STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheriden Woods Health Care Center	321 Stonecrest Drive Bristol, CT 06010

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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 - Some	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** 47489 Based on clinical record reviews, review of facility policy and interviews for five of twenty-four sampled residents (Residents #33, #51, #69, 78, &107) reviewed for Advanced Directives, the facility failed to ensure the physician's orders and the signed advanced directive forms were congruent. The findings include: 1. Resident #33 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side, bipolar disorder, and schizophrenia. Review of the clinical record identified an Advanced Directive form dated [DATE] that identified Resident #33 elected a code status of Do Not Resuscitate (DNR), which means if the resident stops breathing or if the resident's heart stops beating cardiopulmonary resuscitation will not be provided. The admission MDS assessment dated [DATE] identified the Resident #33 had intact cognition and required substantial/maximal assistance with activities of daily living. The Care Plan dated [DATE] identified Resident #33 had an established advanced directive of a code status of CPR, which indicates the performance of cardiopulmonary pulmonary resuscitation in the event that the resident stops breathing or the heart stops beating. Review of the physician's orders for [DATE] identified Resident #33's code status was full code/CPR. The interdisciplinary care plan meeting record dated [DATE] identified the resident represented his/her self and decided that he/she wanted to change his/her code status from DNR to full code and wanted CPR performed in the event that he stopped breathing, or his/her heart stopped beating. Review of the social worker note dated [DATE] at 2:23 PM identified Resident #33's code status of full code/CPR was discussed and in place. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review on [DATE] at 8:47 AM with LPN #8 identified the advanced directive paperwork is done on admission and noted that when staff has to determine code status, they check the electronic health record (EHR) for the code status and then check the physical clinical record for the advanced directive paperwork when making the determination of a resident's code status. LPN #8 further identified the paperwork in the physical clinical record did not reflect the code status in the EHR. Interview on [DATE] at 9:10 AM with the Corporate SW identified the code status paperwork should be completed on admission and with a change in code status. Additionally, he noted that he would expect the code status in the paper chart and the EHR to match. After reviewing the EHR and the physical clinical record, he noted that the code status reflected in the EHR differed from what the signed paperwork in the physical chart was. The Advanced Directive policy identified that prior to or at the time of admission the facility would review and hand out the cardiac/respiratory arrest explanation sheet to the competent resident or responsible party/conservator of the incompetent resident. It further identified that based on the completed CPR/DNR consent form, the nurse is responsible for obtaining an order from the physician for the resident's code status. Additionally, the policy directed to remove any old Advanced Directive paperwork from the chart if the code status changes and replace it with the updated, signed code status paperwork. The facility failed to ensure updated Advanced Directive paperwork was completed and included in the physical clinical record that was reflective of Resident #33's wishes. 2. Resident #51's diagnoses included chronic obstructive pulmonary disease, congestive heart failure, and chronic respiratory failure. The Advanced Directive form dated [DATE] (signed by the resident and the physician) located in the physical clinical record identified Resident #51 had a code status designation of full code. The quarterly MDS assessment dated [DATE] identified Resident #51 was moderately cognitively impaired, required set-up for meals, was dependent for toileting, personal hygiene, and transfers. The Probate Order Decree (a court order dictating code status for conserved individuals) dated [DATE] and received by the Administrator on [DATE] identified Resident #51 had a designated code status change from full code to a status of Do Not Resuscitate (DNR) and Do Not Intubate (DNI). The care plan dated [DATE] identified Resident #51 was a full code with interventions that included reviewing Advanced Directives with the resident and or health care decision maker on a quarterly basis. The care plan conference notes dated [DATE] indicated Advanced Directives remain in place with no changes. The physician's order dated [DATE] directed a code status of Do Not Resuscitate, RN may pronounce. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Subsequent to surveyor inquiry on [DATE], an Advanced Directives form was completed and signed by Person #5 (conservator) and APRN #1 that identified Resident #51's code status was Do Not Resuscitate, Do Not Intubate. An effort to interview Person #5 on [DATE] at 11:30 AM was unsuccessful. 3. Resident #69's diagnoses included Alzheimer's, paranoid schizophrenia, and delusional disorder. Review of the clinical record identified an Advanced Directive form dated [DATE] that noted a code status designation of DNR. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #69 was moderately cognitively impaired and required a maximum assist for toileting, bathing, and upper/lower body dressing. The care plan dated [DATE] identified Resident #69 was a Full Code. Interventions included reviewing Advanced Directives with the resident and/or healthcare decision maker quarterly. Advance Directives to be honored through review. The physician's orders for April/2024 (order origination date [DATE]) directed a code status of Full Code/Cardiopulmonary Resuscitation (CPR). Subsequent to surveyor inquiry, an Advanced Directive form was signed by Person #3 (conservator) on [DATE] and signed by APRN #1 on [DATE] that identified Resident #69's code status designation was Full Code. Although requested from the facility, a Probate Court order Decree for changing Resident #69's Code Status from a Do Not Resuscitate to a Full Code was not provided. An effort to interview Person #3 on [DATE] at 10:55 AM was unsuccessful. 4. Resident #78's diagnosis included dementia, schizoaffective disorder, and schizophrenia. Review of the clinical record identified an Advanced Directive form dated [DATE] that identified Resident #78 had a code status of Full Code. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #78 was severely cognitively impaired and was independent with activities of daily living. A Probate Decree (a court order dictating code status for conserved individuals) dated [DATE] provided by Social Worker #3 (this form was not located in the resident's clinical record) identified Resident #78's code status was changed from Full Code to a status of Do Not Resuscitate (DNR) and Do Not Intubate (DNI). A copy of the decree was sent to Person #4 (Conservator for Resident #78) on [DATE]. A physician's order dated [DATE] directed Resident #78 a code status designation of DNR, do not hospitalize (DNH) and RN may pronounce (RNP). (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated [DATE] identified Resident #78 had a code status of DNR/DNI with interventions that included reviewing Advanced Directives with the resident and/or healthcare decision maker quarterly, Advance Directives to be honored through review. Interview on [DATE] at 2:52 PM with the DNS identified that the process for reviewing advanced directives and getting the forms signed by the resident and/or responsible party would involve reviewing code status with the resident depending on the resident's cognition, and if the resident is responsible for themselves. It would be reviewed by them, and if they were not responsible for themselves, it is reviewed with a family member, or conservator. She further noted that if the resident or family is unsure of what advanced directives are, the facility provides education. Additionally, she noted that the paperwork can be emailed or scanned and that it is required to be returned to the facility within twenty-four hours. The DNS further identified that they received Resident #78's probate decree from the court on [DATE]. Interview on [DATE] at 2:58 PM with the Regional Social Worker and Social Worker #3 (part time) identified that the social workers are responsible for the section of the care plan addressing code status. They further identified that the care plan, advanced directives form, and the physician's orders should all match and not contain conflicting information. In addition, Social Worker #3 provided a copy of Resident #78's probate court decree that she had in her office and noted that they had just received it on [DATE]. She further noted that it should have been in Resident #78's physical record. Interview on [DATE] at 8:50 AM with the DNS, Administrator, Regional Social Worker #2, and Regional Nurse identified that when a resident is conserved the process for changing code status and Advanced Directive wishes involve the MD or APRN reaching out to the conservator or family to discuss the change in status. For Resident #78, APRN #1 reached out to the conservator, then the conservator filed the necessary documentation with probate. The Probate decree hearing was held on [DATE] and the letter was mailed to the facility on [DATE]. They noted that the facility received the decree for Do Not Resuscitate (DNR) and Do Not Intubate (DNI) on Tuesday [DATE] and was unsure of the reason why APRN #1 wrote the order for DNR/DNI on [DATE] without having the physical copy of the probate decree and noted that the order should not be entered into the clinical record until the probate decree is received. Interview on [DATE] at 9:12 AM with APRN #1 identified that Resident #78 had a significant change in condition over the past month or so and had been sent to the hospital to be evaluated. APRN #1 further noted that he had been working closely with Person #4 (conservator) and Person #4 agreed that the resident should be made a DNR, thus submitted the proper paperwork to probate. In addition, APRN #1 identified that Person #4 had given verbal consent to change the code status designation from full code to DNR. He noted that he was unaware that legally he needed to wait for the probate court decree to be received by the facility before changing the order. Additionally, he noted that he was thinking of what was best for the resident's comfort in consideration of the resident's decline. An effort to interview Person #4 on [DATE] at 9:30 AM was unsuccessful. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Advanced Directives policy identified that the facility is to honor a resident's advanced directive regarding end-of-life care. Prior to or at the time of admission, if possible, the facility should review and handout the Cardiac/Respiratory Arrest explanation sheet to the competent resident or responsible party/conservator of the incompetent resident and after reviewing, the appropriate party should complete the CPR/DNR consent form and sign the form. Based on the CPR/DNR consent form, the nurse is responsible for obtaining an order from the physician for the resident's code status. 5. Resident #107 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, acute pancreatitis with infected necrosis, and cerebral infarction due to occlusion or stenosis of small artery. Review of the physical clinical record identified an advanced directive form dated [DATE] signed by Resident #107 and the physician that identified the resident's code status designation was full code. The quarterly MDS assessment dated [DATE] identified Resident #107 had moderate cognitive impairment and was independent with transfers, toileting, and ambulation. Review of Resident #107's physician's orders for April/2024 directed a code status of do not resuscitate (DNR) and do not intubate (DNI). Further review of the orders identified that the orders directing for full code to DNR/DNI were initiated on [DATE]. Review of the clinical record failed to identify any further documentation of why or when the resident elected a change to his/her code status. Interview with Resident #107 on [DATE] at 10:40 AM identified that if he were to stop breathing or if his/her heart stopped, he/she would like to be saved and noted he/she would choose to have CPR performed. Resident #107 further noted that his/her family member was his/her designated POA. Interview and clinical record review on [DATE] at 8:47 AM with LPN #8 identified the advanced directive paperwork is done on admission and noted that when staff has to determine code status, they check the electronic health record (EHR) for the code status and then check the physical clinical record for the advanced directive paperwork when making the determination of a resident's code status. LPN #8 further identified the paperwork in the physical clinical record did not reflect the code status in the EHR. Interview on [DATE] at 9:10 AM with the Corporate SW identified the code status paperwork should be completed on admission and with a change in code status. Additionally, he noted that he would expect the code status in the paper chart and the EHR to match. After reviewing the EHR and the physical clinical record, he noted that the code status reflected in the EHR differed from what the signed paperwork in the physical chart was. Interview with the Resident's Power of Attorney (POA) on [DATE] at 10:07 AM identified there were two POA's and they decided the resident should be a DNR and identified they came into the facility to sign the paperwork. The POA then identified that she is the financial POA. Interview with the DNS on [DATE] at 10:52 AM identified it was her belief that the POA was able to make all decisions for the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Corporate Social Worker on [DATE] at 1:20 PM identified the POA would need medical proxy or conservatorship in order to make medical or advance directive decisions. Subsequent to surveyor inquiry, the Social Worker identified that Resident #107 gave permission for the POA to make the Advanced Directive decision. Review of the Durable Power of Attorney dated [DATE] identified the resident had two people designated as POAs and were able to make financial decisions. The paperwork failed to identify medical decisions. Review of the facility policy for Advanced Directives identified that prior to or at the time of admission the facility will review and hand out the cardiac/respiratory arrest explanation sheet to the competent resident or responsible party/conservator of the incompetent resident. Based on the CPR/DNR consent form, the nurse is responsible for obtaining an order from the physician for the resident's code status. 48335

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility policy review, and interviews for one of two residents (Resident # 120) reviewed for hospitalization , the facility failed to ensure a written summary of the baseline care plan was discussed and provided to the resident and/or representative. The findings include: Resident #120 was admitted on [DATE] with diagnoses that included Covid-19, atrial fibrillation, hypertension, and polyarthritis. Resident #120's baseline care plan was completed on 1/13/24. The admission MDS assessment dated [DATE] identified that Resident #120 had intact cognition and required extensive assistance for toileting, hygiene, bed mobility, transfer, and ambulation. Interview with RN #1 (7-3 shift nursing supervisor) on 4/24/24 at 11:15 AM identified that the nursing supervisors develop the resident baseline care plans on admission and the interdisciplinary team meets and discusses the plan of care with the resident and/or resident representative within 72 hours of the resident's admission. Interview with the Admission's Coordinator on 4/24/24 at 11:20 AM identified that the interdisciplinary team which would consists of rehabilitation staff, nursing and social work staff meet with the resident and/or representative within 72 hours of admission to discuss the resident's plan of care, which is developed within 48 hours of admission. She further noted that she could not find Resident #120's interdisciplinary team documentation that would indicate the resident's baseline care plan was discussed with Resident #120 and/or the resident's representative. Interview with the DNS on 4/24/24 at 1:10 PM identified that the interdisciplinary team did not discuss the baseline care plan with Resident #120 and/or the resident's representative. The Baseline Care Plan policy identified that the facility will develop a plan of care within 48 hours of admission during the admission process as a guide for care until the comprehensive care plan is developed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on clinical record review, observations, review of facility policy and interviews for sample one of two sampled residents (Resident #24) who required total assistance with activities of daily living, the facility failed to ensure that the resident's nails were trimmed. The findings include: Resident #24's diagnoses included dementia, anxiety, contracture of right hand, and macular degeneration. The quarterly MDS assessment dated [DATE] identified Resident #24's cognition was severely impaired, required total assistance for toileting, transfers, personal hygiene, transfers, and was non-ambulatory. The care plan dated 3/11/24 identified Resident #24 had an ADL deficit due to dementia diagnosis with interventions that included explain tasks to resident, breakdown tasks into simple subtasks as able if necessary. The care plan further identified Resident #24 required assistance with grooming with interventions with an intervention for weekly skin inspections. The physician's orders for April/2024 included an order that directed to wash the resident's hands/nails with soap and water daily. Resident #24's Care Card (used by the nurse aides to guide care of the resident) dated 3/11/24 identified the resident's shower day was Tuesdays on the 11:00 PM to 7:00 AM shift. Review of the Weekly Skin Audit-Total body assessments completed for the month of April 2024 did not identify concerns with Resident #24's nails. The Wound Specialist's (APRN #3) note dated 3/20/24 identified a recommendation to wash hands and nails with soap and water daily with routine AM care activities. Observation on 4/23/24 at 10:49 AM identified Resident #24 seated in a wheelchair in his/her room, with arms resting on the armrests of the wheelchair. The right hand appeared to be contracted and the middle fingernail appeared to have a thick, long nail that extended and curved over the tip of the resident's finger. The rest of the fingernails on the right hand also appeared overly long but not discolored in appearance. The left hand also had long fingernails, but they did not appear discolored and were not as long as the right-hand fingernails. Interview with NA #2 on 4/24/24 at 11:28 AM identified that fingernails are trimmed on the resident's shower day, she noted she had clipped Resident #24's fingernails two weeks ago but had not clipped the right middle finger nail because it was thick and discolored. She further noted that she had notified the charge nurse of the condition of the nail. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation with the Infection Preventionist Nurse/Wound Nurse (LPN #2), the Charge Nurse (LPN #6) and NA #2 on 4/24/24 at 11:35 PM identified Resident #24 seated in the wheelchair with a right-hand splint in place. NA #2 assisted in holding Resident #24's right hand while LPN #2 measured the nails. On the right hand, the 2nd fingernail tip measured 0.4 centimeter (cm); the 3rd fingernail was thick at the base of the nail plate with a break towards the end of the plate as the fingernail curved over the pad of the finger that measured 2 cm in length and 1.8 cm in width; the 4th fingernail tip measured 0.4 cm, the 5th fingernail tip measured 0.5cm; and the thumb fingernail measured 0.6cm. Interview with the LPN #6 on 4/24/24 at 11:35 AM identified she was unaware of the condition of Resident #24's fingernails, because she was not the regular nurse on the unit. LPN #6 further noted she signed off the treatment to wash hands/nails with soap and water daily in the Treatment Administration Record (TAR) but had not completed the treatment as yet. Interview with LPN #2 on 4/24/24 at 11:45 AM identified she was unaware of Resident #24's current nail condition. LPN #2 indicated Resident #24 was already seen by the wound APRN in March of 2024 who made the recommendation to wash the hands and fingernails, The APRN did not indicate that the resident's nails could not be trimmed. Interview with the Charge Nurse (LPN #5) on 4/26/24 at 9:48 AM identified that Resident #24's shower occurs on the 11:00 AM to 7:00 AM shift and nail care was not completed on this shift but on the 7:00 AM to 3:00 PM shift. LPN #5 added that she would glance over the resident's nails when conducting the weekly skin audit and did not identify anything significant about Resident #24's nails nor was anything about the resident's nails reported to her by the nurse aides. LPN #5 further added that the unit is staffed with one nurse aide to 24 residents on the night shift; furthermore, she noted she was unaware that nail care was to be provided on her shift. Interview with the Charge Nurse (LPN #3) on 4/26/24 at 11:56 AM identified the nurse aide did report that Resident #24's right hand middle fingernail was long, thick, and discolored but she thought it was addressed with the washing of the hands/nails. LPN #3 added that she identified about a week ago that the right-hand middle fingernail was getting longer and now it appeared that it was going to fall off. LPN #3 added that she should have reported this to the APRN and not assumed that she knew. Interview with the DNS on 4/26/24 at 10:00 AM identified that the weekly skin audit does consist of checking the resident's nails which are trimmed on shower days. The DNS noted that nail care can be done by the nurse aide, the charge nurse, or the supervisor, but could not provide a reason as to why Resident #24's fingernails were in the condition they were in. Review of the Nail Care policy identified that nail care would be provided to residents by the nurse aides. Review of the Weekly Body Audit policy identified that residents would have a body audit to address any skin issues on a weekly basis, which is recommended to be completed on the resident's shower day.

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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** 46117 Based on clinical record review, facility policy review, and interviews for one of two sampled residents (Resident #113) with a non-pressure related wound, the facility failed to ensure the wound was assessed by a registered nurse upon initial observation, and failed to ensure the wound was assessed on a weekly basis. The findings include: Resident #113 's diagnoses included heart failure, lymphedema, chronic embolism, venous insufficiency, and chronic pain. The admission MDS assessment dated [DATE] identified Resident #113 had intact cognition and required limited assistance with toileting, hygiene, bed mobility, transfers, and ambulation. The Resident Care Plan (RCP) dated 3/14/24 identified Resident #113 was at risk for skin breakdown related to impaired mobility and lower extremity edema. Care plan interventions directed to inspect skin for redness, irritation and breakdown during care, weekly skin inspections, treatment as ordered, and pressure reducing mattress/cushion as needed. The physician's order dated 3/23/24 directed to cleanse right great toe with wound cleanser then apply calcium alginate with silver and cover with bordered gauze daily and as needed. Review of nurses' notes from 3/23/24 through 4/23/24 failed to identify that the wound had been initially assessed by an RN and failed to identify weekly wound assessments. Review of treatment administration record (TAR) from 3/24/24 through 4/23/24 identified Resident #113 was administered the treatment to the right great toe as ordered. Interview with LPN #1 on 4/24/24 at 10:30 AM identified that when a new wound is identified, the supervisor is notified and is responsible for evaluating the wound, updating the physician. She further identified that the wound assessment consists of wound measurements, and a description of the wound, and is documented in a nursing note or a non-pressure wound evaluation. Additionally, she noted that the wound nurse is responsible for monitoring the wound on a weekly basis. Interview with LPN #2 (wound nurse) on 4/24/24 at 12:30 PM identified that the nursing supervisor assesses new wounds, and she is responsible for the weekly wound monitoring. She further identified that she was unaware of Resident #113's wound and thus did not complete any weekly monitoring. Interview with the DNS on 4/24/24 at 1:10 PM identified that the initial assessment of a wound is what was previously described by LPN #1 and LPN #2. She further noted that the wound nurse should be updated, and wounds should be monitored weekly. After reviewing Resident #113's clinical record, the DNS identified that there were no documented weekly assessments of the right great toe wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Non-Pressure Wound Assessment policy identified that residents with non-pressure wounds will be assessed, documented, and provided with an appropriate treatment to promote healing. It further noted that the wound would have on-going monitoring and evaluation to ensure optimal resident outcomes. In Connecticut, an RN assessment is required weekly for all wounds and upon identification of any new wounds.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheriden Woods Health Care Center	321 Stonecrest Drive Bristol, CT 06010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - 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** 47900 Based on clinical record review, review of facility policy, and interviews for one of two sampled residents (Resident #27) reviewed for pressure ulcers, the facility failed to ensure that the initial and weekly assessments of the wound were completed by a registered nurse. The findings include: Resident #27's diagnoses included type 1 diabetes mellitus, adult failure to thrive, weakness, anemia, and hyperlipidemia. The admission MDS assessment dated [DATE] identified Resident #27 had intact cognition, required extensive assistance with bed mobility, transfers, toileting, and personal hygiene. The assessment further identified Resident #27 was at risk for the development of pressure ulcers and was admitted with an unstageable pressure injury. The care plan dated 2/22/24 identified Resident #27 was at risk for skin breakdown related to mobility, nutrition, and incontinence with interventions that included weekly skin inspections, off-load heels, and pressure reducing cushion or mattress as needed. The Wound Specialist's (APRN #3) consult note dated 3/6/24 identified Resident #27 had community acquired stage two pressure injuries to the right and left heels that were now resolved. LPN #2's (Wound Nurse) note dated 3/20/24 at 11:08 AM identified Resident #27's right heel deep tissue injury (DTI) reopened and measured 1.0 centimeters in length (cm) by 0.8 cm width, and noted new orders were in place. The Pressure Injury Evaluation form dated 3/20/24 at 12:04 PM completed by LPN #2 identified that this was an initial evaluation of a facility acquired suspected DTI measuring 1 cm in length, 0.8cm in width, no depth with 100 percent healthy tissue. The evaluation further identified that the wound edges were healthy, had a small amount of drainage, the surrounding skin was healthy, no pain at the site, and to start treatment of calcium alginate followed by foam dressing. Review of the Pressure Injury Evaluation forms and nurses' notes for 3/20/24 failed to identify that a registered nurse (RN) assessed the newly identified wound to the right heel. APRN #3's consult note dated 4/3/24 (14 days after the wound was noted by LPN #2) identified Resident #27 had a stage 2 to the right heel that measured 1.8 x 2.4 cm with approximately 40% fibrin and 60% dull red tissue and mild serous drainage and no odor. Review of the Pressure Injury Evaluation forms and the Wound Specialist notes from 3/20/24 to 4/17/24 identified LPN #2 documented the assessments of the right heel wound on 3/20/24, 3/27/24, and 4/10/24, and APRN #3 assessed the wound on 4/3/24 and 4/17/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #2 on 4/24/24 at 3:30 PM identified that she was responsible for wounds and completed wound rounds weekly on Wednesdays. LPN #2 added that the Wound APRN does rounds with her every other week. LPN #2 further identified that on the weeks that the Wound APRN does not conduct the rounds with her, she does the rounds by herself. LPN #2 identified that Resident #27's right heel wound would be considered a new wound and should have initially been assessed by a registered nurse. LPN #2 further indicated that she identified the wound during wound rounds as Resident #27 had a history of wounds that were being monitored and that she had considered the right heel as a reopened wound. Interview with the DNS on 4/25/24 at 3:15 PM identified LPN #2 was responsible for the weekly rounds and monitoring and noted that the Wound APRN does rounds with LPN #2 every other week. The DNS further identified that wounds should be assessed by an RN initially and weekly, and moving forward an RN would be assigned to LPN #2 on the weeks that the Wound APRN was not available. She further added that an RN assessment would have been required when the wound was first identified as per facility policy. The Prevention and Management of Pressure Injury policy identified that an RN assessment is required weekly for all wounds (pressure and non-pressure) and upon identification of any new wounds.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one of four sampled residents (Resident #11) observed during the medication administration, the facility failed to ensure that the consultant pharmacist identified a discrepancy in a written physician's order. The findings include: Resident #11's diagnoses included dementia, psychotic disturbance, type 2 diabetes mellitus without complications, and pain. The quarterly MDS assessment dated [DATE] identified Resident #11 had moderately impaired cognition and was independent with ambulation and transfers but required assistance with bathing, dressing, and toileting. The physician's order dated 4/18/2024 (origination date of order was 1/19/24) directed: administer Gabapentin capsule 300 mg give 100mg by mouth two times a day for pain. The care plan dated 4/22/2024 identified resident had pain/potential for pain related to generalized discomfort and recent falls with interventions that included to administer medications as ordered. Review of the clinical record for the period of 1/9/2024 through 4/8/2024 identified monthly pharmacy regimen reviews were conducted and recommendations were made but none of the recommendations addressed concerns with Gabapentin or the Gabapentin orders. Observation during the medication pass on 4/24/2024 at 10:20 AM identified LPN#7 prepare medications for administration for Resident #11, she removed three white capsules from a blister pack and placed the capsules into a medication cup. Review of the blister pack identified it contained Gabapentin capsules 100mg and the blister pack label directed to administer one capsule by mouth twice daily for pain. Interview with the Pharmacist Consultant Supervisor on 4/24/2024 at 12:18 PM identified that the pharmacy consultant is responsible for reviewing the resident's drug regimen to ensure doses, indications, safety, efficacy, and monitoring or any adverse effects of medications are all within acceptable parameters. He further identified that if an order does not make sense, specifically in reference to Resident #11, the pharmacy consultant should have noticed the confusing order and made a recommendation to nursing that the order be clarified. Interview with APRN #2 on 4/24/2024 at 1:58 PM identified she was the APRN who wrote the Gabapentin order for Resident #11 and was unsure why she entered it as a 300 mg capsule as the intent was 100 mg to be administered twice daily. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Pharmacist from the pharmacy provider on 4/25/2024 at 12:55 PM identified that the prescribed Gabapentin was filled as 100mg capsules to match with the directions for the medication that directed to administer 100mg twice a day. The Pharmacist identified that the protocol of the pharmacy when an unclear order is received is to call the facility and notify someone of the discrepancy. He further identified he was not able to find an email or note of correspondence and stated the protocol was not followed by the pharmacy, because the pharmacy included the correct instructions on the blister pack, but the order was never corrected. Review of the facility's Pharmacy policy and procedure manual identified the pharmacy would communicate issues and make suggestions regarding improvement of services as well as reviewing any situations that may need to be addressed.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record reviews, review of facility policy, and interviews for three of five sampled residents (Residents #9, #64, and #74) reviewed for unnecessary medication, the facility failed to ensure laboratory and/diagnostic medical records were readily accessible and complete in the resident's physical chart and/or electronic medical record system. The findings include: 1. Resident #9's diagnoses included anxiety disorder, bipolar disorder, and delusional disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #9 was moderately cognitively impaired and required partial moderate assistance with toileting, dressing, personal hygiene, required set-up or clean up assistance with eating and oral hygiene and required the use of a walker and wheelchair. The Resident Care Plan dated 4/15/24 identified Resident #9 was at risk for falls with interventions that included monitor for possible side effects from psychotropic medication, MD to consider dosage reduction when clinically appropriate or at least quarterly. Review of the medical record on 4/26/24 at 9:30AM identified that the last laboratory testing results located in the record were from June 2023. A request was made to the facility on [DATE] at 10:00 AM to provide copies of laboratory and/or diagnostic testing results for Resident #9 that were completed within the last year. The ADNS provided a document from the laboratory testing company that identified Resident #9 had blood work drawn on nine occasions for the period of 11/1/2023 to 3/29/2024 that were not present in the medical record. Additionally, the ADNS identified that when the providers review the laboratory results, they sign them to indicate that they have reviewed them. A second interview with the ADNS on 4/26/24 at 1:40 PM identified that there were no laboratory and/or diagnostic testing results in Resident #74's clinical or overflow records. Interview with APRN #2 on 4/26/24 at 12:30 PM identified that she is usually given the laboratory results by the nursing supervisor, she then noted that she reviews the results and signs them and writes recommendations if needed to indicate that she has reviewed them and returns to them to the nursing supervisor. APRN #2 further noted that she did not know what was done with the results once she signs and returns them to the nursing supervisor. She also noted that reviews the labs through the online portal and she writes in her notes that she reviewed them. Additionally, after reviewing all of the laboratory results for the time period of 1/1/23 through 4/26/24, APRN #2 identified there would be no changes she would have made that were not already addressed. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the DNS on 4/26/24 at 1:35 PM identified the process for reviewing laboratory results included the nursing supervisor retrieving the laboratory results from the fax or from the online portal, the nursing supervisor then distributes to the providers to review. She further noted that once the providers review the results, the nursing supervisor's responsibility would be to review and address any recommendations and place the laboratory result(s) in the outbox for the medical records staff to file or upload in the electronic medical record system. Review of the Medical Record policy identified the facility would maintain complete medical records on all residents, that are complete and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. The policy further identified that signed and dated documentation of all care and ancillary services rendered are made part of the medical record including but limited to laboratory results, radiology, and x-ray reports. Therapist reports, reports of tests or treatments done outside the facility. 2. Resident #64's diagnoses included chronic obstructive pulmonary disease (COPD), acute kidney failure, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #64 had moderately impaired cognition, required 2-person physical assistance with personal hygiene, toileting, and was non-ambulatory. Review of Resident #64's clinical record and overflow clinical records on 4/26/24 at 9:00 AM failed to identify laboratory or diagnostic testing completed within the last year. After a request for Resident #64's laboratory results for the past year was made on 4/26/24 at 10:00AM, the ADNS provided a document from the laboratory company that identified Resident #64 had blood work drawn on seven occasions from the timeframe of 1/1/2023 to 4/26/24. The ADNS also provided a copy of the laboratory and diagnostic testing results that she had printed from the laboratory's electronic system. Additionally, the ADNS identified that when the providers review the laboratory results, they sign them to indicate that they have reviewed them. A second interview with the ADNS on 4/26/24 at 1:40 PM identified that there were no laboratory and/or diagnostic testing results in Resident #64's clinical or overflow records. 3. Resident #74's diagnoses included atrial fibrillation, atrial flutter, hypertension, and insomnia. The annual MDS assessment dated [DATE] identified Resident #74 had intact cognition and was independent with personal hygiene, toileting, dressing and ambulation. Review of the monthly physician's order for April/2024 identified an order that directed laboratory Digoxin Serum Level and Magnesium level every 6 months in May/November. Review of Resident #74's clinical record identified laboratory testing results completed June of 2023. The overflow records were reviewed and failed to identify any laboratory and/or diagnostic testing medical records completed within the last year. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with the Medical Records staff person on 4/25/24 at 11:10 AM identified she retrieves paperwork from the nursing supervisor's office outbox and then it is either uploaded into the electronic chart or filed in the paper chart. After a request for Resident #74's laboratory results for the past year was made on 4/26/24 at 10:00AM, the ADNS provided a document from the laboratory company that identified Resident #74 had blood work drawn on eight occasions during the timeframe of 1/1/2023 to 4/26/24. The ADNS also provided a copy of the laboratory and diagnostic testing results that she had printed from the laboratory's electronic system. Additionally, the ADNS identified that when the providers review the laboratory results, they sign them to indicate that they have reviewed them. A second interview with the ADNS on 4/26/24 at 1:40 PM identified that there were no laboratory and/or diagnostic testing results in Resident #74's clinical or overflow records. Interview with APRN #2 on 4/26/24 at 12:30 PM identified that she is usually given the laboratory results by the nursing supervisor, she then noted that she reviews the results and signs them and writes recommendations if needed to indicate that she has reviewed them and returns to them to the nursing supervisor. APRN #2 further noted that she did not know what was done with the results once she signs and returns them to the nursing supervisor. She also noted that reviews the labs through the online portal and she writes in her notes that she reviewed them. Additionally, after reviewing all of the laboratory results for the time period of 1/1/23 through 4/26/24, APRN #2 identified there would be no changes she would have made that were not already addressed. Interview with the DNS on 4/26/24 at 1:35 PM identified the process for reviewing laboratory results included the nursing supervisor retrieving the laboratory results from the fax or from the online portal, the nursing supervisor then distributes to the providers to review. She further noted that once the providers review the results, the nursing supervisor's responsibility would be to review and address any recommendations and place the laboratory result(s) in the outbox for the medical records staff to file or upload in the electronic medical record system. Review of the Medical Record policy identified the facility would maintain complete medical records on all residents, that are complete and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. The policy further identified that signed and dated documentation of all care and ancillary services rendered are made part of the medical record including but limited to laboratory results, radiology, and x-ray reports. Therapist reports, reports of tests or treatments done outside the facility. 47900

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F 0849 Level of Harm - Potential for minimal harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on review of the clinical record, review of facility documentation, and interviews for one sampled resident (Resident #23) reviewed for hospice care, the facility failed to ensure that the clinical record contained hospice documentation, The findings include: Resident #23 's diagnoses included senile degeneration of the brain, dementia, and abnormal weight loss. A physician's order dated 11/19/23 directed to admit Resident #23 to hospice. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #23 was severely cognitively impaired, dependent for all activities of daily living and received hospice care. The care plan dated 3/12/24 identified Resident #23 was at end of life, had an overall decline in status, and death was anticipated. Interventions included assist with meals, encourage food/fluid as tolerated, and provide frequent mouth care to keep mucous membranes moist. Review of the clinical record on 4/22/24 at 12:34 PM failed to identify the following hospice documentation: Interdisciplinary team notes from 11/30/23 through 4/22/24, the plan of care from 11/20/23 through 4/25/24 and the Certificate/Recertification of Terminal Illness from 11/17/24 through 2/14/24, and from 4/15/24 through 6/13/24. Interview on 4/24/24 at 10:56 AM with LPN #8 identified that the hospice notes or paperwork used to be in individual binders now they are kept in the big binder for all hospice residents on the unit. Interview on 4/24/24 at 11:40 AM with Social Worker #1 and the Regional Social Worker identified that a hospice binder is kept on each unit that contains the hospice information for the resident or the information is kept in the resident's chart. Social Worker #1further noted that she was uncertain of the specific hospice paperwork that should be contained in the chart. Interview on 4/24/24 at 11:46 PM with the DNS identified that once a resident is under hospice care, the hospice liaison assists with the paperwork. The DNS further noted that she was unsure what hospice documentation should be contained within the resident's clinical record or in the hospice binder but noted that the documentation/information should be readily available for review. Interview on 4/24/24 at 12:06 PM with the Executive Director of Hospice (RN #4) identified that the hospice company was in the process of changing how they file hospice documentation. She noted that previously they had individual binders for each resident but that they now kept all hospice documentation for all residents on hospice in one binder. Additionally, she could not explain where the hospice documentation was for Resident #23. F (continued on next page)

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F 0849 Level of Harm - Potential for minimal harm Residents Affected - Some	Subsequent to the interview with RN #4, all missing hospice documentation inclusive of the interdisciplinary team notes, care plans and certificates of terminal illness were sent to the facility by the hospice agency. The Medical Record policy identified that all medical records are complete and accurately documented, readily accessible and systematically organized to facilitate retrieving and compiling information. It further noted that all parts of the medical records pertinent to daily care and treatment of the resident shall be maintained in the nursing unit on which the resident resides.