STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075440	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Watermark 3030 Park, The	3030 Park Avenue Bridgeport, CT 06604

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #223) reviewed for ADL's and who required assistance with toileting, the facility failed to ensure care that promoted the resident's dignity. The findings include: Resident #223 was admitted to the facility on [DATE] with diagnoses that included pneumonia, pulmonary hypertension, and chronic obstructive pulmonary disease (COPD). A physician's order dated 2/5/25 directed to administer Lasix (diuretic) 20 mg daily every other day. The nursing skilled evaluation dated 2/5/25 at 10:55 PM identified Resident #223 was alert and oriented and was continent of bladder with yellow urine. The social worker admission collection dated 2/6/25 at 2:56 PM identified Resident #223 was cognitively intact. The social worker note dated 2/6/25 at 3:20 PM identified she had called the resident representative with therapy present who indicated that Resident #223 was continent of bowel and bladder at home prior to going to the hospital and can take him/herself to and from the bathroom. The nursing skilled evaluation dated 2/6/25 at 8:57 PM identified Resident #223 was alert and oriented and was continent of bladder with yellow urine. The care plan dated 2/7/25 identified Resident #223 has mixed bladder incontinence related to weakness. Interventions included to monitor and document signs and symptoms of a urinary tract infection and clean peri area with each incontinent episode. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #223 on 2/9/25 at 10:15 AM indicated he/she has only been at the nursing facility since 2/5/25 and that prior to going to the hospital he/she was continent of bladder and would independently ambulate to the bathroom. Resident #223 indicated that when he/she must go to the bathroom he/she needs to go right away or will have an accident. Resident #223 indicated that this morning he/she put the call light on at about 8:00 AM and had to go to the bathroom and after a while, approximately 8:30 AM, someone came over the intercom and Resident #223 informed that person he/she had to use the bathroom, and that person replied that someone would be down there and shut the call light off. Resident #223 indicated that no one came within a few minutes, so he/she put the call light back on again but no one came into his/her room until 9:00 AM when the NA #2 came in but by that time the resident had urinated and was wet from his/her mid back to just above the knees. Resident #223 indicated that he/she was embarrassed to have wet the bed but just could not hold it that long. Interview with the DNS on 2/10/25 at 2:50 PM indicated that she had spoken to Resident #223 who was consistent in the events and was upset by the incident. The interview with the DNS on 2/11/25 at 8:15 AM indicated that approximately 4:00 PM on 2/10/25 she decided to have the social worker and herself talk to Resident #223 regarding filing a grievance from 2/9/25 about no one answering her call light for an hour resulting in resident being incontinent of urine. The DNS indicated that Resident #223 was receptive to the idea of filing a grievance. A Concern/Grievance Report dated 2/10/25 identified Resident #223 on 2/9/25 at 8:00 AM had placed call light on and no one answered it until 8:30 AM. Investigation and follow up sections were blank. The interview with the Administrator on 2/11/25 at 10:10 AM indicated that whoever answered the call from the desk should have gotten up and went to Resident #223's room and assisted him/her to the bathroom. The Administrator indicated that the call lights were to be answered timely by all staff. The Administrator indicated that the DNS must follow the grievance policy. Interview with LPN #1 on 2/11/25 at 12:25 PM indicated that she does not recall or remember Resident #223 having his/her call light on after 8:00 AM nor does she recall if the bed was soaked in urine and had to be changed when NA #2 had gone in the room about 9:00 AM. LPN #1 indicated that NA #2 was in the room when she had gone In to give Resident #223 his/her medications about 9:10 AM on 2/9/25. Review of the Skilled Nursing Resident Rights Policy identified rights of the residents are always recognized by all staff members, and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance of his/her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of residents. Review of the Resident Rights Policy identified the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. A facility must protect and promote the rights of each resident. A resident has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished and prompt efforts by the facility to resolve grievances the resident may have.

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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. 37721 Based on review of the clinical record, facility documentation, facility policy and interviews for of 3 of 4 residents (Resident #13, 3 and 173) reviewed for advance directives, the facility failed to ensure a physician's order was obtained that reflected the resident/resident representatives wishes for code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops). The findings include: 1. Resident #13 had diagnoses that included atherosclerotic heart disease. An Advance Directive dated 1/23/25 identified in the event of a cardiopulmonary arrest, Resident #13 requested Do Not Resuscitate (DNR). The Advance Directive was signed by the resident representative. A review of the physician orders dated 1/23/25 to 2/9/25 failed to reflect a DNR order was written. An interview with the DNS on 2/11/25 at 11:13 AM identified she would expect the nurse to obtain a physician's order once the advance directive was signed that reflected the resident/representative wishes. A review of the facility policy for Advance Directives directs to determine if a resident has or wishes to formulate and advanced directive on admission. A DNR order form must be completed and signed by the provider and remain in effect until the resident or responsible party provides notification in writing that the DNR is no longer in effect. 2. Resident #3 had diagnoses that included a non-displaced fracture of the left malleolus bony prominence on each side of the ankle) of the left fibula (calf bone) and dementia. An Advance Directive dated 12/13/24 identified in the event of a cardiopulmonary arrest, Resident #3 requested Do Not Resuscitate (DNR). The Advance Directive was signed by the resident representative. A review of the physician orders dated 12/13/24 to 2/9/25 failed to reflect a DNR order was written. An interview with the DNS on 2/11/25 at 11:13 AM identified she would expect the nurse to obtain a physician's order once the advance directive was signed that reflected the resident/representative wishes. A review of the facility policy for Advance Directives directs to determine if a resident has or wishes to formulate and advance directive on admission. A DNR order form must be completed and signed by the provider and remain in effect until the resident or responsible party provides notification in writing that the DNR is no longer in effect. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #173 had diagnoses that included covid 19 and pneumonia. An Advance Directive dated 2/4/25 identified in the event of a cardiopulmonary arrest, the resident requested Do Not Resuscitate (DNR). The Advance Directive was signed by Resident #173. A review of the physician orders dated 1/4/25 to 2/9/25 failed to reflect a DNR order was written. An interview with the DNS on 2/11/25 at 11:13 AM identified she would expect nurse to obtain a physician's order once the advanced directive was signed that reflected the resident wishes. A review of the facility policy for Advance Directives directs to determine if a resident has or wishes to formulate and advanced directive on admission. A DNR order form must be completed and signed by the provider and remain in effect until the resident or responsible party provides notification in writing that the DNR is no longer in effect.

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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** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #223) reviewed for medication administration, the facility failed to notify the physician when medications and creams were not available/provided according to the physician's order. The findings include: Resident #223 was admitted to the facility on [DATE] with diagnoses that included pneumonia, pulmonary hypertension, and chronic obstructive pulmonary disease (COPD). A physician's order dated 2/5/25 directed to administer Mucinex 1200 mg twice a day, Coenzyme Q10 200 mg tablet once a day, Triamcinolone Acetonide external cream 0.1% apply to abdominal folds and under left breast daily, and Anusol external cream 2.5% apply to hemorrhoids twice a day. Review of the nursing notes dated 2/5/25 to 2/10/25 failed to reflect the physician was notified that the Mucinex, Coenzyme Q10, Triamcinolone Acetonide external cream and Anusol had not been administered/applied per the physician's order. The social worker admission collection dated 2/6/25 at 2:56 PM identified Resident #223 was cognitively intact. Review of the MAR dated 2/6/25 to 2/10/25 identified: Mucinex 1200 mg twice a day was not administered 10 out of 10 opportunities. Coenzyme Q10 give a 200 mg tablet once a day was not administered 5 out of 5 opportunities. Triamcinolone Acetonide external cream 0.1% apply to abdominal folds and under left breast daily was not applied 4 out of 5 opportunities. Anusol external cream 2.5% apply to hemorrhoids twice a day was not applied 4 out of 4 opportunities. A physician's order dated 2/7/25 directed to change Anusol external cream 2.5% to once daily. The care plan dated 2/7/25 identified Resident #223 has altered respiratory status related to pneumonia, pulmonary hypertension, and COPD. Interventions included administering medications as ordered. Interview with Resident #223 on 2/9/25 at 9:15 AM indicated that the facility has not been giving him/her all the physician ordered medications and creams. Resident #223 indicated that the nurses just say they don't have it available, so he/she was not sure if it was a pharmacy issue or something else because he/she could have his/her resident representative bring in medications from home. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication observation on 2/10/25 at 8:45 AM identified LPN #1 did not have the Mucinex 1200mg tablet or the CQ10 tablet available. Interview with LPN #1 on 2/10/25 at 9:30 AM indicated that she doesn't have CQ10 or the Mucinex to give to Resident #223. LPN #1 indicated that she would have to notify the pharmacy. LPN #1 indicated that she was only notifying the pharmacy and did not need to notify the physician. The interview with the DNS on 2/11/25 at 8:03 AM indicated that when medications are not available the charge nurse must notify the supervisor or the DNS. The DNS indicated that she was notified prior to surveyor medication observation yesterday. The DNS indicated that if she was aware prior she would have contacted the pharmacy right away and signed the form stating the facility would pay for the over-the-counter medications and creams Resident #223 needed. The DNS indicated that the nurse should have notified the pharmacy right away when the first dose was not available. The DNS indicated that the nurses do not have to notify the physician when a resident misses a medication dose, but sometimes the nurses will notify the physician but not all the time. The DNS indicated that if the nurse notifies the physician, it would be documented in the resident's clinical record. The interview with the Administrator on 2/11/25 at 10:15 AM indicated that if a resident does not receive a medication or treatment the physician had ordered that the nurse or supervisor were responsible to call the pharmacy and notify the physician right away after every missed dose. The Administrator indicated that if the physician was notified of the medication not being given her expectation it would be documented in the clinical record. The interview with MD #1 on 2/11/25 at 11:47 AM indicated that when a new admission comes in, he reviews and approves the medications and treatments from the hospital discharge w-10. MD #1 indicated that he would expect a resident to have all their physician ordered medications from the pharmacy within 24 hours. MD #1 indicated that if a resident does not have a medication after 24 hours, he would have expected the nurse to call him and let him know, because it is good for him to know and determine if a resident needs that medication or if the resident would need something else in its place or if resident would need to be sent back to the hospital. MD #1 indicated that MD #1 indicated that if a resident missed a dose he would expect to be notified. MD #1 indicated that the Mucinex was for Resident #223's cough and would assist with breaking down the mucus so resident cough bring it up. MD #1 indicated that it would be important for Resident #223 to have since he/she was in the hospital for pneumonia. Review of the Medication Administration Policy identified medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only the person legally authorized to do so. Medications are administered in accordance with written orders from the prescriber. If a dose of regularly scheduled medication is withheld or refused an explanatory note is entered in the medical record and if 2 consecutive doses of a medication are withheld or refused the physician is notified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #223) reviewed for medication administration, the facility failed to administer medications and creams according to the physician's order. The findings include: Resident #223 was admitted to the facility on [DATE] with diagnoses that included pneumonia, pulmonary hypertension, and chronic obstructive pulmonary disease (COPD). A physician's order dated 2/5/25 directed to administer Mucinex 1200 mg twice a day, Coenzyme Q10 200 mg tablet once a day, Triamcinolone Acetonide external cream 0.1% apply to abdominal folds and under left breast daily, and Anusol external cream 2.5% apply to hemorrhoids twice a day. Review of the nursing notes dated 2/5/25 to 2/10/25 failed to reflect the physician was notified that the Mucinex, Coenzyme Q10, Triamcinolone Acetonide external cream and Anusol had not been administered/applied per the physician's order. The social worker admission collection dated 2/6/25 at 2:56 PM identified Resident #223 was cognitively intact. Review of the MAR dated 2/6/25 to 2/10/25 identified: Mucinex 1200 mg twice a day was not administered 10 out of 10 opportunities. Coenzyme Q10 give a 200 mg tablet once a day was not administered 5 out of 5 opportunities. Triamcinolone Acetonide external cream 0.1% apply to abdominal folds and under left breast daily was not applied 4 out of 5 opportunities. Anusol external cream 2.5% apply to hemorrhoids twice a day was not applied 4 out of 4 opportunities. A physician's order dated 2/7/25 directed to change Anusol external cream 2.5% to once daily. The care plan dated 2/7/25 identified Resident #223 has altered respiratory status related to pneumonia, pulmonary hypertension, and COPD. Interventions included administering medications as ordered. Interview with Resident #223 on 2/9/25 at 9:15 AM indicated that the facility has not been giving him/her all the physician ordered medications and creams. Resident #223 indicated that the nurses just say they don't have it available, so he/she was not sure if it was a pharmacy issue or something else because he/she could have his/her resident representative bring in medications from home. Medication observation on 2/10/25 at 8:45 AM identified LPN #1 did not have the Mucinex 1200mg tablet or the CQ10 tablet available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1 on 2/10/25 at 9:30 AM indicated that she doesn't have CQ10 or the Mucinex to give to Resident #223. LPN #1 indicated that she would have to notify the pharmacy. LPN #1 indicated that she was only notifying the pharmacy and did not need to notify the physician. The interview with the DNS on 2/11/25 at 8:03 AM indicated that when medications are not available the charge nurse must notify the supervisor or the DNS. The DNS indicated that she was notified prior to surveyor medication observation yesterday. The DNS indicated that if she was aware prior she would have contacted the pharmacy right away and signed the form stating the facility would pay for the over-the-counter medications and creams Resident #223 needed. The DNS indicated that the nurse should have notified the pharmacy right away when the first dose was not available. The DNS indicated that the nurses do not have to notify the physician when a resident misses a medication dose, but sometimes the nurses will notify the physician but not all the time. The DNS indicated that if the nurse notifies the physician, it would be documented in the resident's clinical record. The interview with the Administrator on 2/11/25 at 10:15 AM indicated that if a resident does not receive a medication or treatment the physician had ordered that the nurse or supervisor were responsible to call the pharmacy and notify the physician right away after every missed dose. The Administrator indicated that if the physician was notified of the medication not being given her expectation it would be documented in the clinical record. The Administrator indicated that it was the facility's responsibility to give the resident his/her medications per the physician's orders whether it is from the emergency medication box, the facility over the counter house stock, or the pharmacy. The interview with MD #1 on 2/11/25 at 11:47 AM indicated that when a new admission comes in, he reviews and approves the medications and treatments from the hospital discharge w-10. MD #1 indicated that he would expect a resident to have all their physician ordered medications from the pharmacy within 24 hours. MD #1 indicated that if a resident does not have a medication after 24 hours, he would have expected the nurse to call him and let him know, because it is good for him to know and determine if a resident needs that medication or if the resident would need something else in its place or if resident would need to be sent back to the hospital. MD #1 indicated that MD #1 indicated that if a resident missed a dose he would expect to be notified. MD #1 indicated that the Mucinex was for Resident #223's cough and would assist with breaking down the mucus so resident cough bring it up. MD #1 indicated that it would be important for Resident #223 to have since he/she was in the hospital for pneumonia. Review of the Medication Administration Policy identified medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only the person legally authorized to do so. Medications are administered in accordance with written orders from the prescriber. If a dose of regularly scheduled medication is withheld or refused an explanatory note is entered in the medical record and if 2 consecutive doses of a medication are withheld or refused the physician is notified.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for of 3 of 3 residents (Resident # 7, 3 and 16) reviewed for pressure ulcers, for Resident #7 the facility failed to conduct comprehensive skin assessments by a registered nurse following the identification of a pressure injury consistent with professional standards, for Resident #3, the facility failed to complete a required nutritional assessment related to the presence of a newly identified pressure injury and for Resident #16 the facility failed to ensure the air mattress was set by the residents' weight per the physician order. The findings include: 1. Resident #7 had diagnoses that included fracture of the left femur and difficulty walking. The Hospital Discharge Summary dated 12/16/24 identified wound care for the left femur surgical site with no documented pressure injuries. The Baseline Care Plan dated 12/16/24 identified Resident #7 was at risk for skin breakdown. Interventions included the application of pressure reduction devices and regular repositioning. The Admission RN assessment dated [DATE] at 7:40 PM identified a Stage 1(non-blanchable erythema) pressure injury to the left heel measuring 5.0cm x 0.1 cm. Physician's orders dated 12/16/24 directed skin prep to the bilateral heels every morning and every evening and to float heels while in bed. The Admission MDS dated [DATE] identified Resident #7 was cognitively intact, required one-person partial moderate assist with bed mobility, one to two person assist with dressing, two person assist with transfers and had one unhealed stage 1 pressure injury. Subsequent weekly skin assessments dated 12/23/24 through 1/11/25 identified the continued presence of a non-blanchable pressure injury to the left heel with consistent measurements and no noted changes, however, these wound assessments were not completed by an RN. An RN assessment dated [DATE] at 4:02 PM identified the left heel pressure injury was purple in discoloration, and measured 3.2 cm x 1.8 cm. Orders were obtained for betadine application to maintain dryness and a referral to the wound specialist was made. An Initial Wound Evaluation and management Summary dated 1/16/25 identified an unstageable DTI to the left heel of undetermined thickness measuring 3.2cm x 2.0cm and had been present more than 32 days. Recommendations included offloading the wound, elevating/floating the heels and applying betadine twice daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the ADNS on 2/09/25 at 3:05 PM identified she was responsible for the monitoring and tracking of all wounds at the facility. The ADNS identified Resident #7 had been admitted to the facility with a pressure injury but due to an oversight she failed to track the wounds progression until a change was reported on 1/12/25. Following the discovery, the ADNS completed a comprehensive skin assessment of the skin injury, obtained physician orders and referred Resident #7 to the wound specialist. An interview with the Administrator on 2/10/25 at 12:14 PM identified the ADNS should conduct a comprehensive weekly wound assessment for any resident with a wound including a detailed description and measurements. An interview with the Wound Specialist on 2/10/25 at 2:29 PM identified the progression of Resident #7's pressure injury was unavoidable due to limited mobility and existing comorbidities, despite appropriate interventions being in place. However, the Wound Specialist would expect a comprehensive nursing assessment on admission and thereafter. A review of the facility policy for Pressure Injuries and Surgical Sites for Licensed Nurses directs for newly admitted and existing residents, a licensed nurse will complete an evaluation from the head to most distal extremity within 24 hours of admission that includes any skin issues related to a pressure injury, surgical site, laceration or other skin anomaly identified during the evaluation. A licensed nurse is to document a weekly evaluation of pressure injuries to include the measurement, appearance, color and drainage. The LPN Practice Act Declaratory Ruling allows the LPN to contribute to the nursing assessment by collecting, reporting, and recording subjective and objective patient-related data in an accurate and timely manner. But an LPN cannot perform the assessment independently. 2. Resident #3 had diagnoses that included a non-displaced fracture of the left malleolus bony prominence on each side of the ankle) of the left fibula (calf bone) and dementia. A Nutritional assessment dated [DATE] identified Resident #3 was malnourished and had a stage 1 pressure ulcer on the coccyx that was present on admission. Recommendations included to provide Ensure supplement daily. The Admission MDS dated [DATE] identified Resident #3 was severely cognitively impaired, required two person assist with bed mobility/transfers, was at risk for the development of pressure ulcers and had one unhealed pressure ulcer. The Care Plan dated 12/30/24 identified Resident #3 had limited physical mobility and actual skin impairment of non-blanchable redness to the sacral area related to fragile skin/bony prominence. Interventions included pressure reducing devices, keep skin clean/dry and reposition every two hours to take pressure off the sacral area. A Nursing progress note dated 1/21/25 at 9:44 PM identified Resident #3 had a splint in place on the left lower extremity since admission for a fracture of left ankle and upon removal of splint observed skin to be red and noted callous to the left lateral (outside) foot and redness to the left dorsal (top) foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Initial Wound Evaluation and management Summary dated 1/23/25 identified a stage II pressure wound of the left, lateral foot and an unstageable deep tissue injury of the left, dorsal foot secondary to a medical device. Recommendations included offloading heels and betadine twice daily. Recommendations also included a dietary consultation to evaluate Resident #3's abnormal body mass index (measurement of a person's leanness based on height and weight). A Nutrition progress note dated 1/27/25 identified Resident #3 was stable since admission with meal intake between 75 - 100% and taking 50 - 100% Ensure supplements. Recommendations included to continue the plan of care. A Nutrition progress notes dated 1/29/25 identified Resident #3 no longer wanted Ensure supplementation reporting it was too sweet. Ensure was discontinued upon request. Review of the nutrition assessments and progress notes failed to reflect the newly identified skin injury. An interview with the Dietitian on 2/10/25 at 5:57 AM identified she would complete an assessment and document any newly identified pressure injuries. She would also consider the need for additional supplementation or increased protein intake. The Dietitian further identified she could not recall being made aware of any new skin integrity concerns for Resident #3 but would have documented any new skin injuries in the clinical record. An interview with the Administrator on 2/10/25 at 11:59 AM identified any new injuries were discussed in morning report and risk meetings. The Administrator identified she would expect the dietitian to assess any new skin injury and make any recommendations accordingly. The Administrator further identified, subsequent to surveyor inquiry, she discussed the case with the Dietitian who indicated she was not aware Resident #3 had a pressure injury. An interview with the DNS on 2/11/25 at 11:14 AM identified she would expect the dietitian to document the presence of any newly identified injury and any recommendations. Although requested a policy for the dietitian role and responsibility in wound management was not provided. Performance Expectations of the Dietitian identified they must utilize existing support structures and create new ones to ensure practices and standards are present and contributing to success. 3. Resident #16 was admitted to the facility on [DATE] with diagnoses that included unstageable sacral pressure ulcer, protein-calorie malnutrition, and diabetes. A physician's order dated 12/13/24 directed the use of an air mattress. Check air mattress settings as per weight or manufacturers settings every shift and check for placement and function every shift. The care plan dated 12/16/24 identified Resident #16 was admitted with pressure ulcers to the sacrum, and bilateral heels. Interventions included encouraging Resident #16 to frequently shift weight, educate Resident #16 about proper skin care to prevent skin breakdown, and heel lift boots while in bed. (continued on next page)

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	075440	A. Building B. Wing	02/11/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS dated [DATE] identified Resident #16 had moderately impaired cognition was always incontinent of bowel and had a catheter for urine. Resident #16 required total assistance for toileting, dressing, transfers, and personal hygiene. Resident #16 had 1 community acquired pressure ulcer that was unstageable and 2 pressure ulcers that were deep tissue injuries (DTI). Additionally, Resident #16 was at risk for developing pressure ulcers and had a pressure reducing device for the chair and bed. The care plan dated 1/22/25 identified Resident #16 has a new pressure ulcer to the left lateral heel on 1/16/25 and a new deep tissue injury to the right lateral plantar foot on 1/22/25. Interventions were to apply betadine to the areas. Review of the weight record identified the following weights: 12/14/24 Resident #16 weighed 142.5 lbs. 12/16/24 Resident #16 weighed 147.2 lbs. 12/24/24 Resident #16 weighed 148.2 lbs. 12/30/24 Resident #16 weighed 147.2 lbs. 1/11/25 Resident #16 weighed 136.0 lbs. 1/27/25 Resident #16 weighed 134.0 lbs. 2/3/25 Resident #16 weighed 134.5 lbs. Observation on 2/9/25 at 10:16 AM and 2:15 PM identified Resident #16 was lying on bed in supine position on the air mattress that was set at 75 lbs. Observation on 2/10/25 at 6:13 AM identified Resident #16 was lying on bed in supine position on the air mattress that was set at 75 lbs. Interview with RN #1 (11:00 PM to 7:00 AM charge nurse/supervisor) on 2/10/25 at 8:35 AM indicated that the charge nurse was responsible to check the placement and function of the air mattress every shift and sign off in the EMR that the air mattress had air and was set to the resident's weight. RN #1 indicated that she had looked at Resident #16's air mattress about 1:00 AM and signed off after she had looked at the control box of the air mattress and it was set at 75 lbs. RN #1 indicted that she works every weekend and when she came yesterday Resident #16's air mattress was set at 75 lbs. so she thought it was the right setting so this morning about 1:00 AM she made sure that it was still set at 75 lbs. and signed it off in the EMR. Review of the clinical record, RN #1 indicated that Resident #16's last weight on 2/3/25 was 134.5 lbs. RN #1 indicates that Resident #16 was not able to verbalize if the air mattress was too hard or too soft and that was why the physician order stated to set the air mattress by Resident #16's weight. RN #1 indicated that the purpose of the air mattress was to prevent wounds or to prevent wounds from getting worse if it was at the proper setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interview with ADNS (wound nurse) on 2/10/25 at 11:00 AM indicated that Resident #16 was on an air mattress due to the coccyx wound. ADNS indicated that the air mattress was to prevent wounds from getting worse and to alleviate pressure to the coccyx area. ADNS indicated that there is a physician order to check placement and function every shift by the charge nurse and the air mattress was to be set based on the resident's weight. Observation of Resident #16 with ADNS on 2/10/25 at 11:05 AM identified Resident #16 was lying in bed and ADNS indicated that the setting for the air mattress dial was set between 75 to 80 lbs. the ADNS indicated that Resident 16 weighs more than 80 lbs. After clinical record review, ADNS indicated that Resident #16 weight was 134.5 lbs. so the setting was not at the correct setting, and she would change it. Interview with ADNS on 2/10/25 at 11:16 AM indicated that she had spoken to maintenance, and they informed her the air mattresses were to be set based on the resident's weight. ADNS indicated that Resident #16's air mattress was set at 80 lbs. would be too soft, and Resident #16 could bottom out resulting in his/her buttocks being on the bed frame applying pressure. ADNS indicated that she and maintenance could not find a manufacture booklet for the air mattress used. Interview with the DNS on 2/11/25 at 7:52 AM indicated that the air mattress was set to the resident's weight. The DNS indicated that the nurse's aides were responsible for making sure it was at the correct setting when they went into a resident's room. The DNS indicated that there was not a policy for the air mattresses nor was there a manufacture booklet. Interview with the Administrator on 2/11/25 at 12:00 PM identified there was not a policy for air mattresses and they could not find the manufacturers' booklet for Resident #16's air mattress. Although requested, a facility policy for air mattresses and the manufacturer booklet for air mattresses was not provided. 42117

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #17) reviewed for accidents, the facility failed to implement interventions and supervision to prevent falls. The findings include: Resident #17 had diagnoses that included dementia and history of fracture. A Fall Risk assessment dated [DATE] identified Resident #17 was at risk for falls. The Admission MDS dated [DATE] identified Resident #17 was severely cognitively impaired, required two person assist with bed mobility/transfers and had a history of falls since admission without injury. The Care Plan dated 9/18/24 identified Resident #17 had impaired cognition and was at risk for falls related to dementia. Interventions included anticipating resident needs, ensuring the call bell is within reach and if restless, relocating the resident to a common area for closer supervision instead of assisting them to bed. Physician orders dated 9/19/24 directed assist of one with ADL's. Assist of two with mechanical lift transfer. a. A Nursing progress note dated 10/6/24 at 12:16 PM identified RN #3 witnessed Resident #17 sliding off the wheelchair and mechanical lift pad landing on the footrest while in front of the nurse's station. An assessment identified Resident #17 was unable to verbalize what lead to the incident, had no complaints or discomfort, and was safely transferred back to the wheelchair. The resident representative was notified. The post fall investigation dated 10/6/24 identified Resident #17 was observed to have slid out of his/her wheelchair and mechanical lift pad and onto the floor. The investigation further identified Resident #17 was previously observed to be constantly sliding down in the chair trying to get up and needed constant reminders to scoot back in the chair. The care plan was revised to maintain resident in a common area for close observation. An interview and clinical record review with the Administrator on 2/10/25 at 1:12 PM identified Resident #17's wheelchair and mechanical lift pad should have been evaluated to address repeated incidents of sliding down in the chair. The Administrator further identified simply reminding a resident to scoot back in the chair was not an appropriate intervention for a resident who was cognitively impaired. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Rehabilitation on 2/11/25 at 10:19 AM identified Resident #17 had poor safety awareness and was often kept in staff sight for safety. The Director of Rehabilitation identified she did not receive a request to evaluate Resident #17 related to repeatedly sliding out of their chair to determine if there was general weakness versus behavior. The Director of Rehabilitation further identified Resident #17 would not be able to consistently respond to reminders to self-scoot back in the chair due to his/her behaviors and cognition. An interview with the DNS on 2/11/25 at 10:56 AM identified a referral to evaluate Resident #17's chair and mechanical lift pad should have been completed after he/she was repeatedly observed sliding in the chair. Attempts to interview RN #3 were unsuccessful. A review of the facility policy for Fall Reduction directs all falls to be analyzed at the time of occurrence and root cause identified that lead to the potential breakdown with resident specific interventions put in place pertaining to the individual conditions following the fall. b. A nursing progress note dated 1/12/25 at 8:00 PM Resident #17 was observed on the floor at the nurse's station with the wheelchair on top of him/her. A body assessment was completed with no visible injuries and neurological assessments were initiated. The APRN and resident representative were notified. The post fall investigation dated 1/12/25 identified [NAME] #1 observed Resident #17 standing up from his/her wheelchair in front of the nurse's station holding onto the railing while calling for help. [NAME] #1 went to get a nurse, and upon return, Resident #17 had fallen. The care plan was revised to evaluate for anti-tippers for the wheelchair or obtain reclining wheelchair. An interview and clinical record review with the Administrator on 2/10/25 at 1:12 PM identified Resident #17 was known to have a history of falls and would have required periodic documented supervision checks as determined by the interdisciplinary team. Resident #17 would also be placed in front of the nurse's station or other common area where staff were aware not to leave the area if another staff member was not nearby. The Administrator further identified [NAME] #1 should not have left Resident 17 after identifying a safety concern. An interview with the Director of Housekeeping on 2/10/25 at 3:09 PM identified facility policies direct that housekeeping staff may not touch or provide direct care to a resident. However, for any safety concern, they are required to remain with the resident and call for help. An interview with [NAME] #1 on 2/10/25 at 3:14 PM identified he was in a nearby dining area when he heard Resident #17 call for help. [NAME] #1 then observed Resident #17 alone in front of the nurse's station standing up out of her wheelchair. [NAME] #1 identified that while not permitted to physically intervene with residents, he would normally ask the resident to sit back in the chair, remain with the resident and call for help for any identified safety concern. [NAME] #1 identified instead, in a state of panic, he left the area to find a nurse. Upon return, Resident #17 was on the floor with the wheelchair on top of him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Rehabilitation on 2/11/25 at 10:19 AM identified she did not receive a request to evaluate Resident #17's wheelchair following the fall on 1/12/25. An interview with the DNS on 2/11/25 at 10:56 AM identified [NAME] #1 should have remained with Resident #17 and called for help. The DNS was unable to provide any documented supervision checks for Resident #17. A review of the facility policy for Fall Reduction directs all falls to be analyzed at the time of occurrence and root cause identified that lead to the potential breakdown with resident specific interventions put in place pertaining to the individual conditions following the fall. Although requested, a policy for housekeeping staff interactions and residents regarding safety 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. 37721 Based on review of facility documentation and interviews, the facility failed to maintain a complete and accurate record of residents identified with Multidrug-resistant organisms (MDRO) in accordance with infection control standards. The findings include: A review of the facility infection control program identified no documented surveillance of long term residents with current or a history of MDRO's. An interview and facility documentation review with the ADNS on 2/10/25 at 9:44 AM identified she was the assigned infection preventionist (IP) for the facility for the preceding five months and was responsible for implementing and monitoring infection control activities in the facility. The ADNS identified that although she tracked the MDRO status for short term residents, she had not completed surveillance or tracking on any long-term residents. The ADNS had not observed any long-term resident on enhanced barrier precautions indicating an MDRO when she was first employed at the facility and had not verified their status. The ADNS was unable to provide any documented MDRO tracking from the previous IP. An interview with the Administrator on 2/10/25 at 12:24 PM identified she would expect surveillance for all residents with MDRO's to be maintained with complete and accurate record keeping including appropriate precautions put in place. An interview with the DNS on 2/11/25 at 11:17 AM identified she would expect an MDRO log to be maintained for all residents at the facility. Although requested, a policy for MDRO surveillance was not provided. Centers for Disease Control and Prevention (CDC) provide infection control standards for long-term care facilities that require the implementation of an MDRO surveillance program that includes the tracking and trending of those with MDRO's and infection, communication of MDRO status during transfers and strategies for transmission-based precautions.