prepared an injectable medication. Continued observation identified LPN #6 entered room [ROOM NUMBER] with only donned gloves along with the prepared medication and draw the privacy curtain. Interview with the Charged Nurse (LPN #6) on 8/14/24 at 12:41 PM identified that she only needed to wear a pair of gloves to enter the room. LPN #6 identified that she in fact saw the sign for contact precautions, but the dots were not visible. LPN #6 was asked if Resident #127, the resident who she administered medication, had a physician's order for contact precaution which after reviewing the records using the same computer used for medication administration located on top of the medication cart identified in fact Resident 3127 does have an order for contact precautions. LPN #6 then identified that she should have don gloves and gown prior to entering the room. Interview with the DNS on 8/14/24 at 2:55 PM identified she expected that if a resident was placed on contact precautions that staff would don gown and gloves before entering the room. Interview with the Staff Development Nurse (RN #12) on 8/15/24 at 12:45 PM identified that infection control education which includes transmission-based precaution are included annually for staff. RN #12 indicated that education is provided on various topics as needed by the facility throughout the year including donning and doffing PPE. Review of the Precautions to Prevent Infections identified that contact precautions are intended to prevent the transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. The policy further identified that when a transmission-based precautions would be implemented that staff would be aware of the expectations about hand hygiene, and gown/glove use with clear signage posted on the door or wall outside of the resident's room indicating the type of precautions and required PPE. Resident #6's diagnoses included chronic obstructive pulmonary disease (COPD), metabolic encephalopathy, and muscle wasting and atrophy. The quarterly MDS assessment dated [DATE] identified Resident #6 was cognitively intact, was totally dependent for toileting, transfers, and personal hygiene. Intermittent observations of Resident #6's room door from 8/12/24 to 8/14/24 failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as bathing, showering, device care or care of a urinary catheter. Review of the Discharge Summary dated 8/6/24 identified Resident #6 discharge diagnosis of a history of urinary tract infections with vancomycin-resistant Enterococcus (VRE) and methicillin-resistant Staphylococcus aureus (MRSA). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's MDRO log for the month of August 2024 failed to identify Resident #6 as having any history of an MDRO. Review of the physician's order for August 2024 failed to identify an active order for enhance barrier precautions related to history of MRSA and VRE in urine. Interview with NA #7, LPN #12 and LPN #13 on 8/14/24 at 12:15 PM identified that staff knows when a resident is on any precautions based on the posted signage outside of the resident's room which also states the type of PPE to worn and when to wear the PPE. Interview with the DNS on 8/14/24 at 11:59 PM identified Resident #6 should be on the MDRO list for August 2024 as the resident has a history of an MDRO. The DNS indicated that Resident #6 was removed when sent to the hospital but was never added to the list when returned. The DNS identified that staff is made aware of a resident being on any type of precaution with a posted signage on the door. The DNS further identified that Resident #6 would have a signage of enhanced barrier precaution based on the resident's MDRO's history. Observation and interview with the DNS on 8/14/24 at 2:30 PM failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as dressing, bathing, showering, device care or care of a urinary catheter. The DNS identified that a signage should have been placed on the door. Review of the Enhanced barrier Precautions policy identified that are used as an infection prevention and control intervention to reduce the spread of MDRO to residents. The policy further identified that EBPs are indicated when contact precautions do not otherwise apply for residents infected or colonized with the following: pan-resistant organisms, MRSA and VRE. Review of the MDRO policy identified that residents are screened prior to admission for active or colonized MDRO and PPE and signage would be placed outside of the room for staff or visitors on type of PPE that is required.

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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** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for two of five sampled residents (Resident #30 and Resident #105), reviewed for immunizations, the facility failed to administer the pneumococcal vaccine as requested by the resident upon admission and failed to offer the updated pneumococcal vaccine to the resident. The findings include: 1. Resident #30 was admitted to the facility in the month of July of 2022 with diagnoses that included type 2 diabetes mellitus, disorder of brain, and hyperlipidemia. The quarterly MDS dated [DATE] identified Resident #30 was cognitively intact. Review of the Immunization Consent form dated 7/22/2022 identified Resident #30 had received previous pneumococcal vaccine, hence declining the pneumococcal vaccine 23 and 13 that the facility was only offering at the time of the resident's admission. Review of the clinical records identified that Resident #30 had received the pneumococcal vaccine 23 dated 6/10/2008 prior to his/her admission to the facility. According to the Centers for Disease Control and Prevention (CDC) identified that adults 65years or older have an option to receive the pneumococcal vaccine 20 (PVC 20) if they had already received both Prevnar 13 (PCV 13) at any age or pneumococcal vaccine (PPSV23) at or after age [AGE] years old after consulting with their provider. Interview with the DNS (who is also an Infection Preventionist) on 8/15/24 at 12:30 PM identified that the facility had started to offer PCV20 vaccine in the summer of 2023 in which Resident #30 was still a resident at the facility. The DNS identified that Resident #30 would have been a candidate to receive the vaccination, but she was not the infection control nurse at the time. The DNS identified that it would be a good practice to offer residents new vaccine when it becomes available such as the pneumococcal vaccine. The DNS indicated that the facility utilized the electronic health record system to track the vaccine by running a report but did not have an excel tracking sheet and would have to review the facility's system. The DNS indicated that Resident #30's overflow records failed to identify that the PVC 20 was offered to the resident. Review of the Pneumococcal Vaccine policy identified that pneumococcal vaccine would be administered when informed consent has been given to residents unless medically contraindicated, already given, or refused according to the facility's physician-approved pneumococcal vaccination protocol. 2. Resident #105 was admitted to the facility in the month of April of 2024 with diagnoses that included Parkinson's disease with dyskinesia and fluctuation, muscle weakness, and hyperlipidemia. The admission MDS dated [DATE] identified Resident #105 was cognitively intact. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Immunization Consent form for pneumococcal vaccination identified that Resident #105 gave the facility permission to administer the pneumococcal vaccine as directed by Centers for Disease Control and Prevention (CDC) guidelines and physician on 4/12/24. Review of Resident #105 clinical records failed to identify that he/she had received the vaccination historically or at the facility. Interview with the DNS (who is also an infection preventionist) on 8/13/24 at 12:30 PM identified that Resident #105 did not receive the pneumococcal vaccine as requested after reviewing the records. The DNS identified that it was the responsibility of the Infection Preventionist nurse to select the appropriate vaccine and obtain the physician order so that the vaccine could be administered. The DNS also indicated that the facility had a different Infection Preventionist nurse at the time was unable to state why the vaccine was not given at the time it was requested. Review of the Pneumococcal Vaccine policy identified that pneumococcal vaccine would be administered when informed consent has been given to residents unless medically contraindicated, already given, or refused according to the facility's physician-approved pneumococcal vaccination protocol.

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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** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for one of five sampled residents (Resident #105) reviewed for immunizations, the facility failed to administer the pneumococcal vaccine as requested by the resident upon admission. The findings include: Resident #105 was admitted to the facility in the month of April of 2024 with diagnoses that included Parkinson's disease with dyskinesia and fluctuation, muscle weakness, and hyperlipidemia. The admission MDS dated [DATE] identified Resident #105 was cognitively intact. Review of the Immunization Consent form for COVID-19 vaccination identified that Resident #105 gave the facility permission to administer the COVID-19 vaccine on 4/12/24. Review of Resident #105 clinical records failed to identify that he/she had received the vaccination at the facility as requested. Interview with the DNS (who is also an infection preventionist) on 8/13/24 at 12:30 PM identified that Resident #105 did not receive the COVID-19 vaccine as requested after reviewing the records. The DNS identified that it was the responsibility of the Infection Preventionist nurse to select the appropriate vaccine and obtain the physician order so that the vaccine could be administered. The DNS also indicated that the facility had a different Infection Preventionist nurse at the time and was unable to state why the vaccine was not given at the time in which it was requested. Review of the COVID-19 Vaccination for Residents identified that the facility would obtain a signed consent form for the administration of the COVID-19 vaccine from the resident or the resident's designated health care representative.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 37721 Based on observations, facility documentation review, facility policy and interviews, the facility failed to ensure kitchen equipment was maintained in a safe and functional manner. The findings include: An observation during tour of the kitchen on 8/11/24 at 10:05 AM with [NAME] #1 identified the following: 1. Three of the four ovens of a double oven assembly were not functional. 2. No vent covers for 3 of 4 ovens of a double oven assembly with a moderate amount of gray matter and dried brown spillage on exposed inner components. 3.(1) of (6) wells on the steam table were not functional. 4.The large freezer located outside temperature was reading 14 degrees. Inside the thermometer reading was 8 degrees. Six loaves of (frozen) bread and four tubes of dessert topping located just to the inside of the door were soft and indented when pressed. A review of the outside freezer temperature log 7/1/24 through 7/31/24 identified freezer temperatures for the outside walk-in freezer were recorded between 5- and 20-degrees Fahrenheit. An interview with [NAME] #1 on 8/11/24 at 10:05 AM identified the ovens and steam table well had not been functional for approximately three months. Hot water was used for the nonfunctioning well on the steam table but was not adequate in keeping food temperatures warm. [NAME] #1 identified the ovens were supposed to be replaced and the steam well repaired but was not. [NAME] #1 further identified that freezer temperatures for the outside freezer were as high as 30 degrees. An interview and facility documentation review with the Director of Maintenance on 8/14/24 at 1:24 PM identified he was responsible for ensuring the repair and replacement of equipment in the kitchen. The Director of Maintenance identified the ovens were fixed on 6/13/24. Between 6/13/24 and sometime prior to 7/1/24 the ovens malfunctioned again. The Director of Maintenance obtained approval on 7/1/24 to order and purchase new stoves. The Director of Maintenance had not ordered the ovens and indicated he should have by now. The Director of Maintenance further identified he obtained the part to repair the steam table just the week before but had not had a chance to install it. Requests to review the delivery invoice were not responded to. An interview and facility documentation review with the Food Service Director (FSD) on 8/15/24 at 10:14 AM identified freezer temperatures be maintained below 0 degrees. A vendor had inspected the freezer subsequent to surveyor inquiry on 8/14/24 and determined that stacked food boxes restricted air flow, one of the condensers had stopped working and would require replacement. The FSD identified that although he was not previously aware of the issue, he did not attempt to address the concern when elevated freezer temperatures were first noted. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy for Maintenance Service directed that the maintenance department was responsible for maintaining the building, grounds and equipment in a safe and operable manner.