STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075441	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Watermark East Hill, The	611 East Hill Road Southbury, CT 06488

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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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 2 residents (Resident #2 and 23) reviewed for hospitalization , the facility failed to notify the Office of the State Long-Term Care Ombudsman following the hospital transfers. The findings include: 1. Resident #2 was admitted to the facility on [DATE]. The census form identified Resident #2 began a hospital leave on 5/15/24 and returned to the facility on [DATE]. Further review identified Resident #2 began a hospital leave on 6/29/24 and returned to the facility on [DATE]. The May 2024 Emergency Transfers document and the Long-Term Care Ombudsman Program (LTCOP) Notification Details document dated 6/3/24 failed to identify the Office of the State Long-Term Care Ombudsman had been notified of Resident #2's hospital transfers and the facility failed to provide documentation of the June 2024 Emergency Transfers and the LTCOP Notification Details. Interview and facility documentation review with SW #1 on 1/07/25 at 7:23 AM identified Resident #2's hospital transfers on 5/15/24 and 6/29/24 were not reported to the office of the Long-Term Care Ombudsman. SW #1 identified that she had worked at the facility for approximately 3 years, and that she had only learned, about 1 month ago, that unplanned discharges to the hospital were required to be reported to the Ombudsman. SW #1 indicated that she did not have an answer as to why there was no documentation for the June 2024 Emergency Transfers and the LTCOP Notification Details. Interview with the Administrator on 01/07/25 at 10:02 AM identified that she had worked at this facility for approximately 1 year, and that she had spoken with SW #1 about the expectation for Ombudsman notifications, which would be to compile a monthly report including all residents that have been transferred to another facility (including hospitals), were discharged home, or left against medical advice (AMA) and send the report to the Office of the Long-Term Care Ombudsman. (continued on next page)

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

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

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	The facility's Transfers/Discharges, Emergency Transfers, AMA, and Bed-Holds policy directs that a copy of the notice for emergency transfers must also be sent to the Ombudsman's office but may be sent when practicable. Such notices may be provided in a list format and sent to the Ombudsman's office on a monthly basis for all residents transferring/discharging to an acute care facility during the month. The policy further directs the Administrator to confirm the format and the timing of information to be sent related to emergency transfers with their area Ombudsman. 2. Resident #23 was admitted to the facility in October 2024. Review of the census form identified Resident #23 was transferred to the hospital on 10/18/24 and admitted . Review of the emergency transfers form failed to reflect that the Office of the State Long-Term Care Ombudsman had been notified of residents who had been transferred to the hospital between 6/2024 through 11/2024, including Resident #23's hospitalization of 10/18/24. Interview with SW #1 on 1/7/25 at 2:20 PM identified she was responsible for sending the emergency transfers form to the Office of the State Long-Term Care Ombudsman and indicated she did not notify the Office of the State Long-Term Care Ombudsman of any resident transfer to the hospital for the year 2023 or from 6/2024 through 10/2024. SW #1 did not have a reason the notifications were not made. Interview with the DNS on 1/7/25 at 2:30 PM identified SW #1 was responsible to notify the Office of the State Long-Term Care Ombudsman of any resident that was transferred to the hospital, and she was not aware the notifications were not being done monthly. Interview with the Administrator on 1/7/25 at 2:40 PM identified SW #1 was responsible to notify the Office of the State Long-Term Care Ombudsman of any resident that was transferred to the hospital, and she was not aware the notifications were not being done monthly. The facility's Transfers/Discharges, Emergency Transfers, AMA, and Bed-Holds policy directs that a copy of the notice for emergency transfers must also be sent to the Ombudsman's office but may be sent when practicable. Such notices may be provided in a list format and sent to the Ombudsman's office on a monthly basis for all residents transferring/discharging to an acute care facility during the month. The policy further directs the Administrator to confirm the format and the timing of information to be sent related to emergency transfers with their area Ombudsman. 47457

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #226) reviewed for rehabilitation, the facility failed to develop a baseline care plan for a newly admitted resident with multiple cardiac and respiratory issues who required a specialized device. The findings include: Review of hospital discharge documentation dated 12/31/24 identified Resident #226 was hospitalized from 12/20/24 - 12/31/24 for cardiac surgery that included coronary artery bypass surgery of 4 vessels and removal of an implanted pacemaker/defibrillator wires. The documentation further identified that during the hospitalization , Resident #226 had a spontaneous right sided pneumothorax (collapsed lung) that required chest tube placement and was removed prior discharge. The hospital documentation further identified that post operatively, Resident #226 required the use of a Lifevest device (a wearable defibrillator that continuously monitors the heart and delivers a controlled electrical shock if indicated). Resident #226 was admitted to the facility on [DATE] with diagnoses that included recent coronary artery bypass surgery, heart failure, chronic obstructive pulmonary disease, and atherosclerotic heart disease. The nursing admission assessment dated [DATE] identified Resident #226 was admitted following coronary artery bypass surgery with a right sided pneumothorax and had a Lifevest device in place. The baseline care plan dated 12/31/24 failed to identify documentation related to the resident's cardiac or respiratory diagnoses including his/her recent major cardiac surgery, spontaneous pneumothorax requiring a chest tube placement, or need for the Lifevest device. Interview with LPN #1 (MDS Coordinator) on 1/8/25 at 10:12 AM identified she was responsible for MDS assessments, reviewing and updating baseline and comprehensive care plans, and also had a dual role as a medical records clerk at the facility, and that due to her work load, she had fallen behind on ensuring the resident care plans were reviewed to ensure they were individualized to the resident's individual needs. LPN #1 identified that when a resident was admitted , the baseline care plan included, at a minimum, care plans to address pain, falls, skin, code status, and the admission diagnoses, and that after the comprehensive care plan was developed, the resident's specific needs should have been included. LPN #1 identified if a resident was admitted to the facility with a specialized device, or required additional interventions, such as post operative surgical site care, etc, these should be added to the baseline care plan and then would carry over to the comprehensive care plan. LPN #1 identified Resident #226 should have had a baseline plan that reflected the need for respiratory and cardiac monitoring and the use of the Lifevest device, as these were all identified on the hospital W-10 and should have been included in his/her care plan upon admission to the facility. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility assessment provided to the survey team on 1/8/25 and dated 1/7/25, directed that the facility had the ability to provide person centered directed care and special care needs for all its residents. The assessment also directed that the facility had sufficient resources to provide staff education, competencies, and had policies and procedures for provisions of care for all facility residents. The facility policy on care plans directed at that the facility must develop a baseline care plan for each resident that would include the instructions needed to provide effective and person-centered care of the resident that met the professional standards of quality care. The policy further directed that the baseline care plan must be developed within 48 hours of admission and must include minimum healthcare information necessary to properly care for the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 2 of 5 residents (Resident #9 and 224) reviewed for unnecessary medications, the facility failed to develop a comprehensive care plan with interventions to address fall risk, use of antidepressant, antianxiety, and anticoagulant medications and intravenous antibiotic medication via a specialized central line. The findings include: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included depression, anxiety, and dissection of the thoracic aorta. The admission MDS dated [DATE] identified Resident #9 had moderately impaired cognition, had an active diagnosis of depression and anxiety disorder, was taking medications for antianxiety, antidepressant, and anticoagulant. Additionally, the MDS identified Resident #9 had a fall in the last month prior to admission and a fall in the last 2-6 months before admission. The MDS was completed on 12/30/24. A physician's order dated 12/26/24 directed to administer Lexapro (antidepressant medication) 20 mg daily, Alprazolam (antianxiety medication) 0.25mg one tablet every 12 hours as needed for anxiety, and Heparin solution (blood thinner) 5000 units inject subcutaneously 3 times a day. Review of the care plan on 1/6/25 failed to reflect interventions for the use of antidepressant, antianxiety, and anticoagulant medications or interventions to address the resident's risk of falls. Interview with LPN #1 (MDS coordinator) on 1/7/25 at 2:02 PM indicated she was responsible to do the comprehensive care plan within 21 days of admission. LPN #1 indicated that the comprehensive care plan was to include potential or actual problems that a resident has. LPN #1 indicated that a comprehensive care plan would include the resident's diagnosis and the medications taken. LPN #1 indicated that Resident #9's comprehensive care plan should include his/her fall risk, diagnosis of depression, anxiety and anticoagulant use. LPN #1 indicates that the care plan has a focus area for the problem or diagnosis, then the desired outcomes and the intervention or actions to be taken. LPN #1 indicated that the admission MDS (comprehensive assessment) should have been done by 12/24/24 but was not, and the comprehensive care plan ahould have to been done within the 7 days of the MDS but no later than 12/30/24. LPN #1 indicated that it was not done because she is behind and has no coverage when she is off. Interview and clinical record review with DNS on 1/7/25 at 2:10 PM indicated that the MDS coordinator LPN # 1 was responsible to do the comprehensive care plan. Review of the Care Plan Policy identified care plan is the plan of care that is developed by the interdisciplinary team, the resident and/or resident representative, and the attending physician. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. A comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment (MDS). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46040 2. Review of hospital documentation dated 12/18/24 identified Resident #224 weighed 195 lbs., was receiving Daptomycin (an intravenous antibiotic) daily for 6 weeks, and had a peripherally inserted central catheter (PICC) in place. The hospital documentation also identified to notify the physician for a weight gain of more than 4 lbs. in 2 days. Resident #224 was admitted to the facility on [DATE] with diagnoses that included MRSA bacteremia, chronic kidney disease, and insulin dependent diabetes. The physician's orders dated 12/18/24 directed to infuse 500 mg Daptomycin daily with an end date of 1/14/25: to flush the PICC line pre and post Daptomycin infusion, and to change the PICC dressing every 7 days. The admission MDS dated [DATE] identified Resident #224 had intact cognition, was always continent of bowel, required in indwelling catheter for bladder and was dependent on staff to assist with dressing, toileting, and transfers. The MDS also identified Resident #224 had a PICC line on admission to the facility. The corresponding care plan dated failed to identify interventions related to intravenous medications or the PICC line. Interview with LPN #1 (MDS Coordinator) on 1/8/25 at 10:12 AM identified that she was responsible for MDS assessments, reviewing and updating baseline and comprehensive care plans, and also had a dual role as a medical records clerk at the facility, and that due to her work load, she had fallen behind on ensuring the resident care plans were reviewed to ensure they were individualized to the resident's individual needs. LPN #1 identified that when a resident was admitted , the baseline care plan included, at a minimum, care plans to address pain, falls, skin, code status, and the admission diagnoses, and that after the comprehensive care plan was developed, the resident's specific needs should have been included. LPN #1 identified if a resident was admitted to the facility with a specialized device, or required additional interventions, such as post operative surgical site care, etc, these should be added to the baseline care plan and then would carry over to the comprehensive care plan as these would be identified on the hospital documentation and indicate the need for admission to the facility. LPN #1 identified Resident #224 should have had comprehensive care plan in place to address his/her need for prolonged antibiotic use through a PICC line, as this line was specialized due to the resident's need for long term antibiotic treatment. The facility policy on care plans directed the facility must develop a comprehensive person-centered care plan for each resident that must include measurable objectives and timetable table to meet the resident's needs. The policy further directed that the comprehensive care plan should include any specialized services, be completed within 7 days of the comprehensive assessment, and include desired outcomes.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of facility documentation, facility policy, and interview, the facility failed to ensure that all licensed staff had valid, current CPR certification. The findings include: Review of CPR certification for licensed staff identified 2 RNs and 2 LPNs had valid CPR certification, and 13 LPNs had no CPR certification. Interview with the DNS on [DATE] at 11:00 AM indicated that the nurses are responsible to update their CPR cards when they are due and provide a copy to the DNS and HR. Interview with HR Person #1 on [DATE] at 11:10 AM indicted that the DNS was responsible to track that all licensed nurses had current CPR certification. Review of the nursing schedules dated [DATE] to [DATE] during 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts identified licensed nurses without current valid CPR certification. Interview with the Administrator on [DATE] at 12:00 PM indicated that HR was responsible to track and make sure that all licensed nursing staff are CPR certified. Review of RN #2's personnel file on [DATE] at 12:15 PM identified RN #2 was hired on [DATE]. The file did not contain a valid current CPR certification. Interview with HR Person #1 on [DATE] at 2:10 PM indicated if she were aware that it was her responsibility to track and make sure that all licensed nursing staff were CPR certified, she would have made sure it was done, but it had previously been the responsibility of the DNS. HR Person #1 indicated that she called and received all the CPR cards for everyone except 2 nurses and indicated that the 2 nurses were supervisors. One was the full-time night shift RN who works by himself without any other nurse and the other was the full time 3:00 PM to 11:00 PM RN supervisor who works with one other nurse. Interview with the DNS and Administrator on [DATE] at 6:45 AM indicated that RN #2 does not have CPR certification. The DNS indicated that RN #2 is the only nurse and supervisor on the 11:00 PM to 7:00 AM shift. The Administrator indicated that the CPR card was to be in the employee file prior to hire but wasn't. The DNS indicated that HR Person #1 was responsible to check credentials Interview with the Administrator on [DATE] at 7:00 AM indicated that she was not aware that the CPR certifications were not being obtained at hire and were not being tracked after hire. Review of RN #2's punch detail from [DATE] to [DATE] identified he worked the 11:00 PM to 7:00 AM shift as the only nurse for 79 days out of 112 days. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #2 on [DATE] at 8:25 AM indicated that he was the full-time night nurse at the facility on 11:00 PM to 7:00 AM shift and is the only nurse on duty. RN #2 indicated that he was CPR certified at the hospital in 2021, and it expired in 2023. RN #2 indicated that he had lost the expired CPR card from 2023. RN #2 indicated that when he was hired at this facility he recalls on the on boarding (electronic) paperwork which stated he needed to provide a CPR card, but he had lost his and could not provide it. RN #2 indicated that no one from the facility had asked him for his CPR card since he was hired. RN #2 indicated that since hire in [DATE] no residents have needed CPR during his shifts. Review of the Cardiopulmonary Resuscitation (CPR) Policy identified that CPR will be initiated according to the residents wishes and physicians order when there is an identified cardiac and/or pulmonary arrest event. CPR is to be performed only by a staff person that are certified to do so. All direct care giving staff, when required by state regulations, are required to obtain basic Adult CPR and Obstructive Airway certification and to be re-certified by state regulations. Certification is only obtained by attending a course offered through American Red Cross, and American Heart Association. The facility is to track the staff that are certified in CPR and Obstructed Airway Techniques.

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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** 46040 Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 1 of 2 residents (Resident #224) reviewed for nutrition, the facility failed to ensure that weights were obtained per the physician's order for a newly admitted resident; and for 1 of 2 residents (Resident #226) reviewed for rehabilitation, the facility failed to ensure that a physician's order was obtained related to a specialized cardiac device to ensure function; and failed to ensure respiratory assessments were completed and documented per the physician's order; and for 1 resident (Resident #9) the facility failed to ensure a PPD (purified protein derivative is a skin test that determines if you have Tuberculosis) was completed on admission per the physician's order. The findings include: 1. Review of hospital documentation dated 12/18/24 identified Resident #224 had a weight of 195 lbs., (used to determine Daptomycin dosing) at 500 mg daily for 6 weeks, had a PICC line in place, and to notify the physician for a weight gain of more than 4 lbs. in 2 days. Resident #224 was admitted to the facility on [DATE] with diagnoses that included MRSA bacteremia, chronic kidney disease, and insulin dependent diabetes. A physician's order dated 12/18/24 directed to obtain Resident #224's weight on admission, daily for 3 days, weekly for 4 weeks, and then monthly. A nursing admission assessment, completed by RN #6 on 12/18/24 failed to identify documentation related to Resident #224's admission weight on that date. The care plan dated 12/20/24 directed that Resident #224 was at risk for malnutrition. Interventions directed to monitor closely for weight loss/gain. The nutrition admission assessment dated [DATE] by the Dietitian identified Resident #224 had a weight of 177.4 lbs., that Resident #224 reported a baseline weight of 182 - 183 lbs., and that Resident #224 had a history of recent weight loss but not significant. The admission MDS dated [DATE] identified Resident #224 had intact cognition, was always continent of bowel, required in indwelling catheter for bladder and was dependent on staff to assist with dressing, toileting, and transfers, and was independent with meals. The MDS also identified Resident #224 weighed 178 lbs. and had no recent history of weight gain or loss. Review of the clinical record identified an initial documented weight of 177.4 lbs. on 12/20/24, 2 days after admission to the facility, and a 17.6 lbs. or 9% loss from the last documented weight in the 12/18/24 hospital documentation. Review of the clinical record identified weights following the initial weight on 12/20/24 12/21/24 177.6 lbs. 12/30/24 180.0 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/4/25 187.0 lbs. Further review of the clinical record identified Resident #224 had a weight of 189 lbs. documented on 1/6/25, a 12.6 lb or 6.54 % gain in 17 days. A physician's note dated 1/6/25 identified that Resident #224 was seen due to staff noting a weight gain of 10 lbs. since admission with an initial weight of 177 lbs. and now 189 lbs. The note identified Resident #224 was observed to have bilateral 3 + pitting edema to the lower extremities, dependent edema to the bilateral upper extremities and in the dependent part of the arms and lower skin folds. The assessment identified Resident #224 had fluid overload with increasing weight with a plan to start Lasix (a diuretic medication used to decrease fluid overload) 40 mg daily for 3 days and then 20 mg daily, and to obtain daily weights. Interview with the Dietitian on 1/8/25 at 9:20 AM identified that she completed an initial assessment on 12/20/24 and did not review the hospital documentation related to weights prior to the assessment. The Dietitian identified that she did not believe that the hospital weights were accurate, and did not review them as they often included weights from previous hospital admissions. The Dietitian identified that she was aware Resident #224 received daily Daptomycin therapy. The Dietitian was unable to identify why Resident #224's weight on the hospital documentation was not reviewed prior to her nutritional assessment, given the order for Daptomycin was new and would require a current weight to initiate this medication safely. Interview and record review with RN #6 on 1/8/25 at 9:30 AM identified he completed the admission assessment for Resident #224 on 12/18/24. RN #6's review of Resident #224's clinical record failed to identify an admission weight on that date. RN #6 identified he typically reviewed the hospital documentation, and the admission orders related to the residents' weights, and in this instance he was unsure what happened, but he was unable to locate an admission weight, or a reference to the hospital weight, but he should have ensured the admission weight was obtained. Interview with APRN #1 on 1/8/25 at 9:57 AM identified that he would expect facility nursing staff to obtain the resident's weight on admission per the facility policy, however this could be within 24 hours. APRN #1 identified that the nursing staff should at least review the hospital documentation related to weights, but that it would be hard to review all the hospital discharge paperwork related to weights. APRN #1 identified Resident #224 was currently gaining weight due to fluid retention, and while in the facility had gained weight. APRN #1 was unable to identify if Resident #224 had a true weight loss from the 195 lbs. per the hospital documentation. to 177.4 lbs. on 12/20/24 since the admission weight on 12/18/24 was not obtained. The facility policy on weights directed that residents would be weighed as directed by the physician and standards of care and would be documented in the clinical record. The policy further directed that if the resident had a weight loss or gain, a re-weigh should be obtained at the time of the weight change, and to notify the physician of a significant weight loss or weight gain. The policy further identified a significant weight loss/gain was 5% over one month; 7.5% over 3 months, or greater than 10 % over 6 months. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of hospital discharge documentation dated 12/31/24 identified that Resident #226 was hospitalized from 12/20/24 - 12/31/24 for cardiac surgery that included coronary artery bypass surgery of 4 vessels and removal of implanted pacemaker/defibrillator wires. The documentation further identified that during the hospitalization , Resident #226 had a spontaneous right sided pneumothorax (collapsed lung) that required chest tube placement for which was removed prior to discharge. The hospital documentation further identified that post operatively, Resident #226 required the use of a Lifevest device (a wearable defibrillator that continuously monitors the heart and delivers a controlled electrical shock if indicated). Resident #226 was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive pulmonary disease, and atherosclerotic heart disease. The nursing admission assessment dated [DATE] identified Resident #226 had intact cognition and required the assist of one staff member with transfers and toileting. The admission assessment also identified Resident #226 was admitted following coronary artery bypass surgery of 4 vessels with a right sided pneumothorax and had a Lifevest device in place. The care plan dated 12/31/24 failed to identify interventions related to cardiac or respiratory issues or diagnoses for Resident #226, including need for the Lifevest device. A physician's order dated 12/31/24 directed to complete respiratory assessments daily for 7 days on the 11:00 PM - 7:00 AM shift. Review of the physician's orders failed to identify the Lifevest system, including monitoring checks for function and battery life, or orders related to battery changes. Review of the January 2025 TAR identified that respiratory assessments were signed off as completed daily from 1/1/25 - 1/6/25. Review of the clinical record identified nursing documentation related to respiratory assessment findings for 1/1/25 - 1/2/25. Further review of the clinical record failed to identify any additional documentation related to assessment findings for 1/3/25 - 1/6/24. Observation and interview with Resident #226 on 1/6/25 at 7:24 AM identified he/she had recent major heart surgery and had been admitted to the facility for post-surgery rehabilitation. Resident #226 identified he/she had only recently started rehab but had been having difficulty taking a deep breath at times, which he/she had reported to the clinical staff on 1/4/25, after he/she was provided a shower. During this interview, Resident #226 was observed wearing the Lifevest device. Interview with the DNS on 1/7/25 at 11:33 AM identified that the facility had not provided in service or training to facility staff related to the Lifevest device for Resident #226 prior to or after admission on 12/31/24. The DNS also identified she did not have any documentation that the facility staff had ever been provided education on the Lifevest device. (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 Resident #226 on 1/7/25 at 11:35 AM identified that he/she had all the education materials, including the manual for the device, in his/her room. Resident #226 identified that the device required a rechargeable battery for function and that he/she had been monitoring the battery life and changing the battery daily at 2:30 PM. Resident #226 identified he/she had a replacement battery on a charger located on his/her nightstand. Resident #226 identified he/she had some mild arthritis in his/her hands and this, along with overall weakness from his/her recent surgery, made it difficult at times to remove and replace the battery. Resident #226 identified that the facility nursing staff did not change the battery for the Lifevest device and only assisted with the battery changes at his/her request, when he/she had difficulty removing the old battery. Interview and clinical record review with LPN #2 on 1/7/25 at 12:20 PM identified that she was aware Resident #226 had a Lifevest device on, and that the nursing staff had been instructed that the battery for the device needed to be replaced daily at 2:30 PM by Resident #226. LPN #2 identified that she had not been educated on the device, and that she was aware of how the device worked based on training she received several years prior at another facility. LPN #2 identified upon review of the clinical record she was unable to locate any orders related to the Lifevest device. LPN #2 identified that the 2:30 PM daily battery change was based on Resident #226's preference as this was the time the battery changes occurred while Resident #226 was hospitalized . Interview with the DNS on 1/7/25 at 3:17 PM identified that Resident #226 had an order in place to complete daily respiratory assessments and these were done on the 11:00 PM - 7:00 AM shift. The DNS identified that the nursing staff were to sign off that the assessment had been completed daily on the TAR, and then the actual assessment findings were then documented under the Respiratory Screener observation area in the clinical record, which included detailed exam findings, and for the assessment to be considered completed, both the TAR sign off and the assessment would need to be documented. The DNS identified that the TAR sign off alone did not mean the assessment had been completed, since the assessment findings also needed to be documented. Interview with the DNS and Administrator on 1/8/25 at 1:45 PM identified that the facility staff should have been educated on use and care of the Lifevest device prior to Resident #226's admission to the facility and a physician's order should have been in place related to the battery changes. Review of the clinical record failed to identify instructions or manuals for Resident #226's Lifevest device. Although requested, the facility failed to provide any policies or procedures related to the Lifevest device. The facility policy on physician's orders directed that the DNS and/or medical records designee were responsible to ensure that the physician's orders were provided timely, confirmed with the resident's primary physician, and new admissions would have orders in place to provide care for the resident. The policy further directed that the written orders would include orders related to recommendations for admission to the facility and specialized rehabilitation treatments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility assessment provided to the survey team on 1/8/25 and dated 1/7/25, directed that the facility had the ability to provide person centered directed care and special care needs for all its residents. The assessment also directed that the facility had sufficient resources to provide staff education, competencies, and had policies and procedures for provisions of care for all facility residents. Review of the [NAME] Lifevest 4000 instruction manual materials, located in Resident #226's room, included a patient card which directed that the card [NAME] had a wearable defibrillator on due to high risk of sudden cardiac death, and the device was intended to automatically treat sudden cardiac death events that could occur without warning. The patient card also directed that device must be worn continuously and only be removed for a short shower. The instruction manual directed that if the patient needed to remove the garment for any reason, the battery pack should be removed prior to any removal of the Lifevest device and when reapplying the Lifevest, the electrodes and pads must be applied to bare skin to work accurately, and the battery pack should be reinserted as the last step, once the vest was fully applied. 47457 3. Resident #9 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia and COPD. A physician's order dated 12/13/24 directed to administer PPD 2 step, 0.1ml on admission, if negative, repeat in 1 week. The December 2024 MAR identified Resident #9 had the step-1 PPD planted on 12/13/24 and a negative result was documented on 12/16/24. The MAR failed to identify that the step 2 PPD was repeated, per order. Interview and clinical record review with the Infection Preventionist (RN #1) and the DNS on 1/8/25 at 10:11 AM failed to identify that Resident #9 received the second PPD test. The DNS identified that the facility policy is to complete a 2-step Tuberculosis PPD test on new admissions to the facility. The day after admission the first PPD test is planted and read 48 - 72 hours after placement, and the second PPD test would be planted one week later and read 48 - 72 hours after placement. The DNS indicated that it is the responsibility of the floor nurse to plant and read the PPD, repeat the process one week later, and document all actions in the resident's MAR. The facility's TB Skin Testing for Residents policy directs all residents admitted will be screened for signs and symptoms of Tuberculosis and will complete TST (tuberculin skin test), or provide a statement from the physician stating that the resident is free from active pulmonary communicable TB. If the resident has not had a TST in the last year a 2-step TST will be required.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #7) reviewed for nutrition, the facility failed to follow a physician's order for weight monitoring for a resident with severe protein-calorie malnutrition. The findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses that included dysphagia, hyponatremia, Myelodysplastic Syndrome, and severe protein-calorie malnutrition. A physician's order dated 12/12/24 directed to weigh Resident #7 on admission, daily times 3 days, weekly times 4 weeks, and then monthly: every Monday on day shift. The APRN Admission Note dated 12/13/24 at 8:00 AM identified Resident #7 had moderate protein-calorie malnutrition, likely related to cancer diagnosis. Monitor nutritional status and weight, consider nutritional supplements if needed. Current weight 110.5 lbs. The care plan dated 12/13/24 identified Resident #7 had a nutritional problem related to: severe malnutrition, weight loss, low BMI, increased nutrient needs, hyponatremia, and dysphagia. Interventions included monitoring, recording, and reporting to the physician signs and symptoms of malnutrition: emaciation, muscle wasting, and significant weight loss: 3 pounds in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, and greater than 10% in 6 months. The care plan failed to identity a focus, desired outcomes, or interventions for refusals of care. The admission MDS dated [DATE] identified Resident #7 had intact cognition, required a setup or clean-up assist with eating, had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months, and was not on a physician-prescribed weight-loss regimen. Review of the Weights and Vital Summary and the December 2024 TAR failed to identify weekly weights were completed from 12/14/24 through 12/30/24 (a period of 16 days). The Weights and Vital Summary identified that on 12/12/24 Resident #7 weighed 112 pounds and on 12/31/24 Resident #7 weighed 98 pounds, which is a 12.5% loss. The nurse's notes dated 12/12/24 through 12/31/24 failed to identify that Resident #7 had refused his/her scheduled weights. Interview with Resident #7 on 1/6/25 at 7:34 AM identified that he/she was aware of the recent significant weight loss. Resident #7 identified his/her condition had been improving and he/she was planning on being discharged home at the end of the week. Resident #7 indicated that he/she was recently admitted to the hospital from another facility with sepsis and had already began losing weight prior to his/her admission to this facility. Resident #7 identified that the food at the facility was good, but he/she initially had a poor appetite, which had been improving, and that he/she was working in collaboration with the facility staff regarding his/her weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Dietitian on 1/7/25 at 8:33 AM identified that Resident #7 had begun losing weight prior to admission to this facility, had weighed 103 pounds during his/her hospital admission, and had an admission diagnosis of severe malnutrition. The Dietitian indicated that Resident #7 had refused a shower on 12/22/24 but was unable to identify documentation that Resident #7 had refused to be weighed. The Dietitian further indicated that upon the identification of Resident #7's weight loss, the provider was notified, and she met with Resident #7 to discuss his/her weight loss and subsequently exchanged the Magic Cup supplement for the Mighty Shake supplement, per the resident's preference. The Dietitian indicated that even if Resident #7 had weekly weights taken between 12/12/24 through 12/31/24, she believes the weight loss outcome would have still been the same, but she would have addressed the weight loss and modified the supplements sooner. Interview and clinical record review with LPN #5 on 1/08/25 at 8:44 AM identified that she had identified Resident #7's weight loss, on 12/31/24, and notified the Dietitian and the APRN. LPN #5 further identified that majority of the facility residents, except for a few residents, are weighed weekly, during the day shift on Mondays. LPN #5 indicated that all nursing staff are responsible for obtaining residents' weights, but typically the nurse aide would obtain all the assigned resident's weights and write the weight onto the weight sheet, and the assigned Charge Nurse would enter the resident's weight into the electronic health record. LPN #5 identified that she works full time, on the day shift but was off both Mondays that Resident #7's weights were not obtained. LPN #5 further identified that she was unaware if Resident #7 had refused to be weighed during the timeframe of 12/12/24 through 12/31/24, but that Resident #7 had never refused care/treatment while she had been assigned to him/her. Interview with LPN #2 on 1/08/25 at 9:06 AM identified that she had provided care for Resident #7 only a few times, and he/she had never refused care or weights for her. LPN #2 further identified that if a resident refuses a weight, she would ask him/her the reason for the refusal, then she would educate the resident on the importance of why the weight needs to be obtained and reapproach later, if appropriate. LPN #2 indicated that she would also notify the physician of a weight refusal and document in the clinical record. Interview and clinical record review with the DNS on 1/08/25 at 10:47 AM identified that weights are to be completed per the physician's orders. The DNS indicated that if Resident #7 had refused a weight, she would have expected the nurse to notify the provider and then reapproach on the next shift. The DNS identified that education will be provided to the nursing staff on the weight policy. Interview with APRN #1 on 1/08/25 at 9:44 AM identified that Resident #7's weight loss was anticipated due to his/her diagnoses of Myelodysplastic Syndrome, however he would have expected that Resident #7's weights were obtained per the physician's order because he/she was a brand new resident and identified as having malnutrition. APRN #1 indicated that the Dietitian had adjusted Resident #7's supplements, when the weight loss was identified and that he would not have made any other adjustments. The facility's Weights policy directs all resident maintain acceptable parameters of nutritional status, taking into account the resident's clinical condition. Resident will be weighed as directed by the physician, federal/state regulations, or standards of practice and weights will be documented in the electronic health record. If weight loss or weight gain has occurred, appropriate follow-up is initiated and proper documentation recorded on the resident's status and follow-up taken.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 47457 Based on review of the clinical record, facility documentation, facility policies, and interviews, the facility failed to ensure all licensed nursing and supportive nursing personnel had the appropriate IV training/certification and competencies. The findings include: 1. Review of facility documentation identified that 7 out of 17 licensed nurses, including RN #2 and LPN #4, did not have an IV therapy certification on file. Review of facility documentation identified RN #2 cared for Resident #224 who had a peripherally inserted central catheter (PICC) line, including flushing the PICC line on 12/19/24, 12/20/24, 12/23/24, 12/24/24, 12/25/24, 12/26/24, 12/27/24, 12/31/24, 1/1/25, 1/252, and 1/3/25. Review of facility documentation identified on 1/6/25 LPN #4 administered IV Daptomycin via a PICC to Resident #224. Interview with RN #2 on 1/8/25 at 8:10 AM identified that he had provided care for residents receiving IV therapy, including flushing Resident #224's PICC line. RN #2 indicated that prior to working at this facility, he completed one day of IV training in the Emergency Department, worked in an acute care facility and took care of many IVs. RN #2 further indicated that he currently works only at this facility, and he did not have an IV certification for long-term care. RN #2 could not recall if he had ever completed any competencies or completed an IV skill demonstration while employed at this facility. Interview with the Human Resources Director on 1/8/25 at 7:15 AM indicated that she had been in this position for almost 2 years, and the prior DNS and Administrator had been responsible for obtaining IV certifications for the licensed nursing staff. The Human Resources Director further indicated that prior to this survey she was not aware that it was her responsibility to obtain the IV certifications, and the Administrator had informed her today, that moving forward, she would be responsible to obtain and track IV certifications, upon hire and thereafter. Although attempted an interview with LPN #4 was not obtained. Interview with the DNS on 1/8/25 at 10:11AM identified that she was not aware that 7 out of 17 licensed nurses did not have an IV therapy certification on file. The DNS indicated that Human Resources should be requesting IV certifications during the new employee on-boarding process. The DNS further indicated that she oversees staff development so ultimately the responsibility was hers for ensuring the IV therapy certifications were completed and the staff was competent in the skill sets necessary for IV therapy. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Scope of Practice and Competency Assessment policy directs nurses administering infusion therapy and performing vascular access insertion and management must be qualified and competent based on their licensure and perform only duties within their scope of practice. Initial competency is assessed and documented before the skill is performed without supervision and ongoing competency assessment and documentation is determined by rules and regulations of the State Board of nursing or by facility policy. Documentation of completed continuing education and competency assessments should be available in facility or employee files. The Facility's Responsibilities policy directs that a facility instituting infusion therapy will specify educational requirements for nursing staff including initial training and ongoing competency evaluations and maintain records of personnel qualified by education and experience who may provide infusion therapy in the facility. 2. Review of facility documentation failed to identify that any of the facility's nurse aides had completed IV competency validation for Supportive Nursing Personnel in 2024. Interview and review of facility documentation with the DNS on 1/8/25 at 10:11 AM indicated that the facility had not had a lot of residents requiring IV therapy lately, and that it was her oversite that annual IV therapy education and competency evaluations were not completed for the nurse aides. The DNS further indicated that she was the one responsible for ensuring the annual education and competencies were completed. The facility's Guidelines for Infusion Education for Licensed Nursing Personnel and Supportive Nursing Personnel directs nurse aides caring for residents receiving IV therapy will be provided with IV education initially, yearly, and as needed based on an identified need and competency will be determined by the facility.

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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** 42117 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #174) reviewed for respiratory care, the facility failed to change the oxygen and nebulizer tubing weekly per physician order. The findings include: The hospital discharge summary dated 12/23/24 identified Resident #174 was diagnosed on [DATE] with Covid-19 infection. Resident #174 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, Covid 19 and Dementia. A physician order dated 12/23/24 directed to maintain oxygen via nasal cannula at 2.5 liters may titrate to 2 liters if pulse ox level is greater than 90%. Additionally, administer Levalbuterol inhalation nebulizer solution 0. 63 mg/3ml application inhale orally via nebulizer 4 times a day for congestion and/or shortness of breath and contact precautions isolation precautions every shift related to Covid-19. A physician's order dated 12/25/24 directed to change and date oxygen tubing set and nebulizer tubing every Wednesday night shift. The admission 5-day MDS dated [DATE] identified Resident #174 had severely impaired cognition and required total assistance with dressing, and transfers. Resident #174 was on oxygen on admission and while a resident at the facility. The care plan dated 12/27/24 did not reflect oxygen or nebulizer use. The physician order dated 12/28/24 at 11:59 PM directed to discontinue the contact isolation precautions for Covid-19. Observation on 1/6/25 at 8:00 AM identified Resident #174 was lying in bed wearing a nasal cannula connected to a concentrator set at 2.5 liters of oxygen. The nebulizer was on the nightstand at the bedside with mask inside the top drawer. The oxygen tubing and the nebulizer tubing had a piece of nursing tape attached to the tubing's dated 12/25/24 (12 days prior was last changed). Interview with LPN #2 on 1/6/25 at 9:07 AM indicated that Resident #174 was admitted with covid-19 and was receiving oxygen and nebulizer treatments. LPN #2 indicated that Resident #174's oxygen tubing and nebulizer tubing were to be changed every Wednesday by the charge nurse on the 11:00 PM to 7:00 AM shift. LPN #2 indicated that Resident #174's oxygen tubing he/she was wearing at the time and the nebulizer tubing were both dated 12/25/24. LPN #2 indicated that Resident #174 was receiving nebulizer treatments 4 times a day. LPN #2 indicated that both tubing's should have been changed on 1/1/25. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/6/25 at 9:13 AM identified that the oxygen tubing and nebulizer tubing had a piece of tape that was dated 12/25/24 and was scheduled to be changed every week on Wednesdays by the RN on the 11:00 PM to 7:00 AM shift. The DNS indicated that the nurse must date the tubing when it is changed and the nurse should not sign off that the tubing was changed it they did not change it. The DNS indicated that the oxygen tubing and nebulizer tubing were dated 12/25/24 and should have been changed last Wednesday (1/1/25) per the physician's order and the nurse should not have signed off that he did it when it was not done. Interview with RN #2 on 1/8/25 at 8:25 AM identified that oxygen and nebulizer tubing was to be changed once a week on Wednesdays by the 11:00 to 7: 00 nurse. RN #2 indicated that no one has shown him if there was a place to sign off that the tubing was changed. RN #2 indicated that each tubing when changed must be initial, dated and timed. Review of the facility Respiratory Equipment Changing identified all respiratory therapy equipment must be changed to prevent nosocomial infections. All equipment should be marked with a date that it was changed. All equipment should be changed on a weekly basis as well as needed if it becomes soiled or falls on the ground. This equipment includes nasal cannulas, nebulizer treatment equipment, corrugated tubing, simple masks, oxygen and suction tubing.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15802 Based on observation, review of the clinical record review, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #226) reviewed for rehabilitation, the facility failed to ensure nursing staff were provided training and education related to a specialized device for a newly admitted resident. The findings include: Review of hospital discharge documentation dated 12/31/24 identified that Resident #226 was hospitalized from 12/20/24 - 12/31/24 for cardiac surgery that included coronary artery bypass surgery of 4 vessels and removal of implanted pacemaker/defibrillator wires. The documentation further identified that during the hospitalization , Resident #226 had a spontaneous right sided pneumothorax (collapsed lung) that required chest tube placement for which was removed prior to discharge. The hospital documentation further identified that post operatively, Resident #226 required the use of a Lifevest device (a wearable defibrillator that continuously monitors the heart and delivers a controlled electrical shock if indicated). Resident #226 was admitted to the facility on [DATE] with diagnoses that included heart failure, chronic obstructive pulmonary disease, and atherosclerotic heart disease. The nursing admission assessment dated [DATE] identified Resident #226 had intact cognition and required the assist of one staff member with transfers and toileting. The admission assessment also identified Resident #226 was admitted following coronary artery bypass surgery of 4 vessels with a right sided pneumothorax and had a Lifevest device in place. The care plan dated 12/31/24 failed to identify interventions related to cardiac or respiratory issues or diagnoses for Resident #226, including need for the Lifevest device. Review of the physician's orders failed to identify the Lifevest system, including monitoring checks for function and battery life, or orders related to battery changes. Observation and interview with Resident #226 on 1/6/25 at 7:24 AM identified he/she had recent major heart surgery and had been admitted to the facility for post-surgery rehab. Resident #226 identified he/she had only recently started rehab but had been having difficulty taking a deep breath at times, which he/she had reported to the clinical staff on 1/4/25, after he/she was provided a shower. During this interview, Resident #226 was observed wearing the Lifevest device. Interview with the DNS on 1/7/25 at 11:33 AM identified that the facility had not provided any training to facility staff related to the Lifevest device for Resident #226 prior to or after admission on 12/31/24. The DNS also identified she did not have any documentation that the facility staff had ever been provided education on the Lifevest device. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #226 on 1/7/25 at 11:35 AM identified that he/she had all the education materials, including the manual for the device, in his/her room. Resident #226 identified that the device required a rechargeable battery for function and that he/she had been monitoring the battery life and changing the battery daily at 2:30 PM. Resident #226 identified he/she had a replacement battery on a charger located on his/her nightstand. Resident #226 identified he/she had some mild arthritis in his/her hands and this, along with overall weakness from his/her recent surgery, made it difficult at times to remove and replace the battery. Resident #226 indicated he/she has difficulty removing and replacing the battery at times. Resident #226 identified that the facility nursing staff did not change the battery for the Lifevest device and only assisted with the battery changes at his/her request, when he/she had difficulty removing the old battery. Interview and clinical record review with LPN #2 on 1/7/25 at 12:20 PM identified that she was aware Resident #226 had a Lifevest device on, and that the nursing staff had been instructed that the battery for the device needed to be replaced daily at 2:30 PM by Resident #226. LPN #2 identified that she had not been educated on the device, and that she was aware of how the device worked based on training she received several years prior at another facility. LPN #2 upon review of the clinical record, was unable to locate any orders related to the Lifevest. LPN #2 identified that the 2:30 PM daily battery change was based on Resident #226's preference as this was the time the battery changes occurred while Resident #226 was hospitalized . Interview with NA #6 on 1/7/25 at 12:25 PM identified she was working with another nurse aide as she had only recently started employment at the facility but was assigned to Resident #226. NA #6 identified she was aware Resident #226 had a vest on but was not aware what the vest was for or why Resident #226 required it. NA #6 identified that she had only observed Resident #226 wearing the vest and she had not received any instructions, or training on the vest. Interview with PTA #1 (PT Director), PTA #2, OT #1, and OTA #1 on 1/7/25 at 12:30 PM identified they had each worked with Resident #226 providing PT and OT services daily since 1/1/25 and had not received any education or training from the facility related to the Lifevest device. OTA #1 identified she had never been trained or provided education on the device at any facility she had worked. OT #1 and PTA #2 identified they had both received training in the past on the device while working at another facility and were aware it was a cardiac monitor with a defibrillator. PTA# 1 identified she had received training on the device in the past while working at a different facility and was aware that Resident #226 must have the vest on at all times and that the Lifevest device had a response button that Resident #226 was required to push if the vest determined an irregular heart rhythm, and if he/she did not press the button, the vest would beep and administer a defibrillation shock to the resident. Interview with LPN #1 (MDS Coordinator) on 1/8/25 at 8 AM identified that she could not recall ever receiving education or training related to a Lifevest Device. Interview with the DNS and Administrator on 1/8/25 at 1:45 PM identified that the facility staff should have been educated on use and care of the Lifevest device prior to Resident #226's admission to the facility and a physician's order should have been in place related to the battery changes. Review of the clinical record failed to identify instructions or manuals for Resident #226's Lifevest device. (continued on next page)

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	075441	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at Watermark East Hill, The	611 East Hill Road Southbury, CT 06488

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, the facility failed to provide any policies or procedures related to the Lifevest device. The facility assessment provided to the survey team on 1/8/25 and dated 1/7/25, directed that the facility had the ability to provide person centered directed care and special care needs for all its residents. The assessment also directed that the facility had sufficient resources to provide staff education, competencies, and had policies and procedures for provisions of care for all facility residents. Review of the [NAME] Lifevest 4000 instruction manual materials, located in Resident #226's room, included a patient card which directed that the card [NAME] had a wearable defibrillator on due to high risk of sudden cardiac death, and the device was intended to automatically treat sudden cardiac death events that could occur without warning. The patient card also directed that device must be worn continuously and only be removed for a short shower. The instruction manual directed that if the patient needed to remove the garment for any reason, the battery pack should be removed prior to any removal of the Lifevest device and when reapplying the Lifevest, the electrodes and pads must be applied to bare skin to work accurately, and the battery pack should be reinserted as the last step, once the vest was fully applied.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 42117 Based on review of facility documentation, facility policy, and interviews, the facility failed to complete 90-day performance evaluations, failed to complete annual performance evaluations for nurse aides for 2023 and 2024 and failed to provide the annual mandatory education for 2024. The findings include: Interview with the Director of HR on 1/7/25 at 12:15 PM indicated that performance evaluations were to be completed for new hires at 90 days and then annually, however, the facility had not been completing the 90-day evaluations because the department heads were busy. The Director of HR indicated she was responsible to track, and each month send a list of employees due for their annual evaluations to the department heads via email. The Director of HR indicated when the evaluation is completed it goes to the Executive Director for approval. The Director of HR indicated after that process is complete, she files the evaluations in the employee's file. The Director of HR indicated that when employees come to her and report that their performance evaluation were not done, she will notify the manager/department head. The Director of HR indicated if reported again she will notify the Executive Director. Interview with the DNS on 1/7/25 at 12:39 PM indicated that she was responsible to do the annual performance evaluations for the nursing department and was not sure if a new hire gets an evaluation before the annual. The DNS indicated that she receives a list for the nursing staff due that month for a performance evaluation. After review of the 5 nurse aides personnel files, the DNS identified that the 2023 and 2024 annual evaluations had not been done. The DNS indicated that she was aware that she was behind in doing the annual evaluations. Review of the personnel file of NA #1 identified the date of hire was 8/23/23, and there was not a 90-day or annual evaluation for 2024. Review of the personnel file of NA #2 identified the date of hire was 7/6/23 and there was not a 90-day evaluation or annual evaluation for 2024. Review of the personnel file of NA #3 identified the date of hire was 3/31/22 and there was not a 90-day evaluation or annual evaluation for 2023 and 2024. Review of the personnel file of NA #4 identified the date of hire was 2/28/18 and there was not an annual evaluation for 2023 and 2024. Review of the personnel file of NA #5 identified the date of hire was 4/13/22 and there was not a 90-day evaluation or annual evaluation for 2023 and 2024. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Performance Evaluations Policy identified the facility would evaluate every staff person at the end of the introductory period and then annually. Each new staff person's immediate supervisor or designee shall prepare and provide the staff person with an evaluation using the appropriate evaluation form at the end of the 90-day introductory period and then on an annual basis. Evaluations should occur within one pay period of their anniversary date with any applicable increase to become effective the first full pay period following the anniversary date. Each employee will receive a copy of their evaluations, and the original shall be retained in the employee's personnel file. Interview and clinical record review with DNS on 1/8/25 at 12:15 PM was not able to provide the mandatory education for the nursing staff completed in 2024. Review of the personnel files for NA #1, NA #2, NA #3, NA #4 and NA #5 identified no mandatory education had been done for 2024. Form identified as Employee In-service Yearly listed the following topics for education: fire and disaster safety plan, Safety Chemical safety data sheets, accident prevention, body mechanics, resident rights and abuse, dementia training, infection control, blood borne pathogens, Hepatitis and Tuberculosis, standard infection control precautions, handwashing, understanding agitated behaviors, falls and falls management, emergency evacuation procedure, HIPPPA, incontinent care and skin prevention, pain management, customer service, IV line management, and Dialysis management. Although requested, a facility policy for nurses and nurse aide mandatory annual education, it was not provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37293 Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure shift to shift controlled drugs count was consistently completed. The findings include: Observation on 1/8/25 at 12:00 PM of the medication carts with RN #1 identified the January 2025 change of shift inventory record for controlled drugs were missing nurse's signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift on the following units: The Short End unit was missing 3 signatures (between 1/1/25 - 1/8/25). Interview with LPN #2 on 1/8/25 at 12:20 PM identified it was the responsibility of each oncoming and off going nurse to sign the narcotic count sheet at the beginning of the shift and at the end of each shift at the time the controlled substance count is completed. Interview with RN #1 on 1/8/25 at 12:25 PM identified she was not aware of the missing narcotic count signatures until now during rounds with surveyor. RN #1 indicated the expectation is that the nurses will count the narcotics at change of shift and sign the narcotic count sheet after completing the count. Interview with the DNS on 1/8/25 at 12:30 PM identified she was not aware of the missing narcotic count signatures. The DNS indicated the expectation of the facility is that the oncoming and off going nurse count the controlled substances during each shift change and sign the narcotic count sheet after completing the count. Interview with the Administrator on 1/8/25 at 12:40 PM identified she was not aware of the missing narcotic count signatures. The Administrator indicated the expectation that the nurses will count the narcotics at change of shift and sign the narcotic count sheet after completing the count. Review of the facility-controlled substances count policy identified it is the policy of the facility and its affiliates to account for all Scheduled II - IV medications at the end of each shift and to promptly investigate discrepancies in controlled substances counts. At the end of each shift, the nurse/medication-distributing associate going off and the medication-distributing associate coming on the shift will count all controlled medications for their responsible area and document the count using the pharmacy's declining balance sheet. The medication-distributing associate leaving the shift shall count the medications on the declining balance sheet and the medication-distributing associate coming on the shift will count the actual medications in the container/card. The medication-distributing associate both oncoming and leaving are responsible for signing the controlled medication count/key sign out sheet after completion of the count and proper verification of accuracy has been completed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47457 Based on review of facility documentation, facility policy, and interviews the facility failed to ensure the Infection Preventionist completed specialized training in infection prevention and control. The findings include: The Infection Preventionist (RN #1) was hired on 10/23/24. During entrance conference on 1/6/25 at 8:15 AM the facility failed to provide documentation that RN #1 had completed specialized training in infection control including certification. Further, the DNS did not have a certification in infection control including certification. Interview with RN #1 on 1/7/25 at 10:10 AM identified that she had worked at the facility for approximately 90 days, over 40 hours per week, with majority of the hours dedicated to infection control responsibilities. RN #1 further identified that she had completed the Infection Preventionist certification course in 2019 but was unable to locate the certificate or documentation of modules completed in the CDC's online learning system, where she had completed the training. RN #1 indicated that paper documentation, including her Infection Preventionist certification, was in a binder 5 hours away. RN #1 identified that she had restarted the nursing home Infection Preventionist training modules and hoped to be completed with the learning activities and have her Infection Preventionist certification completed by 1/8/25. Interview with RN #1 and the DNS on 1/8/25 at 10:11 AM identified that RN #1 had completed all the training modules for the nursing home Infection Preventionist course, but she still had to sit for the exam to obtain the certification. RN #1 further identified that, upon hire, nobody had asked for her nursing home Infection Preventionist credentials. The DNS indicated that during the hiring process she did not ask RN #1 for documentation of her Infection Preventionist certification, as hat was the responsibility of the Human Resources department, and that she was unaware that RN #1 did not have documentation of her Infection Preventionist credentials until it was identified by the survey team on 1/6/25. Interview with the Human Resources Director on 1/8/25 at 11:31 AM failed to identify that she had requested or obtained RN #1's Nursing Home Infection Preventionist certification, prior to 10/23/24. The Human Resources Director indicated that she had worked at the facility for 2 years, and under prior leadership it had been the responsibility of the DNS or the Administrator to handle verification of specialized certifications, such as the Infection Preventionist, and she was not aware that obtaining specialized certifications had been her responsibility. Subsequent to surveyor inquiry, RN #1 provided a Nursing Home Infection Preventionist certification dated 1/9/25. The facility's Quality Assessment and Performance Improvement Infection Preventionist policy directs the Infection Preventionist will be qualified by education, training, experience, or certification.