STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475045	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodridge Nursing Home	142 Woodridge Drive Barre, VT 05641

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview the facility failed to ensure that all residents were treated with dignity in regard to dining on 2 of 3 units. Findings include: 1. Per observation of lunch service on the Evergreen unit on 9/8/25 at 12:15 PM, 7 residents were in the side room for lunch sitting at one large table, and one small side table. Lunch was being served on trays, with warming dishes, to one resident at a time. As the trays were placed on the table, the warming lids were stacked in the middle of the table. Trash was also put in the middle of the table. At 12:19 PM, while other residents were eating, Resident #39 said that s/he is really hungry. S/he was not served lunch until 12:43 PM. Resident #86, who was sitting in the common area outside of the side room since the start of lunch service was not served lunch until 12:54 PM. Per interview with the Dietary Manager on 9/10/25 at 1:35 PM, he explained that they cannot get all meals to each unit at the same time because there isn't enough staff to bring each food cart up to the unit. Per interview with the DON on 9/10/25 at approximately 3:00 PM, she confirmed that all residents should be served at the same time if they are sitting at the same table. 2. Per observation of lunch on 9/10/25 at 12:05 PM, Resident #132 was sitting while another resident was eating at same table. Per observation on 9/10/2025 at 12:13 PM, all residents had been served lunch except Resident #132. S/he was told by LNA#1 Your tray is coming up, it's just a little late. On 9/10/2025 at 12:31 PM LNA #1 stated, [The]trays got mixed up, they put [his/her] food on the jitney and accidentally sent it to the unit since [s/he] usually eats in [his/her] room. LNA #1 confirmed Resident #132 had not eaten lunch. Per observation on 9/10/2025 at 12:32 PM Resident #132 was given a tray of food on the unit, 27 minutes after the rest of his/her table.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure a resident's right to be informed in advanced by the physician or other practitioner or professional of the risk and benefits by proposed care, of treatment alternatives or treatment options, and to choose the alternative or option he or she prefers for two of five residents in the sample. (Residents #4 and #12). Findings include: 1.) Per record review, Resident #4 has active orders for Lorazepam 1 mg [milligram] tab: Give 1 tablet by mouth two times a day for Chronic Anxiety, and Lorazepam Oral Tablet 0.5 mg [milligram]: Give 1 tablet by mouth every 12 hours as needed for increased anxiety/restlessness/agitation for 30 Days inability to redirect, both ordered on 8/28/25. Resident #4 also had an order for Lorazepam Oral Tablet 0.5 MG (milligram): Give 0.5 mg by mouth one time a day for anxiety/agitation. This medication was originally ordered on 3/25/25 and discontinued on 5/22/25. Per record review, there is no evidence that residents were educated on the use and/or risk and benefits of the medications. Per record review of the facility's High Risk Medications policy [last revised February 2023] states, 8. Residents and/or representatives will be educated on the use and risks/benefits of high-risk medications, including adverse effects. Per interview with the Unit Manager on 9/10/2025 10:14 AM she stated the facility does not use consent forms for Lorazepam stating, We only do them for antipsychotics like Seroquel and Olanzapine. She confirmed there is no consent form signed by resident or resident representative for Lorazepam in the resident's EMR [Electronic Medical Record]. On 9/10/2025 at 10:30 AM the DON [Director of Nursing] stated that they [the facility] do not use consent forms for psychotropic medications including Lorazepam. 2. Per record review of Resident #12's medical record, an Antipsychotic Informed consent form states that verbal consent was obtained on 1/7/2024 by Resident #12's responsible party for Olanzipine (Antipsychotic)10 mg once a day. Further review revealed a physician's order dated 9/2/2025 for Olanzapine 10 mg by mouth twice a day for dementia with behaviors. A progress note dated 9/2/2025 states Message left to [responsible party] via phone regarding order updates for increase in Olanzapine AM dose . There is no further documentation indicating that Resident #12's responsible party was ever notified of the increase in Olanzipine. Further record review reveals a physician's order for Citalopram (Antidepressant) 20 mg one time a day for dementia with behaviors. There is also no documented evidence that Resident #12's responsible party was provided the right to be informed in advanced by the physician or other practitioner or professional of the risk and benefits of the use of Citalopram or of treatment alternatives or treatment options. Per review of the facility policy titled Antipsychotics states All residents with a new order for antipsychotic medications will have a signed consent form in the medical record. The facility policy titled High Risk Medications lists psychotropic medications as high-risk medications and states Residents and/or representatives will be educated on the use and risks/benefits of high-risk medications, including adverse effects. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 9/10/2025 at 11:00 AM the Assistant Unit Manager at 11:00 AM confirmed that there is no documented evidence in the record that the facility obtained informed consent from Resident #12 or her/his responsible party prior to the increase of Olanzapine to 10 mg twice a day from once a day and that there is no evidence of consent or discussion of risks versus benefits of the Citalopram.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to provide state survey results for residents and resident representatives to readily view. Findings include:Per observation on 9/9/25 at 1:25 PM there were no state survey results available on the second floor where all residents reside.Per interview with Resident #114 during resident council on 9/9/25 at approximately 1:30 PM, s/he stated, It would be nice if we could have access to it [state survey results], I can't get to the first floor because I can't walk. Per record review Resident #114 has a BIMS [Brief Interview of Mental Status] score of 14, indicating that Resident #114 has no cognitive deficit. Resident #114 is dependent on staff for ADLs [Activities of Daily Living] and hygiene.Per interview with the Activities Director on 9/9/25 at 2:28 PM, she confirmed state survey results are not posted on the second floor and are only on the first floor of the building.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interview, the facility failed to ensure that a Resident's choice regarding his/her Advance Directives (wishes regarding life-sustaining treatment) was documented correctly, ordered, and care planned for 1 of 30 residents sampled (Resident #123). Findings include:Per record review, Resident #123's Electronic Health Record (EHR) has an Advanced Directive stating s/he wishes are do not resuscitate (DNR) and trial course of intubation (a tube to assist with breathing) and ventilation treatment for 5 days, signed 12/30/24 by the Resident. The Code Status in the EHR states DNR/DNI (Do Not Intubate), and the Care Plan (initiated on 2/28/25 and revised on 6/30/25) Focus states Advanced directive, [Resident #123] has established advanced directives-DNR/DNI, Date Initiated: 02/28/2025, Revision on: 03/25/2025), and there is an Order for DNR/DNI with a start date of 2/28/25. The Care Plan, Order, and Resident dashboard don't reflect the Resident's wishes of DNR/Trial of intubation for 5 days per her/his documented Advanced Directives.Per interview on 9/9/25 at 1:50 PM, the Assistant Unit Nurse Manager confirmed Resident #123's Advanced Directive reveal their wishes are DNR and trial of five days of intubation. They confirmed the Code Status, Order, and Care Plan don't reflect the Resident's wishes.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure that all residents had a homelike environment for multiple areas of the facility, having the potential to impact many residents. Findings include:Per observation during a walkthrough of the facility on 9/8/25 at approximately 10:30 AM, two hallways of the Evergreen Unit had multiple wheelchairs, carts, lifts, medical machines, and bags lining one side of each hall. This was observed multiple times throughout the recertification survey on 9/8/25 through 9/10/25. Per interview on 9/10/25 at approximately 3:00 PM during a facility tour with the Director of Nursing, multiple hallways of the facility had multiple items in the hallway. She confirmed that the hallway should not be a place to store lifts and wheelchairs as there are spots tucked away in the halls for the equipment to be placed.During the tour, three large approximately 15 feet by 5 feet boards were observed across from the nursing stations by the resident common sitting areas. These boards contained multiple data points related to resident care and staffing concerns, including resident falls and other quality measures. While there was no resident specific data on these boards, they did appear to be business related. The DON stated that the board are used to share positive information with the residents, but does understand how they are not homelike.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and interview, the facility failed to ensure residents could freely file anonymous grievances. This has the potential to impact all residents. Findings include: Per interview with five residents (Residents #114, #57,1#110, #107, and #133) at Resident Council on 9/9/25 at 1:30 PM, they stated they did not know how to file an anonymous grievance. Resident #110 stated, I often wonder who I could go to if there was a problem with staff. I don't want it getting back to me. Per record review Resident #110 has a BIMS [Brief Interview of Mental Status] score of 15, indicating s/he has no cognitive impairment.Per observation of the second floor there were no blank grievance forms able to be located. The blank grievance forms were found behind the nurses station as shown by the Unit Manager.Per review of the facility's Grievances/Complaints-Filing, Investigating and Resolving policy [last reviewed 5/30/25], there is no mention to filing grievances anonymously.Per interview with the Unit Manager on 9/9/25 at 2:15 PM she stated, There's really no way for them [residents or resident representatives] to file an anonymous grievance.Per interview with the Activities Director on 9/9/25 at 2:28 PM, she confirmed that residents and resident representatives have no way of filing an anonymous grievance.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure one of two sampled residents (Resident #4) were free from chemical restraints. Findings include:Per review of Resident #4's medical record, Resident #4 has a BIMS [Brief Interview of Mental Status] score of 4, indicating the resident has cognitive impairment. Resident #4 has diagnoses of Type II Diabetes, CHF [Congestive Heart Failure], anxiety disorder, and chronic pain syndrome. Resident #4 needs substantial/maximal assistance with ADLs [Activities of Daily Living] and hygiene.Per record review, Resident #4 has an order for Lorazepam 0.5 mg [milligram]: Give 1 tablet by mouth every 12 hours as needed for increased anxiety/restlessness/agitation for 30 Days inability to redirect. The order was placed on 8/28/25 and was to be discontinued on 9/27/25. Per record review of the Medication Administration Record, Resident #4 has received the prn [as needed] medication three times. Per record review of the facility's Pharmacy Services policy [last revised 11/18/24] states, e. Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that.4.PRN orders for psychotropic drugs are limited to 14 days.If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.An interview was conducted with the Unit Manager on 9/9/25 at 2:15 PM. The Unit Manager confirmed the order was for thirty days with no rationale documented, stating We were under the impression that after 14 days they could just renew the prescription for 30 days and then 60 days and then 90 days. I think that's what our policy is.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that their policies related to screening for abuse had been implemented for 1 of 5 Employees reviewed (Licensed Nursing Assistant #1). This is a repeat deficiency for this facility, with violations cited during the previous recertification survey dated 11/6/24 and partial survey dated 7/24/25. Findings include: Based on interview and record review, the facility failed to ensure that their policies related to screening for abuse had been implemented for 1 of 5 employees reviewed (Employee #1). The detailed findings are as follows:Licensed Nursing Assistant (LNA) #1, who was a contracted LNA, was hired on 9/3/2025. There was no evidence in the employee file that the Adult Registry review was conducted as required.The facility policy titled Prevention of Abuse Prohibition states that the facility will comply with and review the [NAME] Abuse and Child Protection Registry. Per interview on 9/10/2025 at 5:16 PM the Director of Nursing (DON) provided a copy of an Adult Abuse Registry dated 9/10/2025 stating that Employee #1 had no findings in the Adult Abuse Registry. The DON confirmed that LNA #1 the Adult Abuse Registry check had not been conducted per policy, prior to the LNA working on the floor and that the Adult Abuse Registry check that had been provided was ran that day, 9/10/2025.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure resident's care plans were updated with pertinent information related to their care for two of 30 sampled residents (Residents #40 and #97). Findings include:1.) Per review of Resident #40's medical record, s/he has diagnoses of Parkinson's Disease, hypertension, and muscle weakness. Resident #40 is dependent on staff for hygiene and needs substantial/maximal assistance with ADLs [Activities of Daily Living]. As of 6/16/25, Resident #40 has a BIMS [Brief Interview of Mental Status] score of 0, indicating Resident #40 has cognitive impairment. Per record review of a post fall evaluation on 5/30/25 states, Date / Time of Fall: 05/30/2025 2:38 PM Fall was witnessed. Who witnessed fall: LNA [Licensed Nursing Assistant]. Fall occurred in the hallway. Activity at the time of fall: Being pushed down the hallway in w/c [wheelchair], put foot down on carpet while being pushed and fell out of w/c. Reason for the fall was evident.Did an injury occur as a result of the fall: Yes. Injury details: Hematoma (R) [right] upper forehead, c/o [complain of] (R) rip and hip pain. Did fall result in an ER [Emergency Room] visit/hospitalization: Yes. A rehab screen request note from 5/30/25 states, Leg wrests [sic] were not in use at time of fall. LNA was pushing resident down the hallway when [s/he] out [his/her feet down and fell headfirst out of the chair. Staff do report that even with footrests on [s/he] puts [his/her] feet down and doesn't keep them on the footrests. [S/he] also leans forward in current w/c. [S/he] had a hematoma to the right forehead, c/o right hip and rib pain. Sent to ED [Emergency Department], no sig [significant] findings. Per record review of a general nursing note dated 6/3/25 states, s/p [status post] fall 5/30. Plan of care reviewed with interdisciplinary team. Education provided to LNA regarding transport of resident. Therapy screen also placed as per nursing staff even with footrests on w/c [wheelchair] resident often puts her feet down and has poor positioning in w/c at times. Resident was seen at the ED with no significant findings. Per record review of a general nursing note dated 9/4/25 at 4:22 PM states, Resident needed to be brought back to room for toileting. LNA had footrests in her hand and did not have enough room in the hallway to put footrests on the wheelchair as EVS [environmental services] cart was in the hallway and to make room in the hall, LNA pushed the wheelchair down past the EVS cart to put foot rests on. As she was pushing wheelchair, resident leaned forward and fell out of chair. PT [Physical Therapy] screen placed for broada chair. Per record review of Resident #40's care plan, there are no interventions related to using footrests to prevent the resident from falling documented after the fall on 5/30/25 or 9/4/25. Per interview with the Unit Manager on 9/9/25 at approximately 2:30 PM she confirmed that Resident #40's care plan did not include any information related to using footrests as an intervention to prevent accidents. 2. Per record review, Resident #97 has diagnoses include dementia behavioral disturbance and agitation, and major depressive disorder. Resident #97's care plan reveals that s/he is at risk for elopement, alteration in psychosocial wellbeing, and re-traumatization. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 8/21/25 nursing note reveals that Resident #97 was involved forcefully pushed and grabbed by another resident (Resident #135) and Resident #97 showed visible signs of anxiety including crying and verbally expressed anxiety and fear following physical altercation due to past trauma history. Progress notes after this event show that Resident #97 is anxious, agitated, argumentative, and could be difficult to redirect. An 8/29/25 progress note reveals that Resident #97 was near Resident #135's room and they had a verbal exchange. A 9/1/25 progress note reveals that Resident #97 was tearful this evening. Requesting to have locks on [his/her] door so [Resident #135] couldn't go in there in the night. 'I need a lock, what if [s/he] comes in while I am sleeping? I don't feel safe with [him/her] here, I shouldn't have to hide out in my room all day to get away from [him/her].' A 9/1/25 room transfer note reveals that Resident #97 was moved to a different unit that day for roam control and states that s/he has been roaming often which cause negative engagement with other residents on [his/her] current living unit. Progress notes following Resident #97's room transfer show that s/he continues to have episodes of wandering, agitation, and aggressive verbal behavior that has impacted other residents. Per observation on 9/10/25 at 10:03 AM through 10:16 AM Resident #97 was observed sitting in the common area repetitively yelling and swearing while other residents were in the common area. A 9/10/25 social service note reveals that Resident #97 had an altercation with another resident shortly after the above observation. A facility investigation summary dated 9/12/25 reveals that Resident #97 hit Resident #45, which was observed by staff. Resident #97 was then transferred back to his/her previous room on the memory care unit on 9/10/25. Resident #97's care plan related to wandering was updated on 8/22/25 following the first incident s/he had with Resident #135 on 8/21/25. There were no additional interventions related to Resident #97's psychosocial or trauma care plans that addressed the impact the 8/21/25 had on him/her. Resident #97's elopement, psychosocial, or trauma care plans were not revised following his/her room transfer or 9/1/25, even after s/he showed increased behaviors. There were no new interventions put into place following the room transfer on 9/10/25 to address the impact that Resident #135 had on him/her. Per interview on 9/10/25 at 3:20 PM, the Director of Nursing confirmed that Resident #97 should have care plan revisions for new interventions to ensure their safety immediately. Per interview on 9/10/25 at 3:53 PM, the Unit Manager confirmed that while the care plan focus was updated following the 8/21/25 event, there were no new interventions after 8/22/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from accidents and hazards for two of 30 sampled residents (Residents #40 and #45). Findings include:1.) Per review of Resident #40's medical record s/he has diagnoses of Parkinson's Disease, hypertension, and muscle weakness. Resident #40 is dependent on staff for hygiene and needs substantial/maximal assistance with ADLs [Activities of Daily Living]. As of 6/16/25, Resident #40 has a BIMS [Brief Interview of Mental Status] score of 0, indicating Resident #40 has cognitive impairment. Per record review of a post fall evaluation on 5/30/25 states, Date / Time of Fall: 05/30/2025 2:38 PM Fall was witnessed. Who witnessed fall: LNA [Licensed Nursing Assistant]. Fall occurred in the hallway. Activity at the time of fall: Being pushed down the hallway in w/c [wheelchair], put foot down on carpet while being pushed and fell out of w/c. Reason for the fall was evident.Did an injury occur as a result of the fall: Yes. Injury details: Hematoma (R) [right] upper forehead, c/o [complain of] (R) rip and hip pain. Did fall result in an ER [Emergency Room] visit/hospitalization: Yes. Per record review of a therapy note on 6/3/25 states, Therapy screen request received from nursing s/p fall on 5/30; LNA was pushing resident down the hall, resident unable to hold her feet up and got caught on the carpet, fell out of chair headfirst.Chart reviewed and discussed the resident with nursing. Resident is functionally at baseline; may benefit from broda chair to combat forward leaning and poor [NAME] [lower extremity] support. Therapy to look into getting resident a broda chair. Therapy continues to recommend the following: recline when fatigued/leaning forward and PRN [as needed] use of footrests, i.e., when mobilizing resident. A rehab screen request note from 5/30/25 at 3:00 PM states, Leg wrests [sic] were not in use at time of fall. LNA was pushing resident down the hallway when she out her feet down and fell headfirst out of the chair. Staff do report that even with footrests on [s/he] puts [his/her] feet down and doesn't keep them on the footrests. [S/he] also leans forward in current w/c. [S/he] had a hematoma to the right forehead, c/o right hip and rib pain. Sent to ED, no sig [significant] findings. Per record review of a general nursing note written on 9/4/25 at 4:22 PM states, Resident needed to be brought back to room for toileting. LNA had footrests in her hand and did not have enough room in the hallway to put footrests on the wheelchair as EVS [environmental services] cart was in the hallway and to make room in the hall, LNA pushed the wheelchair down past the EVS cart to put footrests on. As she was pushing wheelchair, resident leaned forward and fell out of chair. PT [physical therapy] screen placed for broada [sic] chair. Per interview with the Unit Manager on 9/10/25 at 10:00 AM she stated footrests were not on when Resident #40 was in his/her wheelchair during the second fall on 9/4/25. She stated, The LNA [Licensed Nursing Assistant] had them in her hand, but they were not on. She was trying to maneuver the resident around a housekeeping cart. The Unit Manager confirmed that both falls were the result of not having footrests on the wheelchair stating, The same thing happened both times. (continued on next page)

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	475045	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodridge Nursing Home	142 Woodridge Drive Barre, VT 05641

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per record review, Resident #97 has diagnoses include dementia behavioral disturbance and agitation, and major depressive disorder. Resident #97's care plan reveals that s/he is at risk for elopement, alteration in psychosocial wellbeing, and re-traumatization. s/HE has a the following care plan focus, [Resident #97] has behavior problem r/t [related to] h/o [history of] behaviors, impaired cognition, refusals of care. [Resident #97] does at times think [s/he's] joking when [s/he] uses a dry sense of humor and raises [his/her] voice but can become offensive to others. A lot of past trauma with the death of two children and being abused at a young age [Resident #97] is triggered easily, revised on 8/22/25. The last behavior intervention was added on 6/23/25. Nursing notes dated 8/21/25 through 9/1/25 reveal that Resident #97 had an altercation with Resident #135 on 8/21/25, was displaying anxious, agitated, wandering behaviors, argumentative, and could be difficult to redirect. A 9/1/25 room transfer note reveals that Resident #97 was moved to a different unit that day for roam control and states that s/he has been roaming often which cause negative engagement with other residents on [him/her] current living unit. Progress notes following Resident #97's room transfer show that s/he continues to have episodes of wandering, agitation, and aggressive verbal behavior that has impacted other residents. Per observation on 9/10/25 at 10:03 AM through 10:16 AM Resident #97 was observed sitting in the common area repetitively yelling and swearing while other residents were in the common area. A 9/10/25 social service note reveals that Resident #97 had an altercation with another resident shortly after the above observation. A facility investigation summary dated 9/12/25 reveals that Resident #97 hit Resident #45, which was observed by staff. Resident #45 was in a wheelchair. Resident #97's care plan related to wandering was updated on 8/22/25 following the first incident s/he had with Resident #135 on 8/21/25. There were no additional interventions added to Resident #97's care plan related to his/her wandering or behavior, even after s/he showed increased behaviors. Per interview on 9/10/25 at 3:53 PM, the Unit Manager confirmed that while the care plan focus was updated following the 8/21/25 event, there were no new interventions after 8/22/25.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Per observation, interview, and record review, the facility failed to ensure that residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections for 2 of 2 sampled residents (Resident #3 & 27). Findings include: Per record review, Resident #3 reveals medical diagnoses which include:Urinary tract infection (an infection in any part of the urinary system);Neuromuscular Dysfunction of Bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should);Acute Kidney Failure (when the kidneys suddenly can't filter waste products from the blood);Retention of Urine (bladder doesn't completely empty when urinating); andChronic Kidney Disease (a long-term condition where the kidneys do not work as well as they should)Resident #3 has orders for an indwelling Foley catheter (a tube that is maintained in the bladder to drain urine constantly). It is connected to a collection bag that requires frequent emptying. Further record review revealed Resident had a Urinary Tract Infection (UTI) diagnosed on [DATE] after a foley catheter change resulted in Resident's output draining cloudy yellow urine, with a volume of 1300 mL (milliliters), and a fever. According to the Cleveland Clinic, the normal range for 24-hour urine volume is 800 to 2,000 milliliters per day, and healthy urine should be light yellow, like the color of light straw or lemonade(https://my.clevelandclinic.org/health/body/urine). Review of the Care Plan (revised 8/27/25) has a Focus area for an indwelling Foley catheter related to the Resident's urinary retention, and the intervention states Document intake [of fluids] and output [of urine] as per facility policy, which was initiated on 2/9/24 with a revision on 2/12/25. Per interview on 9/10/25 at 2:45 PM, the Nurse Manager stated tracking urinary outputs is a Licensed Nursing Assistant's (LNA) task and would run a report to capture the output data documented for the Resident.Per interview on 9/10/25 at 3:51 PM, the Nurse Manager confirmed that the indwelling Foley catheter output was not located in Residents' charts or being tracked, and she was evaluating other Residents' charts for orders to track output. 2. Per record review, Resident #27 reveals medical diagnoses which include:Obstructive and Reflux Uropathy (occurs when urine cannot drain through the urinary tract);Acute Kidney Failure (when the kidneys suddenly can't filter waste products from the blood); andRetention of Urine (bladder doesn't completely empty when urinating)Resident #27 has orders for an indwelling Foley catheter (a tube that is maintained in the bladder to drain urine constantly). It is connected to a collection bag that requires frequent emptying. In the Electronic Health Record (EHR), there is no documentation of the Resident's output of urine. Per Nurse.com, Urine output provides key insights into kidney function and overall fluid balance. A sudden or gradual decrease in urine output, known as oliguria, can be one of the earliest signs that the kidneys are not filtering waste and maintaining fluid balance as they should (https://www.nurse.com/blog/acute-kidney-injury-urine-output-warning-sign/).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide respiratory care in accordance with professional standards for five of five residents (Residents #86, #97, #94, #136, and #34). Findings include:1. Per record review, Resident #86 has diagnoses that include acute and chronic respiratory failure, obstructive sleep apnea, and dependence on supplemental oxygen. A 7/18/25 admission note states that Resident #86 has the following active problem requiring attention Recent acute on chronic respiratory failure requires BiPAP [Bilevel Positive Airway Pressure; a non-invasive ventilation treatment] and 1 to 2 L [liters] of oxygen. [S/He] will continue with respiratory support with BiPAP machine we will continue oxygen 1 to 2L. Resident #86 had the following physician orders Standing Order Other: O2 (oxygen) @ 2LPM via NC [nasal canula] PRN [as needed] to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 [peripheral oxygen saturation] of >90%; If requiring more than 2L notify provider. 2LNC (May wean as tolerated), and BIPAP: Apply at HS [at bedtime] as per home settings every night shift for Sleep Apnea. Per record review, Resident #86's does not have a care plan related to his/her respiratory status, including interventions for oxygen use or a BiPAP machine. Resident #86's MAR (medication administration record) for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 2. Per record review, Resident #97 has chronic obstructive pulmonary disease with (acute) exacerbation. Resident #97 has the following care plan focus, [Resident #97] is at risk for shortness of breath r/t deficiencies or abnormalities of pulmonary function (COPD), initiated on 6/23/25. Multiple progress notes reveal that Resident #97 has shortness of breath during September. Vitals signs show four oxygen stats for Resident #97; 61% on 9/1/25, 91% on 9/2/25, 81% on 9/3/25, and 80% on 9/9/25. Resident #97 has the following physician order Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 88% May administer oxygen prn via NC/mask to maintain SP02 of >88%; If requiring more than 2L notify provider. Per record review, Resident #97's care plan does not include interventions for oxygen use. Resident #97's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 3. Per record review, Resident #94 has diagnoses that include COPD, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. Resident #94 has the following care plan focus, [Resident #94] is at risk for shortness of breath r/t [related to] deficiencies or abnormalities of pulmonary function (COPD), initiated on10/28/24. A 9/4/25 provider note states Will need to watch for increasing O2 requirements. Resident #94 had the following physician orders Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 of >90%; If requiring more than 2L notify provider. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per record review, Resident #94's care plan does not include interventions for oxygen use. Resident #94's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 4. Per record review, Resident #136 has diagnoses that include hypertension and history of cardiac arrest. Per interview on 9/9/25 at 1:37 PM, Resident #136 explained that his/her oxygen tank was empty and s/he does use it as needed. Resident #136 has the following physician order Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 of >90%; If requiring more than 2L notify provider. Per record review, Resident #136's care plan does not include interventions for oxygen use. Resident #136's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. Per interview on 9/9/25 at 2:01 PM, the Unit Manager confirmed that residents should have a care plan if they use oxygen and/or Bipap/CPap machines. She confirmed that Residents #86, #94, #97, and #136's care plans did not include the use of oxygen as an intervention. She stated that Residents #86 and #94's orders should not be PRN as there are on continuous oxygen. She confirmed that she cannot see a way to verify when and how much O2 was administered for these 4 residents based on the MAR. 5. Per record review, Resident #34 has diagnoses that include: Chronic Respiratory Failure with Hypercapnia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body); Interstitial Pulmonary Disease (refers to a group of chronic lung disorders characterized by inflammation and scarring that make it hard for the lungs to get enough oxygen); Chronic Obstructive Pulmonary Disease (COPD is a lung disease characterized by limited airflow); Acute and Chronic Respiratory Failure with Hypoxia (low oxygen in the blood); Bronchiectasis (a condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred); and Heart Failure (failure of the heart to provide sufficient blood flow caused by an impairment of the heart's pumping function) During observations on 9/8/25 at 11:30 AM, Resident #34 was wearing a nasal canula connected to an operational oxygen concentrator (takes air from your surroundings, extracts oxygen, and filters it into purified oxygen to breathe). Resident confirmed s/he uses oxygen to assist with their breathing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #34 has orders for O2 (oxygen) @ 2LPM (liters per minute) via NC (nasal canula) PRN (as needed) to maintain O2 sat (saturation; a measurement of oxygen in blood) of above 90% May administer oxygen prn via NC/mask to maintain SP02 [saturation of peripheral oxygen] of >90%; If requiring more than 2L [liter] notify provider. 2-4 Liter prn to O2 sat 90-92% continuous. A Discharge summary dated [DATE] for Resident #34 states the following: 3 liters per minute nasal canula 24 hours *At nighttime 2L bled into CPAP with a start date of 3/18/16. Further review of the electronic health record (EHR) revealed that oxygen usage was not documented for the Resident. Per interview on 9/9/25 at 4:30 PM, Nurse Manager confirmed oxygen orders and documentation are not in the EHR, and s/he is evaluating orders for all residents on the unit receiving continuous oxygen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to store drugs in accordance with currently accepted professional principles for 1 of 30 sampled residents. Findings include:Per observation on 9/8/25 at approximately 3:00 PM, the following medications were found in Resident #86's room: Clotrimazole External Cream 1 % (Clotrimazole (Topical)), Tacrolimus External Ointment 0.1 % (Tacrolimus (Topical)) and Hydrocortisone External Cream 2.5 % (Hydrocortisone (Topical)). Resident #86 had a roommate.Per interview on 9/8/25 at 3:04 PM, a Licensed Practical Nurse stated that Resident #86 did not have a medication self-administration assessment completed to determine if s/he could have medications in his/her room. She stated that if s/he did, the medications should be in a lock box. Per interview with the Unit Manager on 9/9/25 at 3:54 PM, she confirmed that Resident #86 did not have a medication self-administration assessment and shouldn't have the medications in his/her room. To have medications in the room, a resident would need a medication self-administration assessment determining it to be appropriate and a lock box to place the medications in.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review facility failed to ensure a resident was provided adaptive devices used to promote adequate hydration for one of one (Resident #2). Findings include:Per record review, Resident #2 was admitted to the facility with diagnoses that include type 2 diabetes mellitus, essential tremor, and mild cognitive impairment. Review of Resident #2's care plan reveals that s/he has a swallowing problem related to a medical decline and that s/he had choked on a meatball. Care plan interventions include the use of a 2 handled mug with spouted lid. The care plan also indicates a focus initiated on 1/25/2021 of an alteration in fluid balance related to immunosuppressive medication use, history of renal transplant, uropathy, indwelling foley catheter, history of aspiration pneumonia, and diabetes. Interventions include Encourage to drink fluids of choice and ensure access to favorite beverages, diet ginger ale with small amount of cranberry for color.The care plan also states recommend seated in Broda chair for meals. Items within reach, set up is required (meats cut, containers opened). Resident should be squared up to table (not placed at an angle) to allow optimal functional with self-feeding. adaptive equipment used 2 handled mug w/spouted lid; rim plate; rocker/swivel spoon; straw.Per observations made on 9/8/2025 at 12:30 PM, Resident # 2 was observed during lunch in the day room. Her/His tray had a red two handled mug with a spouted lid, 8oz glass of milk, one can of ginger ale with a straw, a coffee mug, a chocolate ice cream, and a plate with a hamburger cut in half, potato wedges, and a vegetable medley. He/She made five attempts to drink coffee from a mug without a lid and/or straw, contents spilled onto tray and clothing protector. A tremor was noted of bilateral upper extremities. Four staff members were present in the day room assisting other residents. At 12:40 PM, Resident #2 attempted to pick up a sandwich and hold it over the plate. At 12:43 PM he/she placed the sandwich back on the plate; 0% of the meal was consumed. At 12:46 PM, Resident # 2 picked up the spoon and chocolate ice cream and spilled the contents on his/her lap and attempted to bring the spoon with ice cream to his/her mouth again, and again it spilled on his/her lap. At 12:51 PM the Resident began using her/his \fingers to eat the ice cream. As s/he reached for the glass of milk, it spilled onto tray. 0% of the drinks were consumed. At 12:53 PM, Resident #2, used the 2 handled mug with the spouted lid to drink. Resident #2 began using her/his fingers to eat the ice cream. The Resident then used a fork to pick up a potato wedge, took a bite and the remainder fell onto the Resident's lap. At 1:01 PM the Resident attempted to drink out of a cup with no lid or straw and spilled it onto the clothing protector and tray.At 1:05 PM when asked if s/he was thirsty, Resident #2 stated yes. At this time the two Licensed Nursing Assistants (LNAs) who were in the room assisting other residents were made aware that the Resident was having difficulty with and that s/he was thirsty. The LNA confirmed that the Resident was supposed to have covered drinks but only gets one cup on her/his tray. On 9/9/2025 at 8:34 AM, Resident# 2 was observed at breakfast in day room. The food on his/her plate was cut by staff. One mug with two handles and spouted lid with orange juice. A carton of milk, a glass of cranberry juice, a can of ginger ale with a straw, and a cup of coffee were on the tray without a two handled mug with spouted lid that the resident was care-planned for. Four staff members in dining area were assisting other residents. On 9/10/2025 at 8:36 AM, Resident #2 was observed at breakfast in day room. One cup with 2 handles and spouted lid with cranberry juice. The following drinks on the tray were not in the care planned two handled spouted mugs: One open carton of milk with no straw or lid, a can of ginger ale with no straw and a cup of coffee with no lid and no straw.During an interview on 9/10/2025 at 8:53 AM with a Licensed Practical Nurse (LPN) who is familiar with Resident #2, the LPN stated that the Resident should have at least two or three of those cups. The LPN proceeded to call the kitchen and requests two more two handled mugs with spouted lids. The LPN stated, The kitchen said they out are of the mugs, but they do need to provide them.Per interview with the Dietary Supervisor on 9/10/2025 at 9:01 AM, she reported that she had sent two additional mugs to the floor 5 minutes prior to interview, and they have many two handled cups with spouted lids. Staff can call the kitchen to have them brought to the floor. She stated, It is the floors responsibility to transfer beverages into modified cups and let us know if they need more than the one provided on the tray. During interview on 9/10/2025 at 2:47 PM, the Speech Language Pathologist confirmed that residents with adaptive equipment for eating/drinking should have multiple cups for different beverages.On 9/10/2025 at 3:01 PM, the Registered Nurse Unit Manager stated that her expectation is two adaptive cups to be on meal trays for residents. One for hot beverages and one for cold beverages.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety and failed to maintain a sanitary kitchen. This has the potential to impact all residents. Findings include: 1. A kitchen tour was conducted with the Dietary Manager on 9/8/253 at 9:42 AM. Per observation of the kitchen prep area, the following items were found improperly stored:Harissa seasoning with no date,Expired black sesame dated 3/11/24,White sesame marked 6/18 (no year),Expired sesame seed dated 6/21/24,Marjoram dated11/30/23,Bay leaves dated 5/6/24,All spice dated 11/27/24,The Dietary Manager stated that spices should be discarded a year after opening and confirmed that the above spices were expired.Per observation of the walk in refrigerator, the following items were found improperly stored:A container of Jello with no labels or dates,A container of beef stew with no labels or dates,A container of cream cheese frosting with no use by date,A container of expired buttercream frosting marked good through 9/3/25,A container of expired cooked pasta marked good through 9/7/25,A container of expired purred veggies marked good through 8/27/25,A package of tofu- open and not covered marked good through 8/18/25,A used onion wrapped with no labels or dates,A container of expired sauerkraut marked good through 9/2/25,A container of expired steamed veggies marked good through 8/20/25,A container of expired steamed veggies marked good through 9/5/25,Per observation of the walk in freezer, the following items were found improperly stored:A container of expired ice cream dated 6/24/24,A sheet pan of expired pizza dated 4/26/25,A box of potatoes open to air,A box of hashbrowns open to air,A box of pizza shells open to air, A box of hamburger patties open to air,The Dietary Manager stated that prepared and open food should be labeled with the date it was opened or made and the date that it should be discarded, and containers and packages should be sealed. He confirmed that the above items were either expired or improperly stored.Per observation of the dry storage area, the following items were found improperly stored:A box of gram cracker crumbs open to air,Multiple loaves of undated bread.The Dietary Manager explained that they do not label the loaves of bread with dates.Per interview on 9/10/25 at 9:46 AM, a Dietary Staff stated that there are no dates on the bread and there is no way of knowing what its expiration or use by date is. Per interview at 9:49 AM with a second Dietary Staff, she explained that bread should be labeled with orange tags to indicate the use by date and confirmed that the loaves of bread were not dated.2. During the initial kitchen tour on 9/8/25 and again on 9/10/25. multiple areas of the ceiling in the prep areas and the dish room were observed to be covered with thick dust.The Dietary Manger revealed that the housekeeping staff should be cleaning these areas, and it hadn't been done in a couple months.