STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at St. Camillus	494 Elm St Stamford, CT 06902

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #72) reviewed for missing property, the facility failed to ensure a report of a missing item was thoroughly investigated to conclude loss or theft and Observations of the facility environment, the facility failed to ensure a sanitary environment by ensuring a rusted medicine cabinet without doors was replaced and for 1 of 3 sampled residents (Resident #88) who was reviewed for environment, the facility failed to provide a clean, home like environment related to cleaning of a small appliance which was provided by the facility and based on observations and interviews for 3 of 4 shower rooms, the facility failed to provide a homelike, sanitary, and safe environment for the 3 of 4 showers. The findings included: 1. Resident #72 had diagnoses included morbid obesity, heart failure and absence of a right leg above the knee. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #72 was cognitively intact and required total assist with activities of daily living, independent with eating. The Resident Care Plan (RCP) dated 12/5/23 identified Resident #72 was at risk for limited physical mobility and related to obesity and above the knee amputation and had little to no activity involvement related to h/her preference to remain in bed. Interventions directed to provide supportive care and assistance as needed and note the resident's preferred activities include watching television, talking with family and shopping online. A Grievance/ Concern Form dated 1/24/24 identified Resident #72 reported that h/her apple watch was missing. A room search was conducted with resident consent and an investigation initiated including notifications to social services, dietary, housekeeping, laundry, maintenance, and nursing supervisor. A resolution dated 1/29/24 completed by Social Worker (SW) #1 identified the watch was located with education provided to the resident on safe keeping of valuables. The grievance did not include an investigation detailing the recovery of the watch. The social service notes dated 1/29/24 to present did not identify any conclusion regarding the missing watch. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #72 on 7/1/24 at 12:06 PM identified h/her watch went missing months ago and was reported to the nursing supervisor Registered Nurse (RN #4) who looked for it. The watch had not yet been recovered. An interview with RN #4 on 7/08/24 at 12:44 PM identified Resident #72 did report a missing Apple watch to him a few months prior but he was unable to recall all the details of the incident. RN #4 believed he had assisted in searching for the item, reported the incident to the the Administrator at the time and asked staff if they were aware of the missing watch. RN #4 identified Resident #72 never reported the watch had been located. An interview with (former) Social Worker #2 on 7/09/24 at 11:57 AM and 7/11/24 at 10:44 AM identified she was employed by the facility until 6/28/24. Social Worker #2 identified a grievance form should be completed for any reported missing item, and social services would meet with the resident and speak to staff to determine the origin of the missing item. A room search would be completed with consent and the resident would remain informed until the origin/outcome could be determined. If the missing item was not located, the matter would be referred to administration to determine next steps which could include reimbursement. Social Worker #2 identified Resident #72 did initially report a missing Apple watch to her but there was mixed information if the resident actually had the watch in the first place and Resident #72 may have thought another item to have been the watch. Social Worker #2 identified she had only initially heard the watch had been recovered and had not learned the additional information that called into question the actual existence of the watch until after the completion of the grievance form. Social Worker #2 could not recall if any additional steps were made to determine the accuracy of the information, interview staff, or return to Resident #72 to acquire any additional information but would have likely documented if she had. An interview with Social Worker #1 on 7/09/24 at 2:15 PM identified she had documented the watch was recovered based on information provided by Social Worker #2 had informed her and had not actually observed that the watch had been recovered. Subsequent to surveyor inquiry, Social Worker #1 met with Resident #72 and determined through an alternate electronic device owned by Resident #72, that the watch was last discovered on 1/29/24. Social Worker #1 was working with Resident #72 for a replacement. A review of the facility policy for missing items directed that a search be conducted for any reported missing items. If the item is not located, the item will be reported to social services who will initiate a lost item grievance. Social Service will communicate the report of lost items to all department heads and follow up with any action taken and the conclusion will be documented on the form . The resident/ responsible party will be notified of the results. 2. Observation of the environment on 7/1/24 at 12:55 PM identified the medicine cabinet in the bathroom did not have doors, the shelving had rust on it, as confirmed by maintenance, and there were 2 light bulb sockets, disconnected, without light bulbs on top of the cabinet. Observation and interview on 7/1/24 at 12:58 PM with Maintenance Worker #2, identified that he was not sure how long the cabinet had been like that and stated he would fix it now. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 7/1/24 at 1:00 PM with the Director of Maintenance identified he did not know how long the medicine cabinet was without doors and had rust. He also stated he was new to his position. The Maintenance Director indicated he believed the light bulb sockets, disconnected were not a hazard. The Director of Maintenance identified that staff communicate repairs needs through rounds and/or by writing them in the maintenance book . He further indicated he was not made aware of the above needed repairs. The Director of Maintenance identified that cabinet and other repair items would be fixed/replaced within 1 hour. Observation on 7/2/24 at 10:00 AM identified the cabinet was not fixed. Observation on 7/08/24 at 11:02 identified the cabinet was replaced. Review of Maintenance Log for June 2024 and July 2024 identified no documentation of a request for repair for the broken medicine cabinet . Although requested a maintenance policy was not provided. Although requested documentation of maintenance rounds was not provided. 3. Resident #88's diagnosis included chronic obstructive pulmonary disease, anxiety, and COVID 19. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #88 was moderately cognitively impaired, requires set up assist for eating, and oral hygiene. Resident #88 was dependent for toileting, bathing, and dressing. Also identified was Resident #88 needed supervision for personal hygiene. The Resident Care Plan dated 6/4/24 identified Resident #88 was at risk for alteration in respiratory status. Interventions directed to maintain a clear airway, and to monitor for sign and symptoms of respiratory distress. A physician's order dated 6/4/24 for ProAir inhaler (90) base directed that Resident #88 take 2 puffs by mouth every 4 hours as needed for shortness of breath. Observation on 7/1/24 at 11:40AM identified that Resident #88 had a fan in her/his room that had a dark substance noted to each fan blade. Interview with Housekeeping/Maintenance Director on 7/2/24 at 1:40AM identified the fan was not looking very clean, and he was unsure of when it was last cleaned or how long it has been in Resident #88 room. The Housekeeping/Maintenance Director was unsure of the cleaning policy of the fan or if one did exist. Interview with RN#1 on 7/2/24/ at 1:45 PM identified the fan was not clean and was dusty. RN #1 identified that if Resident #88 had a respiratory illness this could have caused a exacerbation. RN #1 was unsure of the policy for cleaning the fans and also stated that he performs environmental rounds monthly. RN # 1 further identified the facility provided the fan to Resident #88. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #88 on 7/3/24 at 10:15AM identified that the fan has been in her/his room for at least 6 months and has never been cleaned. Resident #88 identified when the fan was turned on it would blow dust at her/him. Environmental Logs reviewed but did not identify any concerns or issues with the fan from Resident #88 room. The facility does not have a policy for cleaning fans. 4. Observation during the initial facility tour on 7/1/24 at 12:30PM on the second floor [NAME] shower room identified the following: Chipped, cracked paint on the walls and ceiling, A black substance on the floors, and walls, Torn wallpaper, Rusty shower curtain rod, Nonskid black stripping torn and loose on the floor of the shower. Observation during the initial facility tour on 7/1/24 at 12:30PM on the second floor Cathedral shower room identified the following: Chipped, cracked paint on walls and ceiling, A black substance on the floors, and walls, Torn ripped ceiling above the sink above the light. Cracked cover on the light fixture. Observation on 7/2/24 at 10:16AM on the third floor Cathedral shower room identified the following: Chipped paint on the ceiling and walls. Interview with Director of Housekeeping/Maintenance on 7/2/24 at 1:35PM identified environmental rounds are done every other week. He identified that the black substance to be dirt and the shower curtain rod was rusty and needed to be replaced. He also stated the shower rooms are cleaned daily with grout cleaner and Lysol. The Director of Housekeeping/Maintenance identified that the nonskid tape needed to be replaced on the [NAME] floor shower of the second floor. The Environmental Rounds logs were reviewed and failed to identify any concerns for any of the 4 showers in the facility. 48792 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48950

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46046 Based on observation of Resident Information, review of policy and interviews, the facility failed to inform residents of how to complete a grievance and ensure forms were accessible and available to residents and visitors. The findings include. On 7/8/2024 at 12:57 PM a meeting with 8 residents identified they were unaware of how to complete a grievance or where the forms were located. An interview with Social Worker #1 on 7/9/2024 at 10:00AM indicated the grievance forms were located in the nursing office behind the nursing station on both floors. During an observation and interview with Social Worker #1 on 7/9/2024 at 10:15 AM identified the grievance policy was noted to be posted on a bulletin board to the right when exiting the elevator on the 3rd floor prior to needing to use a code to enter the 3rd units. Further observations and interview with SW#1 identified s/he was unable to locate the grievance forms on the paper wall file in the nursing office behind the nurse's station. SW #1 could not provide any other location for forms but indicated the forms had been provided to the nursing unit in the past and could not explain why the grievance forms were not available. A review of the grievance policy indicated the forms should be easily accessible if the person using wants to remain anonymous. SW #1 indicated the forms are not easily accessible and further indicated the location would be changed to meet the needs of the residents and residents will be informed of the change. Although a copy of the facility grievance policy was requested one was not received.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility policy and interviews for 2 of 7 sampled residents for (Resident #13) who were reviewed for range of motion, the facility failed to ensure the comprehensive care plan was revised for a resident with identified with physical limitations of the hands and for (Resident # 98), the facility failed to develop a care plan to address the residents skin integrity to prevent further skin break down and for 1 of 2 residents reviewed for accidents for (Resident # 54), the facility failed to revise the resident's care plan timely post fall. The findings included: 1. Resident #13 was admitted with diagnoses that included mild cognitive impairment, protein calorie malnutrition and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired, had no functional limitations in the upper/ lower extremities, required partial to moderate assist in bed mobility and oral care and total assist in all other activities of daily living (ADL). The Resident Care Plan, RCP dated 12/12/21 identified Resident #13 had an ADL self-care deficit, impaired cognition and potential alteration in discomfort related to compromised functional mobility. Interventions directed to provide total assist with ADL care, communicate needs and capabilities to resident and family and evaluate for pain, alleviating symptoms, and impact on functional mobility. An Interdisciplinary Rehabilitation screen dated 1/19/22 identified Resident 13 had a left-hand deformity but refused range of motion for bilateral upper extremities and asked the therapist to leave. The Physical Therapy evaluation and Plan of Treatment dated 12/3/22 identified Resident #13 was being referred for services for splinting of a right knee for contracture management. However, Resident #13 was not receptive to the device despite education and services were terminated with emphasis on bed positioning with pillows and bilateral foot booties. No other functional limitations were identified at the time of the evaluation. A Resident Round Screen dated 8/30/23 and 3/1/24 identified Resident #13 now had bilateral hand deformities with no subsequent evaluation or plan to address the functional limitation. An advanced Practice Registered Nurse Progress note beginning 3/8/24 through 6/10/24 note bilateral hand contractures with no signs of discomfort. The Resident Care Plan did not include the deformity/contracture with any interventions for management to prevent progression. An interview with the Director of Nursing on 7/11/24 at 9:11 AM identified the development and revision of the care plan was an interdisciplinary effort and s/he would have expected the care plan to be revised once the physical limitation for Resident #13 was identified. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #98's diagnoses included stage 3 pressure ulcer of the left heel, paraplegia and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #98 was cognitively intact, at risk for pressure ulcers, had no unhealed pressure ulcers and required extensive assistance of two persons for bed mobility. The care plan dated 3/14/2024 indicated Resident #98 was at an increased risk of pressure ulcer development related to functional mobility/paraplegia incontinence and diabetes mellitus. Interventions included: to provide treatments as ordered, avoid positioning on the affected region, monitor dressing to ensure intactness and integrity, monitor nutrition, laboratory work, teach resident/family importance of positional changes, provide supplements as ordered to promote wound healing. The care plan indicated Resident #98 demonstrated poor body alignment requiring the use of a manual adaptive tilt in space wheelchair with headrest, foam cushion, and elevating footrests. The interventions included to follow the 24-hour positioning plan as outlined by the rehabilitation department to observe for poor toleration while out of bed in the adaptive wheelchair and to notify the rehab department with any issues. The care plan further indicated Resident #98 had a self-care deficit related to activity intolerance due to back pain, spinal abnormality and limited mobility. The intervention included in part to assist Resident #98 to apply a knee, ankle, foot orthotic (KAFO) on the left lower leg with assistance of 2 persons during morning care and to be removed during evening care, apply a tubi-grip and or geri-sleeve to left lower leg daily prior to the application of the leg brace (KAFO) and when lying in bed, and to place a roll between the knees and check skin integrity every 4 hours. The interventions further indicated Resident #98 required the assistance of 2 persons to turn and reposition in bed and a mechanical lift transfer with 2 person assist between surfaces. A nurse practitioner provider progress note dated 3/26/2024 identified on examination a new Deep Tissue Injury (DTI) pressure ulcer on Resident #98's left heel. The progress not further indicated to float the heel, provide skin prep and notification of the wound team of the new pressure ulcer with a resulting physician's order dated 3/26/2024. A nursing skin/wound care note dated 3/26/2024 at 5:38 PM indicated an APRN visit occurred and in addition to a new order for skin prep every shift to the left heel (newly noted DTI left heel) Resident #98 was to wear offloading boots to prevent further injury as left heel is prone to skin breakdown due to leg spasms Resident #98 cannot control. A wound physician progress note dated 4/4/2024 indicated a new stage 2 pressure ulcer (Deep Tissue injury progressed to a stage 2 pressure ulcer) with treatment recommendations to apply betadine to base of the wound secure with an ABD pad and rolled gauze to be changed daily with a resulting physician's order obtained on 4/5/2024. A wound care specialist's handwritten progress note dated 4/9/2024 (no time) recommended offloading boots and further indicated the leg brace (AKFO) could be used with occupational and physical therapy evaluation of the brace support surfaces. A wound physician progress note dated 4/23/2024 at 8:14 PM indicated the wound bed of the left heel stage 2 pressure ulcer was found to have slough and a debriding agent, Santyl, was recommended and to apply calcium alginate to the base of the wound secure with an ABD pad and rolled gauze to be changed daily with a physician's order obtained on 4/24/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound physician progress note dated 4/30/2024 at 4:00 PM indicated completing a follow up visit with findings the pressure ulcer had now progressed to a stage 3 pressure ulcer with 100% granulation of the wound base. Treatment recommendation included to cleanse with normal saline, apply Calcium Alginate to the wound base and secure with bordered foam and to change the dressing daily. A physician's order dated 5/31/2024 directed the beds air mattress every shift for functioning and to confirm the setting to be at the resident's current weight or comfort level. On 5/31/224 an entry into the care plan was made to indicate Resident #98 had a stage 3 pressure ulcer of the left heel but no additional interventions were added at that time. The quarterly MDS dated [DATE] indicated Resident #98 had a stage 3 pressure ulcer. Resident #98's care plan was updated on 6/24/2024 to add consulting the dietitian for wound healing. An interview and record review with the DNS on 7/9/24 at 12:35 PM indicated no physician's orders for offloading boots and no indication of the use of offloading boots could be found in the care plan. An interview and record review with the wound care nurse RN#1 on 7/09/24 at 1:00 PM identified there was no physician's order to use offloading boots as recommended by the wound physician on 4/9/2024 and may have been overlooked. RN #1 further indicated he/she had seen Resident #98 wearing off-loading booties at times but was unable to indicated how staff would know how and when to apply offloading boots and to evaluate the effectiveness if there was not a physician order to use them. RN #1 further indicated the care plan did not reflect the recommendation for use of offloading boots and should have been revised by the MDS nurse who would have been updated in morning report of any changes. After surveyor inquiry a physician order dated 7/10/2024 was obtained directing to check offloading boot placement every shift and the discontinuation of donning the KAFO on the left lower extremity in the am removing it in the evening. After surveyor inquiry a physician's orders dated 7/10/2024 were obtained directing to use bilateral lower leg foam cushion on bilateral leg rests of the wheelchair for proper leg positioning while out of bed in the adaptive wheelchair, and to discontinue use of the KAFO and tubi-grip/geri-sleeve to left lower extremity and to put the use of the KAFO on hold from 7/10/2024 through 7/17/2024. After surveyor inquiry on 7/10/2024 the care plan interventions were updated to include the use of a bilateral lower leg foam cushion on the leg rests of the w/c for proper positioning while out of bed in the AWC and to wear bilateral off-loading boots while seated in the wheelchair and while in bed. This intervention was also added to the nurse aide care card on 7/10/2024 (93 days after the recommendation for its use). The care plan was further updated on 7/10/2024 indicating Resident #98 refuses booties and offloading devices at times indicating not needing them and indicated the left KAFO is on hold until the stage 3 pressure ulcer is resolved. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy for Care Planning directed a comprehensive care plan will be developed for each resident to guide care givers and assist residents to achieve or maintain their highest practical level of wellbeing. The care plan will be reviewed quarterly and as necessary to reflect changes in the resident status. 3.Resident #54's diagnoses included muscle weakness, acute respiratory failure with hypoxia and vascular dementia. A physician's order dated 3/24/24 directed to have bed on Lower Position and scoop mattress. The significant change MDS assessment dated [DATE] indicated Resident 54 had impaired cognition and requires partial assist with bed mobility and bed to chair transfers and maximal assistance with toilet transfer. The care plan dated 4/26/24 indicated Resident 54 is at risk for falls. Interventions include adjusting height of bed as needed to promote safe transfers out of bed, analyze previous falls to determine whether pattern/ trend can be addressed, anticipate residents needs and follow facility fall protocols. The focus section of the 4/26/24 care plan was revised on 6/24/24, however, it did not show where the interventions were updated. A nurse's note dated 6/24/24 at 7:20 PM identified Resident 54 was found on the floor inside her/his room. The charge nurse responded to yelling coming from the resident's room but Resident 54 was unable to provide account of the events. Interview with DNS 07/11/24 11:00 AM indicated that post fall, staff are expected to see what interventions are in place and add new interventions to prevent injuries. The DNS reports nurses and care plan coordinator are responsible for updating the care after falls. DNS requested for the Care Plan Coordinator to print the most recent/ revised care plan. Interview with DNS at 12:26 PM indicated that the care plan we reviewed together earlier, is the most updated version available. Facility's policy indicates Each time a resident experience a fall, an interdisciplinary fall assessment will be completed . The care plan will be revised with any interim interventions to minimize the risk of injuries. 46046 49100

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37721 Based on observation, facility policy and interviews for 1 of 3 Residents (Resident #45), observed during medication administration, the facility failed to meet professional standards when staff borrowed(Resident # 202 's Lactulose medication to administer to Resident # 45 when the resident's medication was not available. The findings include. Resident #45's diagnosis included Type 2 diabetes mellitus and incontinence. A physician's order dated 9/30/2023 directed to administer Lactulose Oral Solution 10grams/15ml and to provide 15 ml's orally, once daily for constipation and to hold for loose stool or diarrhea. The 6/9/2024 quarterly Minimum Data Set (MDS) assessment indicated moderate cognitive loss. The care plan dated 6/25/2024 indicated Resident #45 was at risk for complications related to constipation. Intervention included: monitoring medications for side effects and to follow facility bowel protocol for bowel management while increasing fiber and fluid intake and to update the physician with any concerns. On 7/8/2024 at 8:02 AM an observation and interview with LPN #1 during medication administration to Resident #45 at which time LPN #1 proceeded to pour the correct dose of Lactulose syrup(laxative) as ordered by the physician for Resident #45 but on observation the bottle of lactulose syrup was prescribed belonged to another resident (Resident #202). LPN #1 indicated Resident #45's supply of Lactulose syrup was depleted and an order was sent to the pharmacy the day before. LPN #1 further indicated his/her usual practice is to utilize other resident's medication when the resident's supply was out. An interview on 7/08/24 at 8:15 AM with the RN Unit Manager indicated the facility practice is not to borrow medications from other residents and to ensure medications are reordered to ensure the medication is available for the resident. After surveyor inquiry, LPN #1 was immediately re-educating LPN #1. The facility policy labeled Medication Administration - General Guidelines, indicated in part if a medication cannot be located the pharmacy should be contacted and medication supplied for one resident is never administered to another Resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical record, observations, and interview for 1 of 2 residents reviewed for pressure ulcers (Resident # 98), the facility failed to ensure staff consistently provided evidence of turning and repositioning the resident prior to the development of a pressure ulcer and the facility failed to ensure physician's orders were obtained for recommendations made by a consulting wound physician contributing to the pressure ulcer's further decline. The findings included. Resident #98's diagnoses included Stage 3 pressure ulcer of the left heel, paraplegia, and diabetes mellitus. A physician's order dated 1/16/2024 directed to provide a pressure redistribution mattress every shift. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #98 was cognitively intact, at risk for pressure ulcers, had no unhealed pressure ulcers and required extensive assistance of two persons for bed mobility. A physician's order dated 3/6/2024 directed to assist Resident #98 out of bed to an Adaptive Wheelchair (AWC) per the 24-hour positioning plan every shift. The Resident Care Plan (RCP) dated 3/14/2024 indicated Resident #98 was at risk for pressure ulcer development related to functional mobility/paraplegia, incontinence, and diabetes mellitus. Interventions included: to provide treatments as ordered, avoid positioning on the affected region, to monitor the dressing's integrity, monitor nutrition, laboratory work, teach resident/family importance of positional changes, and to provide supplements as ordered to promote wound healing. The RCP dated 3/14/2024 indicated Resident #98 demonstrated poor body alignment requiring the use of a manual adaptive tilt in space wheelchair with headrest, foam cushion, and elevating footrests. The interventions included: to follow the 24-hour positioning plan as outlined by the rehabilitation department, to observe for poor toleration while out of bed in the adaptive wheelchair and to notify the therapy department with any issues. The RCP further indicated Resident #98 had a self-care deficit related to activity intolerance due to back pain, spinal abnormality, and limited mobility. The intervention included in part to assist Resident #98 to apply a Knee Ankle Foot Orthotic (KAFO) on the left lower leg with assistance of 2 persons during morning care and to be removed during evening care, apply a Tubi-grip and or Geri-sleeve to the left lower leg daily prior to the application of the leg brace (KAFO) and when lying in bed, and to place a roll between the knees and to check skin integrity every 4 hours. Additionally, directed Resident #98 required the assistance of 2 persons to turn and reposition in bed and a mechanical lift transfer with 2 persons assist between surfaces. a.A progress note dated 3/26/2024 indicated on examination a new Deep Tissue Injury (DTI) pressure ulcer was observed on Resident #98's left heel. The progress notes further indicated to float the heel, provide skin prep, and indicated the wound team was notified of the new pressure ulcer with resulting physician's orders dated 3/26/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing skin/wound care note dated 3/26/2024 at 5:38 PM indicated an Advance Practice Registered Nurse (APRN) visit occurred and in addition to a new order for skin prep every shift to the left heel to the (newly noted DTI left heel) Resident #98 was to wear offloading boots to prevent further injury as left heel was prone to skin breakdown due to uncontrollable leg spasms. A wound physician progress note dated 4/4/2024 indicated a new stage 2 pressure ulcer (Deep Tissue injury progressed to a stage 2 pressure ulcer) with treatment recommendations to apply betadine to base of the wound secure with an ABD pad and rolled gauze to be changed daily with a physician's order obtained on 4/5/2024. A wound care specialist's handwritten progress note dated 4/9/2024 (no time) recommended offloading boots and further indicated the leg brace (AKFO) could be used with occupational and physical therapy evaluation of the brace support surfaces. A wound physician progress note dated 4/23/2024 at 8:14 PM indicated the wound bed of the left heel stage 2 pressure ulcer was found to have slough and a debriding agent, Santyl, was recommended, to apply Calcium Alginate to the base of the wound and to secure with an ABD pad and rolled gauze to be changed daily with a physician's order obtained on 4/24/2024. A wound physician progress note dated 4/30/2024 at 4:00 PM indicated completing a follow up visit finding the left heel pressure ulcer had progressed (worsened) to a stage 3 pressure ulcer with 100% granulation of the wound base. Treatment recommendation included cleansing with normal saline, applying Calcium Alginate to the wound base and secure with bordered foam and to change the dressing daily. Physician treatment orders were obtained. The Nurse Aide documentation sheet dated 4/1/2024 through 4/30/2024 had no documentation of the provision of turning and repositioning between 8:00AM and 4:00PM on 4/1/2024, from 12:00AM-6:00 AM on 4/14/2024, 12:00 AM-6:00AM on 4/20/2024, 4:00PM-10:00PM on 4/28/2024, 8:00AM-4:00PM on 4/29/2024 and 4:00PM-11:00PM on 4/30/2024. An interview on 7/18/2024 at 11:47 AM with MD#3 indicated that although turning and repositioning is a fundamental practice in an effort to prevent pressure ulcers and without it could contribute to pressure ulcer formation, he/she could not say with certainty if the dates and time periods of the missing turning and repositioning documentation directly contributed to the formation of the DTI pressure ulcer found on 4/30/2024. On 7/18/2024 at 1:05 PM an interview and record review with the DNS and the Administrator indicated he/she was unable to explain why there was missing documentation on the nurse aide flow sheet for 4/1,14, 20, 28, and 29/2024 prior to the discovery of the Deep Tissue Injury pressure ulcer on 4/30/2024 and missing documentation on the evening shift of 4/30/2024 for the provision of turning and repositioning. The DNS indicated he/she would have expected documentation to have been completed by the end of the shift, indicated the nursing supervisors were responsible for ensuring the nurse aides documentation of care provided for each resident was completed prior to the end of the shift. The DNS further indicated on 5/29/2024 a QAPI (Quality Assurance Performance Improvement) was initiated to start a process for the nursing supervisors to run a report an hour before the shift end to determine what nurse aides have yet to document then speaking to the staff to ensure completion of the task . The DNS also indicated she has found an improvement in consistent documentation of resident care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy dated as revised on 9/28/2023 labeled Skin Care Management Pressure Injury Treatment indicated in part the pressure injury treatment program should focus on assessing the resident and the status of the pressure ulcers, the current support surfaces, pressure ulcer care, managing bacterial colonization and infection, education, and quality improvement. The policy further indicated a deep tissue injury (DTI or DTPI) result from intense and/or prolonged pressure and shear forces at the bone-muscle level and may rapidly evolve to reveal the true extent of tissue damage. b.A physician's order dated 5/31/2024 directed the check bed air mattress every shift for functioning and to confirm the setting to be at the resident's current weight or comfort level. On 5/31/224 a care plan entry indicated Resident #98 had a stage 3 pressure ulcer of the left heel with no additional interventions. The quarterly MDS assessment dated [DATE] indicated Resident #98 had a stage 3 pressure ulcer. Resident #98's care plan was updated on 6/24/2024 to consult the dietitian for wound healing. An interview and record review with the DNS on 7/9/2024 at 12:35 PM indicated no physician's orders for offloading boots and no indication of the use of offloading boots could be found in the care plan. An interview and record review with the wound care nurse Registered Nurse (RN#1) on 7/9/2024 at 1:00 PM indicated there was no physician's order to use offloading boots as recommended by the wound physician on 4/9/2024 which must have been overlooked. RN #1 further indicated he/she had seen Resident #98 wearing off-loading booties at times but was unable to indicate how staff would know how and when to apply offloading boots and to evaluate the effectiveness if there was not a physician's order to use them. After surveyor inquiry a physician's order dated 7/10/2024 (90 days later) was obtained directing to check offloading boot placement every shift and the discontinuation of donning the KAFO on the left lower extremity in the am removing it in the evening. After surveyor inquiry physician orders dated 7/10/2024 were obtained directing to use bilateral lower leg foam cushion on bilateral leg rests of the wheelchair for proper leg positioning while out of bed in the adaptive wheelchair, and to discontinue use of the KAFO and tubi-grip/geri-sleeve to left lower extremity and to place the use of the KAFO on hold from 7/10/2024 through 7/17/2024. After surveyor inquiry on 7/10/2024 the care plan interventions were updated to include the use of a bilateral lower leg foam cushion(blue) on the leg rests of the w/c for proper positioning while out of bed in the AWC and to wear bilateral off-loading boots while seated in the wheelchair and while in bed. This intervention was also added to the nurse aide care card on 7/10/2024 (93 days after the recommendation for its use). The care plan was further updated on 7/10/2024 indicating Resident #98 refuses booties and offloading devices at times indicating not needing them and indicated the left KAFO to be on hold until the stage 3 pressure ulcer resolves. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/2024 at 10:40 AM an observation, interview and record review with Nursing Supervisor, RN #5, during observation of Resident #98 sitting in the AWC with lower legs crossed at the feet wearing socks, and legs in between the footrests and a blue foam cushion just below the knees across both footrests identified areas of pressure to both feet. The areas receiving pressure at the time were the right great toe, left upper ankle, top of the left foot and the right shin above ankle. Although RN #5 indicated there was an order for offloading booties and Resident #98 could be non-compliant RN #5 was unable to find a physician's order prior to 7/10/2024 for the use of offloading boots and was unable to find a care plan indicating Resident #98 was noncompliant with care, and was unable to explain or provide documentation as to how licensed nurses monitored for pressure of the feet and heels while out of bed in the AWC. RN #5 further indicated Resident # 98 had been mostly bed bound per his/her choice until around July 4, 2024. On 7/10/2024 at 11:10 AM an interview with Nurse Aide (NA #6) with RN #5 present indicated he/she has worked in the facility for years and is familiar with his/her regularly assigned residents but had not worked on Resident #98's unit for some time, had received a verbal report of how to care for the residents on his/her assignment from the off going NA he/she was replacing. NA #6 further indicated he/she had provided AM care for Resident #98 along with the off going NA, and Resident #98 told them what care was to be done. NA#6 indicated no NA care cards were on paper, on his/ her person, in the resident rooms or at the nurse's station and s/he can remember what is needed for all the residents on the assignment but was unaware Resident #98 should have had pressure relieving booties on both feet. On 7/10/2024 an observation and interview at 11:15 AM with RN #5 found the electronic tablets in the work room behind the nurse's station the nurse aides use to document care provided at the end of the day but was unable to find information that described the care needed for each resident. RN #5 further indicated the process the nurse aides are to follow is to review the assignment on the tablet at the beginning of the shift and to document on them at the end of the shift and further indicated this did not occur with NA #6 and the process could use some improvement. On 7/10/24 at 11:30 AM interview and record review with the DNS and RN #5 indicated there were no orders for pressure relieving boots although Resident #98 had some available in his/her room, and both had seen Resident #98 wearing them at times no documentation to show the start date, consistent use or evaluation of the effectiveness of the use of the booties or a care plan indicating the need for offloading booties was found. RN #5 was able to find an area in the nurse aide tablet that would bring up items that have been added to the nursing care plan that electronically produce the nurse aide care card and was unable to find electronic communication within the care card of the need for use of offloading boots. An interview with the wound Medical Doctor (MD) #3 on 7/11/2024 at 11:25 AM indicated Resident #98's left heel pressure ulcer could have been prevented but once discovered were managed. MD #3 further indicated many factors could have contributed to the decline of a DTI as the DTI is making a big process occurring below the surface of the skin caused by unrelieved pressure and could not be sure if not using pressure relieving boots consistently as recommended could have by itself caused the decline as many factors play a part in pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Medical Director (MD #2) on 7/15/2024 at 12:34 PM indicated he/she would have expected the wound nurse to have provided the APRN of the facility with the wound physician's recommendations for Resident #98 for review and written orders. MD #2 further indicated not having a physician's order for the offloading boots and monitoring of its use could have contributed to the decline of the pressure ulcer along with multiple factors that could predispose the development of or decline in a pressure ulcer. The facility policy labeled Prevention of Pressure Injuries indicated in part a Risk assessment would be completed on admission, weekly and with any change of condition, use a standardized screening tool to determine risk factors for developing a pressure ulcer. The policy further indicated preventative skin care, use of a pressure relieving mattress may be recommended to aid in the prevention and or healing of a pressure ulcer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 2 of 7 sampled residents (Resident #13 and Resident #97) reviewed for position and mobility, the facility failed to ensure further evaluation and timely treatment were implemented for resident(s) with newly identified limited mobility to maintain, improve or prevent further decline in range of motion and mobility over time and for 1 of 7 residents reviewed for contractures (Resident # 86) the facility failed to ensure the application of braces and/or splints as per physician's orders.The findings included: 1.Resident #13 was admitted with diagnoses that included mild cognitive impairment, protein calorie malnutrition and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 as moderately cognitively impaired, had no functional limitations in the upper/ lower extremities, required partial to moderate assist in bed mobility, oral care, and total assist in all other Activities of Daily Living (ADL). The Resident Care Plan, (RCP) dated 12/12/21 identified Resident #13 had an ADL self-care deficit, impaired cognition and potential alteration in discomfort related to compromised functional mobility. Interventions directed to provide total assistance with ADL care, communicate needs and capabilities to the resident and family and evaluate for pain, alleviating symptoms, and impact on functional mobility. An Interdisciplinary Rehabilitation screen dated 1/19/22 identified Resident #13 had a left-hand deformity but refused range of motion for bilateral upper extremities and asked the therapist to leave. A review of the clinical record identified that there were no subsequent rehabilitation screens through 12/2/22 for Resident #13 that further identified the status of the left-hand deformity, the functional restriction to the left hand or any plan to address the limitation. The Physical Therapy evaluation and Plan of Treatment dated 12/3/22 identified Resident #13 as being referred for services for splinting of a right knee for contracture management. However, Resident #13 was not receptive to the device despite education and services being terminated with emphasis on bed positioning with pillows and bilateral foot booties. No other functional limitations to the upper extremities/hands were identified at the time of the evaluation. A Resident Round Screen dated 8/30/23 and 3/1/24 identified Resident #13 now had bilateral hand deformities with no subsequent evaluation or plan to address the functional limitation. An Interdisciplinary Rehabilitation screen dated 5/16/24 identified Resident #13 presented with deformities in both hands with the left hand presenting with severe distal interphalangeal or DIP (contracture at the tips of the fingers) and that the right hand would benefit from a splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evaluation following the screen to identify the extent of the functional limitation. An Advanced Practice Registered Nurse Progress note beginning 3/8/24 through 6/10/24 note bilateral hand contractures with no signs of discomfort. An observation on 7/02/24 at 11:12 AM identified bilateral hand contractions with no splint/brace noted. An interview with the Director of Rehabilitation on 7/08/24 at 11:40 AM identified rehabilitation screens were completed on admission and quarterly for every resident to determine any functional changes. Any change would be fully evaluated to determine the extent of limitation and treatment initiated to prevent further progression. The Director of Rehabilitation identified that although Resident #13 had deformities and contractures on both hands, a full evaluation was never conducted for Resident #13 to determine the extent of the limitation(s) and treatment was not initiated to prevent further progression and should have been. After surveyor inquiry, an Occupational Therapy Evaluation and Plan of Treatment dated 7/8/24 identified Resident #13 was being evaluated for left- and right-hand splints for contractures. Functional limitations were noted to the left and right upper extremity bilaterally. Right hand grip strength was less than 5lbs and left and strength was unable to be tested . Functional limitations were not present due to the contract. Recommendations included contracture management and possible splint for both hands. A second interview with the Director of Rehabilitation on 7/8/24 at 1:33 PM identified Resident #13 demonstrated increased tightness during the evaluation indicative of a progression of the contractures. An interview with the Director of Nursing Services (DNS) on 7/10/24 at 11:41 AM identified residents should be screened on admission by rehabilitation staff to determine if an evaluation was indicated. The DNS further identified she would expect the evaluation and treatment to have been initiated at the time an abnormality was identified. An interview with Advanced Practice Registered Nurse (APRN) #1 on 7/11/24 at 9:48 AM identified she began services with the facility beginning December 2023 and Resident #13 was known to her. APRN #1 identified Resident #13 had a functional limitation to one or both hands that was likely unavoidable. However, whether a contracture or deformity, APRN #1 would expect staff to complete screening at regular intervals and further evaluate and implementation of any measures to prevent the progression of the limitation. APRN #1 further identified that not implementing preventative measures at an earlier time could have led to further decline in Resident #13's contracture(s). An interview with the Medical Director on 7/11/24 at 1:26 PM identified she was employed by the facility beginning May 2024 and was not completely familiar with Resident #13 and any limitations. The Medical Director identified that she would expect that once an abnormality was identified, a treatment plan should be discussed interdisciplinary with rehabilitation providing any necessary services to prevent further decline. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Clinical Services Policies and Procedures dated 1/2018 directed that a screening process is used to identify the need for a rehabilitation evaluation and determine a resident's ability to perform in either skilled or restorative nursing. 2. Resident #97 had diagnoses that included cerebral infarction (stroke) with hemiplegia (paralysis) and hemiparesis (weakness) unspecified and breakdown of skeletal muscle due to direct or indirect muscle injury. The MDS assessment dated [DATE] identified Resident #97 as severely cognitively impaired and dependent with all ADL skills. The RCP dated 5/19/23 identified Resident #97 had an ADL self-care deficit related to stroke and impaired cognitive function. Interventions directed to cue and reorient and supervise as needed. a. An Occupational Evaluation and Plan of Treatment dated 5/19/23 identified Resident #97 presented with impairments in balance, dexterity and fine/gross motor coordination, mobility, strength, and attention resulting in limitations/restrictions in self-care which required services to increase functional activity tolerance and maximize independence with ADL's. Impairments limited in the right and left upper extremity with inability to flex or extend at the elbow in the left extremity. The Occupational Treatment notes dated 5/22/23 through 6/28/23 identified Resident liked to keep the left upper in a flexed position and that passive range of motion (completed by therapist) was performed for those areas for improved range of motion. The Occupational Discharge Summary dated 7/3/23 identified Resident #13 allowed the therapist to range muscles of the bilateral upper extremities but fought against upper body dressing. Resident #97 was discharged to the care of nursing without any further recommendations to prevent further loss of limitation to the right upper extremity. The Interdisciplinary Rehabilitation Screens dated 1/29/24, 2/8/24 identified Resident #97 demonstrated increased tone throughout the body with no further evaluation/intervention. A Contracture Splint Rounds dated 5/16/24 identified Resident #97 as being referred for contractures of the left knee, left hip and left elbow. An Interdisciplinary Rehabilitation Screen dated 5/24/24 identified Range of motion was unable to be completed due to increased tone but also noted that range of motion was unable to be performed to the upper extremity (unidentified) due to increased tone with no further evaluation. An interview with the Director of Rehabilitation on 7/08/24 at 11:40 AM identified rehabilitation screens were completed on admission and quarterly for every resident to determine any functional changes. Any change would be fully evaluated to determine the extent of limitation and treatment initiated to prevent further progression. After surveyor inquiry, an Occupational Therapy Evaluation and Plan of Treatment dated 7/9/24 identified Resident #97 presented with contractures of the left upper and left extremity and was trialing splints for the left upper extremity and hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second interview and clinical record review with the Director of Rehabilitation on 7/10/24 at 3:27 PM identified Resident #97 should have been discharged from rehabilitation services with a range of motion program to prevent the development of contractures. The Director of Rehabilitation further indicated, once the increased tone was identified, a full evaluation should have been completed to determine the extent with interventions to prevent further progression at the time identified. Resident #97 was referred for splinting on 5/16/24. b. A Physical Therapy Evaluation and Plan of Treatment dated 5/19/23 identified Resident #97 presented with new onset or reduced dynamic balance and decrease in functional mobility. The right and left lower extremities presented within functional limits for strength and range of motion with recommended services to increase activity tolerance and left extremity range of motion/ strength. The Physical Therapy Treatment notes dated 5/22/23 through 6/23/23 identified Resident #97 tended to maintain the left lower extremity and hip in a flexed/abducted position. Therapy included passive range of motion to the left lower extremity and tapping/stroking to the left hip to facilitate muscle relaxation and promote left hip range of motion. The Physical Therapy Discharge Summary dated 6/23/23 identified skilled services included range of motion exercises to maintain joint mobility and prevent contracture. Resident #97 was discharged to the unit with nursing assistance, pressure relieving booties and repositioning every two hours to prevent pressure ulcers with current level of function prognosis identified as good with consistent staff follow through. The summary did not include any further recommendations to maintain or prevent further contractures. An APRN progress note dated 9/14/23 identified a request was made to see Resident #97 to approve a request for a knee splint/brace. Resident #97 was noted to have a left knee contracture and abnormalities of gait and mobility and needed a splint as medically necessary to aid in providing patient with potential to complete ADL's. The case was discussed with nursing and rehabilitation. A review of the clinical record did not include a documented physician's order for the splint/brace or its implementation. Subsequent Interdisciplinary Rehabilitation Screens dated 1/29/24, 2/8/24 identified Resident #97 demonstrated increased tone throughout the body with no further evaluation/intervention. An Interdisciplinary Rehabilitation Screen dated 5/24/24 identified Range of motion was unable to be completed due to increased tone extremity (unidentified) due to increased tone in the lower with no further evaluation. An interview and clinical record review with the Director of Rehabilitation on 7/11/24 at 12:02 PM identified she had never received the referral for a brace/splint for Resident #97 and was unaware s/he had contractures prior to completion of a recent evaluation dated 7/8/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and facility documentation review with the Director of Nursing Services, DNS on 7/11/24 at 9:27 AM identified any concerns related to changes in a resident's function was discussed at a weekly risk meeting that included the medical provider. The DNS identified that Resident #97 was not documented as having been discussed at any risk meeting dated 6/30/23 through present. The DNS further identified she was unaware that a brace/splint had been recommended and would have expected a physician order to have been transcribed to facilitate the implementation of the brace. An interview with APRN #1 on 7/11/24 at 9:29 AM identified she began services with the facility beginning December 2023 and that Resident #97 was known to her. APRN #1 identified Resident #97's contractures were unavoidable second to h/her stroke. However, APRN #1 would expect staff to complete screening at regular intervals and further evaluate and implement any measures to prevent the progression of the limitation. APRN #1 further identified that not implementing preventative measures at an earlier time could have led to further decline in Resident #97 contracture(s). An interview with APRN #2 on 7/11/24 at 1:45 AM identified she stopped providing services for the facility effective December 2023. APRN #2 identified she would have provided a prescription directly to rehabilitation services when ordering a splint and they would initiate the process of acquisition with an outside vendor for fitting. APRN #2 believed she had written the prescription for the brace but understood it took a while to obtain so did not recall ever actually seeing the brace. An interview with the Medical Director on PM 7/11/24 at 1:26 PM identified she started working at the facility on May 202024 and was not completely familiar with Resident #97 and any limitations. The Medical Director identified that although contractures in a resident with a history of stroke was unavoidable, she would expect that once an abnormality was identified, a treatment plan should be discussed interdisciplinary with rehabilitation providing any necessary services to prevent further decline. A review of the Clinical Services Policies and Procedures dated 1/2018 directed that a screening process is used to identify the need for a rehabilitation evaluation and determine a resident's ability to perform in either skilled or restorative nursing. Although requested, a policy for implementing rehabilitations services for a splint/brace was requested. None was provided. 3. Resident #86's diagnoses included Hemiplegia and Hemiparesis, Cerebral Infarction, and Metabolic Encephalopathy. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #86 as severely cognitively impaired and required maximum assistance for personal hygiene, and was dependent for toileting, and showering. The Resident Care Plan dated 7/8/24 identified the resident had limited physical mobility and a left knee contracture. Interventions included application of a left elbow splint after AM care and remove before PM care, application of a left knee splint after AM care and remove before PM care, and application of left palm roll splint after AM care and remove before PM care. (continued on next page)

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	075320	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at St. Camillus	494 Elm St Stamford, CT 06902

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 7/10/24, subsequent to surveyor inquiry, directed to wear left elbow splint after AM care and remove before PM care, wear left knee splint after AM care and remove before PM care, to wear left palm roll splint after AM care and remove before PM care, and to wear left knee splint after AM care and remove before PM care. A Social Services note dated 7/2/24 at 6:49 PM identified in an IDT meeting that resident received a left knee brace, left elbow, and hand brace per rehab. The Treatment Administration Record (TAR) for the month of June 2024 indicated that the left elbow splint was applied after AM care and removed prior to PM care. The Treatment Administration Record (TAR) for 7/1/24 - 7/10/24 did not indicate that the left elbow splint, left knee splint and left palm roll splint were applied. Further the TAR identified that the orders for the left knee splint, left palm roll splint, and the left elbow splint were pending confirmation subsequent to surveyor inquiry. Splint application instructions for the elbow splint, hand splint, were taped to the Residents closet door with the aide care plan. An Occupational Therapy Evaluation and Plan of Care dated 5/22/24-7/16/24 identified that Resident #86 had functional limitations due to contractures, further identified that Resident #86 had a resting hand splint, an elbow extension splint, and a knee extension splint. An Occupational Therapy discharge summary dated 6/18/24 at 4:11 PM written by OT#1 identified that Resident #86 was being discharged from therapy and staff were trained for donning and duffing left-hand splint, left elbow splint, and left knee splint. Further the documentation identified that a splint/brace program was established and prognosis was good with consistent follow through. Observations on 7/10/24 at 12:00 PM, identified Resident #86 sitting in a custom wheelchair without any splints on her elbow, knee, or hand. Interview with LPN # 1 on 7/10/24 at 12:10 PM identified that he was unaware that Resident #86 was supposed to be wearing splints, further he stated that it was not indicated on the TAR to apply any splints. Interview with OT #1 on 7/10/24 at 12:45 PM identified that Resident #86 was to have a left elbow splint, left wrist splint, and left knee splint to be applied after am care and removed at bedtime. Further she stated that she was applying them until resident was discharged from therapy, then she educated the NAs and included diagrams and instructions. Written instructions with diagrams were found on the closet door. Interview and observation with RN #2 on 7/10/24 at 1:00 PM identified that the splints were not on the resident, and they were in the closet drawer. Further she identified that she did not know what the order was for the application of the splints, she would have to confirm with the MD. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA#1 on 7/10/24 at 1:43 PM identified that application of the splints is not part of the care she provides. Someone else comes in sometimes and puts them on but not her, further she stated that the nurse tells her in the morning what to do for each resident and was not told to apply the splints. Review of the splinting policy dated 1/18 directed, in part, the treating therapist is to provide instruction to the nursing staff regarding the wearing schedule, application and removal of the splint, precautions, and when to contact the therapist. 48792

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record review, facility policy, staff interviews for 1 of 1 resident reviewed for specialized treatment (Resident #48), the facility failed to consistently maintain the resident's communication log regarding the resident's status with the specialized treatment center. The findings include: Resident #48's diagnosis of end-stage kidney disease, dementia, and Parkinson's disease. The quarterly MDS assessment dated [DATE] identified Resident #48 was cognitively intact and required set-up assistance with eating, personal hygiene, and transferring to and from the bed. A care plan dated 7/3/2024 indicated the resident was at risk for dehydration, or fluid deficit related to end stage kidney disease and receiving specialized treatment. Interventions included: monitoring intake and output, and monitoring vital signs as ordered/per protocol. The care plan also indicated that Resident #48 required specialized treatment three times per week on Tuesdays, Thursdays, and Saturdays. On 7/8/2024, a review of the resident's specialized treatment communication log identified that certain line items were missing from the communication form. The missing items were the following: For 6/18/2024, the name of the nurse, the condition of the specialized access site, and the time of the resident's last meal were missing. For 6/29/2024 and 6/22/2024, the condition of the specialized access site was missing. For 7/4/2024 and 7/2/2024, the name of the nurse and the condition of the specialized access site were missing. For 7/6/2024, the name of the nurse, the condition of the specialized access site, the resident's last vital signs, and the time of the resident's last meal were missing. On 7/8/2024 at 12:26 PM, an interview and record review with the nurse unit manager (RN#2) identified the expectation was for the specialized treatment center communication log to be completed. Additionally, RN#2 indicated that, at the least, the form should contain the resident's last vital signs, weight, and the status of the specialized access site. RN#2 further indicated the mediation list was not routinely added to the communication log because the facility had provided the specialized treatment center with a medication list for the resident, and only changes to the medications would be communicated in the log. Additionally, RN#2 indicated that the specialized treatment center does not have access to the resident's electronic medical record and that communication is held through the specialized treatment communication log and by telephone. On 7/8/2024 at 12:36 PM, an interview with LPN #1 identified Resident #48 had an external specialized treatment catheter on his/her chest that was being used for specialized treatment and that the resident also had an arteriovenous (AV) fistula that was new and was not yet being used for the specialized treatment. LPN#1 indicated that staff were expected to monitor both specialized access sites daily for signs of bleeding and infection. Additionally, LPN#1 indicated that he believed only the resident's vital signs were required to be put in the specialized treatment communication log. LPN#1 further indicated that the nursing supervisor would be the one communicating with the specialized center if there was a change in the resident's condition. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for communication and documentation of specialized treatment indicated notes facility staff are to complete the specialized treatment communication record. A review of the facilities Specialized Treatment Provided by a Certified Specialized Treatment Center Facility policy indicated that there should be a communication process between the long-term care facility and the specialized treatment center. The policy identified that communication included vital signs and the provision of meals before, during, and/or after specialized treatment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on the tour of the Dietary Department, observations, policy review, and staff interviews, the facility failed to ensure the kitchen was maintained in a clean, sanitary manner and failed to ensure staff applied proper beard guards and failed to consistently labeled and stored food to reflect their age or shelf life. The findings included: Tour of the dietary department on 7/1/24 at 10:40AM, during the initial walk through of the kitchen with the Dietary Manager (DM) identified the following: a. The kitchen was observed to have ceiling tiles with a brown substance noted on them. b. The dishwasher wash station identified that a piece of a cover was broken and discolored in the clean area. c. The dishwasher had black substance noted around the edges. d. The tiles in the kitchen and dishwasher room were observed with a black substance. e. The floor throughout the kitchen was noted to have dirt, debris, and food. f. The second-floor nourishment refrigerator was noted to have a red substance covering the bottom of it on the inside. g. The day cook was not wearing a beard guard. h. The ceiling vent in the main kitchen was noted to have a brown substance around it. i. The baking oven was covered with a brown substance inside and out. j. The cooktop in the kitchen was covered with a brown substance. k. The dry goods storage area was observed to have numerous items that were noted unlabeled or dated, items included were cereal marked with 11/21(unsure of year), elbow pasta opened without a date, 2 bags of egg noodles opened without a date, sprinkles opened, not sealed and without a date. l. The main refrigerator was observed to have a bag of 5 rolls which was not sealed or dated. m. The Ice cream freezer was observed with a large container of frozen strawberries underneath the tubs of ice cream without a lid or date. n. The freezer was observed with numerous items not labeled or dated, a large box containing chicken tenders, shelved items without dates included ribs, Tortillas, chocolate chips, a quiche, (not sealed) 1 Pie crust, 5 waffles, 1 loaf of [NAME] soda bread, broccoli, a large tray of Danish, (not sealed) a box of smoked chicken kielbasa which had frost on it. (not sealed) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. The temperature logs for the freezer and the refrigerator were missing numerous evening readings, from June 2024 freezer Temp Log missing dates that included 6/20/24, 6/21/24, 6/22/24, 6/23/24, 6/24/24, 6/25/24, 6/26/24, 6/27/24, 6/28/24, 6/29/24, and 6/30/24. The June 2024 refrigerator Temp Logs reviewed and identified missing dates from the evening that included 6/20/24, 6/21/24, 6/24/24 6/25/24, 6/26/24, 6/27/24, 6/28/24, 6/29/24, and 6/30/24. On 6/22/24, and 6/23/24 there are no temperatures recordings for AM or PM for the freezer and the refrigerator. Interview with the Dietary Manager DM on 7/1/24 at 1:25PM identified that all staff are responsible for labeling and dating of items once opened. Interview with the DM on 7/3/24 at 10:25AM identified that hair covering is to be worn once staff is around food and beard covering is included in this policy. DM was unsure why this policy was not followed. DM identified the policy for monitoring the temperatures for the freezer and the refrigerator are to be done twice a day and that the night cook was not logging the temperatures, he also identified that he did an in-service with the night cook. The DM identified that all open items should be sealed once the items are opened and not left out to air. Interview with the DM on 7/3/24 at 1:45PM identified that the facility hired a company to steam clean the kitchen and that it was not as clean as it should be. The DM identified that there was dust on the ceiling, dirt and grease were by the dishwasher, the tile was dirty, and the wash station had a broken piece which the DM stated he reported a week earlier to maintenance. The DM stated that there is not a maintenance log for documenting items that need to be fixed in the kitchen. Interview with the DM on 7/3/24 at 2:00PM identified that he was handling the entire building and was unable to fix the clean area by the dishwasher. Review of the policy for Hair Restraints dated 1/2017 identified that compliance with the local and federal service code requires that anyone with the kitchen, who will have close contact with preparation or service of food, food storage areas, equipment will keep hair effectively/appropriately restrained to include facial hair. The purpose of hair restraints is to prevent hair from contacting food and food equipment surfaces, and to deter food services employees from touching their hair. Review of the policy for Refrigeration Temperature Recording dated 4/29/20 identified that Temp Logs were to be completed twice a day and that the day cook is responsible to record in the morning upon opening the kitchen and the evening cook is responsible to record the temperatures upon closing the kitchen. Review of the policy for Food storage dated 4/29/20 identified that Dry storage items will be required to have a date including day, month, and year. The facility uses the Date Marking Policy in conjunction with the Food Storage Policy ensuring ready to eat, closed, or opened foods maintain as expiration or use by date system. The temperatures of all refrigerators and freezers within the Dietary Department will be recorded a minimum of two times in the morning and the evening,