STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415033	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heatherwood Rehabilitation & Health Care Center	398 Bellevue Avenue Newport, RI 02840

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 45263 41729 37158 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of quality relative to following physician's orders for 1 of 1 resident reviewed for obtaining and documenting weights on dialysis treatment days, Resident ID # 61, 1 of 10 residents reviewed with a pressure relieving device, Resident ID #62, and 1 of 2 residents reviewed who receives TED [thrombo-embolis deterrent- a type of compression stocking designed to help prevent blood clots and swelling in the legs] stockings daily, Resident ID # 67. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. 1. Record review revealed Resident ID #61 was initially admitted to the facility in October of 2019 with diagnoses including, but not limited to, end stage renal disease and dependence on renal dialysis. Record review a physician's order dated 10/27/2023 to record the residen't weights in the computer system per the dialysis center recommendations every Monday, Wednesday and Friday. Record review of the documented weights, failed to reveal evidence of the resident's weights on the following dates: -7/5/2024 -7/8/2024 -7/17/2024 -7/19/2024 (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7/24/2024 -8/2/2024 -8/7/2024 -8/12/2024 -8/14/2024 -8/16/2024 -8/26/2024 -8/28/2024 -9/4/2024 2. Record review revealed Resident ID #62 was admitted to the facility in May of 2019 with diagnoses including, but not limited to, Alzheimer's Disease and a history of a pressure injury (localized damage to the skin and/or underlying soft tissue usually over a bony prominence). Record review revealed a physician's order dated 4/26/2023 which states, May have Air Mattress for skin integrity. Check function and settings every shift. Surveyor observations on the following dates and times revealed the resident was lying in bed with the air mattress setting at 200/static: -9/4/2024 at 10:02 AM -9/5/2024 at 10:57 AM -9/6/2024 at approximately 9:00 AM Additionally, during surveyor observations on the above-mentioned dates and times the resident's air mattress pressure pump device revealed a white sticker affixed to the upper right portion of the air pump that indicates set to 100. Further the pump indicated a setting for alternating or static, and the mattress was set to static. During a surveyor interview on 9/6/2024 at 11:59 AM with Licensed Practical Nurse, Staff A, she acknowledged the air mattress setting was on 200/static and that the mattress should be set to 100, but she did not think it should be set to static. Additionally, she revealed the nurses check the air mattress function and setting each shift. Further, she revealed the setting is per the resident's weight but she could not explain why the air mattress was on static. Further record review revealed the resident's weight was 114 pounds. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review revealed Resident ID #67 was admitted to the facility in December of 2022 with diagnosis including, but not limited to, arteriosclerotic heart disease and pulmonary embolism (when a blood clot gets stuck in an artery in the lung, blocking blood flow). During a surveyor observation on 9/4/2024 at 9:01 AM revealed swelling to the resident's right and left lower extremity, the right lower extremity was observed to be more swollen than the left. Record review revealed a physician's orders dated 6/16/2024 for TEDs: apply in the AM and Remove at HS [hour of sleep] . Surveyor observations on the following dates and times revealed the resident was observed with only the left TED stocking on: -9/4/2024 at 12:03 PM and 12:21 PM -9/5/2024 at 10:03 AM, 12:04 PM and at 12:15 PM During a surveyor interview on 9/5/2024 at 12:18 PM with Registered Nurse, Staff B, he acknowledged that the resident did not have a TED stocking applied to his/her right lower extremity as ordered. Additionally, he was unable to explain why the TED stockings were not applied to both lower extremities as ordered. During a surveyor interview on 9/6/2024 at approximately 1:30 PM with the Director of Nursing Services, she was unable to explain why the above-mentioned physician orders were not followed. Additionally, she was unable to to explain if the air mattress should have been on an alternating or static setting.

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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 0686 Level of Harm - 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** 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure a resident who is at risk for pressure ulcers receives the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents reviewed with an actual pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence), Resident ID #67. Findings are as follows: Record review revealed the resident was readmitted to the facility in June of 2024 with diagnoses including, but not limited to, diabetes, Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) and a stage 3 pressure ulcer (a wound that involves full-thickness skin loss that extends into the subcutaneous tissue) of the sacral region. Review of a Significant Change Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident is cognitively intact. Additionally, it revealed the resident requires extensive assistance of 2 staff members for bed mobility. Record review of a document dated 7/28/2024 titled, Braden Scale for Prediction of Pressure Score Risk, revealed a score of 16, indicating the resident is at risk for developing pressure ulcers. Record review of a care plan revised on 8/6/2024, revealed the resident is at risk for potential alterations in skin integrity related to decreased and impaired mobility, with interventions including, but not limited to, skin condition checks weekly, inspect feet daily with care, and assess skin under footwear. Record review of a physician's order dated 6/16/2024, revealed an order for weekly body checks on Thursdays. Review of the August 2024 Treatment Administration Record (TAR) revealed the last body check for the resident was completed on 8/22/2024. Additional review failed to reveal evidence that the weekly body check was completed on 8/29/2024, as ordered. During a surveyor interview with the resident on 9/5/2024 at 2:54 PM, s/he revealed that s/he has pain to his/her right heel periodically and receives pain medication from the staff. Additionally, the resident indicated that s/he was told by staff that s/he has an open wound to his/her right heel and that the wound has been there since late August of this year. During a surveyor observation on 9/5/2024 at 2:52 PM of the resident's right heel, revealed an open wound to the resident's right heel, without a treatment or covered by a dressing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a surveyor observation of the resident's right heel on 9/5/2024 at 3:12 PM, in the presence of a Registered Nurse, Staff B, revealed an open wound to the resident's right heel. During a surveyor interview immediately following the above observation with Staff B, he acknowledged that the resident has an open wound to his/her right heel. Staff B could not provide evidence as to when the resident's right heel was first observed to be open, but he indicated that the resident's right heel has remained unchanged over the last few days. Staff B further indicated that he had applied skin prep (a skin protectant that should not be applied directly to an open wound) to the resident's right heel on the morning of 9/5/2024 and that he did not notify the physician of the open wound to the resident's right heel. After the wound was brought to the facility's attention, record review revealed a progress note titled, Wound Note dated 9/5/2024 at 7:51 PM, revealing the resident had a right heel deep tissue pressure injury which was resolved on 8/26/2024 but has reopened. Additionally, the note revealed the wound to the resident's right heel was measured as 3 centimeters (cm) in width by 2 cm in length by 0.2 cm in depth. During a surveyor observation and simultaneous interview on 9/5/2024 at 3:34 PM with the Director of Nursing Services (DNS), she acknowledged that the resident had an open wound to his/her right heel. Additionally, the DNS indicated that the wound did not have a dressing or treatment order and further indicated that the wound did not appear to have just opened as of today. The DNS acknowledged that the facility was not aware of the resident's right heel wound until it was brought to their attention by the surveyor on 9/5/2024. The DNS further indicated that she would expect the staff to notify the physician of changes to the resident's skin condition and obtain an appropriate treatment for the wound.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47939 37158 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents with limited range of motion receive appropriate treatment to prevent further decline in range of motion for 3 of 4 residents reviewed, Resident ID #s 18, 61 and 70. Findings are as follows: 1. Record review revealed Resident ID #18 was readmitted to the facility in December of 2023 with diagnoses including, but not limited to, stroke and hemiplegia (paralysis on one side of the body). Record review revealed a physician's orders dated 4/23/2024 for Left resting hand orthosis [splint] may be worn during day hours, as tolerated. Surveyor observations on the following dates and times revealed the resident was without his/her left hand splint applied as ordered: -9/3/2024 at approximately 9:45 AM and 12:00 PM -9/4/2024 at approximately 10:00 AM -9/6/2024 at 8:53 AM and 10:15 AM Record review of the nursing progress notes failed to reveal evidence that the resident removed or refused to wear his/her hand splint. During a surveyor interview on 9/6/2024 at 11:15 AM with the Assistant Director of Nursing Services (ADNS), she acknowledged that the left hand splint had not been applied. Additionally, she indicated she was the nurse assigned to Resident ID #18 on 9/4/2024 and revealed she did not apply the left hand splint as she could not locate the splint. During a surveyor interview on 9/6/2024 at 2:03 PM with the Director of Nursing Services (DNS), she revealed that she would expect the splint to be applied as ordered. 2. Record review revealed Resident ID #61 was admitted to the facility in October of 2019 with diagnoses which include, but are not limited to, stroke and hemiplegia. Record review of the physician's orders revealed an order dated 10/24/2023 for Right resting hand splint to be donned [to put on] during the day, as tolerated every shift. Surveyor observations on the following dates and times revealed the resident lying in bed without his/her right-hand splint applied: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/5/2024 at 1:20 PM -9/6/2024 at approximately 12:45 PM -9/6/2024 at 1:10 PM Further observations revealed the resident's splint was located on the window sill on 9/5/2024 and 9/6/2024 during the above observations. Record review of the progress notes failed to reveal evidence that the resident removed or refused to wear his/her hand splint. During a surveyor interview on 9/6/2024 at 1:10 PM in the presence of the DNS, she acknowledged the right-hand splint was not applied and noted it to be on the resident's window sill. Further, she was unable to explain why the splint was not applied as ordered. 3. Record review revealed Resident ID #70 was readmitted to the facility in December of 2022 with diagnoses including, but not limited to, stroke and hemiplegia. Record review of the physician's orders revealed an order dated 6/18/2023 for Right resting hand splint to be donned during the day, as tolerated every shift. Surveyor observations on the following dates and times revealed the resident lying in bed without his/her right-hand splint applied: -9/4/2024 at 10:37 AM -9/6/2024 at 11:12 AM -9/6/2024 at 1:15 PM -9/6/2024 at 1:34 PM Record review of the progress notes failed to reveal evidence that the resident removed or refused to wear his/her hand splint. During a surveyor observation and simultaneous interview on 9/6/2024 at 1:15 PM with the DNS, she acknowledged the right-hand splint was not applied and was unable to explain why the splint was not applied as ordered.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39496 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents that are fed through a feeding tube receive the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed receiving nutrition via a gastrostomy tube (a feeding tube that delivers nutrition, hydration and medication to your stomach through the abdomen), Resident ID #197. Findings are as follows: Review of a facility policy titled, Enteral Feeding states in part, Enteral feeding provides an alternative method of nutritional support via a gastrostomy .tube and is used to enhance and maintain nutritional status when there is an inability to take adequate nutrients orally .PROCEDURE Check physician order for formula, rate and water flushes .Check feeding tube placement with stethoscope .Aspirate [a process to use a syringe to check for contents remaining] stomach contents to check for residual [quantity of tube feed remaining in the stomach] .Hold feeding for residual amount designated by physician order .Flush tube with 30 cc of water .Record intake, flush and free water volume administered . Record review revealed that the resident was readmitted to the facility in August of 2024 with a diagnoses including, but not limited to, dysphagia (difficulty swallowing) and gastrostomy. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed s/he has a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Record review of the medical record revealed that the resident had a gastrostomy tube placed on 7/17/2024. Record review of a care plan last updated on 8/20/2024 revealed that the resident requires enteral feeding for nutrition and hydration related to dysphagia due to an osteophyte (abnormal bony outgrowth or projection). The approaches listed include, but are not limited to, check placement and residuals of tube prior to feeding every shift and administer enteral nutrition and flushes per physician order. Record review revealed the following physician's orders: - 8/15/2024, Check tube placement by aspirating stomach contents before meals. - 8/15/2024, Check tube placement by auscultating (listening to) air passage before meals. - 8/20/2024, 75 milliliters water before and after bolus (administering a large amount of tube feeding in a short period of time) feeding four times a day at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. - 8/20/2024, Glucerna (type of feeding) 1.2 CAL give a 360-ounce carton bolus four times daily at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the resident's progress notes revealed several notes since admission indicating that the resident was administering his/her own bolus feedings. During a surveyor interview on 9/6/2024 at 11:07 AM with the resident, s/he revealed that s/he administers his/her own bolus feedings. When asked by the surveyor if the nurses check the tube placement before the administration of the tube feeding, s/he stated that they do not. The resident also indicated that s/he does not check the tube placement before the administration of the tube feeding. During a surveyor interview on 9/5/2024 at 12:54 PM with Licensed Practical Nurse, Staff C, she revealed that she frequently has the resident on her assignment, and the resident self-administers his/her bolus feedings and flushes. When asked if she checks for tube placement prior to the resident administering the bolus feeding, she acknowledged that sometimes she does not. During a surveyor interview on 9/5/2024 at 1:01 PM with the Director of Nursing Services, she acknowledged that the resident does self-administer the bolus. She was unable to provide evidence of a completed assessment indicating that the resident was competent to safely self-administer the bolus feeding.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 residents reviewed for respiratory care, Resident ID #49. Findings are as follows: Record review of a facility policy, with a revision date of November 2020, titled, Oxygen Administration Nasal Cannula states in part, .Replace and date cannula [tubing that delivers oxygen through the nose] and tubing weekly or when visibly soiled or damaged . Record review revealed the resident was admitted to the facility in May of 2023 with a diagnosis including, but not limited to, chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lungs that blocks airflow and makes it difficult to breathe). Review of a physician's order dated 6/24/2024 revealed an order for the resident to receive supplemental oxygen at 1-2 liters/minute via nasal cannula as needed every shift. During surveyor observations on the following dates and times, the resident was observed receiving oxygen via nasal cannula which was discolored throughout and the tubing was dated 7/18: -9/3/2024 at 9:08 AM -9/4/2024 at 9:22 AM and 9:59 AM During a surveyor interview with the resident on 9/5/2024 at 8:55 AM, s/he indicated that s/he uses oxygen nightly as well as during the day when needed. During a surveyor interview with the Director of Nursing Services (DNS) on 9/5/2024 at 9:02 AM, she indicated that she would expect the oxygen tubing to be changed weekly, per the facility's policy. Additionally, she was unable to provide evidence as to why the tubing was not changed.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 47939 Based on record review and staff interview, it has been determined that the facility failed to ensure that nursing staff have the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care for 2 of 2 Registered Nurses (RNs) reviewed, Staff B and Staff D and 4 of 6 Nursing Assistants (NAs) reviewed, Staff E, F, G and H. Findings are as follows: Record review failed to reveal evidence of any competencies that were completed for the following nursing staff : -RN, Staff B -RN, Staff D -NA, Staff E -NA, Staff F -NA, Staff G -NA, Staff H During a surveyor interview on 9/5/2024 at 3:45 PM with the Infection Preventionist, during the Staffing Task, she was unable to provide evidence of any completed nursing competencies for the above-mentioned staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 39496 Based on record review and staff interview, it has been determined that the pharmacist failed to report irregularities to the attending physician, the facility's Medical Director, and the Director of Nursing Services (DNS) for 1 of 8 residents reviewed for monthly drug regimen reviews, Resident ID #59. Findings are as follows: Record review of a facility policy titled Drug Regimen Review- Monthly revealed in part, .the consultant Pharmacist shall review the medical record of each resident and perform a Drug Regimen Review at least once each calendar month. The Consultant Pharmacist shall identify, document and report possible medication irregularities for review and action by the attending Physician, where appropriate .Consultant Pharmacist .Shall perform Medication Regimen Review for each resident at least monthly. This review shall be performed by evaluating the medical record of each resident, which contains the current Medication Regimen as documented on the most recent Physician's Order Sheets or electronic record of current orders . Record review revealed Resident ID #59 was admitted to the facility in April of 2023 with a diagnosis including, but not limited to, type 2 diabetes mellitus (a condition that causes high blood sugar levels). Record review revealed a physician's order dated 6/7/2024 for Fiasp (a type of insulin) 100 unit/milliliter (ml) sliding scale. Special instructions: Per sliding scale if blood sugar is less than 70, call MD [medical doctor] If blood sugar is 150 to 199, give 1 units If blood sugar is 200 to 249, give 2 units If blood sugar is 250 to 300, give 3 units If blood sugar is 301 to 349, give 4 units If blood sugar is 350 to 399, give 6 units If blood sugar is 400 to 449, give 8 units If blood sugar is 450 to 500, give 10 units. If blood sugar is greater than 500, call MD . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the August 2024 Medication Administration Record (MAR) from 8/3/2024 through 8/14/2024 revealed the Fiasp was administered outside of the ordered parameters on the following dates and times: 8/3/2024 at 7:30 AM and 11:30 AM 8/4/2024 at 7:30 AM 8/6/2024 at 4:30 PM 8/8/2024 at 7:30 AM and 11:30 AM 8/9/2024 at 7:30 AM 8/10/2024 at 11:30 AM 8/13/2024 at 7:30 AM and 11:30 AM Review of the Pharmacist Consultation Recommendation Report dated 8/15/2024, failed to reveal evidence that the pharmacist identified that the Fiasp insulin was administered outside of the ordered parameters on the above-mentioned dates and times. During a surveyor interview on 9/6/2024 at 1:15 PM with the Regional Clinical Nurse, she revealed that she would expect the pharmacist to have identified that the Fiasp was administered outside of parameters on the August medication regimen review. She was unable to provide evidence that the above irregularities were identified by the pharmacy, or reported to the attending physician, the facility's Medical Director, and the Director of Nursing Services as required. Cross reference F760

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Heatherwood Rehabilitation & Health Care Center	398 Bellevue Avenue Newport, RI 02840

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 39496 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 1 of 4 residents reviewed receiving insulin, Resident ID #59 and 1 of 4 residents reviewed receiving an Antipsychotic medication (medications that mainly treat psychosis and, related conditions and symptoms), Resident ID #74. Findings are as follows: 1. Record review revealed Resident ID #59 was admitted to the facility in April of 2023 with a diagnosis including, but not limited to, type 2 diabetes mellitus. Record review revealed a physician's order dated 6/7/2024 for Fiasp (insulin) 100 unit/milliliter (ml) sliding scale. Special instructions: Per sliding scale if blood sugar is less than 70, call MD [medical doctor] If blood sugar is 150 to 199, give 1 units. If blood sugar is 200 to 249, give 2 units If blood sugar is 250 to 300, give 3 units If blood sugar is 301 to 349, give 4 units If blood sugar is 350 to 399, give 6 units If blood sugar is 400 to 449, give 8 units If blood sugar is 450 to 500, give 10 units. If blood sugar is greater than 500, call MD . Review of the August 2024 Medication Administration Record (MAR) revealed that the Fiasp was given outside of parameters on the following dates and times: 8/3/2024 at 7:30 AM- blood sugar (BS) 211 (1 unit administered) and 11:30-BS 210 (1 unit administered) 8/4/2024 at 7:30 AM- BS 205 (1 unit administered) 8/6/2024 at 4:30 PM- BS 200 (1 unit administered) 8/8/2024 at 7:30 AM- BS 280 (2 units administered) and 11:30 AM-BS 225 (1 unit administered) 8/9/2024 at 7:30 AM- BS 252 (2 units administered) (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/10/2024 at 11:30 AM- BS 228 (3 units administered) 8/13/2024 at 7:30 AM- BS 236 (1 unit administered) and 11:30 AM- BS 200 (1 unit administered) 8/15/2024 at 7:30 AM- BS 272 (2 units administered) and 11:30 AM- BS 196 (0 units administered) 8/16/2024 at 7:30 AM- BS 244 (1 unit administered) and 11:30 AM- BS 225 (1 unit administered) 8/17/2024 at 11:30 AM- BS 216 (1 unit administered) 8/19/2024 at 7:30 AM- BS 190 (0 units administered) 8/23/2024 at 7:30 AM- BS 209 (1 unit administered) and 11:30 AM- BS 238 (1 unit administered) 8/25/2024 at 11:30 AM- BS 354 (4 units administered) 8/26/2024 at 7:30 AM- BS 253 (2 units administered) 8/27/2024 at 7:30 AM- BS 250 (2 units administered) and 11:30 AM- BS 221(1 unit administered) Review of the September 2024 MAR revealed that the Fiasp was given outside of parameters on the following dates and times: 9/3/2024 at 7:30 AM- BS 357 (4 units administered) 2. Record review revealed Resident ID #74 was admitted to the facility in February of 2022 with a diagnosis including, but not limited to, paranoid schizophrenia (is a term used for a subtype of schizophrenia with delusions and auditory hallucinations). Record review revealed a physician's order dated 7/26/2024 for Quetiapine extended release tablet (antipsychotic medication) 50 milligrams by mouth at bedtime. Review of the September 2024 MAR revealed that the Quetiapine 50 milligrams was not administered as ordered on the following dates and times, due to the medication being unavailable: 9/1/2024 at 8:00 PM 9/3/2024 at 8:00 PM 9/4/2024 at 8:00 PM 9/5/2024 at 8:00 PM During a surveyor interview on 9/6/2024 at 10:21 AM and at 2:05 PM with the Director of Nursing Services, she acknowledged that the above medications were not administered as ordered on the above dates and times. Additionally, she revealed her expectation is that the physician would be notified if an ordered medication was unavailable and not administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47939

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41729 37158 Based on surveyor observation and staff interview, it has been determined that the facility failed to store drugs and biological's in accordance with currently accepted professional principles relative to 1 of 2 medication rooms observed, 2 of 2 medication carts observed on unit 2, and 2 residents observed with medications at the bedside, Resident ID #s 22 and 63. Findings are as follows: 1. Surveyor observation on 9/5/2024 at 9:39 AM in the presence of Medication Aide, Staff I, of the basement medication storage room revealed the following: -Six medication bottles of Calcium 600 mg (milligram) with Vitamin D 10 mcg (microgram) with an expiration date of 8/2024. -Two medication bottles of Acetaminophen 160 mg/5 ml (milliliter), one with an expiration date of 1/2024 and the other with an expiration date of 2/2024. During a surveyor interview at time of observation with Staff I, she acknowledged the medications were expired and indicated they should be discarded. 2. During a surveyor observation on 9/4/2024 from 12:25 PM to 12:55 PM of the second floor revealed the following: -Medication Cart A was observed unlocked, unattended with the second drawer of the cart left half ajar. -Medication Cart B was observed unlocked and unattended. Multiple staff and residents were observed ambulating by both medication carts while unattended by staff and left unlocked. During a surveyor interview on 9/4/2024 at 12:56 PM with Medication Aide, Staff J, he acknowledged that medication carts A and B were left unattended and unlocked and that the second drawer to medication cart A was left half ajar. During an interview on 9/5/2024 at 9:00 AM with the Director of Nursing Services (DNS), she indicated that her expectation is that medication carts are to be kept locked when unattended. 3a. During a surveyor observation on 9/3/2024 at 9:41 AM of Resident ID #63's bedside table, revealed a plastic medication cup containing 5 medications that were unattended and left on the resident's bedside table while the resident was asleep. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview immediately following the observation with the Nursing Assistant, Staff K, she acknowledged the medications at the bedside. During a surveyor interview on 9/3/2024 at 9:51 AM with Licensed Practical Nurse, Staff C, she acknowledged that medications were left on the resident's bedside table. Additionally, Staff C was unable to explain which medications were left at the resident's bedside, as she indicated that she had not yet administered the resident's morning medications. 3b. Surveyor observation on 9/4/2024 at 8:49 AM during Resident ID #22's medication pass revealed Staff J, was unable to locate the resident's Spiriva (a daily medication that assists with symptoms due to chronic breathing conditions) inhaler in the medication cart to administer with the rest of the resident's medications. Upon entering the resident's room, the Spiriva inhaler was observed on the resident's bedside table by the surveyor. After Staff J administered the resident's medications to him/her, Staff J and the surveyor walked back into the hallway to the medication cart. The surveyor alerted Staff J that the Spiriva inhaler was observed on the resident's bedside table. Staff J and the surveyor re-entered the resident's room to retrieve the inhaler. During a surveyor interview on 9/5/2024 at 8:58 AM with Staff J, he revealed that he administered the Spiriva inhaler to Resident ID #22 yesterday and that he may have left the inhaler on his/her bedside table. During a surveyor interview at 9/5/2024 at 1:12 PM and on 9/6/2024 at 1:17 PM with the Director of Nursing Services, she indicated that she would not expect medications to be left at the bedside unattended and that staff administering the medications are to remain with the resident until all medications are administered. Additionally, she would expect expired medications to be discarded. 39496

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that the menus meet the nutritional needs of the residents in accordance with established national guidelines, that are reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy. Findings are as follows: Record review of the facility's diet manual titled, US Foods Menu Solutions 2015, failed to meet the current established national guidelines (the United States Department of Agriculture established and reviewed national guidelines every 5 years, to promote health, meet nutrient needs and provide guidance for healthy dietary patterns by life stages). The diet manual provided to the surveyor from the facility was from 2010 to 2015, indicating the guidelines were outdated as the current national guidelines were revised in 2020 with new recommendations. Record review of the facility's menu, failed to reveal evidence of the therapeutic exchanges (in the exchange system, foods with a similar nutritional content per serving size are grouped together. The foods within each list can be exchanged for one another during meal planning) to ensure the nutritional adequacy for residents requiring the following physician diet orders, Low Concentrated Sweets (LSC), 50-gram fat (low fat diet), Cardiac, No Added Salt (NAS), Renal, Mechanical Soft and Puree. Record review of the menu for 9/3/2024 revealed the following: -Swedish Meatballs -Egg Noodles -Broccoli Surveyor observation of the lunch meal service on 9/3/2024 at approximately 11:30 AM revealed Swedish meatballs in gravy were being served. Record review of the packaging label for the Swedish meatballs revealed a serving size consisted of 1 cup of the meatballs, without gravy. Record review of the recipe provided by the Food Service Director (FSD) was obtained from All Recipes (a recipe retrieved from the internet). The recipe did not provide a nutritional analysis and listed the serving size to be 1 cup. Further surveyor observation of the lunch meal service revealed that a 4 oz. ladle was being used to portion the Swedish meatballs and gravy, which did not equal the 1 cup serving size as indicated on the packaging label for the Swedish meatballs or the recipe that the FSD provided. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a surveyor interview on 9/3/2024 at approximately 1:30 PM with the FSD he was unable to provide evidence that a standardized recipe (recipes that include ingredients, portion size, cooking temperatures, and nutritional analysis), are used for meal preparation. Additionally, he was unable to provide evidence of the nutrient content of the lunch meal that was served. During a surveyor observation of the lunch meal service and interview with Dietary staff member, Staff M on 9/4/2024 at approximately 11:50 AM, he revealed he has been trained on what to serve resident who require Renal diet, LCS diet, 50 GM Fat, NAS diet. During a surveyor interview with the FSD on 9/4/2024 at approximately 12:00 PM, he was unable to provide evidence that, although Staff M stated that he was trained on therapeutic diets, there is no evidence to support that training. Surveyor observation of the lunch meal service on 9/5/2024 revealed the pureed peas had a very light green color. During a surveyor interview with Cook, Staff N, immediately following the above observation, he revealed that he does not use a recipe when preparing pureed foods. He further revealed that he was trained on how to prepare pureed foods. During a surveyor interview with the FSD on 9/4/2024 at approximately 2:30 PM, he was unable to provide evidence that, although Staff N stated that he was trained on therapeutic diets, there is no evidence to support that training. Additionally, he was unable to provide evidence that the facility utilized standardized recipes for meal preparation, to ensure the nutritional adequacy of the foods being served. During a surveyor interview on 9/4/2024 at approximately 2:45 PM with the Registered Dietitian, she revealed she is not involved in the facility's menu planning. Additionally, she revealed she has not reviewed or signed the facility's menu to ensure its nutritional adequacy, or the appropriateness of therapeutic diets served.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 45263 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure residents receive and consume food in the appropriate form, for 1 of 3 residents observed with physician orders for a mechanical soft diet, Resident ID #39. Findings are as follows: Record review revealed the resident was admitted to the facility in January of 2018 with a diagnosis including, but not limited to, dementia. Record review of a physician's diet order 9/13/2023 states in part, .LCS [Low Concentrated Sweets]; Mechanical soft [proteins that are ground or cut up] . Record review of the lunch menu for Thursday September 6, 2024 revealed the following: -Salisbury Steak -Mashed Potatoes -Peas During a surveyor observation during the lunch meal on 9/5/2024 at approximately 12:30 PM, the resident was eating his/her lunch. Record review of the resident's diet ticket during the above observation revealed in part, .LCS/Chopped . Further observation of the resident's meal tray revealed that the Salisbury Steak was cut in strips that were approximately 1 1/2 inch x 1 inch. During a surveyor interview at approximately on 9/5/2024 at 12:50 PM with Nursing Assistant, Staff O, she revealed that sometimes the dietary staff will cut the resident's food before it is served to the resident and sometimes the nursing staff cut the food. Staff O further revealed that she cut the resident's Salisbury Steak today. Additionally, she acknowledged Salisbury Steak was cut in strips that were approximately 1 1/2 inch x 1 inch. During a surveyor interview on 9/5/2024 at 1:45 PM with Speech Language Pathologist, Staff P, she revealed that a resident with a diet order of mechanical soft, would have the Salisbury Steak cut into pieces less than a 1/2 an inch in size. 47939

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45263 Based on surveyor observation, record review and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety relative to the main kitchen and for 1 of 3 nursing unit kitchenettes. Findings are as follows: 1a. The Rhode Island Food Code 2018 Edition 4-501.114, states in part, .a chemical sanitizer for a manual or mechanical operation at contact times .shall be used as follows: (A) A chlorine solution shall have a minimum concentration range 50-99 . 4-501.116 Ware washing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device . 1b. According to the State Operational Manual, Appendix PP- Guidance to Surveyors for Long Term Care Facilities, last revised 8/8/2024, states in part, .The chemical solution must be maintained at the correct concentration, based on periodic testing, at least once per shift . During a surveyor observation on 9/3/2024 at approximately 8:30 AM of the main kitchen, revealed the dish machine was in use. During a surveyor interview on 9/3/2024 at approximately 8:50 AM with Dietary Aide, Staff L, she revealed that the dish machine was converted from a high temperature sanitizing dish machine to a chlorine-based sanitizing dish machine. Additionally, when asked for a test strip to test the concentration of the chlorine-based sanitizing solution, Staff L provided the surveyor with a test strip that is used to test quaternary ammonium (a chemical solution used for sanitizing) sanitizer, not a chlorine-based sanitizer test strip. During a surveyor interview with the Food Service Director (FSD) immediately following the above observation, he revealed the dish machine was changed from a high temperature sanitizing dish machine, which used hot water to sanitize, to a chemical sanitizer, using a chlorine-based solution to sanitize. Upon further interview he was unable to reveal when the conversion took place. Additionally, he was unable to provide evidence that the dish machine was being monitored to ensure the chemical sanitizing solution was at the appropriate concentration or that the appropriate test strips were available. During surveyor interviews on 9/3/2024 at approximately 9:30 AM and 11:30 AM with the FSD, he revealed the service company for the dish machine had not yet been contacted to obtain the appropriate test strips or to check the functionality of the machine. During a surveyor interview on 9/3/2024 at approximately 2:00 PM with the Administrator, he revealed that the service company was just contacted and would be at the facility before the days end. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a surveyor observation and interview on 9/3/2024 at approximately 3:00 PM, with the facility's service technician, he revealed he had the appropriate test strips with him. Additionally, when he tested the chlorine-based sanitizer in the dish machine twice. The test stripa read less than 50 PPM (parts per million), indicating the dish machine was not sanitizing (the required level is 50 - 99 PPM). The facility's failure to ensure that dishes and utensils were properly sanitized had the potential to cause more than minimal harm or death due to the risk of foodborne illness. 2. The Rhode Island Food Code 2018 Edition 4-601.11 states in part, .Nonfood contact surfaces shall be kept free of an accumulation of dirt, dust food residue and other debris . During a surveyor observation on 9/3/2024 at approximately 8:45 AM of the main kitchen revealed the following: - Three utility carts with heavy staining and scoring - [NAME] colored food spills under the steam table - Reach in refrigerator had a moderate amount of food crumbs on the bottom surface - Baker's rack (rack that holds pans) with a buildup of grime on the ridges along the back side of the rack - Grease build up along the sides and the corners of the stove - Third floor kitchenette refrigerator had a moderate number of brown spills along the back sides of the second and third shelves - Storage area under the tilt skillet with a moderate amount of grease and grime build up - Bottom of the plate holder had an accumulation of a black crumb-like substance - The floor mixer had a significant accumulation of rust During a surveyor interview on 9/4/2024 at approximately 2:30 PM with the FSD, he was unable to provide evidence of a cleaning schedule for the above mentioned observations. 3. The Rhode Island Food Code 2018 Edition 4-501.12 states in part, .Surfaces that are subject to scratching and scoring shall be .discarded if they can no longer be effectively cleaned and sanitized . During a surveyor observation on 9/3/2024 at approximately 9:50 AM, revealed 22 red lip plates with heavy scoring and deep scratches to the surface. During a surveyor interview on 9/4/2024 at approximately 2:30 PM with the FSD, he was unable to provide evidence of purchase orders for the replacement of the red lip plates. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. The Rhode Island Food Code 2018 Edition 3-501.13 states in part, .Thawing . (A) Under refrigeration that maintains food temperature at .41 degrees F [Fahrenheit] or less; or (B) Completely submerged under running water: (1) At a water temperature of .(70 degrees F) or below . (C) Thawed in a microwave oven . During a surveyor observation on 9/4/2024 at approximately 1:52 PM, 3 packages of beef stew meat were sitting in a pan, thawing at room temperature. During a surveyor interview immediately following this observation with the FSD, he was unable to explain why the beef stew meat was thawing at room temperature. 5. The Rhode Island Food Code 2018 Edition 3.501.16 states in part, .Time/Temperature Control for Safety Food, Hot and Cold Holding .shall be maintained at .5 degrees C (41 degrees F) or less . During a surveyor observation on 9/3/2024 at approximately 11:30 AM during the lunch meal service in the main kitchen, [NAME] slaw, egg salad and ham salad sandwiches were observed on a tray in front of the steam table. The following temperatures were obtained: - Cold holding temperature reading of the egg salad was 49.1 degrees F. - Cold holding temperature reading of the ham salad was 48.9 degrees F. Additionally, record review failed to reveal evidence of a recorded cold holding temperature for the [NAME] slaw that was being served as a vegetable. During a surveyor observation on 9/4/2024 at approximately 11:40 AM, revealed 12 seafood salad sandwiches on a tray in front of the steam table. When the temperature was checked, the internal cold holding temperature was 50 degrees F. During a surveyor interview on 9/4/2024 at approximately 11:45 AM with the FSD, he acknowledged that the cold holding temperatures for the seafood, egg and ham salads were not within the acceptable temperature parameters for potentially cold hazardous foods. Additionally, he revealed the cold holding temperature for the coleslaw was not taken prior to the onset of the lunch meal. 6. The Rhode Island Food Code 2018 Edition 4-901.11 states in part, .Equipment and Utensils, Air-Drying Required .After cleaning and SANITIZING, EQUIPMENT and UTENSILS . (B) May not be cloth dried . During a surveyor observation on 9/3/2024 at approximately 9:30 AM and on 9/4/2024 at 9:45 AM, of the Dietary Aide, Staff Q, she was observed drying wet meal trays with a napkin. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a surveyor interview on 9/4/2024 at approximately 2:30 PM with the FSD, he was unable to explain why Staff Q was drying the meal trays with a napkin. 7. The Rhode Island Food Code 2018 Edition 4-601.11 states in part, .food contact surfaces shall be cleaned to sight . During a surveyor observation on 9/4/2024 at approximately 1:50 PM of the ice machine, revealed the lower portion of the ice chute had an accumulation of a black and pink substance. During a surveyor interview on 9/4/2024 at approximately 2:30 PM with the Regional Clinical Nurse, she acknowledged the ice machine was in need of cleaning and service.

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Heatherwood Rehabilitation & Health Care Center	398 Bellevue Avenue Newport, RI 02840

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41729 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to maintain medical records that are accurately documented in accordance with professional standards and practices for 2 of 4 residents reviewed with a splint (a device used to prevent decreased range of motion), Resident ID #s 61 and 70, and 1 of 2 residents reviewed who has an order for TED stockings (thrombo-embolis deterrent- a type of compression stocking designed to help prevent blood clots and swelling in the legs) daily, Resident ID #67. Findings are as follows: 1. Record review revealed Resident ID #61 was admitted to the facility in October of 2019 with diagnoses which include, but are not limited to, stroke and hemiplegia (paralysis on one side of the body). Record review of the physician's orders revealed an order dated 10/24/2023 for Right resting hand splint to be donned [to put on] during the day, as tolerated every shift. Surveyor observation on 9/5/2024 at 1:20 PM revealed the resident lying in the bed, without his/her right-hand splint applied as ordered. Further observation revealed the resident's splint was observed on the window sill. Record review of the September 2024 Treatment Administration Record (TAR) revealed the right-hand splint was inaccurately signed off as applied during the day shift on 9/5/2024. During a surveyor interview and observation of the resident on 9/6/2024 at 1:10 PM with the Director of Nursing Services (DNS), she acknowledged that the resident was not wearing the splint and she was unable to explain why the splint was signed off on the TAR as being applied when it was not. 2. Record review revealed Resident ID #67 was admitted to the facility in December of 2022 with diagnoses including, but not limited to, arteriosclerotic heart disease and pulmonary embolism (when a blood clot gets stuck in an artery in the lung, blocking blood flow). During a surveyor observation on 9/4/2024 at 9:01 AM, revealed swelling to the resident's right and left lower extremity, the right lower extremity was observed to be more swollen than the left. Record review of the physician's orders revealed an order dated 6/16/2024 for TEDs: apply in the AM and Remove at HS [hour of sleep] . Surveyor observations on the following dates and times revealed the resident was observed with only the left TED stocking on: -9/4/2024 at 12:03 PM and 12:21 PM -9/5/2024 at 10:03 AM, 12:04 PM and at 12:15 PM (continued on next page)

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the September 2024 TAR revealed the above-mentioned physician's order was inaccurately signed off as being completed during the day shifts on 9/4/2024 and on 9/5/2024. During a surveyor interview and observation of the resident on 9/5/2024 at 12:18 PM with Registered Nurse, Staff B, he acknowledged that the resident did not have a TED stocking applied to his/her right lower extremity as ordered. Additionally, he was unable to explain why the TED stockings were not applied to both lower extremities as ordered. He was unable to explain why he had documented that both TED stockings were applied when they were not. During a surveyor interview on 9/6/2024 at approximately 1:30 PM with the DNS, she was unable to explain why both TED stockings were signed off on the TAR as being applied when they were not. 3. Record review revealed Resident ID #70 was readmitted to the facility in December of 2022 with diagnoses including, but not limited to, stroke and hemiplegia. Record review of the physician's orders revealed an order dated 6/18/2023 for Right resting hand splint to be donned during the day, as tolerated every shift. Surveyor observation on 9/4/2024 at 10:07 AM revealed the resident lying in the bed without his/her right hand splint applied, as ordered. Record review of the September 2024 TAR revealed the right-hand splint was inaccurately signed off as applied on 9/4/2024. During a surveyor interview and observation of the resident on 9/6/2024 at 1:15 PM with the DNS, she acknowledged that the resident was not wearing the splint and she was unable to explain why the splint was signed off on the TAR as being applied when it was not. 37158

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47939 39496 Based on surveyor observation and staff interview, it has been determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents, staff and the public related to the basement conference room. Findings are as follows: Surveyor observation in the basement conference room on 9/5/2024 at 12:07 PM, revealed a large amount of water pouring down from the ceiling light onto a table below, spraying liquid droplets in an approximate four foot radius, saturating a surveyor's computer, resident records and personnel training records. During a surveyor interview on 9/5/2024 at 12:09 PM with the Assistant Director of Maintenance, Staff R, he revealed the cause of the water coming from the ceiling was due to a toilet on the second floor that was clogged by a large bowel movement and was overflowing. Additionally, he revealed this happened on two previous occasions last week. Staff R further revealed that he did not inform anyone of issue with the toilet overflowing because he felt that he had fixed the issue by plunging the toilet. During a surveyor interview on 9/5/2024 at 12:26 PM with the Administrator, he acknowledged that the water was caused by an overflowing toilet on the second floor. Additionally, he revealed that he was not made aware of this issue by staff previously, and would have expected that maintenance would have informed him that the toilet had previously overflowed. During a surveyor interview on 9/5/2024 at 1:28 PM with the Director of Nursing Services, she revealed that she was not aware that the toilet had overflowed previously causing unsanitary water to enter the basement conference room through the light. She was unable to explain how the room was sanitized after the previous occasions. During a subsequent surveyor interview on 9/5/2024 at 1:35 PM with Staff R, he revealed that the facility just purchased a new toilet for the resident's bathroom, where the toilet overflowed.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47939 Based on record review and staff interview it has been determined that the facility failed to develop, implement, and maintain an effective training program for annual training for existing employees consistent with their expected roles, relative to education involving abuse, resident rights, infection control, dementia, behavioral health management, trauma informed care, communication and QAPI (Quality Assurance and Performance Improvement), per the facility assessment, for 8 of 8 employees, Staff B, D, E, F, G, H, S and T. . Findings are as follows: Review of the Facility Assessment, dated 7/19/2024, revealed in part, training and competencies are completed upon hire, annually and on an as needed basis. Additional review of the assessment indicated the following training are required for direct care staff: Abuse Resident Rights Infection Control Dementia & Alzheimer's Disease Behavioral Health Communication QAPI program Record review revealed Registered Nurse (RN), Staff B was hired on 3/12/2015. Review of his training records failed to reveal evidence that he received education or training relative to communication and the QAPI program. Record review revealed RN, Staff D was hired on 5/29/2019. Review of her training record failed to reveal evidence that she received education or training relative to communication, abuse, the QAPI program, behavioral health and dementia & Alzheimer's disease. Record review revealed Nursing Assistant (NA), Staff E was hired on 10/5/2016. Review of her training records failed to reveal evidence that she received education or training relative to communication, abuse, the QAPI program, behavioral health, infection control, dementia & Alzheimer's disease, and resident rights. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed NA, Staff F was hired on 3/1/2022. Review of her training records failed to reveal evidence that she received education or training relative to the QAPI program. Record review revealed NA, Staff G was hired on 2/5/2020. Review of his training records failed to reveal evidence that he received education or training relative to communication, abuse, the QAPI program, infection control and resident rights. Record review revealed NA, Staff H was hired on 8/29/2013. Review of her facility training record failed to reveal evidence that she received education or training relative to communication, abuse, the QAPI program, behavioral health, infection control, dementia & Alzheimer's disease, and resident rights. Record review revealed NA, Staff S, was hired on 4/16/2014. Review of his training record failed to reveal evidence that he received education or training relative to communication and the QAPI program. Record review revealed NA, Staff T was hired on 10/10/2010. Review of his training record failed to reveal evidence that he received education or training relative to communication, abuse, the QAPI program, behavioral health, infection control, dementia & Alzheimer's disease, and resident rights. During a surveyor interview on 9/5/2024 at 4:25 PM and 9/6/2024 at 8:44 AM, with the Director of Nursing Services, she was unable to provide evidence that the above-mentioned in-services were completed for Staff B, D, E, F, G, H, S and T, as per the facility assessment.