STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075321	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Living Center, Inc	14 Club Rd Windham, CT 06280

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 residents (Resident #208) reviewed for Nutrition, the facility failed to identify preferences for meals and provide choices for food items. The findings include: Resident #208 was admitted to the facility in November of 2024 and had diagnoses that included fracture of upper end of the right humerus and diabetes. A Physician's order dated 11/21/24 at 4:36 PM directed to provide a regular diet, regular thin consistency. A Dietary admission assessment dated [DATE] at 2:11 PM identified Resident #208 wanted a diet change to a diabetic diet with limited carbohydrate portions, increased vegetables and protein. The assessment indicated the Food Service Director would updated. On 11/25/24 at 2:21 PM a Physician's order directed to provide a consistent carbohydrate diet, regular texture, regular thin consistency per resident request. The admission Minimum Data Set assessment dated [DATE] identified Resident #208 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14) and required set up assistance for eating and oral hygiene, partial moderate assistance for bed mobility, transfers and toileting. A Dietitian note dated 11/30/24 at 10:08 AM identified a 5 pound (lb) (3%) weight gain in 9 days and to continue a carbohydrate-controlled diet related to diabetes. The recommendation was to continue the current diet and monitor for new weight fluctuations. The Resident Care Plan dated 12/4/24 identified Resident #208 was at risk for alteration in nutrition due to advanced age and type 2 diabetes with a therapeutic carbohydrate-controlled diet. Interventions included to serve a consistent carbohydrate diet with regular texture and regular thin consistency, provide diet as ordered, Dietary assessment and consult as needed, labs as ordered, monitor intake of meals, and obtain weights as ordered. (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nutrition/Dietary note dated 12/6/24 at 4:45 PM by the Dietitian identified the Assistant Director of Nursing (ADNS) reported Resident #208 requested to see the Dietitian. The note indicated Resident #208 reported updated preferences related to his/her diabetes diagnosis and would continue a diabetic diet. The note indicated specific preferences were updated and she would remain available for follow-up as needed. Observation on 12/9/24 at 5:18 PM, of Resident #208 ' s saved meal tickets identified the following: 12/8/24: Breakfast: under the entree and bread sections: 1/2 cup of egg and sausage bake was noted and under the bread section: 1 slice of buttered toast was noted 12/8/24: Lunch: under the entree section: 1 cup of pork fried rice was noted, under the vegetable section 1/2 cup of oriental vegetables was noted. Handwritten instructions on the meal ticket noted: no meat, no rice, no pork and there was an X marked next to dinner roll, mashed potatoes and tropical fruit cup indicating Resident #208 should not have been served these meal items. 12/9/24 Lunch: the bottom of the meal ticket identified: no breads/pork/beef/dessert, under the entree and bread sections: substitute needed was noted, under the vegetable section: 1/2 cup of peas and carrots was noted. Interview with Resident #208 on 12/9/24 at 5:18 PM identified for breakfast on 12/8/24 he/she was served oatmeal, egg sausage bake and toast and subsequently only ate the oatmeal. Resident #208 indicated for lunch on 12/8/24 he/she was served pork fried rice, oriental vegetables, and mashed potatoes and subsequently only ate the oriental vegetables. Resident #208 identified for lunch on 12/9/24 he/she was served a breaded chicken patty, peas and carrots, and pudding and subsequently only ate the chicken after scraping off the breading and peas. Resident #208 identified he/she did not eat pork, root vegetables, breads or desserts. Observation of Resident #208's dinner meal tray on 12/09/24 5:34 PM identified he/she was served a turkey salad sandwich on white bread, a bowl of pumpkin soup with crackers, a cup of three bean salad, a cup of red Jello with whipped cream and a cup of milk. Observation of the dinner meal ticket identified: no breads/pork/beef/dessert, 8 oz of milk with each meal, and small starch portion was typed at the bottom of the meal ticket. Under the soup section: pumpkin soup was noted, under the entree section: substitute for the entree needed was noted, under the starch section: 1 oz of potato chips was noted, under the vegetable section 1/2 cup three bean salad was noted, under the dessert section: substitute needed for dessert was noted. Resident #208 ate the soup, the turkey salad inside the sandwich and the three bean salad. Interview and review of the meal tickets for Resident #208 with the Food Service Director on 12/9/24 at 5:47 PM identified that the meal tickets noted no breads/pork/beef/dessert, 8 oz of milk each meal/small starch portion. The Food Service Director indicated the dietary aides were not reading the entire ticket, and she would provide education for reading the entire ticket. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Menu Selection policy directed, in part, Residents are offered the ability to choose menu selections from offered choices available. Residents will be offered the availability to choose their meal options ahead of time. A staff member will be available to meet with the resident to determine their choices for meals. The resident can choose their meals up to a week in advance from menu options and always available menu. A resident can change their meal selection at any time to a different available option that does not conflict with their current physicians' orders. Review of the Resident Food Preferences policy directed, in part, a Nutritional assessment will include an evaluation of individual food preferences. After a resident's admission, the Dietitian or nursing staff will identify a resident's food preference. When possible, this will be done by direct interview with the resident. The Dietitian will visit residents periodically to determine if revisions are needed regarding food preferences. The nursing staff will inform the kitchen about resident requests. The Food Service Department will offer a limited number of food substitutes for individuals who do not want to eat the primary meal. The facility provides selective food items as a part of an always available menu.

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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** 50167 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #12) reviewed for the environment, the facility failed to ensure resident room temperatures were comfortable. The findings included: Resident #12 was admitted to the facility in April of 2023 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #12 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 14). Observations on 12/4/24 at 11:30 AM, identified Resident #12 lying in bed, closest to the window, wearing a red jacket (fleece material), and covered in two thick plush blankets. The room temperature was observed to be cool. Interview with Resident #12 on 12/4/24 at 11:30 AM, identified the room temperature had been cold for a couple of weeks and when Resident #12 communicated feeling cold to the staff, a warm blanket would be provided. On 12/5/24 at 9:30 AM the Life Safety surveyor was notified of the cool temperature in Resident #12 ' s room and obtained room temperatures of 69 degrees Fahrenheit by the window and 71 degrees Fahrenheit near the hallway door. The Life Safety surveyor also identified the room baseboards were cold and had no heat flow. Subsequent to surveyor inquiry, the Maintenance Assistant assessed the heating system and identified the rooms heating unit was not functioning and the system needed to be bled. After bleeding the system, the heat began functioning. Maintenance Logs reviewed for the St. [NAME] wing on 12/6/24 at 11:50 AM identified there were no heating concerns noted for the month of December. There were no Maintenance Logs for the months of October and November. Interview with the Director of Nursing (DNS) on 12/9/24 at 4:18 PM identified there was a Maintenance Log, located at each unit ' s nurse's station, where the staff would log concerns or issues related to resident rooms. The DNS indicated the Maintenance Assistant would make rounds on each unit, review the logs, address logged concerns and then sign off on the log. She further identified that the Director of Maintenance keeps logs from prior months and participates in monthly environmental rounds. Interview with Nurse Aide (NA) #5 on 12/10/24 at 8:44 AM, identified she worked on 12/3/24 during the 11:00 PM to 7:00 AM shift and provided care to Resident #12. NA #5 indicated the room felt chilly, but did not check the room's thermostat. (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 the Director of Maintenance on 12/10/24 at 10:49 AM identified there were no monthly Maintenance Logs documented for October and November, and he was not made aware of any heating issues on the units. He indicated that staff utilize the Maintenance Logs at the nurses stations and share information verbally in person. He identified an ongoing issue with a component of the heating system called a zone valve, which would get stuck and block heat flow, and indicated he should have had a system in place to monitor the zone valves. The Director of Maintenance identified he did not consistently participate in the facility monthly environmental rounds and indicated that this issue would have been identified had a member of maintenance been present during environmental rounds. The Director of Maintenance could not identify when he last attended monthly environmental rounds. The facility policy titled Homelike Environment directed, in part, the facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. Although requested, a facility policy for Environmental Rounds was not provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observation, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #81) reviewed for pressure injuries, the facility failed to ensure a dietician assessment was completed in a timely manner for a resident with a new facility acquired pressure injury and failed to perform preventative weekly skin assessments per provider order and facility policy and failed to perform weekly wound assessments per provider order. The findings include: Resident #81 was admitted to the facility in November of 2023 and had diagnoses that included Parkinson ' s disease, diabetes, and aphasia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #81 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required partial/moderate assistance with bed mobility and transfers and was at risk for developing pressure injuries. The Resident Care Plan (RCP) dated 7/31/2024 identified Resident #81 had potential for impaired skin integrity related to Parkinson ' s disease, diabetes, incontinence, and stage 2 pressure injury to the right buttock identified in April of 2024. Interventions included completion of a skin evaluation weekly on shower day, provide supplements as ordered, updated provider as needed regarding pressure injury, and obtain dietician consult as needed. The RCP further identified Resident #81 was at risk for malnutrition related to variable meal intake, and Resident #81 ' s increased nutrient needs related to presence of a Stage 2 pressure injury to the right buttock. Interventions included to provide and serve supplements as ordered, obtain evaluation by the registered dietician with diet change recommendations as needed and administer liquid protein once daily. A Skin Assessment by RN #2 dated 10/17/2024 at 6:44 AM identified Resident #81 had a new right buttock stage 2 pressure injury (wound) measuring 3 centimeters (cm) by 2 cm which was cleansed with normal saline followed by a topical moisture barrier. The Skin Assessment identified the provider, dietician, and supervisor/wound nurse were notified of the new skin issue, and a treatment order was initiated. 1. A Dietician progress note by Dietician #2 on 10/24/24 at 2:09 PM identified Resident #81 was seen for a high risk assessment related to a new right buttock stage 2 pressure injury. A new order for liquid protein once a day was initiated. This assessment was conducted 7 days after the development of the new pressure injury and resulted in an added intervention of supplemental protein to aid in wound healing. A Provider order dated 10/24/2024 directed administration of liquid protein by mouth one time of day for a stage 2 wound to the right buttock. The provider order failed to identify the amount of liquid protein that was ordered for administration by the nurse. Review of the Nutritional Assessment Policy directed, in part, the dietician will conduct a nutritional assessment as indicated by a change in condition that places the resident at risk for impaired nutrition. Situations which placed the resident at increased risk for impaired nutrition included increased demand for calories and protein resulting from wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A provider order dated 10/31/2024 directed the charge nurse to complete a weekly skin assessment and document the skin assessment (Skin Assessment-V2) under the assessments section in the electronic medical record (EMR) on Sunday ' s during the 3 PM to 11 PM shift. Review of the facility document titled Skin Checks on Shower Days identified 22 licensed nurses were provided education on 11/1/24 for a new skin assessment protocol. The education instructed nurses would receive a notification within the Electronic Medical Record (EMR), on residents scheduled shower days, directing them to complete a Skin Assessment. The nurses were instructed that when performing an Skin Assessment for a resident with a wound being treated by the wound doctor, the nurse was to document the type and location of the wound on the Skin Assessments. The education failed to instruct nurses to document wounds that were not being treated by the wound doctor on the Skin Assessment. Review of the clinical record identified weekly Skin Assessments were not completed on 10/20/24, 10/27/24, 11/3/24 (20 days with no skin assessment), and 12/1/24, despite the presence of a new facility acquired pressure injury. The Skin Assessments completed on 11/9/2024, 11/16/2024, and 11/23/2024 failed to include documentation of an existing pressure injury or the resolution of the pressure injury to the right buttock. Subsequent to surveyor inquiry a Skin Assessment was performed on 12/7/24 which identified a new dry, superficial area to the left elbow measuring 1 cm by 1 cm, but did not include documentation of an existing pressure injury or the resolution of the pressure injury to the right buttock. Interview with the ADNS on 12/10/24 at 10:20 AM identified weekly Skin Assessments should be documented by the charge nurse in the assessment section of the EMR. He identified licensed nurses should include documentation of existing skin issues within the Skin Assessments. The ADNS indicated licensed nurses received education on 11/1/24 related to the facility ' s new process for Skin Assessments. 3. A Wound-Weekly Progress Notes assessment by the Assistant Director of Nursing Services (ADNS) dated 10/25/24 at 2:16 PM identified Resident #81 had an improved facility acquired right buttock pressure injury, onset date unknown, which measured 2.4 cm by 0.4 cm. A physician ' s order dated 11/6/24 directed to measure wound(s) to the right upper and right medical buttock every Wednesday on the 7 AM to 3 PM shift. A physician ' s order clarification dated 11/20/24 directed to complete a wound assessment for buttock wounds every Wednesday on the 7 AM to 3 PM shift. Review of the clinical record for Wound-Weekly Progress Notes assessments in the assessment section of the EMR identified there were no documented wound assessments during the week of 10/27/24 through 11/2/24, and on 11/20/24, 11/27/24, and 12/4/24 according to provider order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #81 ' s skin integrity with the Director of Nursing Services (DNS) and Nurse Aide (NA) #8 on 12/10/24 at 9:10 AM identified Resident #81 had 2 small superficial stage 2 pressure injuries (wounds) to the upper and lower coccyx with red wound beds and scant drainage. The DNS indicated she would have the charge nurse initiate a wound evaluation and ensure Resident #81 was added to the weekly wound rounds schedule for the wound doctor to evaluate. The DNS indicated that the observed wounds were new as the Skin Assessment performed on 12/7/24 did not identify wounds to the coccyx or buttocks, and a new treatment would be initiated. Interview with the ADNS on 12/10/24 at 10:20 AM identified he performed weekly wound rounds with the doctor and was responsible for entering subsequent wound assessments into the EMR. He further identified charge nurses were responsible for assessing and documenting all other wounds not seen by the doctor during wound rounds. The ADNS confirmed Resident #81 had stage 2 wounds to the right upper and medial buttocks as documented on 11/13/24 but was unable to identify why wound assessments were missing for 11/20/2024, 11/27/2024 and 12/4/2024. The ADNS indicated the right upper and medial buttock wounds were healed and there should have been documentation of the healed wounds in the clinical record. He was unable to provide a healed date for the wounds. The ADNS indicated he was notified by the charge nurse of 2 new stage 2 pressure injuries that morning. The ADNS identified that charge nurses were responsible for documentation of new or existing wounds, that were not followed by the wound doctor during wound rounds, during weekly skin assessments. The ADNS was unable to explain how charge nurses would identify a decline in wound status if they were not consistently assessing a wound or how they would know when to report wound status to a provider. Review of the Pressure Ulcer Prevention Policy directed, in part, the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, family and addressed and weekly Skin Assessments and documentation completed in EMR.

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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** 50250 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #210) reviewed for accidents, the facility failed to follow the plan of care to prevent an accident for a resident who was at risk of falls. The findings include: Resident #210 was admitted to the facility in October of 2022 with diagnoses that included acute and chronic respiratory failure, heart failure, long term (current) use of anticoagulants and difficulty in walking. Physician ' s order dated [DATE] directed to administer oxygen at 3 liters (L) per minute via nasal cannula. Physician's order dated [DATE] directed to place a sensor alarm to Resident #210's bed and chair every shift for safety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #210 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 12) and was dependent for toileting hygiene, required moderate assistance with positioning from lying to sitting on the side of the bed and supervision assistance from sitting to standing. Additionally, the MDS identified that Resident #210 had other health conditions that caused him/her to experience shortness of breath or trouble breathing with exertion e. g. walking, bathing, transferring, when sitting at rest, and when lying flat. The MDS identified Resident #210 was receiving oxygen therapy, was prescribed an anticoagulant, and required bed alarm and chair alarm to monitor his/her movement and alert staff when movement was detected. The MDS further identified that Resident #210 had sustained a fall prior to admission to the facility. The Resident Care Plan (RCP) dated [DATE] identified Resident #210 had a history of falls related to poor safety awareness and cognitive deficits. The identified goal was a decreased risk of injury related to falls as evidenced by maximum interventions placed to provide a safe, calming environment with minimal risk of injury should a fall/incident occur. Interventions included use of bed and chair alarms and to check the function and placement every shift, provide toileting assistance at the appropriate frequency and as needed, keep bed in lowest position with brakes locked, observe Resident #210 frequently and place him/her in a supervised area when out of bed. The RCP further identified that Resident #210 had chronic respiratory failure with interstitial lung disease and hypoxia (deficiency in the amount of oxygen reaching tissues). Interventions included administering oxygen as ordered, checking for placement frequently and obtaining vital signs as ordered. The RCP further identified that Resident #210 was at potential risk for injury/bleed related to the use of anticoagulation medications for atrial fibrillation (a fib), interventions included monitoring Resident #210 for active bleeding, cyanosis and pallor and obtaining labs as ordered. The Resident Care Card (RCC) for the month of [DATE] identified that Resident #210 was alert but forgetful and required an assist of 1 with a rolling walker and gait belt for ambulation. Additionally, the RCP directed to place bed and chair sensor alarms and to check for placement and function every shift. The RCP also directed to pad oxygen cannula and check oxygen setting frequently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Services note dated [DATE] at 3:07 PM written by Social Worker #1 identified that Resident #210 presented with periods of increased confusion, hallucinations and delusions particularly in the evening. The note further identified that Resident #210 had exhibited poor safety awareness with self-transfer attempts and was removing his/her oxygen despite ongoing education and oxygen saturation readings ranged from 79% to 97% while on 3L of oxygen but drops quickly with little activity including ambulating to and from the bathroom. A Nurses noted dated [DATE] at 6:20 PM written by LPN #5 identified that on 3:00 PM to 11:00 PM shift, Resident #210 was alert and forgetful with intermittent confusion and ambulated him/herself to the bathroom. The note further identified that Resident #210 was found sitting on the toilet without his/her oxygen but was brought back to his/her recliner and oxygen was applied at 3.5 L. The note identified that Resident #210 ' s oxygen saturation levels were between 81%-84% but increased to 87% when oxygen was applied. The note further identified that Resident #210 ' s oxygen increased to 93% after Morphine was administered at 5:39 PM. A Reportable Event form dated [DATE] at 3:40 AM written by LPN #6, identified that staff heard a loud thump from Resident #210's room and when they responded they found Resident #210 lying in supine position (lying on back with face and torso facing up) on the floor. The form identified that Resident #210 was unresponsive, was observed with a left eye bruise and small trickle of blood near the outer side of the left eye and LPN #6 was unable to obtain vital signs. The Registered Nurse Supervisor (RN #4) and physician were notified. The form identified LPN #4 called 911 and applied oxygen, but Resident #210 deceased within ,d+[DATE] minutes. The report identified that Resident #210 was cognitively impaired, had experienced episodes of restlessness, mood swings and agitation prior to the fall and had a bed sensor/alarm in place which was always connected. The form further identified that Resident #210 self-transferred out of bed and the bed sensor/alarm did not sound. The form identified the bed sensor/alarm was later taken apart and the alarm control unit was found to be broken. A Nurse's note dated [DATE] at 4:28 AM by RN #2, identified that at 3:40 AM she was alerted by LPN #6 that Resident #210 was on floor. RN #2 ' s note indicated he/she responded and found Resident #210 in his/her room by the bathroom door in a supine position. The note identified that Resident #210 was unresponsive and was noted to have a small amount of blood coming from the left eye. The note indicated that RN #2 was unable to obtain vital signs, called 911 and notified RN #4. The note further identified that Resident #210 was pronounced deceased at 3:45 AM. Additionally, the note indicated that EMS arrived at 3:50 AM and confirmed Resident #210's death and Resident #210's daughter was notified at 4:05 AM. A Nurses note dated [DATE] at 7:02 AM written by LPN #6, identified that prior to Resident #210 ' s fall incident on [DATE], he/she had not voided during the 11:00 PM to 7:00 AM shift. The note further identified that Resident #210 had remained asleep through the 11:00 PM to 7:00 AM shift prior to self-transferring from bed and falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 on [DATE] at 3:37 PM identified that she responded to the fall incident on [DATE] after being called by the LPN #6. RN #4 identified that she found Resident #210 on the floor in the supine position, unresponsive and was bleeding slightly from the back of his/her head due to a small cut on the back of his/her head. RN #4 identified that Resident #210 did not have his oxygen tubing applied when he/she fell but the oxygen tubing was on the floor a few feet away. RN #4 identified that she did not check the bed alarm function at the beginning of the 11:00 PM to 7:00 AM shift because Resident #210 was asleep, and she did not want to wake him up because he would become restless, but she observed that the bed alarm/sensor was plugged in. RN #4 identified that checking the bed sensor/alarm is a routine safety task that should be done at the beginning of shift. RN #4 identified that checking for bed alarm function entails moving/rolling the resident completely off the sensor pad that is normally placed underneath the resident and then rolling the resident back. RN #4 further identified that Resident #210 was a fall risk, and the bed alarm should have sounded when Resident #210 moved out of bed alerting staff to respond timely to prevent him/her from falling and redirect him/her, but the bed alarm did not sound. RN #4 identified that both nurses and nurses assistants were responsible for checking bed alarm placement and function at the beginning of their shifts. Interview with NA #8 on [DATE] at 11:51 AM, identified that she heard a loud bang and when she responded, she found Resident #210 laying on the floor on his/her back in his/her room near the bathroom door. NA #8 further identified that Resident #210 was still and not moving. NA #8 identified that at the beginning of her shift when she did rounds, Resident #210 was sleeping, and the bed alarm was plugged in. NA #8 identified that she did not check the bed alarm's function because Resident #8 was sleeping, and she did not want to wake him/her up. NA #8 identified that she would normally check for bed alarm placement and functioning at the beginning of the shift. NA #8 further identified that checking for bed alarm function entails moving/rolling the resident completely off the sensor pad that is normally placed underneath the resident and then rolling the resident back. Rolling the Resident off the sensor pad would activate the bed alarm to sound. Interview with the DNS on [DATE] at 12:30 PM, identified that bed alarm placement was implemented as an intervention protocol to mitigate Resident #210's fall risk. The DNS identified that the bed alarm last sounded around 4:00 PM on the 3:00 PM to 11:00 PM shift when Resident #210 self-transferred to the bathroom. The DNS identified that the bed alarm control unit was found to be broken resulting in the failure to sound when Resident # 210 got out of bed. The DNS further identified that the NA's were responsible for checking the bed alarm function. Although requested, a bed alarm policy was not provided. Although requested, competencies or staff education related to bed alarm function checks by NA's was not provided. Review of facility policy titled, Fall Prevention Program, identified, in part, that the purpose of the fall preventive program is to prevent avoidable falls and injuries that result from falls. The program further identified that the plan of care will be individualized to resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 residents (Resident #203) reviewed for nutrition and hydration, the facility failed to obtain accurate weights and failed to notify the provider of weight increases according to provider order. The findings include: Resident #203 was admitted to the facility in December of 2024 and had diagnoses that included periprosthetic fracture around the internal prosthetic right hip, diabetes, congestive heart failure (CHF) and hypertension. The Admission assessment dated [DATE] identified Resident #203 was alert and oriented to person, place and time. The Resident Care Plan dated 12/2/24 identified CHF and a risk for complications due to CHF. Interventions included to administer medications as ordered, check labs as ordered, chest x-ray as needed, daily weights for CHF, report weight gain of 3 pounds (lbs.) or more in a day to physician, diet as ordered, notify Physician of signs or symptoms of CHF exacerbation, and weigh as ordered. A Physician's order dated 12/4/24 directed to obtain daily weights for 3 days. A Physician's order dated 12/5/24 directed to obtain daily weights for CHF and directed to report a weight gain of 3 lbs. or more, within 1 day, to the physician. A Weights and Vital signs summary identified the following weight entries: 12/3/24 at 12:30 PM: 150.2 lbs. standing scale 12/4/24 at 11:06 AM: 133.4 lbs. standing scale (16.8 lb (11.2%) weight loss) 12/5/24 at 2:15 PM: 150.4 lbs. wheelchair scale (17 lb (12.7%) weight gain) 12/6/24 at 2:40 PM: 150 lbs. standing scale 12/7/24 at 1:45 PM: 134.2 lbs. wheelchair scale (15.8 lb (10.5%) weight loss) 12/7/24 at 10:01 PM: 135 lbs. sitting scale 12/8/24 at 2:39 PM: 134.6 lbs. standing scale 12/9/24 at 12:02 PM: 132.6 lbs. standing scale 12/10/24 at 11:20 AM: 137.4 lbs. standing scale (4.8 lb (3.6%) weight gain) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/24 at 11:22 AM; 133.4 lbs. standing scale Review of the clinical record for December of 2024 failed to identify provider notification of the documented weight changes. Subsequent to surveyor inquiry, a handwritten Weights worksheet dated 12/7/24 was provided and identified the following weights: 12/03/24: 134.2 lbs., 12/04/24: 133.4 lbs., 12/6/24: 134.2 lbs. A Weight change note by the Dietitian dated 12/8/24 at 9:11 AM identified a significant weight change and recommended continuing daily weights and obtaining a baseline weight. A Nurse Practitioner note dated 12/9/24 at 3:00 PM identified, in part, no weight changes, no evidence of fluid overload. Interview and review of the clinical record with the Assistant Director of Nursing (ADNS) on 12/10/24 at 11:30 AM identified the physician should have been notified of the weight changes. The ADNS further identified the weights should have been obtained using the same scale. The ADNS could not determine the reason for the weight fluctuations. Subsequent to surveyor inquiry, on 12/10/24 at 11:30 AM, a standing reweight was obtained and identified a weight of 133.4 lbs. Subsequent to surveyor inquiry, on 12/10/24 at 1:30 PM the ADNS identified that he notified the provider of the weight changes and received orders for bloodwork. Review of the facility policy for Weight Assessment and Intervention, in part, directed the nursing staff will measure resident weights within a month and as scheduled by the physician, dietitian or the interdisciplinary team. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the physician or and Dietitian. The responsible party will also be notified. The dietitian will discuss undesired weight gain with the resident and/or family. Interventions for undesired weight gain should consider resident preferences and rights. 51183

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50167 Based on observations, review of facility documentation, facility policy, and interviews, the facility failed to ensure shift to shift controlled drug reconciliation was consistently completed and failed to maintain documentation of bi-monthly controlled drug audits. The findings include: 1. Observations on 12/9/24 at 1:50 PM of the St. [NAME]'s A medication cart with the Assistant Director of Nursing (ADNS) identified the December Change of Shift Inventory Record for Required Drugs sheet (the controlled drug reconciliation form that the on-coming and off-going nurses complete to ensure controlled drugs are counted) were missing signatures on the following dates: A. 12/3/24: 7:30 AM to 3:00 PM off-going, 3:30 PM to 11:00 PM off-going B. 12/4/24: 7:30 AM to 3:00 PM off-going, 3:30 PM to 11:00 PM off-going C. 12/6/24: 7:30 AM to 3:00 PM on-coming and off-going, 11:30 PM to 7:00 AM off-going D. 12/8/24: 7:30 AM to 3:00 PM off-going, 3:30 PM to 11:00 PM on-coming and 11:30 PM to 7:00 AM off-going Interview with LPN #1 on 12/9/24 at 1:55 PM identified she worked on the St. [NAME] unit on 12/8/24 from 7:00 AM until 7:30 PM, and she forgot to sign the change of shift controlled drug reconciliation form because she continued to work past her regular shift hours. LPN #1 indicated it was the responsibility of all the nurses to sign the controlled drug reconciliation form at the change of shift when the controlled drug count is completed. Interview with the ADNS on 12/9/24 at 2:00 PM identified that he was not aware of the missing signatures on the controlled drug reconciliation form, and it is his responsibility as the ADNS to check it, and he did not do so. The controlled drug reconciliation form should be checked weekly. 2. Observation with the ADNS on 12/9/24 at 2:15 PM identified the facility was unable to provide bi-monthly controlled drug audit sheets. Interview on 12/9/24 at 2:21 PM with the Director of Nursing (DNS) identified that she goes to each of the medication carts to review the controlled drug book and verify the counts in the cart, then matches the count to the pharmacy delivery sheets which were delivered with the controlled drugs by the pharmacy. The DNS indicated that she previously maintained a book with audit sheets but that process fell off. Review of the facility policy titled Handling and Destroying Narcotics indicated strict narcotics count should be done at the start and end of each shift. The incoming and outgoing nurses will both sign the narcotics book before handing out the key. Additionally, directed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51101 Based on interviews, review of the clinical record, and facility policy for 1 of 9 residents (Resident #57) reviewed for food and nutrition, the facility failed to assist a dependent resident with menu selection. The findings include: Resident #57 was admitted to the facility in July of 2023 and had diagnoses that included legal blindness, gastro-esophageal reflux disease, and feeding difficulties A provider order dated 12/12/23 directed a regular diet, regular texture with an allergy to eggs and egg derivates. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 13), required set up assistance for eating, and was dependent for toileting, bathing, and transfers. The Resident Care Plan (RCP) dated 10/30/24 identified Resident #57 had impaired visual function related to legal blindness. Interventions included reviewing medications for side effects which affect vision and telling the resident where their items were placed. Additionally, the RCP identified Resident #57 was at risk for malnutrition due to varied meal intakes. Interventions included to provide diet as ordered, monitor intake of meals, offer meal alternates as needed, and provide assistance with meals as needed. Interview with Resident #57 on 12/9/24 at 3:09 PM identified he/she was not informed of the facility meal menus or given an option to select food preferences for meals but was just provided with the scheduled meal. Additionally, Resident #57 identified that he/she had informed staff that he/she would like to be informed of meal options and given the opportunity to make selections, but nothing had been done. Interview with the Food Service Director on 12/09/24 at 3:40 PM identified that the process for assisting residents with menus, food preferences and informing residents of what is on the menu is completed by the Nurse Aids (NA). Interview with NA #3 on 12/09/24 at 3:59 PM identified that NA's assist residents with filling out menus and selecting meal options. NA #3 further indicated that she did not assist Resident #57 with his/her meal selections and believed that this was completed on first shift. Interview with LPN #3 on 12/09/24 at 4:06 PM indicated that NA ' s or the recreation department help residents' complete meal selections and could not answer why it was not completed. LPN #3 stated she did not know who was overall responsible for ensuring menu selection was completed. Interview with the Director of Recreation on 12/09/24 at 5:05 PM identified that recreation helped with menu selection in the past and would help if requested, but that NA ' s were responsible for assisting residents with their menu selection. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing Services (DNS) on 12/09/24 at 5:40 PM identified that it was the responsibility of the NA to assist residents with menu selection and could not answer why it was not being completed for Resident #57. Additionally, the DNS stated that according to the policy, residents who were not capable of making their food selections would be assisted. Review of the Resident Menu Selections Policy identified, in part, residents would be offered the availability to choose their meal options ahead of time. A staff member would be available to meet with the resident or responsible party to determine their choices for meals. The resident could choose their meals up to one week in advance from the menu options or always available menu. A resident could change their meal selection at any time to a different available option that did not conflict with their current physician orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 6 of 13 residents (Resident #22, Resident #36, Resident #44, Resident #64, Resident #71 and Resident #89) reviewed for Enhanced Barrier Precautions (EBP) and 1 of 2 residents (Resident #211) reviewed for Transmission Based Precautions (TBP), the facility failed to initiate Enhanced Barrier Precautions (EBP) per Center of Disease Control (CDC) guidelines for residents with a history of Multiple Drug Resistant Organisms (MDROs) and failed to perform hand hygiene after exiting a resident room and before entering another resident room and failed to maintain Transmission Based Precautions (TBP) while assisting a resident with a positive COVID-19 diagnosis. The findings include: 1. Resident #22, Resident #36 and Resident #44 had diagnoses that included a history of Methicillin Resistant Staphylococcus Aureus (MRSA) Resident #64 had diagnoses that included a history of Clostridium Difficile (C. Diff.). Resident #71 had diagnoses that included a history Extended Spectrum Beta Lactamases (ESBL). Resident #89 had diagnoses that included a history of Methicillin Suseptible Staphylococcus Aureus. Review of the History vs Active MDRO list compared to the Enhanced Barrier Precautions list provided by the Infection Control Nurse identified Resident #22, Resident #36, Resident #44, Resident #64, Resident #71 and Resident #89 were not on EBP. Interview and review of MDRO list, EBP list and current CDC guidelines with the Director of Nursing on 12/9/24 at 2:35 PM identified that Resident #22, Resident #36, Resident #44, Resident #64, Resident #71 and Resident #89 were identified to have a history of an MDRO and should have been placed on EBP. Center for Disease Control (CDC) guidelines identified April 1, 2024: Implementation of Enhanced Barrier Precautions (EBP) in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms. Multidrug-resistant Organism (MDRO): bacteria or fungi resistant to multiple antimicrobials and colonization identifies a germ is found on or in the body but is not causing infection. Many nursing home residents are unknowingly colonized with an MDRO, especially residents with risk factors like indwelling medical devices or wounds. Residents who have an MDRO can develop serious infections, remain colonized for long time periods, and spread MDROs to others. EBP are indicated for nursing home residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply, wounds and/or indwelling medical devices. EBP is not limited to outbreaks or specific MDROs. Review of the facility policy titled Enhanced Barrier Precautions directed, in part, to be used when caring for residents during high contact care activities for residents with an infection or colonization with a CDC targeted MDRO when contact precautions do not otherwise apply. The facility will utilize the orange enhanced barrier precautions signs to be placed outside of the resident's room, to notify staff of proper PPE usage. PPE will be stored on the unit for staff availability. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 12/9/24 at 4:58 PM identified NA #6 was passing meal trays with gloves on. NA #6 delivered a tray to room [ROOM NUMBER] with gloves on, exited the room without the benefit of changing her gloves and performing hand hygiene, then went into room [ROOM NUMBER] to deliver another meal tray. Interview on 12/9/24 at 4:58 PM with NA #6, upon exiting room [ROOM NUMBER], indicated she was not thinking about her gloves and forgot to perform hand hygiene. NA #6 then removed her gloves and performed hand hygiene. Interview with LPN #4 on 12/9/24 at 5:18 PM identified that gloves should not be worn in the hallway or to pass meal trays and upon disposal of gloves, hands are to be sanitized prior to serving the next tray. LPN #4 did not know why NA #7 was wearing gloves to pass meal trays and did not remove the gloves and sanitize her hands before passing the next tray. A facility policy titled Standard Precautions and Other Precautions identified, in part, hand hygiene refers to handwashing with soap (antimicrobial or non-antimicrobial) or alcohol-based hand rubs (gels, foams, rinses) that do not require water. In the absence of visible soiling of hands, alcohol-based hand rubs are preferred for hand hygiene. Wash hands after removing gloves. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. 3. Resident #211 was admitted to the facility on [DATE] with diagnoses that included Covid-19 and was identified to require TBP and Contact/Droplet precautions. A Physician's order dated 12/3/24 at 3:00 PM directed to maintain strict isolation precautions and included instructions to render all care, meals, and services within Resident #211 ' s room due to Covid-19. A Physician's order dated 12/4/24 at 7:00 AM directed contact and droplet precautions for Covid-19. Observation on 12/9/24 at 5:00 PM, identified NA #7 wore only a surgical mask, without the benefit of Personal Protective Equipment (PPE), when entering Resident #211's room to deliver a meal tray. NA #7 was observed assisting Resident #211 with positioning in his/her chair and then setting up the meal tray, all within close proximity to Resdient #211. Signage was observed to be posted outside of Resident #211's room regarding precautions and required Personal Protection Equipment (PPE). Interview with NA #7 on 12/9/24 at 5:00 PM indicated NA #7 was unaware that Resident #211 was on TBP as identified by the signage posted outside of Resident #211 ' s room. NA #7 further indicated she was unaware she needed to wear an N95 mask to enter a room for a resident on TBP for Covid-19. Subsequent to surveyor identification of NA #7 rendering care without the use of PPE for Resident #211, the DNS verbally educated NA #7 regarding contact/droplet precautions and the required PPE to enter a room with TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #4 on 12/9/24 at 5:18 PM identified that NA #7 should have been aware that Resident #211 was on TBP due to Covid-19 because NA #7 received report the start of the shift and was informed that Resident #211 was positive for Covid-19, in addition to the signage outside of the room. LPN #4 identified that meal trays for residents on isolation precautions should be served last. Interview with the DNS on 12/9/24 at 5:45 PM identified that gloves should not be worn in the hallways to pass meal trays and hands are to be washed upon the removal of gloves. A facility policy titled Standard Precautions and Other Precautions identified, in part, residents on contact and/or isolation precaution will have precautions set up and available to staff and family members including personal protection equipment. Residents, staff and visitors will be educated about the precautions as necessary and hand washing. Alcohol gel sanitizer will be available for use. Resident ' s room will show Stop or Please see the nurse sign in the room.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 8 residents (Resident #85 and Resident #98) reviewed for infection control, the facility failed to identify and document vaccination status and offer vaccinations for resdients newly admitted to the facility. The findings include: 1. Resident #85 was admitted to the facility in October of 2024, with diagnoses that included Alzheimer's Disease, Atrial Fibrillation, Asthma and Osteoporosis. The admission Minimum Data Set assessment dated [DATE] identified Resident #85 was severely cognitively impaired (Brief Interview for Metal status (BIMS) score of 3). Review of the Electronic Health Record (EHR) immunization record identified that a Moderna Covid-19 vaccine was administered on 11/18/24 and an Influenza vaccine was administered on 12/9/24 but failed to identify if a Pneumovax vaccine was offered, refused or administered. The facility failed to identify any documentation of a Vaccine Administration Consent form was completed for the Pneumovax vaccine for Resident #85. 2. Resident #98 was admitted to the facility in October of 2024 with Diagnoses that included Acute Respiratory Failure with Hypoxia and Pneumonia due to Covid- 19. The admission Minimum Data Set assessment dated [DATE] identified Resident #98 was Cognitively intact (Brief interview of Mental Status (BIMS) score of 14). Review of the Electronic Health Record (EHR) immunization record failed to identify if any immunizations had been offered, refused or administered. The facility failed to identify documentation of Vaccine Administration Consent forms were completed for any vaccinations. Interview and clinical record review with the Director of Nursing (DNS) on 12/9/24 at 2:35 PM identified that the Infection Control Nurse (ICN) interviewed residents and resident representatives and used CTWIZ (an electronic vaccine tracking system) to identify vaccination status. The DNS indicated education was provided to residents and families within the admissions packet which included immunization fact sheets. The DNS indicated that the education should have been offered upon admission to the facility and would be in the immunization tab of the EHR if it were offered. Additionally, the DNS indicated she did not know why vaccines were not offered and further identified that the ICN is new to the role. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Vaccination of Residents policy directed, in part, all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. Provision of such education shall be documented in the resident's medical record. All new residents shall be assessed for current vaccination status upon admission. If vaccines are refused, the refusal shall be documented in the resident's medical record. If the resident receives a vaccine, the following information shall be documented in the resident's medical record: site of administration, date of administration, lot number of the vaccine, expiration date and the name of the person administering the vaccine.