STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075323	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	2428 Easton Tnpk Fairfield, CT 06825

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #54 and 87) reviewed for advance directives, the facility failed to obtain the residents code status (code status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops) on admission. The findings include: 1. Review of the hospital discharge paperwork dated [DATE] did not reflect the residents code status. Resident #54 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, adult failure to thrive, and heart failure. The admission MDS dated [DATE] identified Resident #54 had severely impaired cognition and almost always constant pain. The social worker note dated [DATE] at 4:53 PM indicated that Resident #54 was a full code (full code directs the medical team to take all possible measures to save the residents life in the event of a medical emergency). The social worker assessment dated [DATE] at 1:38 PM, in the electronic medical record, included a section for the advance directives, which was blank. The nurses note dated [DATE] at 1:58 PM indicated staff attempted to get Resident #54 to sign consents and advance directive. Resident #54 was confused and did not want to sign at this time. This writer called the resident representative and left a message. The advance directives form dated [DATE] identified Resident #54 was a Do Not Resuscitate (DNR means the resident does not want any life saving measures in the event of cardiopulmonary arrest). According to the form, the DNR was obtained over the phone from the resident representative and signed only by LPN #8. A physician's order dated [DATE] (17 days after admission) directed Resident #54 was DNR. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated [DATE] identified code status of DNR with interventions that included following the advance directive guidelines. Facility will honor and follow wishes of the resident/responsible party and review advance directives with resident/responsible party on admission and at least quarterly. Interview with LPN #4 on [DATE] at 7:36 AM indicated that the consent for code status is obtained on the day of admission and done by the charge nurse. LPN #8 indicated that if a nurse had to call a resident representative for the advance directive there has to be 2 nurses to witness and hear the resident representative give the directive for a full code or a DNR and both nurses have to sign the form. Interview with the ADNS on [DATE] at 8:19 AM indicated that on admission the charge nurse or supervisor gets the advance directive signed and if they have to call the resident representative then 2 RN's have to be on the phone call and get a telephone consent. The ADNS indicated the call would be made on the day of admission and if unable to reach resident representative the nurse would write a progress note indicating unable to reach for code status. The ADNS after clinical record review indicated that the advance directive dated [DATE] was only signed by 1 nurse and was not valid. The ADNS indicated that since admission [DATE] until now without a valid code status, Resident #54 would be a full code and staff would have to perform CPR if needed. The ADNS indicated that the code status should have been obtained on admission. Interview with the DNS on [DATE] at 8:37 AM indicated that the advance directives were to be done on day of admission and if unable to reach resident representative there would be a progress note identifying the nurse tried to reach the resident representative for the code status but was not able to or that the resident representative needed more time and was educated. Resident #54 would be a full code until the resident representative decided. The DNS indicated that if the family is not present that 2 nurses, one preferably an RN must co-sign the advance directive form and when resident representative comes in the next visit would sign it. The DNS indicated that the current code status form was only signed by LPN #8 on [DATE] and was not valid without a second nurses signature. The DNS indicated that Resident #54 was a full code since day of admission. Interview with the DNS on [DATE] at 9:19 AM indicated that she had just spoken with Resident #54's representative and the ADNS was present. The DNS indicated that she had gone over each area such as cardiopulmonary resuscitation, artificial respiration, and artificial nutrition with resident representative. The DNS indicated that she had informed the resident representative that he/she needed to come in and sign the form. The DNS indicated that she would get the physician's order and update the care plan. The nurses note written by DNS on [DATE] at 12:32 PM identified this writer spoke with the resident's representative to discuss advance directive who indicated Resident #54 to be a DNR. A physician's order dated [DATE] at 12:46 PM directed Resident #54 was a do not resuscitate. (61 days from day of admission). After surveyor inquiry, the advance directive form dated [DATE] directed Resident #54 requested DNR status cosigned by the DNS and the ADNS. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Advanced Care Planning Code Status Policy identified upon admission if the resident was a DNR at the hospital it can be valid no more than 48 hours at the facility. Upon admission the option for choosing to resuscitate (CPR) or do not resuscitate (DNR) will be offered and reviewed with resident or resident representative. The consent or refusal form will be signed by the resident and witnessed. Physician orders must be written accordingly. 43032 47457 2. Resident #87 was admitted to the facility on [DATE] with diagnoses that included dissection of the ascending aorta, acute respiratory failure, and gastrostomy malfunction. The Advance Directive Consent/Acknowledgement and Release Form failed to reflect Resident #87's choices for the administration of life support systems and his/her signature. The admission MDS dated [DATE] identified Resident #87 had intact cognition. The care plan dated [DATE] identified Resident #87's code status: CPR. Interventions included to provide information to resident/responsible party to complete Advance Directives and assist as necessary, review Advance Directives with resident/responsible party on admission and at least quarterly, and honor Advance Directives as directed by resident/responsible party for guidance. The Care Plan Meeting note dated [DATE] at 3:09 PM failed to identify Resident #87's Advance Directives were reviewed. The physician's orders dated [DATE] through [DATE] failed to identify an order directing Resident #87's code status. Interview and review of the clinical record with RN #1 on [DATE] at 11:32 AM failed to identify a signed and completed Advance Directive Consent/Acknowledgement and Release Form and an order for CPR (Cardiopulmonary Resuscitation) or DNR (Do Not Resuscitate) were in Resident #87's clinical record. RN #1 indicated that she was not sure why Resident #87's code status was not in the physician's orders or why the Advance Directive consent was left blank. RN #1 further indicated that Resident #87 was responsible for self and advance directives should be reviewed and signed by the resident or responsible party on admission or readmission to the facility. RN #1 identified that it is the responsibility of the charge nurse or nursing supervisor, admitting the resident, to ensure the consent is signed and orders are entered. Subsequent to surveyor inquiry, an Advance Directive Consent/Acknowledgement and Release Form was completed and signed by Resident #87, on [DATE]. The physician's orders dated [DATE] directed full code, cardiopulmonary Resuscitation. Interview with the DNS on [DATE] at 1:32 PM identified that she would expect the charge nurse or nurse supervisor to ensure the Advance Directive Consent/Acknowledgement and Release Form was signed and the appropriate code status ordered on admission or within 24 hours of admission to the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Advanced Care Planning Code Status policy directs upon admission, the option of choosing to resuscitate or not to resuscitate will be offered and reviewed with the resident/ family/surrogate/designated representative. The consent/refusal form will be signed and witnessed. Physician orders must be written accordingly.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 residents (Resident #40) reviewed for notification of change, the facility failed to ensure the resident representative was notified when the APRN made changes to the residents medication regimen. The findings include: Resident #40 was admitted to the facility with diagnoses that included dementia, congestive heart failure, and knee pain. The care plan dated 9/22/23 identified Resident #40 had congestive heart failure with lower extremity edema and was at risk for fluid deficit because resident is on diuretic. Interventions included giving medications as ordered. Additionally, Resident #40 has chronic knee and hip pain. The social worker note dated 9/22/23 identified Person #1 was notified an increase in Trazadone (antidepressant medication) for Resident #40's insomnia and depression. Person #1 requested resident to be seen by APRN for knee pain. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition and required touching assistance with toileting, dressing, and personal hygiene. A physician's order dated 11/29/23 directed to administer Aspirin 81 mg once daily in the morning, Potassium Chloride ER tablet extended release 10 MEQ once a day to replace potassium, Lasix 20 mg in the morning every other day and Tylenol 650 mg every 8 hours as needed for pain. The nurses note dated 12/12/23 at 12:04 PM identified Resident #40 received Tylenol 650 mg for pain. The APRN note dated 12/12/23 at 4:36 PM identified Resident #40 was receiving the following medications Trazodone 50 mg at bedtime, Lasix 20mg every other day, Potassium Chloride ER 10 MEQ daily, and Aspirin 81 mg chewable daily. The APRN indicated that she was requested to see Resident #40 for edema. Resident #40 has back and knee pain. Resident #40 had no edema. Congestive heart failure has no signs of fluid overload. Will discontinue the Lasix and monitor residents' weight for 1 week and reevaluate. Aspirin 81 mg, called Person #1 to discuss risk versus benefit but unable to reach. Discontinue Potassium and Lasix. A physician order dated 12/12/23 directed to discontinue Lasix and Potassium. Review of progress notes dated 12/12/23 - 12/30/23 failed to reflect that Person #1 had been notified of the discontinued medications Lasix and Potassium Chloride. The APRN note dated 12/13/23 at 12:07 PM identified Resident #40 is alert, appears more confused, and frail status post emergency room visit after a fall in the shower. Resident #40 has knee and back pain. Resident #40 has no new pain. Aspirin will be discontinued due to increased risk of falls and bleeding. Attempted to reach Person #1 to updated unable to reach. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 12/13/23 identified the discontinuation of the Aspirin 81 mg. Review of the clinical record and interview with the ADNS on 7/30/24 at 12:12 PM indicated that the APRN attempted to update Person #1 on 12/12/23 about discontinuing the medications but was unable to reach him/her. The ADNS indicated that there were notes about other things like needing urine and weights but nothing about the medications that were being discontinued. The ADNS indicated that the expectation was that the nurses would continue to try to call Person #1 and document the attempts made until Person #1 was reached. The ADNS indicated that nursing was able to reach Person #1 for other things during that time. Interview with the DNS on 7/30/24 at 12:45 PM indicated that when a resident has any medication changes the resident representative should be updated at that time the same day by the APRN or physician so they can explain why there is a medication change. The DNS indicated that on 12/12/23 and 12/13/23 when the APRN had discontinued medications she should have made multiple attempts to reach Person #1. After clinical record review, the DNS indicated that in December 2023 the APRN had reached out but did not speak with Person #1. The DNS indicated that the expectation was the APRN, or nursing would have updated Person #1 at the time the medications were being discontinued and documented when they had reached and updated Person #1. The DNS indicated that she was not aware that Person #1 was not updated about the discontinued medications until April 2024 when Person #1 had informed her that he/she had just found out that all the medications had been discontinued. The DNS indicated at that time, in April 2024, Person #1 had written a letter because Person #1 was upset he/she was never notified that of the medications were discontinued and wanted to know when and why they were discontinued. Review of the facility Change of Condition Notification Policy identified the facility will inform the resident, residents' representative, and physician when there is a change in condition. The facility will ensure that a residents change in condition is evaluated and documented properly. The facility will ensure that the change of condition is reported to the physician and resident representative. The licensed nurse per state regulations will notify the resident, physician, and resident representative of the change in condition. Repeated attempts will be made to reach the resident representative and physician until successful. The nurse will document all attempts, noting the date and time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15802 Based on observation, review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #181) reviewed for accidental hazards, the facility failed to ensure medication was not left at the bedside. The findings include: Resident #181 was admitted to the facility on [DATE] with diagnoses that included cerebrospinal fluid leak, surgery on the nervous system, and depression. The care plan dated 7/25/24 identified Resident #181 had a potential for pain related to back surgery. Interventions included administering medications per the physician's orders. A physician's order dated 7/24/24 directed to administer the following. 5mg Bisacodyl EC Delayed release, 1 tablet by mouth, daily, for bowel management. 300mg Gabapentin, 1 capsule, by mouth, three times daily, for pain 2mg Hydromorphone HCL (narcotic), 1 tablet, by mouth, every 6 hours, as needed for pain. 250mg Acetazolamide, 1 tablet, by mouth, twice daily, for edema. A physician's order dated 7/25/24 directed to administer the following. 150mg Bupropion HCL ER, 2 tablets, by mouth, daily, for depression. A physician's order dated 7/26/24 directed to administer the following. 25mg Topiramate, 1 tablet, by mouth, daily, for seizures. Observation on 7/28/24 at 9:13 AM identified a medicine cup, containing 7 pills, at Resident #181's bedside. Resident #181 indicated he/she wanted to wait until after breakfast to take the medications because he/she threw up the day before, after taking the medications on an empty stomach. Interview with LPN #1 on 7/28/24 at 9:16 AM identified that Resident #181 had requested Hydromorphone for pain, so she brought in Hydromorphone along with Resident #181's scheduled morning medications, about 15 minutes earlier. LPN #1 further identified that Resident #181 had reported pain but wanted to eat something because he/she felt sick after taking the medications on an empty stomach, yesterday. LPN #1 indicated that she had left the medications at the bedside and was unsure if Resident #181 had taken them. LPN #1 further indicated that she should not have left medications at the bedside and should have remained with Resident #181 until he/she had taken the medications or should have removed the medications and returned with them after Resident #181 had eaten breakfast. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 on 7/28/24 at 9:20 AM identified that when medications are administered, she would expect the nurse to administer the medication using the 5 rights of medication administration and to observe that all the medications were taken. RN #1 further identified that if medications are refused, then the nurse should properly waste them and reattempt, later. Interview and review of the MAR dated 7/28/24 with LPN #1 identified the following medications were left at the bedside, at approximately 8:15 AM. 5mg Bisacodyl EC Delayed release, 1 tablet. 300mg Gabapentin, 1 capsule. 2mg Hydromorphone, 1 tablet. 250mg Acetazolamide, 1 tablet. 150mg Bupropion HCL ER, 2 tablets. 25mg Topiramate, 1 tablet. LPN #1 identified that she returned to Resident #181's room, subsequent to surveyor interview, and attempted to administer the morning medications. Resident #181 took the Hydromorphone tablet but refused the rest of the medications, as he/she was still eating breakfast. LPN #1 further identified that she discarded the other medications and later administered them after Resident #181 had eaten. Interview with the DNS on 7/29/24 at 11:21 AM identified that her expectation is that medications are not left at the bedside and that the nurse remains with the resident until all the medications are taken; if a resident refuses a medication, then the medications are to be removed from the room and offered, later. The DNS further identified that Resident #181 had not been evaluated, ordered, or care planned to self-administer medications. The facility's Medication Pass policy directs medications to be administered safely and timely per the physician's orders, always observe the resident until they have swallowed all medications that have been administered, and do not leave medication in medication cup at the bedside or on tableside. The policy further directs that medications must be re-offered before they are considered refused, and medications that are refused.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #1 and 11) reviewed for unnecessary medications, the facility failed to ensure that the residents' had vital signs monitored at least monthly and neurological checks were done after unwitnessed falls, and for 1 of 8 residents (Resident #15) reviewed for nutrition, the facility failed to monitor the blood sugar for a resident with a diagnosis of Type 2 diabetes, and for 1 of 6 residents (Resident #31) reviewed for accidents, the facility failed to ensure neurological vital signs were completed according to facility policy, and for 1 of 4 residents (Resident #44) reviewed for skin conditions, the facility failed to administer a specialty medication according to the physician's orders and subsequently the resident missed 3 doses and 4 doses were administered late. The findings include: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included rectal cancer, congestive heart failure, and chronic obstructive pulmonary disease (COPD). The admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition, was always incontinent of bladder, had a colostomy in place for bowel, and required maximal staff assistance with eating, dressing, and bathing. The physician's orders dated 12/22/23 directed to administer Spironolactone (a diuretic) 25 mg daily for fluid retention; Metoprolol ER (a blood pressure medication) 25 mg daily for hypertension; Albuterol nebulizer (a medication for shortness of breath) 3 ml inhaled orally 4 times daily; Acetylcysteine solution (a medication for thickened mucus secretions related to COPD) 3 ML inhaled orally every 6 hours for COPD; Torsemide (a diuretic) #3-20 mg tablets (for a total of 60 mgs) by mouth every Monday and Friday for fluid overload; and Apixaban (an anticoagulant) 5 mg every 12 hours for atrial fibrillation. The care plan dated 2/11/24 identified Resident #1 had a history of renal insufficiency related to Stage III kidney disease. Interventions included to monitor vital signs and notify the physician of any significant abnormalities, monitor for signs and symptoms of hypovolemia (volume depletion) including increases pulse, respirations, decreased systolic blood pressure; and for hypervolemia (volume overload) including increased blood pressure and lung crackle. The care plan also identified Resident #1 had a history of congestive heart failure and hypertension. Interventions included to give cardiac medications, monitor vital signs as ordered, and monitor and report any signs/symptoms of congestive heart failure or hypokalemia that included increased heart rate (tachycardia) or dysrhythmias. Review of the clinical record 2/15/24 - 3/31/2024, over a month, failed to identify any documentation related vital sign monitoring. An APRN note dated 4/1/24 by APRN #3 identified Resident #1 was seen along with APRN #4 (wound care) for evaluation of wounds at the left and right heels. The note identified the left heel appeared infected with drainage and pus and the right heel appeared to be worsening. The treatment plan included STAT x rays of the bilateral heels, wound cultures, start Bactrim (an antibiotic) twice daily for 7 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 4/1/24 at 2:57 PM identified to start Bactrim every 12 hours for 7 days, obtain an X rays to rule out osteomyelitis (an infection of the bone) and that wound cultures had been obtained. Review of the clinical record identified on 4/1/24 at 2:59 PM the following vital signs were documented for Resident #1: Blood pressure 139/77; Pulse 75 bpm; Respiratory rate 20; Temperature 98.3 F. An APRN note dated 4/2/24 by APRN #3 identified Resident #1's right heel Xray was concerning for osteomyelitis and that Resident #1 had been sent to the hospital for treatment. Review of the clinical record identified Resident #1 was hospitalized from 4/2/24 - 4/10/24 and transitioned to hospice care on 4/13/24. 2. Resident #11 was admitted to the facility on [DATE] with diagnosis that included breast cancer, heart failure, and obstructive sleep apnea (OSA). The care plan dated 12/5/23 identified Resident #11 was at risk for falls related to functional decline and diuretic use. Interventions directed the use of the appropriate socks/footwear and therapy screen/evaluation as needed. The admission MDS dated [DATE] identified Resident #11 had severely impaired cognition, was occasionally incontinent of bowel and bladder and required touch assistance and supervision from staff with toileting, dressing, and bathing. The MDS also identified Resident #11 had no history of falls prior to admission to the facility. The physician's orders signed 12/10/23 directed Resident #11 required Xarelto (an anticoagulant) 15 mg by mouth once daily for DVT prophylaxis; Furosemide (a diuretic) #2-40 mg tablets (for a total of 80 mg) by mouth once daily for fluid retention; Budesonide (a steroid inhaler) 2 ml inhaled orally twice daily for asthma, and CPAP applied at bedtime and off in the morning for sleep disturbance, to be worn continuously. The care plan dated 12/29/23 identified Resident #11 had altered respiratory status due to difficulty breathing and OSA. Interventions included administering medications as ordered and monitor for effectiveness, side effects, and monitor for signs/symptoms of respiratory distress including increased respirations, decreased pulse oximetry, increased heart rate, and report to the physician as needed. a. Review of the clinical record failed to identify any documentation of vital sign monitoring for Resident #11 from 1/12/24 - 4/8/24 (a total of 12 weeks or 3 months). Further review of the clinical record failed to identify any documentation of vital sign monitoring from 4/15/24 - 6/3/24 (a total of 7 weeks). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/30/24 at 11:17AM identified that the standard of care within the facility included monitoring vital signs at least monthly unless otherwise specified by the physician or if the resident's condition warranted a change in monitoring. The DNS identified that Resident #1 would not have monthly vital sign monitoring while on hospice but should have had vital signs checked in March 2024. The DNS identified she would have to look into why Resident #11 did not have any vital signs monitoring in February, March or May 2024 as Resident #11 should have had vital signs checked at least monthly. The facility policy on change of condition directed that the licensed nurse would conduct a complete physical/mental evaluation and document the findings in the medical record, including the resident's reactions to symptoms (i.e. pain, anxiety, or discomfort) which must be documented. The facility policy on hydration directed that the purpose of the policy was to identify risk factors that could lead to dehydration, develop the appropriate plan of care, and monitor the effectiveness of the plan and revise as necessary. The policy further directed risk factors included renal disease, use of diuretics and cardiovascular agents, infections, and pressure ulcers. The policy also directed that possible sign of dehydration included orthostasis (an alternate term for orthostatic hypotension). Although requested, the facility failed to provide policies on vital sign monitoring, hospice, nursing documentation, and nursing assessments. b. A reportable event form dated 1/9/24 at 5:30 PM identified Resident #11 had an unwitnessed fall. Review of the neurological check flowsheet identified neurological checks were not done according to the facility policy and were not done after 1/10/24 on the 11:00 PM - 7:00 AM shift. A reportable event form dated 4/12/24 at 4:30 PM identified Resident #11 had an unwitnessed fall. Review of the neurological check flowsheet identified neurological checks were not done according to the facility policy and were not done after 4/13/24 on the 11:00 PM -7:00 AM shift. A reportable event form dated 6/15/24 at 11:00 AM identified Resident #11 had an unwitnessed fall. Review of the clinical record failed to identify any neurological checks had been completed after the 6/15/24 fall. A reportable event form dated 7/2/24 at 2:30 PM identified Resident #11 had an unwitnessed fall which resulted in a right proximal humerus fracture and hospitalization from [DATE] - 7/5/24. Interview with the DNS on 7/30/24 at 11:17AM identified that she had just been informed by RN #4 that the neurological check flowsheets utilized by the nursing staff had not been updated and did not reflect the frequency of neurological checks directed in the facility policy. The DNS identified it was her understanding that the neurological checks were being done per policy. The DNS also identified that Resident #11 should have had neurological checks done following the 6/15/24 fall. The facility policy on neurological evaluations directed that neurological assessments would be completed following an unwitnessed fall. The policy further directed that evaluations would check pupil reaction, level of consciousness, motor function, speech, facial symmetry and vital signs. The policy directed the checks would done the following intervals: initially every 15 minutes x 4 (1 hour), every 30 minutes x 4 (2 hours), every 2 hours x 4 (8 hours), every shift x 8 (64 hours). (continued on next page)

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	075323	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	2428 Easton Tnpk Fairfield, CT 06825

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with APRN #6 on 7/30/24 at 2:18 PM identified Resident #15 is non-compliant, and APRN #6 has not currently treated the resident for diabetes. APRN #6 identified that Resident #15 is not on any Insulin or oral medications to treat diabetes and it is her expectation that anyone with a diagnosis of diabetes have a HbA1c blood test every 6 months to measure the resident's blood sugar levels and provide treatment if the test indicates it is necessary. APRN #6 could not identify why a HbA1c was not previously ordered and identified she did not see the discharge summary from the hospital dated 4/26/24 regarding the Insulin orders. APRN #6 identified it is the responsibility of nursing to enter all orders and any Insulin orders according to the discharge summary dated 4/26/24 should have been transcribed. The Diabetes Management Protocol states it is the policy of this facility to manage residents with diabetes and to document such care, with protocols for both hyperglycemia and hypoglycemia. Although requested, a policy for diabetic care, diabetic monitoring and diets for residents with Type 2 diabetes was requested, however not provided. 4. Resident #31 was admitted to the facility with diagnoses that included multiple sclerosis, muscle weakness, and abnormal posture. The quarterly MDS dated [DATE] identified Resident #31 had intact cognition and required moderate assistance with dressing, toileting, and personal hygiene. The care plan dated 1/16/24 identified Resident #31 had 12 falls in 2023 and 7 falls in 2024. Interventions included to provide education and remind the resident to call for assistance, resident to use a reacher, resident to wear proper footwear, and dycem to wheelchair. A physician's order dated 2/11/24 directed to provide the assistance of 1 for transfers and activities of daily living. a. A reportable event form dated 1/11/24 at 5:30 PM identified Resident #31 had an unwitnessed fall in the resident room next to the bed and sustained a skin tear to left leg. Review of the neurological assessment form dated 1/11/24 identified neurological assessments were not completed every 8 hours for 64 hours. b. A reportable event form dated 2/7/24 at 2:45 PM identified Resident #31 had an unwitnessed fall in recreation room. Review of the neurological assessment form dated 2/7/24 identified neurological assessments were not completed every 8 hours for 64 hours. c. A reportable event form dated 2/22/24 at 2:30 PM identified Resident #31 had an unwitnessed fall in the bathroom and was noted with bruise to the lateral right eye. Review of the neurological assessment form dated 2/22/24 at 2:20 PM identified the neurological assessments were not completed every 8 hours for 64 hours. Additionally, the motor section did not address strength of legs and was incomplete. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. A reportable event form dated 3/16/24 at 7:15 PM identified an unwitnessed fall in the room next to the bed. Resident #31 had a laceration to the back of the head. Review of the neurological assessment form dated 3/16/24 at 8:45 PM identified no nurses' signatures in place, scribbling over numbers for the level of consciousness and motor function, and writing over the times. Additionally, neurological assessments were not completed every 8 hours for 64 hours. e. A reportable event form dated 3/30/24 at 2:45 AM identified Resident #31 had an unwitnessed fall in the resident's room and sustained a left eyebrow laceration. Pressure dressing applied and the resident was sent to the emergency room and returned at 9:30 PM. Neurological assessments were not completed every 8 hours for 64 hours. f. A reportable event form dated 4/14/24 at 4:30 PM identified an unwitnessed fall in the bathroom. Neurological assessments were not completed every 8 hours for 64 hours. g. A reportable event form dated 4/15/24 at 8:00 PM identified an unwitnessed fall in the resident's room. Review of the clinical record failed to reflect that neurological assessments had been done and interview with the DNS on 7/30/24 at 7:25 AM indicated she was not able to find the neurological assessments from the 4/14/24 unwitnessed fall. h. A reportable event form dated 6/9/24 at 7:00 PM identified an unwitnessed fall in resident's bathroom. Review of the neurological assessment form dated 6/9/24 identified the neurological assessments were not completed every 8 hours for 64 hours. i. A reportable event form dated 7/2/24 at 7:30 PM identified an unwitnessed fall in resident's bathroom. Review of the neurological assessment form dated 7/2/24 identified the neurological assessments were not completed every 8 hours for 64 hours. Interview with the DNS on 7/30/24 at 7:28 AM indicated at the time of a resident fall, the RN supervisor does an assessment while the resident remains on the floor for an unwitnessed fall. The DNS indicated the nurse will initiate the neurological assessments per facility policy and notify the physician or APRN if there are any changes in the neurological assessments. The DNS indicated that the charge nurse and RN supervisor were responsible to make sure the neurological assessments and vital signs were completed based on the sheet every 15 minutes x 4, every 30 minutes x 4, every 2 hours x 4, and every shift (8 hours) for 64 hours. After review of the reportable events for 9 unwitnessed falls dated 1/11/24 - 7/4/24, the DNS identified that the neurological assessment forms indicated that the nurses were not doing the neurological assessments and vital signs every shift per the facility policy as required. Additionally, the DNS indicated that the nurses were at times doing every 1 hour instead of every 2 hours, writing on top of other times, not putting in their initials, and not coding accurately on the forms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Neurological Assessment Policy identified the licensed nurse performs neurological evaluations whenever there is the possibility of a head injury, changes in mentation, or an unwitnessed fall. Accurate evaluation and monitoring for changes in residents' neurological status to allow prompt medical notification and treatment. The neuro flow sheet includes vital signs (temperature, pulse, respirations, and blood pressure) and information regarding pupil reaction of both eyes, level consciousness, motor function, speech, facial symmetry, and headache. Any resident with an unwitnessed fall will have an initial neurological evaluation by the LPN or RN per state regulations followed by neurological monitoring per policy. After the initial evaluation, the neurological exam is repeated every 15 minutes for 4 times (1 hour), every 30 minutes for 4 times (2 hours), every 2 hours for 4 times (8 hours), and then every shift for 8 times (64 hours). The results are documented on the Neuro Care Flowsheet in the electronic health report. Any changes that indicated a decrease or change in neurological function will be reported to the primary or on-call physician immediately. 46040 47457 5. Resident #44 was admitted to the facility on [DATE] with diagnoses that included local infection of the skin and subcutaneous tissue, Hidradenitis Suppurativa, and cellulitis of the groin. The quarterly MDS dated [DATE] identified Resident #44 had intact cognition, had a wound infection, had open skin lesions, and had received medication injections within the last 7 days. The care plan dated 3/12/24 identified Resident #44 had actual/potential for pain related to: disease process, muscle spasms, wounds and groin. Interventions included to administer medications per the physician's orders. The nurse's note dated 3/14/24 at 9:30 PM identified that Resident #44 was on an antibiotic for a skin infection in the axillary region due to Hidradenitis Suppurativa, resident is also being managed for genital area pain and swelling. The APRN note dated 3/14/24 at 3:36 PM identified acute/chronic Hidradenitis Suppurativa of right axilla and status post I&D (incision and drainage) on 3/6/24. Patient on Doxycycline and Clindamycin and will need follow up surgery appointment to reassess wound and duration of antibiotics. 1. This resident is at significant risk of worsening medical status and risk of hospitalization . 2. Multiple comorbidities requiring intensive management with frequent medication changes and or other treatments. 3. Shared decision making completed involving eliciting resident and/or family preferences, patient education and explaining risks and benefits of management options. 4. Complex data reviewed including labs, x-rays consults, medications and differential diagnosis, all of which have been assessed, reviewed, and analyzed. A physician's order dated 5/3/24 directed to administer 40 mg/0.4ml Humira pen-injector, subcutaneously one time a day every 7 days for inflammation. Review of the May 2024 MAR and progress notes identified the following documentation regarding the Humira injections. a. On 5/3/24 Humira administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 5/10/24 Humira administered. c. On 5/17/24 Humira not administered. The nurse's note dated 5/17/24 at 12:34 PM identified the 40 mg/0.4ml Humira pen-injector was not available, the pharmacy was called and will deliver on next run. d. On 5/24/24 Humira not administered. The nurse's note dated 5/24/24 at 12:06 PM identified Humira injection still not available. Third call placed to the pharmacy who stated medication back in supply and will be delivered on first run. The APRN was updated and ok to retime for tomorrow. Resident is his/her own responsible party. e. On 5/25/24 Humira administered (15 days in between the 5/10 and 5/25 injections). Review of the June 2024 MAR and progress notes identified the following documentation regarding the Humira injections. a. On 6/1/24 Humira administered. b. On 6/8/24 Humira not administered. The nurse's note dated 6/8/24 at 8:28 AM identified the 40 mg/0.4ml Humira pen-injector was not in stock and was reordered. c. On 6/15/24 Humira not administered. The nurse's note date 6/12/24 at 11:32 AM identified the 40 mg/0.4ml Humira pen-injector was on order, not received from pharmacy. The APRN note dated 6/13/24 at 11:28 AM identified per nursing, weekly Humira was not available, spoke with pharmacy via phone they stated medication was delivered yesterday, discussed with nursing they were able to locate the medication in the facility. The nurse's note dated 6/19/24 at 12:44 PM identified this week's dose was already given on 2/17 due to medication not being available, last week. The APRN note dated 6/21/24 at 2:24 PM identified Resident #44 had severe Hidradenitis Suppurativa and was currently on Humira, resident is not receiving medication consistently as per treatment recommendation for Hidradenitis Suppurativa, and is at higher risk for developing antibodies from inconsistent medication administration, leading to treatment failure period at this point dermatology close monitoring is imperative for management, consult placed to dermatology for further evaluation management. The APRN note dated 6/21/24 at 7:04 AM identified dermatologist follow up in four weeks, please obtain dermatologist for ongoing follow up of Hidradenitis Suppurativa and biological treatment with Humira. d. On 6/22/24 Humira not administered. e. On 6/24/24 Humira administered (15 days in between the 6/1/24 and 6/24/24 injections). Review of the July 2024 MAR and progress notes identified the following documentation regarding the Humira injections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 7/2/24 Humira administered (8 days in between the 6/24/24 and 7/2/24 injections). The APRN notes dated 7/2/24 at 11:05 AM, 7/8/24 at 3:56 PM, and 7/9/24 at 12:52 PM identified that Resident #44 was currently on Humira and is not receiving medication consistently as per treatment recommendation for Hidradenitis Suppurativa and is at higher risk for developing antibodies from inconsistent medication administration, leading to treatment failure. b. On 7/9/24 Humira administered. c. On 7/18/24 Humira administered (9 days in between the 7/9/24 and 7/18/24 injections). d. On 7/25/24 Humira administered. Interview with Resident #44 on 7/28/24 at 9:50 AM identified that he/she had been in and out of the facility for about 1 year and has Hidradenitis which can lead to skin abscesses. Resident #44 indicated that staff are not consistent with the weekly Humira injections, and the injections are not received on time because there is an issue with the pharmacy. Resident #44 further indicated that he/she had been to the hospital with a skin infection and stomach problems, in the last few months. Resident #44 indicated that the facility wants him/her to see a Dermatologist, but he/she does not think that is necessary. Interview with RN #1 on 7/29/24 at 12:37 PM identified that Resident #44's Humira is scheduled weekly, but sometimes the pharmacy doesn't send it on time; the facility nurses call the pharmacy, and they state it will be delivered but then it won't come. RN #1 indicated that this happens at least once a month. RN #1 further indicated that the medication is usually administered within a day or two of when it is scheduled, and they adjust the medication administration schedule with the approval of the APRN. Interview and review of the Humira dispensary documentation with Pharmacist #1 on 7/30/24 at 9:51 AM identified the following. On 5/21/24 a request was received but pharmacy did not have insurance information on file, after the resident's hospitalization and readmission. Due to the cost of the medication, the pharmacy had to wait for the authorization to fill it. Two Humira pens were delivered to the facility on [DATE]. On 6/10/24 a refill request was received and 2 Humira pens were delivered to the facility on [DATE]. On 7/16/24 a refill request was received and 2 Humira pens were delivered to the facility on [DATE]. On 7/26/24 a refill request was received and 4 Humira pens were delivered to the facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacist #1 indicated that Humira can take an additional day for delivery because it comes directly from the wholesaler and is not kept in stock because it is an expensive medication; typically, medication refills should have a 24 hour or less turnaround from request to delivery, but delivery for Humira can be greater than 24 hours. Pharmacist #1 identified that a refill request can be made prior to the facility running out of the medication, the refill request will go into the system and when the medication is due, the pharmacy will send it to the facility. Interview with APRN # 6 on 7/30/24 at 10:26 AM identified that, last month, the nursing staff made her aware that Resident #44's Humira had not been received by the pharmacy due to dosing and concentration availability, and she personally called the pharmacy and reordered the medication, and pharmacy indicated that the medication would be delivered the next day. APRN #6 indicated that she would expect the facility nurses to notify any 1 of the 4 APRNs or the on call medical provider of any missed Humira doses. Interview with the DNS on 7/30/24 at 1:12 PM identified that she was unaware that Resident #44 was not getting his/her Humira injections on a consistent schedule, and she would expect that the RN supervisor and herself to be notified if there is an issue getting the medication from the pharmacy. The DNS further indicated that her expectation for reordering specialty medications that are scheduled weekly, is that when the last dose is administered the pharmacy refill request is made, to ensure a timely delivery. The DNS identified that she provides on-going monthly education to notify the APRN if a medication is unavailable. Interview with APRN #5 on 7/30/24 at 1:40 PM identified that Resident #44 has a severe case of Hidradenitis Suppurativa and per her notes, inconsistency of treatment can cause Humira to not work anymore period. APRN #5 further indicated that Resident #44 has refused appointments for referrals to the Dermatologist, as well as other specialty providers. APRN #5 indicated that her primary concern was that the resident is refusing a specialist to oversee the Humira management; she will continue to work with the Medical Director in the meantime, but she is unsure how Resident #44 wants to proceed with preventative management sine he/she refuses to see the specialty providers. The facility's Ordering and Obtaining Medications policy directs drugs will be obtained and administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Verbal orders will be received only by licensed nurses or pharmacists and confirmed in writing by the physician on a timely basis. The policy further directs that demand items should be ordered from the pharmacy when the quantity remaining is equal to a 3-day supply or less. The facility's Medication Pass policy directs that medications are administered safely and timely per the physician's orders. The policy further directs that medications that are withheld, refused, or given at a time other than scheduled: initial encircled and documented an explanatory note in the progress notes. Although requested a Specialty Medication policy was not provided. Although the physician's order directed that Humira be administered once every 7 days, between 5/1/24 - 7/31/24, 3 months, the facility failed to administer Humira (to treat a severe case of Hidradenitis Suppurativa) 3 times and administered it late 4 times.

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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** 43032 47457 Based on observation, review of the clinical record, facility policies, and interviews for 1 of 8 residents (Resident #26) reviewed for nutrition, the facility failed to ensure feeding assistance was provided to a dependent resident with a history of weight loss, in a timely manner. The findings include: Resident #26 was admitted to the facility on [DATE] with diagnoses that included dysphagia, vascular dementia, cerebral infarction, hemiplegia, and hemiparesis. The care plan dated 4/14/24 identified Resident #26 had a potential for fluid deficit related to nausea and poor intake. Interventions included assisting with meals and fluids, as needed, and to encourage the resident to complete fluids offered. The care plan further identified Resident #26 had the following nutritional diagnoses: inadequate oral intake, swallowing difficulty, underweight, unintentional weight loss, and malnutrition. Interventions included providing feeding/dining assistance. A physician's order dated 6/1/24 directed to provide a pureed texture house diet, thin consistency. The quarterly MDS dated [DATE] identified Resident #26 had severely impaired cognition, had an active diagnosis of malnutrition/was at risk for malnutrition, had a 5% or more weight loss in the last month, was not on a physician-prescribed weight-loss regimen, and was dependent for eating. The Nutritional Evaluation's Assessment Summary and Care Plan Decision dated 7/8/24 identified Resident #26 had a diagnosis of vascular dementia and was a total feed; showing an unavoidable 5% weight loss in the past month related to decreased oral intake. The resident was receiving a daily Ensure Plus supplement and a frozen nutritional cup with the lunch tray, further weight loss is expected due to dementia; plan: house, puree texture diet as ordered, increase Ensure plus to twice daily, frozen nutritional cup, total feed, and monitor weekly weights. Observations on 7/29/24 at 7:19 AM identified the breakfast cart arrived on unit Passport A, at 7:33 AM the facility staff began to distribute the breakfast trays, and at 7:36AM, NA #3 delivered a breakfast tray to Resident #26's room. Constant observation from 7:36 AM through 8:25 AM identified Resident #26's breakfast tray remained on the bedside table, and none of the facility nursing staff entered the room to feed the resident. This writer approached RN #1 at 8:25 AM inquiring who was responsible for feeding Resident #26. NA #4 entered Resident #26's room at 8:26 AM and indicated that she was not the nurse aide assigned to Resident #26, but she would feed him/her breakfast. NA #4 provided Resident #26 with mouth care at 8:27 AM and at 8:29 AM left the room to reheat pureed oatmeal and pureed scrambled eggs. Interview on 7/29/24 at 8:29 AM with NA #1 identified that she was the nurse aide assigned to Resident #26, but she was not aware that that he/she was on her assignment as there had been confusion among the nurse aides, that morning, about who was assigned to who. NA #1 indicated that she had not attempted to feed Resident #26, yet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/29/24 at 8:33 AM identified NA #4 began feeding Resident #26 breakfast; NA #1 took over to finish the feeding. Interview on 7/29/24 at 8:36 AM with NA #3 identified that she had delivered Resident #26's breakfast tray that morning but could not recall the time of delivery because she had dropped off many other trays on that unit, too. NA #3 indicated that she did not attempt to feed Resident #26 when she had dropped off the tray because she had to call the kitchen for another resident, who did not receive a breakfast tray; then she must have forgotten to go back to feed Resident #26. Interview on 7/29/24 at 8:40 AM with RN #1 identified that she would expect meal trays to be passed out first to the independent residents; the nurse aides would then bring in the meal trays to the residents that are dependent for eating and feed the resident upon bringing in the tray, reheating the food if necessary. Interview on 7/29/24 at 11:24 AM with the DNS identified that a meal tray should not sit at the bedside for an hour. The DNS indicated that her expectation is that once a tray is passed to a dependent resident the nurse aide should ensure the temperature of the food is appropriate and should then assist with the feeding. The DNS further indicated that she had already begun re-educating the staff on the timeliness of feeding dependent residents. The facility's Nutrition policy directs that the facility maintains acceptable parameters of nutritional status, such as usual or desirable body weight range, and electrolyte balance, for the resident unless the resident's clinical condition demonstrates that it is not possible or resident preferences indicate otherwise. The policy further directs that the nutritional status of the resident is assessed upon admission, quarterly, annually, when a significant change occurs, and/or more frequently as deemed necessary by the interdisciplinary team. The nutritional assessment may include but is not limited to the following information: food and fluid intake, altered nutrient intake, chewing and swallowing abnormalities, cognitive and functional abilities, and the need for a therapeutic diet. The residents' nutrition and hydration care and services are consistent with their comprehensive assessment. The facility's Residents' [NAME] of Rights policy directs residents have the right to receive quality care and services with reasonable accommodation of individual needs and preferences, except when the resident's health or safety or the health or safety of others would be endangered by such accommodation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record, facility documentation, facility policy, and interview for 2 of 2 residents (Resident #79 and 82) reviewed for respiratory care, the facility failed to ensure oxygen was administered as ordered. The findings include: 1. Resident #79 was admitted to the facility on [DATE] with diagnoses that included anemia, syncope, and collapse. The admission MDS dated [DATE] identified Resident #79 had moderately impaired cognition, and was not receiving respiratory treatments, including oxygen therapy. The physician's orders dated 7/5/24 directed to administer 800mg Molnupiravir (antiviral medication to treat Covid 19), twice daily for 5 days, and administer 1 - 2 liters of oxygen to maintain oxygen saturation above 92%, as needed for hypoxia. The care plan dated 7/22/24 identified Resident #79 had 1 - 2 liters of oxygen therapy ordered, to maintain oxygen saturation greater than 92%. Interventions included: oxygen settings via nasal cannula, as ordered. Observation with LPN #2 on 7/28/24 at 8:40 AM identified Resident #79 had a nasal cannula in his/her nose with oxygen running, however, the tubing connector, that had been wrapped in surgical tape, was laying on the floor and was not connected to the oxygen concentrator. LPN #2 indicated that she was not aware that the tubing connector was on the floor, disconnected from the oxygen concentrator, and had been taped. LPN #2 indicated that she would replace Resident #79's oxygen tubing. It was unknown at that time how long the resident was without oxygen due to the tubing being disconnected from the concentrator. Observation and interview with the DNS on 7/28/24 at 8:43 AM identified that the tubing connector should not have been taped because the tubing connector should fit properly on the concentrator. The DNS was unsure why the tubing was taped and why the tubing was not connected to the concentrator. 2. Resident #82 was admitted to the facility on [DATE] with diagnoses that included interstitial pulmonary disease, chronic respiratory failure, and pneumonia. A physician's order dated 6/6/24 directed to administer continuous oxygen at 2 liters per minute via nasal cannula every shift for shortness of breath related to interstitial pulmonary disease. The admission MDS dated [DATE] identified Resident # 82 had moderately impaired cognition and was receiving respiratory treatments, including oxygen therapy. The care plan dated 7/3/24 identified Resident #82 had altered respiratory status and difficulty breathing; oxygen therapy 2 liters per minute to maintain oxygen saturation greater than 92%. Interventions included updating the physician as needed with any changes in condition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the DNS on 7/28/24 at 8:50 AM identified Resident #82 had a nasal cannula in his/her nose with oxygen running, however, the tubing connector, that had been wrapped in surgical tape, was laying on the floor and was not connected to the oxygen concentrator. The DNS indicated that the tubing connector should not have been taped, the tubing connector should fit properly on the concentrator, and she would ensure the oxygen tubing was replaced with new tubing. The DNS was unsure why the tubing was taped and why the tubing was not connected to the concentrator. It was unknown at that time how long the resident was without oxygen due to the tubing being disconnected from the concentrator. Interview with the DNS on 7/29/24 at 11:15 AM identified that she had spoken to the 7/27/24 3:00 PM - 11:00 PM shift RN Supervisor and the 11:00 PM - 7:00 AM shift RN Supervisor (who was an agency nurse) and identified that some of the oxygen tubing were not connecting properly to the concentrators, which was why some of the tubing connectors were tapped. The DNS further identified that it was not a widespread issue, the 2 residents that were identified with disconnected oxygen tubing had the tubing that was not fitting properly, and since those residents moved around a lot in bed, the tubing had pulled off, so the nurse used tape to secure the fit. The DNS identified that she audited the oxygen tubing connections throughout the entire house and replaced all the tubing with new tubing, ensuring a proper fit. The DNS further identified that she educated the nursing staff on oxygen therapy and the education remained on-going. The facility's Oxygen Therapy policy instructs on how to treat hypoxemia, decrease work of breathing and decrease myocardial work in patients requiring supplemental oxygen therapy due to respiratory or cardiac insufficiency. The policy's procedure directs the verification of the flow of oxygen at the patient end of the delivery device.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37293 Based on observation, review of facility documentation, facility policy, and interviews for 6 of 6 medication carts, the facility failed to consistently complete shift to shift narcotic/controlled drug counts. The findings include: Observation on 7/28/24 between 7:25 AM - 8:05 AM of the medication carts with LPN #3 (Discharge Planner) identified the July 2024 narcotic drug change of shift audit sheet (the narcotic count that the on-coming and off-going nurses complete to ensure the narcotic medications are counted) were missing signatures on multiple dates on the 7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift on the following units: The Passport A unit was missing 38 signatures. The Passport B unit was missing 44 signatures. The Passport C unit was missing 34 signatures. The [NAME] 1 unit was missing 23 signatures. The [NAME] 2 unit was missing 23 signatures. The [NAME] unit was missing 5 signatures. Interview with LPN #7 on 7/28/24 at 7:27 AM identified she has been employed by the facility for approximately [AGE] years. LPN #7 indicated it was the responsibility of all the nurses to sign the narcotic drug change of shift audit sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. Interview with LPN #2 on 7/28/24 at 7:28 AM identified she has been employed by the facility for approximately 2 months. LPN #2 indicated all the nurses are responsible for signing the narcotic drug change of shift audit sheet at the beginning of the shift and at the end of each shift. Interview with LPN #1 on 7/28/24 at 7:30 AM identified she has been employed by the facility for approximately 4 months. LPN #1 indicated it was the responsibility of all the nurses to sign the narcotic drug change of shift audit sheet at the beginning of the shift and at the end of each shift. Interview with LPN #3 (Discharge Planner) on 7/28/24 at 7:58 AM identified he was not aware of the issue. LPN #3 indicated it was the responsibility of all the nurses to sign the narcotic drug change of shift audit sheet at the beginning of the shift and at the end of each shift when the controlled substance count is completed. Interview with the DNS on 7/28/24 at 8:16 AM identified she was not aware of the missing narcotic drug change of shift audit sheet signatures until now. The DNS indicated the expectation of the facility is that the on-coming and off-going nurses count the controlled substances during each shift change and sign the narcotic drug change of shift audit sheet after completing the count. Interview with the Administrator on 7/28/24 at 8:25 AM identified she was not aware of the missing narcotic drug change of shift audit sheet signatures. The Administrator indicated the expectation is that the nurses will count the narcotics at change of shift and sign the narcotic drug change of shift audit sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the controlled substance handling policy identified all controlled drugs will be subject to special receipt, handling, storage, disposal and record keeping. A physical inventory of all controlled drugs is made at the change of each shift by two licensed nurses and is documented on an audit record. If a nurse is late, the supervisor will go to the floor and count with the nurse who is leaving. The drugs are never to leave the cabinet on the floor. The supervisor will then go to the floor and count with the nurse when she arrives.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 residents (Resident #6) reviewed for unnecessary medications, the facility failed to ensure resident was free from unnecessary medication (Nicotine patch). The findings include: Resident #6 was admitted to the facility with diagnoses that included nicotine dependance, intellectual disabilities, anxiety, asthma, and chronic obstructive pulmonary disease (COPD). The APRN note dated 4/11/24 identified Resident #6 was admitted in October of 2022. Resident #6 is confused at baseline. Resident #6 smoking status is he/she smokes daily. APRN was asked to see Resident #6 for increased behaviors. Resident #6 expressed to APRN that he/she was frustrated with not being able to smoke which caused him/her to have increased episodes of agitation. Resident #6 psychiatric APRN had given new orders for medication adjustment. Plan to start Nicotine patch for increased agitation and anxiety. A physician's order dated 4/11/24 directed to administer the Nicotine patch (nicotine dependance) 7mg once per day for 24 hours and remove per schedule. Check resident for cigarettes and lighter after each visit with family member. The quarterly MDS dated [DATE] identified Resident #6 had severely impaired cognition and required partial assistance or supervision with dressing, toileting, and personal hygiene. Resident #6 required supervision or touching assistance with transfers and ambulation. The care plan dated 4/25/24 identified Resident #6 had the potential to smoke. Interventions included educating resident on smoking and evaluate desire to stop. Review of the progress notes dated 5/1/24 - 7/28/24 did not reflect Resident #6 had a desire to smoke. Pharmacy Medication Regimen Review dated 5/10/24 identified Resident #6 was receiving the Nicotine patch 7mg without a stop date. Recommend stopping the Nicotine patch in 2 weeks. Please evaluate and add to the order to discontinue the patch after 2 weeks. APRN #1 checked off that she agreed with the recommendation and will do the recommendation signed by APRN #1 on 6/13/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview APRN #1 on 7/30/24 at 8:45 AM indicated that she had seen Resident #6 for mental status changes. APRN #1 indicated that she was not aware that Resident #6 had been smoking at the time she saw resident due to mental status changes. APRN #1 indicated that the pharmacy comes into the facility on ce a month and makes recommendations after revieing the residents' medical record and medications. APRN #1 indicated that the supervisor/unit manager gives her the pharmacy recommendations each month and she reviews the recommendations. APRN #1 indicated that on the recommendation form she will check off yes, she agrees, or no she does not agree, and then give the forms to the supervisor/unit manager. APRN #1 indicated that her expectation is on the day she signs the pharmacy recommendation forms, the supervisor would be responsible to execute the recommendation. APRN #1 indicated that she signs off on the hard copy of the pharmacy recommendation and then hands off the forms to the supervisor on that day and then the supervisor puts the orders in per facility policy. APRN #1 indicated that since she signed the pharmacy recommendation to discontinue the Nicotine patch on 6/13/24 she would have expected the Nicotine patch would have been discontinued on 6/13/24. Interview with the ADNS on 7/30/24 at 8:50 AM indicated the pharmacy reviews the resident's medical records every month and makes recommendations. The ADNS indicated the pharmacist emails the recommendations and reports to the DNS, ADNS and MDS coordinator. The ADNS indicated the DNS reviews the report and distributes the individual resident recommendations to the unit managers/supervisors to give to the appropriate APRN's or physicians based on what the recommendation is for. The ADNS indicates the APRN, and physicians are responsible to change their own orders in the electronic medical record at the time they review the recommendations. The ADNS indicated once the APRN and physicians sign off on the form it is returned to the DNS and then the DNS gives to medical records to upload into that residents' medical record. After review of the clinical record, the ADNS indicated the Nicotine patch 7mg order went into place on 4/11/24 and Resident #6 received the Nicotine patch because the APRN wrote in her note that Resident #6 had a desire to smoke and was causing resident agitation. The ADNS indicated that the expectation was that APRN would have discontinued the order on 6/13/24 and write a note reflecting the pharmacy recommendation. Interview with the DNS on 7/30/24 at 9:09 AM indicated that she receives the monthly pharmacy recommendations via email, and she prints the reports and gives it to the unit managers. The DNS indicated the unit managers are responsible for giving the individual resident recommendations to the appropriate APRN's. The DNS indicated the APRNs agree or disagree with the recommendations on the forms. The DNS indicated that some of the APRN's put in or discontinue their own orders and other APRN's don't. The DNS indicated that the unit managers were responsible for making sure the pharmacy recommendations orders were put in the resident's electronic medical record in the physician's orders or discontinuing the orders if needed. The DNS indicated that once the unit manager makes sure all recommendations are verified and completed, they are left in her mailbox. The DNS indicated she missed this recommendation for Resident #6. The DNS indicated that the pharmacy recommendation dated 5/10/24 and signed off on 6/13/24 should have been discontinued, but it was not discontinued. Review of the facility Pharmacy Medication Review Policy identified the consultant pharmacist reviews the medication regime of each resident at least monthly. Findings and recommendations are communicated to those with responsibility to implement the recommendations, and to answer in a timely manner. The Consultant Pharmacist will submit their monthly recommendation reports to the DNS and follow up on the recommendations to verify that appropriate action has been taken and or responded to within a reasonable time frame. The completed pharmacy recommendations will be uploaded in the electronic medical record. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Transcription of Orders Policy identified to establish requirements for accepting, transcribing, and reviewing orders. Orders from an authorized licensed independent practitioner are accepted by an RN or LPN. Orders are for medications, labs, diagnostics, and consultants. Orders can be written in the electronic health record or obtained over the phone, verbally, or consultant's recommendations. Transcribing is the recording of the orders done by the RN or LPN.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42117 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 resident (Resident #40) reviewed for dental, the facility failed to provide a timely resolution for lost dentures. The findings include: Resident #40 was admitted to the facility with diagnoses that included dementia, congestive heart failure, and dysphasia. The care plan dated 9/22/23 identified Resident #40 received a therapeutic diet due to heart failure. Interventions included diet as ordered per physician and provide feeding assistance as needed The care conference social worker note dated 9/22/23 identified Resident #40's appetite was fair. Person #1 indicated that since they started to receive a select menu and have been doing the select menus for Resident #40 to select foods, things have improved. FSD will follow up with Person #1 regarding food preferences. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition and required touching assistance with toileting, dressing, and personal hygiene. Additionally, Resident #40 had no swallowing disorders and had no weight loss. A physician's order dated 11/29/23 directed to provide a no added salt diet, regular whole texture and regular consistency. The nurses note dated 3/31/24 at 9:53 PM indicated that the dentures were not found. A physician's order dated 4/3/24 directed to change diet to a mechanical soft texture. The nurses note dated 4/3/24 at 2:31 PM identified Person #1 was notified the diet was downgraded to a ground diet and a speech consult. The nurses note written by RN #5 (MDS coordinator) on 4/9/24 at 9:06 AM identified Resident #40's diet was downgraded to mechanical soft related to the missing upper partial denture. A grievance form dated 4/12/24 identified Resident #40's dentures were missing since 3/31/24. Residents room was searched, and the kitchen and laundry were notified. On 4/17/24 dental follow up in the facility and yes for dentures. The RDH (dental hygienist) #1 on 4/17/24 at 8:05 PM indicated that Resident #40 was placed in the dental book by nursing for missing dentures. Resident #40 was seen in his/her room and reported dentures were missing. Resident #40 (severely cognitively impaired) was asked if he/she would like new dentures made. Resident #40 replied he/she wanted to see if they turned up. As per order from Dentist #1 resident will be seen for further evaluation. The nurses note dated 4/18/24 at 12:03 PM identified Person #1 was contacted and stated he/she wanted the dentures made. The dental company was contacted. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 7/30/24 at 11:47 AM indicated on 4/12/24 Person #1 notified the facility that Resident #40's dentures were missing. The ADNS indicated that staff did a room search and notified laundry and the kitchen. The ADNS indicated that Resident #40 was seen by the dental hygienist on 4/17/24 and noted that Resident #40 would be seen by the dentist. The ADNS indicated that per the medical record Resident #40 has not been seen by the dentist. The ADNS indicated there was a payment issue related to the facility. Interview with the DNS on 7/30/24 at 12:23 PM indicated that there was a grievance regarding the missing dentures when Person #1 reported the dentures were lost on 4/12/24. The DNS indicated that Resident #40 has not received the replacement dentures because there was payment issue and the facility had to pay for the replacement dentures. The DNS indicated that she had thought it was taken care of until today when Person #1 reported that it still was not done. The DNS indicated that today after the meeting with Person #1 she called the dental company and informed them they had to come into the facility to make new dentures as soon as possible for Resident #40 and the facility will pay for it. Interview with SW #2 on 7/30/24 at 12:24 PM indicated that the DNS was correct, and it was a payment issue because the facility would have to pay for the lost dentures. SW #2 indicated that when RDH #1 was at the facility on 4/17/24 and came to her, she had told RDH #1 that Resident #40 had dementia and that Resident #40 needed the dentures. Interview with the Administrator 7/30/24 at 1:40 PM indicated that she was responsible for the grievance book. The Administrator indicated that when a grievance is filed that she brings it up at the daily morning report and the department head and social worker are responsible to complete the grievance. The Administrator indicated that she was aware that Resident #40 was missing dentures and was waiting for nursing to see if Resident #40 was eligible to receive new dentures from the insurance/Medicaid or if the facility would have to pay for them. The Administrator indicated that she was waiting for the form from dental to sign indicating that the facility would pay for the replacement dentures. The Adminiitsrator indicated that she has not received the form rom dental since 4/12/24 when the grievance was filled out. Interview with RHD #1 with Administrator present on 7/30/24 at 2:14 PM RHD #1 indicated that she recalls on 4/17/24 she had seen Resident #40 because she was in the dental book for lost dentures. RDH #1 indicated that Resident #40 indicated that she wanted to look for dentures first, so she was waiting to hear from someone that Resident #40 was ready for the new dentures. RDH #1 indicated she does not recall speaking with SW #2 about moving forward with making the dentures for the resident because the resident had dementia. RDH #1 indicated that she inquired with insurance/Medicaid and the dentures would not be covered as it's only covered every 7 years. RDH #1 indicated that the dentist did not see the resident because she did not have coverage. RDH #1 indicated that she was waiting to hear from facility, SW #2, the resident, or the family if they wanted the dentures made and would pay for the dentures. RDH #1 indicated that she had called SW #2 last week and SW#2 stated the facility would pay for the dentures. RDH #1 indicated that she would come to the facility to start the denture process and give the Administrator the acknowledgement form to sign for responsibility for payment of the dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RDH #1 on 7/30/24 at 2:40 PM indicated after reviewing her notes that were not in the Resident #40's clinical record indicated after 4/17/24 she did not notify anyone at the facility, the resident, or resident representative that the insurance would not pay for the replacement dentures. RDH #1 indicated that she spoke to SW #2 on 7/23/24 and informed SW #2 for the first time that the insurance would not pay for the dentures. RDH #1 indicated that on 7/23/24 was the first time she had notified anyone that the insurance/Medicaid would not cover the new dentures and had inquired if Resident #40 still needed new dentures and who was going to pay for them. RDH #1 indicated that SW #2 gave her permission that the facility would pay for the replacement dentures. Interview with the Administrator on 7/30/24 at 2:46 PM indicated that SW #2 did not inform her that she had spoken to dental and had given permission that the facility would pay for the replacement dentures. Review of the Resident Lost Property Policy identified the facility would conduct a thorough search for the lost property and if unable to locate the property, and the residents representative requests reimbursement, facility shall assess whether reimbursement is appropriate, and if so, the appropriate value of the reimbursement. The facility will document as a grievance and follow the grievance policy. Review of the Dental Services Policy identified the facility is responsible for providing an outside source, routine, and emergency dental services to meet the needs of each resident. The facility must provide assistance for dental care upon resident or resident representative's request. Documentation of dental visits will be maintained in the resident's electronic medical record. At which time the resident loses their dentures, and they cannot be located, a dental referral will be made in 3 days of the facility being aware. Dentures that are lost or broken due to unavoidable circumstances will be financially covered by the facility. Review of the facility Grievance Policy identified the facility will support the resident or responsible party to voice grievances or concerns regarding lost items. Upon receipt of the grievance or concern the facility will take appropriate measures to seek a resolution to the grievance. The Grievance Officer (the Administrator) will be responsible for ensuring that all grievances are responded to in a timely manner. Grievances The completed form will be taken to the social worker or the Administrator. The department head is responsible for investigating the concern and developing a plan to resolve it. Once the resolution is resolved it will be brought back to the social worker. The social worker will contact the department head if the completed form has not been returned within 72 hours and will notify the Administrator that it has not been resolved. The Administrator is responsible for reviewing grievances/concerns weekly to ensure that they have been investigated and resolved to the residents' responsible party satisfaction.