STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075057	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 14528 37002 37293 Based on review of the clinical record, facility policies, facility documentation and interviews for 5 residents (Residents #29, 77, 79, 88 and 342) who were reviewed for change in condition, the facility failed to notify the physician when a treatment (tubi grips) was not offered and/or refused, failed to notify the physician when the resident was involved in an incident during a mechanical lift transfer, failed to ensure that the resident representative was notified of the need to transfer the resident to the emergency room , and failed to inform the POA of medication changes and a decline in condition. The finding includes: 1. Resident #29 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, polyneuropathy, diabetes, and hypertension. The care plan dated 3/24/21 identified an altered cardiovascular status related to hypertension and hyperlipidemia. Interventions included to observe for and report any signs or symptoms of dependent edema. The care plan dated 3/24/21 identified a potential for fluid overload related to diuretic use. Interventions directed to administer medications as ordered. The annual MDS dated [DATE] identified Resident #29 had intact cognition, was always continent of bowel and bladder and required supervision for activities of daily living and assist of 1 for transfers, personal hygiene, and toileting. A physician's order dated 7/27/21 directed to apply tubi grips to bilateral lower extremities in the morning and remove at bedtime every 12 hours for edema. Review of the nurse's progress notes dated 8/1/21 - 9/13/21 failed to reflect resident refusals to wear tubi grips, or that the APRN/ MD were notified of refusals to wear tubi grips. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #29 on 9/8/21 at 10 :00 AM indicated the charge nurse had not put on his/her tubi grip stocking for over a month. Resident #29 noted he/she would wear them if the nurse had asked but hasn't ask. Observations on 9/8/21 at 10:00 AM and 2:00 PM identified Resident #29 was sitting in the wheelchair dressed in residents' room and only had on nonskid socks and did not benefit from tubi grips to bilateral lower extremities with bilateral lower extremity edema present. Observations on 9/9/21 at 10:00 AM and 1:50 PM identified Resident #29 was dressed in the wheelchair wearing non skid socks without the benefit of the tubi grip stocking for the edema to bilateral lower extremities. Interview with LPN #1 on 9/9/21 at 2:25 PM identified he was responsible to apply the tubi grips to Resident #29's bilateral lower extremities per the physician order, because of the dependent edema that was present. LPN #1 indicated he had been documenting Resident #29 was refusing the tubi grips per the physician order, but because Resident #29 had a long time ago refused them, LPN #1 assumed Resident #29 would refuse them and had not asked. LPN #1 indicated he had not asked Resident #29 in a while except maybe once or twice even though he was documenting in the medical record that she was refusing daily. Review of medical record LPN #1 indicated the month of August and September 2021 he had put Resident #29 had refused the tubi grips but probably only ask a couple of times. LPN #1 indicated he had not asked Resident #29 this week or last week if she/he would wear them. LPN #1 did a thorough room search in the nightstand, drawers, closet, and bathroom and was not able to locate a pair of tubi grips to apply to Resident #29's swollen legs in the residents room. LPN #1 approached Resident #29 and offered the tubi grips to bilateral lower extremities if he got a pair and Resident #29 was agreeable to put them on. LPN #1 indicated if Resident #29 had refused the tubi grips he would be responsible to notify the APRN or physician of the refusals by the second day and document it in the progress notes. LPN #1 indicated he did not notify an APRN or a physician and did not document anything. Interview and observation with Resident #29 on 9/13/21 at 11:00 AM indicated she/he was wearing white ted stockings (Anti Embolism Stockings) to bilateral lower extremities. Resident #29 noted she/he liked having them on because it makes his/her legs feel better and helps with the swelling. Interview and observation with LPN #1 on 9/13/21 at 10:25 AM indicated he had put the white ted stockings (Anti Embolism Stockings) on Resident #29 on 9/10/21 and 9/13/21 he indicated Resident #29 was agreeable to put them on to bilateral lower extremities. LPN #1 indicated he did not know what tubi grips were, so he decided to use ted stockings (Anti Embolism Stockings) indicated central supply only had the large size Anti Embolism Stockings, so LPN #1 noted he tried them on Resident #29. LPN #1 indicated he did not measure the resident's legs prior to applying the Anti Embolism Stockings on 9/10/21 and 9/13/21 without a physician order. LPN #1 indicated he had a physician order for tubi grips and he thought the ted stockings (Anti Embolism Stockings) were the same thing. LPN #1 questioning if he needed a new order for the ted stockings (Anti Embolism Stockings). Interview and observation with the DNS on 9/13/21 at 2:15 PM indicated Resident #29 had on ted stockings (Anti Embolism Stockings) to bilateral lower extremities and the facility does not have a physician order for the ted stockings (Anti Embolism Stockings) they have a physician order only for the tubi grips and they are not the same. The DNS was not aware LPN #1 had placed Resident #29 in the Anti Embolism Stockings on 9/10/21 and 9/13/21 until the surveyor brought this to the DNS attention. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with LPN #1 and the DNS on 9/13/21 at 2:15 PM the DNS indicated if a resident refuses a medication or a treatment the APRN or physician have to be notified and a progress note to explain by the resident refuses and that the physician was notified. LPN #1 indicated he had been documenting that Resident #29 was refusing the tubi grips but did not ask Resident #29 daily. LPN #1 indicated he had assumed Resident #29 would refuse them, so he didn't ask. The DNS indicated LPN #1 must follow the physician order and was expected to ask Resident #29 every day prior to documenting that Resident #29 had refused without even asking. The DNS indicated her expectation was that LPN #1 would ask every day and document accurately. The Medication Administration Record dated August 1-31, 2021 identified that LPN #1 indicated Resident #29 had refused the tubi grips on the 20 days he worked. Review of facility Charge Nurse Job Description identified the major duties and responsibilities included follow the physician's orders, review resident records daily to assure accuracy and completeness, document comprehensive and complete nursing notes, document and report any unusual or significant findings and contact the physician, and follow facility policies and procedures. Review of facility policy Documentation in Resident Records identified the medical record shall be legible, factual, signed and dated. Review of facility Policy Change of Condition in a Resident Status identified the charge nurse will notify the resident physician when there was a refusal of a medication or a treatment. The RN supervisor will assess the residents change in condition and document their findings in the medical record. The charge nurse will record in the residents' medical record information relative to change in the residents' medical condition or status. Notifications will be made within 24 hours of a change occurring in the residents medical condition or status. 2. Resident #77 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, multiple pressure areas, contractures of the right and left knee, contractures of the right and left ankle, cognitive deficit, and communication deficit. A physician's order dated 8/8/21 directed to get daily weights and if weight gain 2-3 pounds or more in a day or worsening swelling in ankles, legs, or abdomen, call MD once a day. The admission MDS dated [DATE] identified Resident #77 had severely impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. The nurse's note from admitted d 8/8/21 - 9/12/21 did not identify Resident # 77 refused daily weights. The APRN /MD progress notes dated 8/9/21- 9/10/21 did not address daily weights. An interview with LPN #1 on 9/13/21 at 9:40 AM indicated Resident #77's daily weights are scheduled at 6:00 AM and he was not told that Resident #77 had refused or asked to try to get the weight on day shift. LPN #1 indicated if Resident #77 had refused a weight there should be a progress note explaining why the resident refused the weight and the second refusal the APRN would be notified and be in a progress note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and medical record review with the DNS on 9/13/21 at 9:45 AM indicted the nursing staff are responsible to get the daily weights per the physician order. The DNS indicated the daily weights were scheduled at 6:00 AM daily, but review of medical record indicated there were only 2 weights done, on 8/8/21 and 8/20/21, from 8/8/21- 9/13/21. The DNS indicated there was not a progress note indicating there was any refusals from Resident #77 since admission and there weren't any progress notes indicating the responsible party, APRN or physician were notified of the weights not being done or refused. The DNS indicated she would expect the responsible party, APRN would be notified if the weights were not done on the second day. The DNS indicated she expects the nurses to follow the physician orders and if there was a reason why they don't let the APRN or physician now. An interview with APRN #2 on 9/14/21 at 12:25 PM indicated Resident #77 was on daily weights since admission from the hospital because Resident #77 had an echo performed that was questionable for diastolic heart failure and ejection fraction of 55%. APRN #2 indicated she only saw 2 weights done since admission and was not notified that the weights were not being done or the resident was refusing the weight. APRN #2 indicated she should have been notified if Resident #77 was refusing weights or why they were not done. APRN #2 indicated she will decrease the weights to 3 times a week to try to get a baseline and better compliance by staff. After surveyor inquiry, the APRN note dated 9/14/21 at 12:56 indicated Resident #77 was on daily weight as part of the discharge summary without a diagnosis, but on chart review diastolic dysfunction inconclusive with poor quality study most likely due to contractures. The daily weights will cause unnecessary pain to resident with no history of actual heart failure exacerbation. will add diagnosis of diastolic CHF and will change weights to 3 times a week. Review of Change of Condition in a Resident Status Policy indicated the facility shall notify the resident, his/her attending physician, and representative of changes in the resident's medical condition. The nurse will notify the residents physician or on call physician when there has been a refusal of treatment or medication. Notifications will be made within 24 hours of a change occurring and will document in the medical record. 3. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. Review of the weight's summary dated 5/18/21 identified Resident #79 weighed 402.1 lbs. Review of the May 2021 physician's orders directed to transfer Resident #79 via a mechanical lift with the assistance of 3 staff. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, and transfer activity occurred only once or twice with 2 plus person physical assistance. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #79 on 8/16/21 at 1:05 PM identified that sometime in May 2021, during a mechanical lift transfer from the bed to the wheelchair, with NA #1 and NA #23, the lift tilted to the side with the resident in it, and the nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she was upset that the incident happened and was scared and thought that he/she was going to fall on the floor. Resident #79 indicated that during the incident they were all screaming as the nurse aides were trying to get him/her into the wheelchair. Resident #79 indicated that both nurse aides are small and short, and during the incident, part of the lift hit the resident in the head and the resident landed in the wheelchair in a slouching position. Resident #79 indicated after the incident, NA #23 was pinned in back of the wheelchair against the wall, and the lift flipped backwards and fell on to NA #1 and she got hurt. Resident #79 indicated NA #1 and NA #23 started yelling for LPN #1. Resident #79 indicated LPN #1 came into the room and helped to reposition him/her properly in the wheelchair and help the 2 nurse aides. Resident #79 indicated he/she does not remember if LPN #1 or RN #4 looked at his/her head after the incident. Interview with LPN #1 on 8/16/21 at 3:47 PM identified he heard the nurse aides screaming his name from Resident #79's room. LPN #1 indicated that when he entered the room, Resident #79 was in the wheelchair, still connected to the lift, and the lift was tilted. It was chaotic and the nurse aides were screaming. LPN #1 had to calm the nurse aides down because they were screaming, and when he did, they repositioned the resident correctly in the wheelchair and released him/her from the lift. LPN #1 identified he did not notify the physician or the conservator when Resident #79 was involved in the lift incident on 5/28/21 because the resident did not fall on the floor. LPN #1 indicated he was not aware that the resident required 3 staff with the lift transfers. Interview with the nursing supervisor (RN #4) on 8/16/21 at 4:00 PM identified she did not notify the physician or the conservator when Resident #79 was involved in the lift incident on 5/28/21. When RN #4 entered Resident #79's room there were 4 staff in the room. RN #4 indicated she did not do a reportable even form because the resident did not fall on the floor. RN #4 indicated she did assess the resident at the time of the incident, but the resident was not hurt. RN #4 indicated she was not aware that the resident was hit in the head. There was no investigation or follow up assessment during the next shifts or days after the incident because the resident did not fall on the floor. Interview with the Administrator on 8/17/21 at 1:42 PM identified she was aware that NA #1 was injured during the lift incident with Resident #79, but she was not aware the resident was hit in the head. The staff did not do a reportable event form because the resident did not fall. Additionally, the Administrator indicated RN #4 or LPN #1 should have notified the physician or the APRN when Resident #79 was involved in the lift incident on 5/28/21. Further, the nurse should have completed an assessment, and documented it in the clinical record after the incident. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was on vacation when Resident #79 was involved the lift incident on 5/28/21. The Former DNS indicated RN #4 or LPN #1 should have notified the physician, and the conservator of the incident. The Former DNS indicated she was informed that a nurse aide got hurt during the lift incident. The Former DNS indicated she would expect that the supervisor would have taken care of the situation, including completing a reportable event form. The supervisor should have done and documented an assessment of the resident's condition after the incident. The Former DNS indicated she was not aware that staff did not document this incident in the clinical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #79's attending physician, (MD #2) on 8/17/21 at 4:06 PM identified she was not aware that Resident #79 was involved in a mechanical lift incident on 5/28/21. MD #2 indicated that the facility should have notified her or the APRN even though the resident did not get injured. MD #2 indicated that the staff should have followed the order and provide the assistance of 3 staff during the lift transfer. Additionally, MD #2 indicated that the nurse should have done an assessment of the resident's condition after the incident. Review of the change of condition in a resident status policy identified the facility shall notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: An accident or incident involving the resident. The facility failed to notify the physician and the conservator on 5/28/21 when the mechanical lift tilted during Resident #79's transfer from the bed to the wheelchair and he/she was hit in the head by the lift. 4. R #88's diagnoses included Cerebral Vascular Accident (CVA) and heart disease. The annual minimum data assessment dated [DATE] identified that R #88 had mildly impaired cognition and hearing was adequate. The annual minimum data set (MDS) assessment dated [DATE] identified that R #88 had mildly impaired cognition. The demographic sheet noted that Person (P) #6 was R #88's responsible party and emergency contact. Power of Attorney papers dated 10/5/20 indicated that P #6 was R #88's Power of Attorney. Nursing narratives by LPN #8 dated 8/3/21 on the evening shift indicated that P #88 complained of ear pain unrelieved with medication and requested to be sent to the ER. Physician orders dated 8/3/21 directed to send to ER. Transfer documentation dated 8/3/21 noted P #8 and was sent to the ER at 8:57 PM. Nursing documentation did not identify that Person #6 had been notified of the ER transfer. Interview with Person #6 on 9/14/21 at 11:26 AM noted that she was not notified of the transfer of R #88 to theER on [DATE], should have been notified and found out from R #88 after R #88's return (8/4/21). Interview with LPN #2 on 9/14 21 at 3:01 PM indicated that she did not recall notifying P #6 of R #88's transfer on 8/3/21, did not recall asking the Supervisor to notify P #6 and would have documented the notification in the nursing notes. The facility policy entitled Change of Condition in a Resident Status identified that, unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the family or representative when it is necessary to transfer the resident to the hospital/treatment center. 5. Resident # 342's diagnoses included dementia with behavior disturbance. The admission MDS assessment dated [DATE] identified Resident #342 was severely cognitively impaired and required supervision with transfers and walking, extensive assistance with dressing and hygiene, and supervision with eating. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 1/15/21 identified the resident used psychotropic medications related to behavior management. Interventions included educate the family about risks, benefits and side effects, monitor behavior, observe for adverse reactions of psychotropic medications including refusal to eat, fatigue, insomnia, loss of appetite, weight loss, and new behavior symptoms. a.The physician's order dated 1/12/21 directed to give Trazodone 25 mg by mouth every 8 hours as needed for anxiety. The physician's order dated 1/21/21 directed to increase Depakote sprinkles to 500mg by mouth twice daily. The physician's order dated 2/16/21 directed to decrease Olanzapine to 2.5 mg by mouth twice daily. Review of the clinical record failed to identify the POA was notified of the medication changes. Interview with Person #2, Resident #342's POA, on 9/10/21 at 10:30 AM identified he/she was never notified of any changes to the resident's medication with the exception of a dose change for Ativan. Interview with APRN #1 on 9/10/21 identified he/she does not notify the family or POA of psychotropic medications. APRN #1 identified the facility contracts a psychiatric APRN to adjust psychotropic medications and they should notify the family of any psychotropic medication changes. Interview with APRN #3 on 9/15/21 at 11:00 AM identified he/she assesses residents and makes recommendations for psychotropic medications that must be approved by the facility doctor. APRN #3 identified the facility is responsible to notifying the family or POA after the doctor approves his/her recommendations. APRN #3 identified that he/she would call the family if requested to address their concerns. b. Review of the clinical record identified the resident's weight was 166 lbs on 1/12/21. The resident weight record identified the resident's weight on 2/3/21 was 153 lbs, a 13 pound weight loss from 1/12/21. Review of the clinical record failed to identify Person #2 was notified of Resident #342's significant weight loss. Interview with Dietitian #1 on 9/9/21 at 2:00 PM identified that he/she does not notify families of resident's weight loss and it is the responsibility of nursing to notify them. c. The APRN note dated 1/29/21 identified that nursing reported Resident #342 had been primarily sleeping during the days for the past two days, arousable but not his/her norm as the resident is usually walking around the unit most of the day. Ativan decreased. The nurses note dated 2/2/21 identified Resident #342 appeared very sleepy, putting his/her head down on the table, not opening mouth for meals or medications. Held Ativan for lethargy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The APRN note dated 2/3/21 identified patient's routine labs resulted in BUN 67, unable to receive IVF due to mentation status, will encourage 250 ml additional fluids with all meals. The APRN note dated 2/10/21 identified patient continues with lethargy, unable to get medication or fluids in the resident. Friday's (2/5/21) labs signified acute dehydration. Noted sunken eye sockets. Needing assistance to walk this morning, Resident #342's baseline is independent without device. Send to ER for evaluation. Review of the clinical record failed to identify that Person #2 was notified of Resident #342's abnormal lab results, dehydration, and lethargy. Interview with Person #2 on 9/10/10 at 10:30 AM identified he/she was not notified of Resident #42's lethargy, dehydration, and decline in activity until the facility called Person #2 to notify him/her that Resident #342 was being transferred to the hospital. Interview with APRN #1 on 9/10/21 at 1:00 PM identified that he/she usually does notify resident's families of changes in condition including abnormal lab results and dehydration documents it in the medical record. APRN #1 did not provide an explanation for why Person #2 was not notified of Resident #342's change in condition. 42117

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35682 Based on observation, review of the clinical record, facility documentation, facility policy and interview and review of, for 2 of 4 sampled resident rooms (Resident #44 and 77), for 3 of 3 resident lounges, and for 1 of 2 medication storage rooms the facility failed to ensure a clean comfortable, homelike environment and maintain a clean and sanitary medication refrigerator and for 1 of 3 residents (Resident #343), the facility failed to ensure the resident's personal property was protected from loss or theft. The findings include: 1. Observation of Resident #44's room on 9/8/21 at 10:00 AM identified the following: The privacy curtain near the window was tied in a knot on the bottom; fabric was noted with streaks of reddish/brown material. The oxygen concentrator surface area was coated with dirt/dust/white debris. A standing oscillating fan which was running, was noted with dust/dirt/debris coating the fan blades and cover. Interview and observation of Resident #44's room with the Director of Housekeeping on 9/10/21 at 12:50PM identified that housekeeping staff should clean resident rooms and bathrooms daily including mopping floors, cleaning overbed tables and any surfaces that are visibly soiled. The Director of Housekeeping identified she was not aware the privacy curtain was currently soiled, indicated that privacy curtains should be changed when visibly soiled, and her housekeeping staff should have noticed it was dirty and informed her. Additionally, although privacy curtains would be changed during terminal cleaning, they currently only deep clean rooms when a resident is discharged . The Director of Housekeeping further identified she has plans to implement terminal cleaning of 1 room per unit per day, indicating that all rooms would then have a thorough cleaning each month. 2. Observation of Resident #77's room on 9/10/21 at 12:15 PM identified the following: Visibly soiled floor, sticky when walking. Dirty waste pail with no plastic bag liner. Used disposable gloves on floor. 3. Intermittent observation of the resident lounges on all 3 units from 9/8/21 through 9/13/21 identified the following: A Wing Lounge: 3 of 3 upholstered chairs and 1 upholstered couch with brown stains. B Wing Lounge: Strong urine odor noted in room; 2 of 3 upholstered chairs with multiple brown stains, 2 of 2 upholstered couches with multiple brown stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C Wing Lounge: 2 of 12 upholstered chairs with brown stains. Interview with the Director of Housekeeping on 9/10/21 at 9:00 AM identified she was aware of the stained furniture in all 3 lounges and had made attempts to clean them. She identified that the stains were difficult to remove, and an extracting machine would work better, however the facility does not have one at this time. The Director of Housekeeping identified the last time housekeeping attempted to clean the upholstered furniture was about a month ago however there was no documentation to support this. Interview with the DNS on 9/13/21 at 10:30 AM identified that she expected the housekeeping staff to maintain a clean comfortable environment for the residents because it is their home. Although a policy was requested for Housekeeping Responsibilities, only a Quality Assurance Checklist for housekeeping was provided that currently was not in place. 4. Observation of the A/B Wing medication storage room with RN #4, (7:00 AM - 3:00 PM Supervisor) on 9/9/21 at 2:30 PM, identified a small medication storage room with a foul odor noted upon opening the door. Observation identified one large medication refrigerator with orange rust noted on the outside bottom of door. Observed on the inside back wall of the refrigerator was a moderate amount of black material and a pool of water noted on the bottom floor. Interview with RN #4 at the time of observation identified she was not aware of the condition of the refrigerator and although she could not explain where the foul odor in the storage room was coming from, she indicated it was probably coming from this refrigerator. RN #4 identified that housekeeping staff were responsible for cleaning the refrigerators, but it was the nurse's responsibility to inform housekeeping when it required cleaning. Subsequent to surveyor inquiry, the refrigerator was cleaned. The following day, on 9/10/21, a new refrigerator had been purchased to replace the old one. Observation of the A/B Wing medication storage room with RN #4 on 9/13/21 at 8:40 AM, identified a new clean medication refrigerator was in place. Additionally, no foul odor in the medication room was noted. Review of the Medication Storage policy identified medications will be stored in an orderly, organized manner in a clean area. 5. Resident #343's diagnosis included rheumatoid arthritis. The MDS dated [DATE] identified Resident #343 has intact cognition and is independent with activities of daily living. The social services note dated 3/4/2020 identified Resident #343 reported that several garments that were purchased while he/she was in the facility are missing and cannot be found. Resident #343 requested to be reimbursed for the missing items. The grievance dated 3/4/20 identified Resident #343 is missing clothing and is scheduled to be discharged on [DATE] and wants to be reimbursed before he/she goes home. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Social Worker #5 on 9/10/21 at 11:00 AM identified that she was unable to follow up with Resident #343 regarding the missing items because his/her last day of employment at the facility was on 3/5/21 the day after Resident #343 reported the missing clothes to him/her. Interview with the administrator on 9/10/21 at 10:00 AM identified that although the facility completed a grievance, they were unable to find documentation that Resident #343 was paid for his/her missing items. The administrator identified if a resident file a grievance for missing items, if the facility is unable to locate the items they either replace the items or reimburse the resident, and attach a copy of the receipt to the grievance. 37002

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on observation, review of clinical records, facility documentation, interviews, and policies, for six (6) of sixteen (16) residents, who required total assistance with bathing, incontinent care, and repositioning, (Resident #60, #27, #44, #4, #77, and #17), the facility neglected to provide the necessary care resulting in Immediate Jeopardy, and for one of three residents reviewed for abuse (Resident #45), the facility failed to ensure that the resident was free from abuse. Additionally, for 9 residents (Resident #5, 23, 32, 35, 39, 40, 47, 53, 63) who were not provided incontinent care on 8/19/21 during the 3:00 PM - 11:00 PM shift, the facility failed to ensure the residents was free from neglect. And for 1 resident (Resident #79), who rang the call bell for over 2 hours during the 11:00 PM - 7:00 AM shift without a response, the facility failed to ensure the resident was free from neglect. The findings include Please Cross Reference F 725 The findings include: 1. Resident #60's diagnoses included dementia with behavioral disturbances. The MDS dated [DATE] identified the Resident had severe cognitive impairment, required limited assistance of one staff for toilet use, occasionally incontinent of urine and frequently incontinent of bowel. The RCP dated 8/1/21 identified the Resident had an ADL deficit related to Dementia. Interventions included assist with ADL's as needed. On 9/4/21 at 12:35 PM during tour of C wing, Resident #60 was observed placing a plate of food in the top drawer of the dresser. Upon surveyor inquiry, NA #6 stated, oh s/he always does that. NA #6 was observed to remove the plate of food from the dresser drawer. At 12:38PM, the commode near R #60's bed was soiled with feces including the floor. The Resident was observed with visible feces on his/her hands. NA #6 was heard to say to the LPN on the unit, in the presence of the Administrator, the Resident needs to be cleaned and we need housekeeping. Observation at 12:55 PM noted NA #6 walking down the hallway and reported to the nurse she was going to lunch. Interview at that time with NA #6 stated that she did not provide care to the Resident because s/he's not my Resident and she (NA #6) needed to go to lunch. The NA further stated that she was going to tell the Resident's Aide when she found her, that Resident #60 needed incontinent care. The facility failed to provide care to the Resident for at least seventeen (17) minutes although numerous staff members were aware the Resident was incontinent and had feces on his/her hands. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator and LPN #3 on 9/4/21 at 12:55 PM stated NA #6 should have provided care to the Resident when s/he was observed with feces on his/her hands. After surveyor inquiry, the NA #6 was instructed to provide incontinent care to the Resident and then suspended pending investigation. Interview with the Administrator and DON on 9/5/21 at 2:00 PM stated that although they removed NA #6 from the schedule, they had not yet started the investigation related to neglecting to provide care to Resident #60. 2. On 9/4/21 during a tour of the facility starting at 11:45 AM, the following was observed: On the A wing- 15 of the 26 Residents were observed in bed, B wing- 8 of 33 Residents were observed in bed, and on the C wing- 12 of the 33 Residents were observed in bed. Interviews with the staff on the units during tour stated some Residents prefer to stay in bed until after lunch and they were doing the best they could. On 9/4/21, the facility submitted an action plan to the Department to address the care needs of the Residents. The facility identified that the Supervisor would conduct rounds on Residents every two (2) hours to ensure timely care was provided and the Charge Nurses were to assist with rounds on the units. 3. Resident #27's diagnoses included altered mental state and dementia. The annual MDS dated [DATE] identified the Resident had moderately impaired cognition, total dependence on staff for toilet use, extensive assistance with personal hygiene, and frequently incontinent of bowel and bladder. The RCP dated 6/30/21 identified the resident had bowel and bladder incontinence related to impaired cognition and mobility. Interventions included offer toileting on rounds. On 9/5/21 at 10:30 AM, Resident #27 was observed lying in bed on his/her back. Observations at 12:01 PM noted the Resident was in the same position, in bed lying on his/her back. Observation with RN #2 (Supervisor) at 12:01 PM identified that the Resident's brief and bottom sheet were saturated with urine. The brief had areas of dark and light yellow, and visible brownish colored rings. The Resident's bottom bed sheet was noted with darkened rings of urine. Interview at that time with RN #2 stated that she was responsible to cover the NA's assignment due to a call out and for the first 2 hours of the shift (7AM-9AM) she was not able to provide any personal care to any residents. RN #2 stated she was trying to get breakfast trays out and oversee the building during that time. Interview with NA #1 at 12:01 PM stated she had yet to provide any care to the Resident because she was the only NA on the unit. RN #2 and NA #1 further stated during the period of 7:00 AM until 12:01 PM, the Resident was boosted in bed for breakfast but not checked for incontinence. Interview with the DON on 9/5/21 at 1:30 PM stated that Residents should be checked for and provided incontinent care every two hours. 4. Resident #44 had diagnoses that included spinal stenosis and dementia. A care plan dated 6/8/21 identified that the Resident had potential for skin integrity impairment related to bladder incontinence and immobility with interventions that included to observe for incontinence on rounds and as required, and to wash, rinse and dry the perineum after incontinent episodes. A quarterly MDS dated [DATE] identified that the Resident had severe cognitive impairment, required extensive assistance of two for bed mobility, extensive assistance for bathing, was frequently incontinent of bowel and bladder, was at risk for pressure ulcers, and had Incontinent Associated Dermatitis (IAD). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Nurse Aide #8 on 9/6/21 at 5:45 PM identified that she had entered the resident's room around 5:00 PM to provide incontinent care and found the Resident with the lunch tray still in front of h/her and the resident covered in food particles. NA #8 further stated that she provided incontinent care for the Resident at 5:00 PM and identified that the incontinent brief was saturated with urine, and the bed linens had also been saturated with urine requiring a complete linen change of the bed. Interview with NA #1 on 9/6/21 at 7:40 PM identified that she had worked the 7:00 AM to 3:00 PM shift, there were only two (2) NA's for 33 residents and the other NA had left at 12:00 PM leaving her to care for 33 Resident's from 12:00 PM until 2:00 PM when her shift ended. No other NAs worked on the unit from 2:00 PM to 3:00 PM. NA #1 stated that Resident #44 was only provided with his/her meals during her shift and although she adjusted the position of the Resident at meal time to prepare for the meal, she did not provide any other positioning, bathing, or incontinent care for the entire 7:00 AM to 3:00 PM shift (a total of 8 hours). NA#1 stated that she did not inform the Charge Nurse or the Supervisor that she could not provide care for Residents #44 because that is the usual staffing pattern, and there have been times where she has worked the 7:00 AM to 3:00PM shift for 33 residents by herself, and the administration is already aware of the staffing issues. 5. Resident #4 had diagnoses that included osteoarthritis and bipolar disorder. A quarterly MDS dated [DATE] identified that the resident was cognitively intact, required extensive assist of two staff for bed mobility, total care for bathing, was frequently incontinent of bladder, always incontinent of bowel, and was at risk for skin breakdown. A care plan dated 7/27/21 identified that the resident was at risk for pressure ulcers related to immobility and incontinence with interventions to keep skin clean and dry, to offer toileting on rounds, and to encourage repositioning four times a shift. Observation with the Director of Nurses (DON) on 9/6/21 at 6:35 PM of Resident #4's incontinent care identified that when the Nurse Aide rolled the Resident over to remove the incontinent brief, the brief was saturated with urine that was brown in color and had a strong urine odor and when NA #1 removed the brief it tore in half. Interview with the Resident on 9/6/21 at 6:15 PM identified that she had last had care at 5:00 AM and she had been wet all day. Interview with the Director of Nurses at the time of the observation identified that it would seem that the Resident had been not been provided with incontinent care for at least 3-4 hours and should be provided with incontinent care every 2 hours. Interview with NA #1 on 9/6/21 at 7:40 PM identified that she had worked the 7:00 AM to 3:00 PM shift, there were only two (2) NA's for 33 Residents and the other NA had left at 12:00 PM leaving her to care for 33 Residents from 12:00 PM until 2:00 PM when her shift ended. No other NAs worked on the unit from 2:00 PM to 3:00 PM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA #1 stated that Resident #4 was only provided with his/her meals during her shift and although she adjusted the position of the Resident at meal time to prepare for the meal, she did not provide any other positioning, bathing, or incontinent care for the entire 7:00 AM to 3:00 PM shift (a total of 8 hours). NA#1 stated that she did not inform the Charge Nurse or the Supervisor that she could not provide care for Residents #4 because that is the usual staffing pattern, and there have been times where she has worked the 7:00 AM to 3:00PM shift for 33 residents by herself, and the administration is already aware of the staffing issues. 6. Resident #77 had diagnoses that included multiple sclerosis and contractures of multiple sites. A five (5) day MDS dated [DATE] identified that the Resident had severe cognitive impairment, required total care of two staff for bed mobility, required extensive assistance with bathing, was frequently incontinent of bladder, had pressure ulcers, and was at risk for further pressure ulcers. A care plan dated 8/23/21 identified that the Resident was at risk for pressure ulcers related to history of pressure ulcers, incontinence, impaired mobility, and refusing care at times, with interventions that included to assist with repositioning 4 times a shift, and to keep skin clean and dry. Review of wound sheets dated 9/2/21 identified that the resident's pressure ulcers were present on admission, and included the following, the resident had a stage II pressure ulcer to the left and right heel, the right lateral ankle, and the left lateral foot. The wound sheet further identified the Right greater trochanter had a stage III pressure ulcer, and the coccyx had a stage IV pressure ulcer. Observation with the DON on 9/6/21 at 6:00 PM of Resident #77's incontinent care identified that the incontinent brief was saturated with brown colored urine, and the bed linens beneath the incontinent brief had a large brown stain. Interview with the DON at the time of the observation identified that the diaper appeared to be saturated in urine, and the brown stain was most likely dried urine. The Resident's perineal area had redness and the Resident's buttocks had blanchable redness. Interview with Nurse Aide (NA) #1 on 9/6/21 at 7:40 PM identified that she had worked the 7:00 AM to 3:00 PM shift and there were only two (2) NA's for 33 Residents, and the other NA had left at 12:00 PM, leaving her the only NA until 2:00 PM when her shift ended. NA #1 stated that she entered Resident #77's room on 2 occasions to offer care, which the Resident refused, however she did not report the refusals to the Charge Nurse, although she was aware that she should have. Furthermore, NA #1 stated she was aware that the Resident should be given incontinent care every 2 hours (4 times a shift), and she was not able to go back to the Resident's room because she did not have time to do so. NA #1 identified that Resident #77 was provided with repositioning at mealtime, but otherwise she did not provide positioning, incontinent care, or bathing for the entire 7:00 AM to 3:00 PM shift. Interview with Licensed Practical Nurse (LPN) # 1 on 9/7/21 at 4:14 AM identified that he was the charge nurse for Resident #77 on 9/6/21 during the 7:00 AM to 3:00 PM shift. LPN #1 stated that NA#1 did not report that the Resident refused care on the 7:00 AM to 3:00 PM shift. LPN#1 stated that the Resident does refuse care, but if it had been reported to him, he would have gone in and talked to the Resident, which would usually result in h/her accepting care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Resident #17 had diagnoses of schizophrenia and diabetes. A re-admission assessment dated [DATE] identified that the Resident was alert to person only, required total care with bathing, toileting, extensive assistance with mobility, and was incontinent once or more per shift. A care plan dated 9/6/21 identified that the Resident had potential for pressure ulcers related to incontinence and immobility with interventions that included to assist with toileting as needed, assist with repositioning 4 times a shift, and pressure reducing cushion to the wheelchair and mattress to the bed. Interview with NA #8 on 9/6/21 at 5:45 PM identified that she had entered the Resident's room around 5:30 PM to provide incontinent care, and identified that the incontinent brief was saturated with urine, and the bed linens had also been saturated with urine requiring a complete linen change of the bed. Interview with NA #9 on 9/6/21 at 8:00 PM identified that she had worked the 11:00 PM to 7:00 PM shift from 9/5-9/6/21, and that she had provided incontinent care and repositioning care to Resident #4 and Resident #77 around 5:00 AM. NA #9 stated that NA #10 was assigned to Resident #17 and #44 and did last rounds at 5:00 AM. Multiple attempts were made to reach NA #10 but were unsuccessful. Interview with NA #1 on 9/6/21 at 7:40 PM identified that she had worked the 7:00 AM to 3:00 PM shift, there were only two (2) NA's for 33 residents and the other NA had left at 12:00 PM leaving her to care for 33 Resident's from 12:00 PM until 2:00 PM when her shift ended. No other NAs worked on the unit from 2:00 PM to 3:00 PM. NA #1 stated that Resident #17 was only provided with his/her meals during her shift and although she adjusted the position of the Resident at meal time to prepare for the meal, she did not provide any other positioning, bathing, or incontinent care for the entire 7:00 AM to 3:00 PM shift (a total of 8 hours). NA#1 stated that she did not inform the Charge Nurse or the Supervisor that she could not provide care for Residents #17 because that is the usual staffing pattern, and there have been times where she has worked the 7:00 AM to 3:00PM shift for 33 residents by herself, and the administration is already aware of the staffing issues. NA #1 further stated that it was impossible to provide care to all 33 Residents on the unit including Resident #4, #17, #44, and #77 who all required turning, repositioning and incontinent care every 2 hours. Interview with the Director of Nurses on 9/6/21 at 6:36 PM identified that she had been in the building since 11:00 AM on 9/6/21, and was unaware that there were only 2 NA's on the B wing, was unaware that there was only 1 NA on the B wing from 12:00 PM to 2:00 PM, and that there were no Aides on the B wing from 2:00 PM to 3:00 PM. The DON identified that the Resident's should have been provided with bathing, incontinent care, and repositioning every 2 hours. The DON further identified that she had not assisted with any care on any of the units, she stated that if they need help, they will let me know. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Registered Nurse (RN) #1 on 9/7/21 at 10:30 AM identified that she was the Nursing Supervisor on 9/6/21 for the 7:00 AM to 3:00 PM shift, and was aware of the staffing issue on the B wing, and she had tried to contact all of the staffing agencies and called all of the staff and no one was able to come in that day. RN #1 identified that she had provided care to Resident #79 throughout the shift but did not provide any care for any other residents on B wing. Interview with LPN #1 on 9/7/21 at 4:14 AM identified that the staffing on 9/6/21 for the 7:00 AM to 3:00 PM shift on 9/6/21 was not unusual, and he helps as much as he can, but on 9/6/21 he did not provide any care to Resident #4, #17, #44, or #77, nor was he informed by NA#1 that she could not complete her assignment, if he had been informed he would have done his best to help her. All residents had a skin audit on 9/6/21 and no new areas of skin integrity impairment were identified. Residents #4, #17, #44, and #77 were last provided incontinent care turning and repositioning at approximately 5:00 AM on 9/6/21 and were then provided incontinent care and positioning between 5:00 PM and 6:00 PM by the 3:00 PM to 11:00 PM shift. The Resident's did not receive incontinent care and positioning for 12 and 13 hours. Although the facility submitted a plan on 9/4/21 that identified the Supervisors would conduct rounds every two hours, Charge nurses to assist with rounds on the units, and NA's to perform rounds to assigned residents every two hours and as needed, review of the audits dated 9/5/21 and 9/6/21 failed to identify the audits were consistently completed. Review of the audit results with the RN Supervisor (RN#2) on 9/5/21 at 10:00 AM identified she has been unable to make rounds every two hours in accordance with the action plan because of short staffing. Interview with the DON on 9/5/21 at 12:40 PM stated that staff education began on 9/4/21 to address the timeliness of providing care, audits were developed to monitor care and the Supervisors were expected to complete these audits to ensure care was provided every two hours. Review of the audits with the Administrator on 9/6/21 at 6:30 PM verified that the audits were incomplete for 9/5/21 and 9/6/21. The Administrator identified that she was unsure if they were done or not, as the DON had told the staff to pass along the need to do the audits in shift report. Review of the Activity of Daily Living (ADL) policy identified that the residents will be provided with ADL's with the support and assistance they need. Review of the abuse/neglect policy identified all Residents have the right to be free from physical abuse and neglect. The policy identified neglect is any failure to provide goods or services necessary to avoid physical harm or mental anguish. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/7/21, the facility submitted a revised action plan to address the failure to provide care to residents in a timely manner which included: Education that care would be provided to Residents every two (2) hours and as needed, Supervisors and Charge Nurses on each wing (A, B, C) would verify care was provided then document which resident was observed utilizing the audit tool. All NAs would be reeducated that care would be provided every two hours and as needed and immediately report if a resident refuses care and if the NA cannot complete their assignment. Care audits will be done daily for a week, weekly for a month, and monthly for 3 months to monitor that care is being provided then be reviewed at the Quality Assurance meetings. During an onsite visit on 9/8/21, the action plan was verified as implemented, therefore, the Immediate Jeopardy was abated. 8) R #45's diagnoses included cerebral infarction with hemiplegia, major depressive disorder, and anxiety. The quarterly MDS dated [DATE] identified the resident with severe cognitive impairment, rejection of care, and supervision to limited assistance with ADL's. The RCP dated 7/19/21 identified the resident used psychotropic medications related to behavioral management. Interventions include administer medications as ordered, monitor target behaviors, encourage resident to express feelings and psych follow up. Facility documentation dated 8/26/21 at 10:00 PM noted a staff to resident altercation. NA (#11) pushed R #45 by linen closet and kept antagonizing the resident. The documentation identified that the RN Supervisor heard yelling and saw NA #11 and resident standing by wall and the resident lunged forward at NA, the NA was yelling at the resident and pushed the resident. The documentation identified the NA left the unit and came back 3 times and got in the face of the resident and was yelling at the resident. The documentation further identified the allegation was not substantiated as the resident was the aggressor and the agency NA had a reactionary response to the situation. Review of Nurse's notes dated 8/26/21 at 11:57 PM noted that yelling was heard in hallway at approximately 10:00 PM and noted R #45 standing up by wall and attempting to go towards NA who was yelling and stating, I'm sick of you, come and get it. The note identified the RN told the NA to leave the unit. The note identified the NA came back to the unit 3 times and one time the NA went into R #45's room. Interview with RN #2 (RN Supervisor) on 9/4/21 at 2:30 PM stated that she was at the nursing station when she heard yelling in the A wing hallway. RN #2 stated that she ran to the unit and saw R #45 standing against the wall near the linen closet and saw NA #11 standing in front of the resident yelling at him/her get out of her face and leave me alone. RN #2 stated that she immediately separated the resident and NA and told the NA to leave the unit. RN #2 stated that while she was assessing the resident the NA came back towards the resident making a fist with one hand and punching it into the other stating I'm gonna get you. RN #2 stated the NA was very aggressive towards the resident and she had to stand between the resident and NA. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #3 on 9/4/21 at 3:10 PM stated that she was at the linen closet and R #45 was behind the door and grabbed her arm, then NA #11 came to the linen closet and told the resident to leave me alone. NA #3 stated that the resident made a comment to NA #11 and NA #11 told the resident get up, get up and do something about it. NA #3 stated the resident stood up and NA #11 put her hands on the resident's chest and shoved the resident into the wall. NA #3 stated that the RN Supervisor (RN #2) came running down and told NA #11 to leave the unit and was trying to calm the resident down and get the resident back into the wheelchair. NA #3 stated that NA #11 kept coming back towards the resident calling the resident names and making a fist and punching it into her other hand. NA #3 stated that at no time did the resident touch NA #11. Interview with LPN #7 on 9/10/21 at 12:17 PM stated that she was at the nursing station when she heard a loud commotion going on down the hallway and she heard NA #11 telling the resident I'm tired of you picking on me, talking smack. LPN #7 stated she saw NA #11 slapping her fists into the palm of her other hand and telling the resident if you want to do something stand up. LPN #7 stated she saw the resident stand up from the wheelchair and the NA placed her hands on the resident and pushed the resident across the hall into the wall. LPN #7 stated that she told the Supervisor what happened, and she and the supervisor went down the hallway. LPN #7 stated that at no time did she see the resident touch the NA. Interview with NA #11 on 9/10/21 at 12:30 PM stated that she was getting linen out of the closet when R #45 was there and swearing at her. NA #11 stated that the resident stood up and grabbed my neck and arm choking me. NA #11 stated she pushed the resident off her and was told she had to leave. NA #11 further stated that at no time did she touch the resident except to take his/her hands off her. Interview with LPN #6 on 9/10/21 at 12:47 PM stated that she was in the hallway doing her medication pass when NA #3 called her to say R #45 had his hands on her arms. LPN #6 stated to the resident to remove his/her hands and the resident did. LPN #6 stated that she heard arguing and saw R #45 at the linen closet pushing the wheelchair petals into the door bumping NA #11. LPN #6 stated that she heard NA #11 saying to the resident come on man, and she told the resident to move away. LPN #6 stated within seconds they were arguing again and heard NA #11 saying I'm tired of you always messing with me. LPN #6 stated she told the resident again to move away. LPN #6 stated that she observed the NA making a fist and punching her other hand and the resident stated what you gonna do, don't make me stand up. LPN #6 stated that NA #11 said stand up, stand up. LPN #6 stated the resident stood up and lunged towards NA #11, putting his/her hands on the NA's left shoulder and on the top of the chest below the neck, and NA #11 pushed the resident off her onto the wall across the hall. LPN #6 stated that the other nurse and supervisor came, and the resident and NA were separated. LPN #6 stated that the resident is unstable on feet and she was not sure if the resident lunged toward the resident or was off balance. The facility failed to ensure that Resident #45 was free from abuse. Review of the abuse/neglect policy identified all Residents have the right to be free from abuse. 37293 9. Resident #5 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, hemiplegia affecting right dominant side, heart failure. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurse aide care card identified to check Resident #5 for incontinence on rounds and wash, rinse and dry perineum, change clothing as needed after incontinence episodes and encourage Resident #5 to participate with ADLs as able. The quarterly MDS dated [DATE] identified Resident #5 had severely impaired cognition, required total assistance with toilet use, and was always incontinent of urine and stool. Review of the nurse aide flowsheet dated 8/19/21 on the 3:00 PM - 11:00 PM shift identified toilet use (incontinent care) activity did not occur. The August 2021 nurse aide flowsheet failed to reflect complete documentation for all shifts. The care plan dated 8/11/21 identified Resident #5 has bladder incontinence related to confusion, impaired mobility, inability to communicate needs, and physical limitations. Interventions included to check for incontinence on rounds. Wash, rinse and dry perineum. Change clothing as needed after incontinence episodes. Interview with RN #3 on 9/2/21 at 5:36 PM identified on 8/19/21 he was notified by LPN #9 and NA #14 that 9 residents were found soaked, saturated, and soiled with urine or feces when rounds were made at the beginning of the 11:00 PM - 7:00 AM shift. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift during her round she observed Resident #5's bed linens were saturated with urine, so she provided Resident #5 a bed bath and changed the bed linen. NA #14 indicated after she provided care to Resident #5, she notified LPN #9 and RN #3 that Resident #5 was soiled and saturated and left in a urine-soaked bed. Interview with LPN #9 on 9/7/21 at 8:57 AM identified when she made round on 8/19/21 at the beginning of her shift on the 11:00 PM - 7:00 AM she and NA #14 observed Resident #5 bed linens were saturated with urine, and NA #14 provided Resident #5 with a bed bath and changed the bed linen. LPN #9 indicated she notified RN #3 that Resident #5 bed was soiled and saturated and left in a urine-soaked bed. Interview LPN #9 on 9/7/21 at 9:00 AM identified after care was provided to Resident #5, she and NA #14 made round and observed a total of 9 residents that were saturated and soiled with urine or feces. 10. Resident #23 was admitted to the facility on [DATE] with diagnoses that include transient cerebral ischemic attack, hemiplegia left nondominant side, and cognitive deficits following cerebral infarction. The nurse aide care card identified to offer Resident #23 the bed pan/commode every 2 hours. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition and required supervision with toilet use and was always continent of urine and stool. The care plan dated 6/22/21 identified Resident #23 has an ADL self-performance and mobility deficit related to deconditioning left sided weakness. Interventions failed to reflect how peri-care was provided. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the August 2021 nurse aide flowsheet identified toilet use activity did not occur. Additionally, documentation was incomplete for all shifts. Interview LPN #9 on 9/7/21 at 9:00 AM identified after care was provided to Resident #5, she and NA #14 made round and observed a total of 9 residents that were saturated and soiled with urine or feces. Resident #23 and his/her bed linens were saturated with urine, so she provided Resident #23 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #23 and the bed linen was saturated with urine. LPN #9 indicated NA #14 provided Resident #23 with a bed bath and changed the bed linen. 11. Resident #32 was admitted to the facility on [DATE] with diagnoses that include severe morbid obesity due to excess calories, mild cognitive impairment, Alzheimer's disease. The nurse aide care card identified to offer Resident #32 to the toilet at 3:00 AM rounds. Instruct Resident #32 to use bed pan for toileting. The care card failed to reflect how resident uses the toilet during the day and evening. The quarterly MDS dated [DATE] identified Resident #32 had moderately impaired cognition, required extensive assistance with toilet use and was frequently incontinent of urine and stool. Review of the August 2021 nurse aide flowsheet identified Resident #32 was continent. The flowsheet failed to reflect complete documentation for all shifts. The care plan dated 8/19/21 identified Resident #32 had an ADL self-care performance and mobility deficit related to impaired cognition and deconditioning. Interventions included to encourage the resident to assist in ADL performance to promote independence. The care plan failed to reflect interventions related to continence and toilet use. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 when she arrived for the 11:00 PM - 7:00 AM shift, Resident #32 and his/her bed linens were saturated with urine. NA #14 identified Resident #32 placed him/herself into the wheelchair and propelled him/herself to the nurse's station. Resident #32's brief was saturated with urine which left a trail of urine on the floor from the residents room to the nurse's station. NA #14 indicated she provided Resident #32 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #32 was completely soaked/saturated in urine. LPN #9 indicated Resident #32 came to the nurse's desk and a trail of urine followed him/her from the room to the nurse's desk. NA #14 provided Resident #32 with bed bath and linen change. 12. Resident #35 was admitted to the facility on [DATE]/18 with diagnoses that included dementia, macular degeneration and anxiety disorder. The nurse aide care card identified Resident #35 was incontinent: check for incontinence on rounds. Wash, rinse, and dry perineum. Change clothing as needed after incontinence episodes. The physician's order dated 6/28/21 directed to provide extensive assistance for ADL's. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan dated 6/29/21 identified Resident #35 has bladder incontinence related to confusion, dementia, impaired mobility, inability to communicate needs. Interventions included to check for incontinence on rounds. Wash, rinse, and dry perineum. Change clothi [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32736 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of nine residents (Resident #345) reviewed for abuse, the facility failed to ensure the resident was free of misappropriation of property. The findings include: Resident #345's diagnoses included Alzheimer's disease. The admission nursing assessment dated [DATE] identified that R #345 had was alert and oriented, and required total staff assistance for personal hygiene. The personal effects inventory dated 10/8/2020 identified Resident #345 was admitted to the facility with an i-phone and an i-phone charger. The Resident Care Plan (RCP) dated 10/13/2020 identified a risk for psychosocial well-being concern. Interventions directed to provide alternative methods of communicate with family/visits, i.e. face time, skype, and phone calls. The nurse's note dated 11/22/2020 at 12:21 PM identified that Resident #345 was discharged to home with family, personal belongings and medications. Review of facility grievance form dated 11/23/2020 identified Resident #345 was discharged to home without his/her cell phone. The family indicated that they called the cell phone company to attempt to locate/track the phone and the cell phone company had notified them of a person who had access to the phone. The grievance form indicated that the facility notified the local police department and reported the allegation of misappropriation to the State Agency. Review of facility incident report dated 11/24/2020 identified the cell phone company had traced Resident #345's missing cell phone to a facility employee. Interview, clinical record review, and facility documentation review with the Administrator on 9/14/2021 at 11 AM identified Resident #345 was admitted for a short term stay and had a personal i-phone upon admission. Resident #345 was discharged to home on 11/22/2020 with his/her personal belongings. On 11/23/2020, Resident #345's family called to notify the facility that Resident #345's i-phone was missing. The facility completed a grievance form, and the cell phone company notified the family that Resident #345's cell phone was accessed by someone and provided the family with the person's name. The Administrator indicated that the person who had access to Resident #345's i-phone was Housekeeper #1. She further indicated the Housekeeper #1 was suspended pending the investigation, and his employment was subsequently terminated. Housekeeper #1 was unavailable for interview during the survey. The facility failed to ensure resident personal property was protected from misappropriation by staff. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Abuse and Neglect Policy, dated 4/17, directed in part, that misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings without the resident's consent. Review of facility Resident Rights Policy, dated 11/17, directed in part, that the facility will treat each resident with respect and dignity, and will promote the rights of the resident. The Policy further directed Resident Rights included respect, dignity and the right to have personal property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentations, facility policy, and interviews for 9 residents (Resident #5, 23, 32, 35, 39, 40, 47, 53, 63) who on 8/19/21 were found by staff at the beginning of the 11:00 PM - 7:00 AM shift saturated with urine and feces, which was reported to the administrator, and for 1 resident (Resident #79), who reported to staff that he/she had rang the call bell for 2 hours without response and had to lay in a urine saturated bed, the facility failed to report the allegations of neglect to the state agency. The findings include: 1. Interview with RN #3 on 9/2/21 at 5:36 PM identified on 8/19/21, he was notified by LPN #9 and NA #14 that 9 residents had been found soaked, saturated, and soiled with urine or feces when rounds were made at the beginning of the 11:00 PM - 7:00 AM shift. Resident #5 was one of the residents. Resident #5 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, hemiplegia affecting right dominant side, heart failure. The quarterly MDS dated [DATE] identified Resident #5 had severely impaired cognition, required total assistance with toilet use, and was always incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, during her round she observed Resident #5's bed linens were saturated with urine, so she provided Resident #5 a bed bath and changed the bed linen. NA #14 indicated after she provided care to Resident #5, she notified LPN #9 and RN #3 that Resident #5 was soiled and saturated and left in a urine-soaked bed. Interview with LPN #9 on 9/7/21 at 8:57 AM identified when she made rounds on 8/19/21 at the beginning of her shift on the 11:00 PM - 7:00 AM she and NA #14 observed Resident #5's bed linens were saturated with urine. NA #14 provided Resident #5 with a bed bath and changed the bed linen. LPN #9 indicated she notified RN #3 that Resident #5 bed was soiled and saturated and left in a urine-soaked bed. LPN #9 indicated that after NA #14 provided care to Resident #5, she and NA #14 made rounds and observed a total of 9 residents that were saturated and soiled with urine or feces. The residents were Resident #5, 23, 32, 35, 39, 40, 47, 53, and 63. 2. Resident #23 was admitted to the facility on [DATE] with diagnoses that include history of stroke and cognitive deficits. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition, required supervision with toilet use, and was always continent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift she and LPN #9 did rounds and found Resident #23 saturated in a urine-soaked bed. Resident #23 required a bed bath and linen change at that time. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #23 and the bed linen was saturated with urine. LPN #9 indicated NA #14 provided Resident #23 with a bed bath and changed the bed linen. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #32 was admitted to the facility on [DATE] with diagnoses that included obesity and Alzheimer's disease. The quarterly MDS dated [DATE] identified Resident #32 had moderately impaired cognition, required extensive assistance with toilet use, and was frequently incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #32 and his/her bed linens were saturated with urine. NA #14 identified Resident #32 had placed him/herself into the wheelchair and propelled him/herself to the nurse's station. Resident #32's brief was saturated with urine which left a trail of urine on the floor from the resident's room to the nurse's station. NA #14 indicated the resident required and she provided Resident #32 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #32 was completely soaked and saturated in urine. LPN #9 indicated Resident #32 came to the nurse's desk and a trail of urine followed him/her from the room to the nurse's desk. 4. Resident #35 was admitted to the facility on [DATE]/18 with diagnoses that include dementia, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #35 had severely impaired cognition, required extensive two-person physical assistance with toilet use, and was frequently incontinent of urine and stool. A nurse's note dated 8/20/21 at 4:35 AM identified Resident #35 was found to be laying in a completely soaked bed. The residents brief was soaked and breaking down, leaving the little beads all over the resident, and the resident's private peri area was reddened. Resident #35 had dried feces on his/her buttocks. After Resident #35 was cleaned and a complete bed change was done, Resident #35 was in tears when thanking NA #14. Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #35 was found in a urine saturated bed, his/her bed linens were saturated with urine and the resident had dried feces on his/her buttocks. NA #14 provided Resident #35 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #35 and the bed linens were saturated with urine and dried feces to buttocks. LPN #9 indicated NA #14 provided Resident #35 with a bed bath and changed bed linen. 5. Resident #39 was admitted to the facility on [DATE] with diagnoses that include dementia and bipolar disorder. The quarterly MDS dated [DATE] identified Resident #39 had severely impaired cognition, required extensive assistance with toilet use, was frequently incontinent of urine and always incontinent of stool. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #39 was found in a urine saturated bed and the resident had had a large bowel movement. NA #14 provided Resident #39 with a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #39 and the bed linen was saturated with urine and Resident #39 had a bowel movement. LPN #9 indicated NA #14 provided Resident #39 with a bed bath and changed bed linen. 6. Resident #40 was admitted to the facility on [DATE] with diagnoses that include seizures and mild cognitive impairment. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition, required extensive two-person physical assistance with toilet use, and was frequently incontinent of urine and stool. Review of the general note from e-record dated 8/19/21 at 7:01 AM identified Resident #40 was found sitting in his/her wheelchair fully clothed, with a johnny gown in his/her lap. Resident #40 was completely soaked. Resident #40 indicated to staff they handed me my johnny gown, turned off the light and walked out the door and I did not see them since. Interview with NA #14 on 9/3/21 at 6:05 PM identified Resident #40 was found in his/her room on 8/20/21 at 12:30 AM sitting in the wheelchair, fully clothed in the dark, with the door closed. Resident #40 was holding a johnny gown in his/her hand and indicated the girls said that they were coming back and gave him/her the johnny gown and they never came back. Resident #40 was saturated in urine and feces. NA #14 indicated she provided care to the resident but did not need to change the bed linen, because the resident had never been put in bed. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #40 was sitting in his/her wheelchair on 8/20/21 at 12:30 AM with johnny coat on his/her lap in the dark with the door closed. Resident #40 indicated they had given him/her a johnny coat and said they will come back, and they did not come back. NA #14 provided Resident #40 with care and put him/her to bed. 7. Resident #47 was admitted to the facility on [DATE] with diagnoses that include vascular dementia and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #47 had severely impaired cognition, required extensive assistance with toilet use, and was always incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, Resident #47 was found in bed with saturated with urine. NA #14 provided Resident #47 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #47 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #47 with a bed bath and changed the bed linen. 8. Resident #53 was admitted to the facility on [DATE] with diagnoses that include catatonic schizophrenia. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS dated [DATE] identified Resident #53 had severely impaired cognition, required extensive two-person physical assistance with toilet use, was frequently incontinent of urine and always incontinent of stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, Resident #53 was found in bed saturated with urine, so much that the urine was dripping off the bed onto to the floor. NA #14 provided Resident #53 a bed bath and changed the urine saturated bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #53 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #53 with a bed bath and changed the bed linen. 9. Resident #63 was admitted to the facility on [DATE] with diagnoses that include dementia and congestive heart failure. The quarterly MDS dated [DATE] identified Resident #63 had severely impaired cognition, required extensive assistance with toilet use and was frequently incontinent of urine and stool. Review of the general note from e-record dated 8/20/21 at 5:40 AM identified Resident #63 was found at the beginning of the shift soaked lying in bed. Interview with NA #14 on 9/3/21 at 6:05 PM identified at the beginning of the 11:00 PM - 7:00 AM shift on 8/19/21, Resident #63 was found in a urine saturated bed. NA #14 provided Resident #47 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #63 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #63 with a bed bath and changed the bed linen. Interview with RN #2 on 9/2/21 at 5:05 PM identified she worked on 8/19/21 during the 3:00 PM - 11:00 PM shift and was not aware that 9 residents had not been provided incontinent care. RN #2 indicated she did make round on the C wing but did not go into the resident rooms. RN #2 indicated it is the responsibility of the nurse aides to provide incontinent care and put residents to bed. If the resident refuses care, the nurse aide is to report it to the charge nurse. RN #2 indicated she was not notified of any issues on C wing. Interview with the Administrator on 9/3/21 at 1:00 PM identified she was made aware of the allegation of neglect which occurred during the 3:00 PM - 11:00 PM shift on 8/19/21 when she came in on the morning of 8/20/21. The Administrator identified the 11:00 PM - 7:00 AM supervisor had left a list of 9 residents under her door which indicated that incontinent care had not been provided to the residents by the 3:00 PM -11:00 PM staff. Additionally, that care was provided by NA #14 during the 11:00 PM - 7:00 AM shift. The Administrator indicated that she placed the list on her desk and went to morning meeting followed by running an errand for the facility picking up antigen test supplies and then indicated it slipped her mind. The Administrator indicated the expectation of the facility is that all residents are treated with respect, dignity, and incontinent care should have been performed by the 3:00 PM - 11:00 PM shift. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 9/3/21 at 4:55 PM identified she did not work on 8/20/21 and was not aware of the allegation of neglect of the 9 residents who had not been provided incontinent care on 8/19/21 during the 3:00 PM - 11:00 AM shift. The DNS indicated the expectation of the facility was that all residents are treated with respect, dignity, and good customer service. Interview with LPN #2 on 9/7/21 at 11:50 AM identified she worked on 8/19/21 on the 3:00 PM - 11:00 PM shift on C wing. LPN #2 indicated she was not aware that 9 residents had not been provided incontinent care. LPN #2 indicated she had sufficient nurse aides on the unit on 8/19/21 during the 3:00 PM - 11:00 PM shift on C wing. LPN #2 indicated it is the responsibility of the nurse aide to make rounds and provide incontinent care and put residents back to bed. LPN #2 indicated she can't remember the day specifically, but indicated that she was directed to inform the nurse aides on the wing to complete the documentation on all resident flowsheets, even if they were not assigned to the residents. Review of the incontinent care policy identified incontinent care will cleanse the perineum, help prevent skin breakdown, and prevent odors and infections. Incontinent care will be provided to any resident who is incontinent of bowel and/or bladder by the CNA. Frequency of incontinent care will be determined by the interdisciplinary team. The procedure may be performed in the bathroom or while the resident is in bed. Review of the abuse and neglect policy identified residents have the right to be free from abuse, corporal punishment, involuntary seclusion, and psychosocial harm. Resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Neglect - any failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. Reporting mechanism: Facility in-house reporting - whenever there is a witnessed or alleged report of a resident abuse action, as defined above, the following is initiated. The Administrator or on-call designee and Director of Nursing Services are to be notified immediately. Review of the resident rights policy identified all resident have rights guaranteed to them under Federal and State laws and regulations. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality, as well as honor and value their input. Right to perform facility services or refuse. The facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Each resident will be treated with dignity and respect. 10. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. (continued on next page)

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	075057	A. Building B. Wing	09/28/2021

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the May 2021 physician's orders directed to transfer Resident #79 via a mechanical lift with the assistance of 3 staff as the resident is unable to ambulate. Additionally, the orders identified Resident #79 requires the assistance of 2 staff (extensive assistance) for upper/lower body dressing, and toilet transfers and limited assistance for personal hygiene. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, required extensive two-person physical assistance with toilet use and extensive one-person physical assistance with personal hygiene. Additionally, the MDS indicated Resident #79 was always continent of urine. Interview with Resident #79 on 8/16/21 at 1:05 PM identified that usually when he/she rings the call bell, it takes the nurse aides 40 minutes to an hour to answer. Resident #79 indicated that sometime in June 2021, during the 11:00 PM - 7:00 AM shift, he/she needed help and rang the call bell for approximately 4 hours, but the staff did not answer or come to his/her room. In another incident, Resident #79 indicated recently, after returning from a hospitalization , during an 11:00 PM - 7:00 AM shift, the resident rang the call light because he/she had to urinate. Resident #79 could not remember the exact time but was also yelling for help. The staff on the night shift never came into his/her room to help or provide care so he/she had to urinate in the bed and lay in it. Resident #79 indicated that when the 7:00 AM - 3:00 PM shift arrived, the nurse aide answered the call light a little after 7:00 AM. Resident #79 indicated at that time, NA #1 provided care and the resident reported to NA #1 that he/she had been ringing for help since 5:00 AM and had been laying in urine because no one came to help. Resident #79 indicated he/she lays in bed waiting for staff to answer the call bell, it happens all the time, it goes on all the time. The resident stated he/she many times has had to urinate right in his/her bed and lay in the urine, screaming for help because no one comes, and he/she indicated the bed gets cold because it's wet. The resident indicated he/she has had to call 911 in the past when staff don't answer the call bell. The resident indicated he/she rings for the bedpan and will urinate on the bedpan, but if no one comes, he/she has no choice and cannot hold it, so will urinate in the bed. If staff answer his/her call light in a timely manner, he/she uses the bed pan. Interview with Resident #4, (Resident #79's roommate), on 8/16/21 at 1:12 PM identified he/she does not remember the exact date but does remember an incident when he/she was woken up by Resident #79 screaming for help at approximately 5:00 AM. Resident #4 indicated the night shift did not come to answer the call bell or come in the room to help Resident #79. It wasn't until the day shift arrived that Resident #79 received help. Interview with NA #1 on 8/16/21 at 1:30 PM identified she does not remember exactly the day or date, but it happened when Resident #79 came back from the hospital recently. NA #1 indicated when she came in at 7:00 AM, Resident #79's light was ringing, and she answered the call light. NA #1 indicated Resident #79 was crying and stated that the nurse aide (lady) on the night shift did not provide care. NA #1 indicated Resident #79 and his/her bed and linens were saturated with urine, so she provided Resident #79 a bed bath and changed the bed linen. NA #1 indicated after she provided care to Resident #79, she notified RN #2 and LPN #1 of Resident #79's complaint that the night shift had not provided care and that Resident #79 was soiled and saturated and left in a urine-soaked bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #1 on 8/16/21 at 3:47 PM identified he is the regular nurse on the B unit and assigned to Resident #79. LPN #1 indicated he does not remember NA #1 reporting to him that Resident #79 was complaining about the night shift not answering the call light or providing the resident the bed pan, and subsequently the resident soiled and saturated the bed with urine. LPN #1 indicated that one time during the day shift, he does remember an incident when Resident #79's family member called the facility and reported that if someone does not go into the resident room to provide toileting assistance that he/she was going to call 911. Interview with RN #4 on 8/16/21 at 4:00 PM identified she does not remember NA #1 informing her that Resident #79 complained that the night shift did not provide care during the shift and that the resident was left in a urine-soaked bed. Interview with Social Worker #1 on 8/17/21 at 9:53 AM identified she was not aware of the resident's complaint regarding the night shift not providing him/her with care during the night. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was not aware of the alleged complaint by Resident #79 that the 11:00 PM - 7:00 AM shift did not provide care for 2 hours and that the resident was left in a urine-soaked bed. The facility failed to report an allegation of neglect when Resident #79, who was alert, oriented and continent, reported to NA #1 that staff had not answered his/her calls to use the bed pan for 2 hours during the night shift, and that he/she had urinated in the bed which was saturated with urine. Review of the abuse and neglect policy identified residents have the right to be free from abuse, corporal punishment, involuntary seclusion, and psychosocial harm. Resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Neglect - any failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. Reporting mechanism: Facility in-house reporting - whenever there is a witnessed or alleged report of a resident abuse action, as defined above, the following is initiated. The Administrator or on-call designee and Director of Nursing Services are to be notified immediately. Witnessed or alleged abuse action to a resident will be reported within 2 hours by telephone to the DPH by the Administrator, DNS, or designee. Follow up written report will be filed within 72 hours.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentations, facility policy, and interviews for 9 residents (Resident #5, 23, 32, 35, 39, 40, 47, 53, 63) who were found by staff on 8/19/21, at the beginning of the 11:00 PM - 7:00 AM shift, saturated with urine and feces, which was reported to the administrator, and for 1 resident (Resident #79), who reported to staff that he/she had rang the call bell for 2 hours without response and had to lay in a urine saturated bed, the facility failed to investigate the allegations of neglect. The findings include: 1. Interview with RN #3 on 9/2/21 at 5:36 PM identified on 8/19/21, he was notified by LPN #9 and NA #14 that 9 residents had been found soaked, saturated, and soiled with urine or feces when rounds were made at the beginning of the 11:00 PM - 7:00 AM shift. Resident #5 was one of the residents. Resident #5 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, hemiplegia affecting right dominant side, heart failure. The quarterly MDS dated [DATE] identified Resident #5 had severely impaired cognition, required total assistance with toilet use, and was always incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, during her round she observed Resident #5's bed linens were saturated with urine, so she provided Resident #5 a bed bath and changed the bed linen. NA #14 indicated after she provided care to Resident #5, she notified LPN #9 and RN #3 that Resident #5 was soiled and saturated and left in a urine-soaked bed. Interview with LPN #9 on 9/7/21 at 8:57 AM identified when she made rounds on 8/19/21 at the beginning of her shift on the 11:00 PM - 7:00 AM she and NA #14 observed Resident #5's bed linens were saturated with urine. NA #14 provided Resident #5 with a bed bath and changed the bed linen. LPN #9 indicated she notified RN #3 that Resident #5 bed was soiled and saturated and left in a urine-soaked bed. LPN #9 indicated that after NA #14 provided care to Resident #5, she and NA #14 made rounds and observed a total of 9 residents that were saturated and soiled with urine or feces. The residents were Resident #5, 23, 32, 35, 39, 40, 47, 53, and 63. 2. Resident #23 was admitted to the facility on [DATE] with diagnoses that include history of stroke and cognitive deficits. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition, required supervision with toilet use, and was always continent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift she and LPN #9 did rounds and found Resident #23 saturated in a urine-soaked bed. Resident #23 required a bed bath and linen change at that time. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #23 and the bed linen was saturated with urine. LPN #9 indicated NA #14 provided Resident #23 with a bed bath and changed the bed linen. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #32 was admitted to the facility on [DATE] with diagnoses that included obesity and Alzheimer's disease. The quarterly MDS dated [DATE] identified Resident #32 had moderately impaired cognition, required extensive assistance with toilet use, and was frequently incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #32 and his/her bed linens were saturated with urine. NA #14 identified Resident #32 had placed him/herself into the wheelchair and propelled him/herself to the nurse's station. Resident #32's brief was saturated with urine which left a trail of urine on the floor from the resident's room to the nurse's station. NA #14 indicated the resident required and she provided Resident #32 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #32 was completely soaked and saturated in urine. LPN #9 indicated Resident #32 came to the nurse's desk and a trail of urine followed him/her from the room to the nurse's desk. 4. Resident #35 was admitted to the facility on [DATE]/18 with diagnoses that include dementia, and anxiety disorder. The quarterly MDS dated [DATE] identified Resident #35 had severely impaired cognition, required extensive two-person physical assistance with toilet use, and was frequently incontinent of urine and stool. A nurse's note dated 8/20/21 at 4:35 AM identified Resident #35 was found to be laying in a completely soaked bed. The residents brief was soaked and breaking down, leaving the little beads all over the resident, and the resident's private peri area was reddened. Resident #35 had dried feces on his/her buttocks. After Resident #35 was cleaned and a complete bed change was done, Resident #35 was in tears when thanking NA #14. Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #35 was found in a urine saturated bed, his/her bed linens were saturated with urine and the resident had dried feces on his/her buttocks. NA #14 provided Resident #35 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #35 and the bed linens were saturated with urine and dried feces to buttocks. LPN #9 indicated NA #14 provided Resident #35 with a bed bath and changed bed linen. 5. Resident #39 was admitted to the facility on [DATE] with diagnoses that include dementia and bipolar disorder. The quarterly MDS dated [DATE] identified Resident #39 had severely impaired cognition, required extensive assistance with toilet use, was frequently incontinent of urine and always incontinent of stool. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #14 on 9/3/21 at 6:05 PM identified that on 8/19/21 at the start of the 11:00 PM - 7:00 AM shift, Resident #39 was found in a urine saturated bed and the resident had had a large bowel movement. NA #14 provided Resident #39 with a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #39 and the bed linen was saturated with urine and Resident #39 had a bowel movement. LPN #9 indicated NA #14 provided Resident #39 with a bed bath and changed bed linen. 6. Resident #40 was admitted to the facility on [DATE] with diagnoses that include seizures and mild cognitive impairment. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition, required extensive two-person physical assistance with toilet use, and was frequently incontinent of urine and stool. Review of the general note from e-record dated 8/19/21 at 7:01 AM identified Resident #40 was found sitting in his/her wheelchair fully clothed, with a johnny gown in his/her lap. Resident #40 was completely soaked. Resident #40 indicated to staff they handed me my johnny gown, turned off the light and walked out the door and I did not see them since. Interview with NA #14 on 9/3/21 at 6:05 PM identified Resident #40 was found in his/her room on 8/20/21 at 12:30 AM sitting in the wheelchair, fully clothed in the dark, with the door closed. Resident #40 was holding a johnny gown in his/her hand and indicated the girls said that they were coming back and gave him/her the johnny gown and they never came back. Resident #40 was saturated in urine and feces. NA #14 indicated she provided care to the resident but did not need to change the bed linen, because the resident had never been put in bed. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #40 was sitting in his/her wheelchair on 8/20/21 at 12:30 AM with johnny coat on his/her lap in the dark with the door closed. Resident #40 indicated they had given him/her a johnny coat and said they will come back, and they did not come back. NA #14 provided Resident #40 with care and put him/her to bed. 7. Resident #47 was admitted to the facility on [DATE] with diagnoses that include vascular dementia and chronic obstructive pulmonary disease. The quarterly MDS dated [DATE] identified Resident #47 had severely impaired cognition, required extensive assistance with toilet use, and was always incontinent of urine and stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, Resident #47 was found in bed with saturated with urine. NA #14 provided Resident #47 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #47 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #47 with a bed bath and changed the bed linen. 8. Resident #53 was admitted to the facility on [DATE] with diagnoses that include catatonic schizophrenia. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS dated [DATE] identified Resident #53 had severely impaired cognition, required extensive two-person physical assistance with toilet use, was frequently incontinent of urine and always incontinent of stool. Interview with NA #14 on 9/3/21 at 6:05 PM identified on 8/19/21 at the beginning of the 11:00 PM - 7:00 AM shift, Resident #53 was found in bed saturated with urine, so much that the urine was dripping off the bed onto to the floor. NA #14 provided Resident #53 a bed bath and changed the urine saturated bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #53 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #53 with a bed bath and changed the bed linen. 9. Resident #63 was admitted to the facility on [DATE] with diagnoses that include dementia and congestive heart failure. The quarterly MDS dated [DATE] identified Resident #63 had severely impaired cognition, required extensive assistance with toilet use and was frequently incontinent of urine and stool. Review of the general note from e-record dated 8/20/21 at 5:40 AM identified Resident #63 was found at the beginning of the shift soaked lying in bed. Interview with NA #14 on 9/3/21 at 6:05 PM identified at the beginning of the 11:00 PM - 7:00 AM shift on 8/19/21, Resident #63 was found in a urine saturated bed. NA #14 provided Resident #47 a bed bath and changed the bed linen. Interview with LPN #9 on 9/7/21 at 8:57 AM identified Resident #63 and the bed linen were saturated with urine. LPN #9 indicated NA #14 provided Resident #63 with a bed bath and changed the bed linen. Interview with RN #2 on 9/2/21 at 5:05 PM identified she worked on 8/19/21 during the 3:00 PM - 11:00 PM shift and was not aware that 9 residents had not been provided incontinent care. RN #2 indicated she did make round on the C wing but did not go into the resident rooms. RN #2 indicated it is the responsibility of the nurse aides to provide incontinent care and put residents to bed. If the resident refuses care, the nurse aide is to report it to the charge nurse. RN #2 indicated she was not notified of any issues on C wing. Interview with the Administrator on 9/3/21 at 1:00 PM identified she was made aware of the allegation of neglect which occurred during the 3:00 PM - 11:00 PM shift on 8/19/21 when she came in on the morning of 8/20/21. The Administrator identified the 11:00 PM - 7:00 AM supervisor had left a list of 9 residents under her door which indicated that incontinent care had not been provided to the residents by the 3:00 PM -11:00 PM staff. Additionally, that care was provided by NA #14 during the 11:00 PM - 7:00 AM shift. The Administrator indicated that she placed the list on her desk and went to morning meeting followed by running an errand for the facility picking up antigen test supplies and then indicated it slipped her mind. The Administrator indicated the expectation of the facility is that all residents are treated with respect, dignity, and incontinent care should have been performed by the 3:00 PM - 11:00 PM shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 9/3/21 at 4:55 PM identified she did not work on 8/20/21 and was not aware of the allegation of neglect of the 9 residents who had not been provided incontinent care on 8/19/21 during the 3:00 PM - 11:00 AM shift. The DNS indicated the expectation of the facility was that all residents are treated with respect, dignity, and good customer service. Interview with LPN #2 on 9/7/21 at 11:50 AM identified she worked on 8/19/21 on the 3:00 PM - 11:00 PM shift on C wing. LPN #2 indicated she was not aware that 9 residents had not been provided incontinent care. LPN #2 indicated she had sufficient nurse aides on the unit on 8/19/21 during the 3:00 PM - 11:00 PM shift on C wing. LPN #2 indicated it is the responsibility of the nurse aide to make rounds and provide incontinent care and put residents back to bed. LPN #2 indicated she can't remember the day specifically, but indicated that she was directed to inform the nurse aides on the wing to complete the documentation on all resident flowsheets, even if they were not assigned to the residents. 10. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. Review of the May 2021 physician's orders directed to transfer Resident #79 via a mechanical lift with the assistance of 3 staff as the resident is unable to ambulate. Additionally, the orders identified Resident #79 requires the assistance of 2 staff (extensive assistance) for upper/lower body dressing, and toilet transfers and limited assistance for personal hygiene. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, required extensive two-person physical assistance with toilet use and extensive one-person physical assistance with personal hygiene. Additionally, the MDS indicated Resident #79 was always continent of urine. Interview with Resident #79 on 8/16/21 at 1:05 PM identified that usually when he/she rings the call bell, it takes the nurse aides 40 minutes to an hour to answer. Resident #79 indicated that sometime in June 2021, during the 11:00 PM - 7:00 AM shift, he/she needed help and rang the call bell for approximately 4 hours, but the staff did not answer or come to his/her room. In another incident, Resident #79 indicated recently, after returning from a hospitalization , during an 11:00 PM - 7:00 AM shift, the resident rang the call light because he/she had to urinate. Resident #79 could not remember the exact time but was also yelling for help. The staff on the night shift never came into his/her room to help or provide care so he/she had to urinate in the bed and lay in it. Resident #79 indicated that when the 7:00 AM - 3:00 PM shift arrived, the nurse aide answered the call light a little after 7:00 AM. Resident #79 indicated at that time, NA #1 provided care and the resident reported to NA #1 that he/she had been ringing for help since 5:00 AM and had been laying in urine because no one came to help. Resident #79 indicated he/she lays in bed waiting for staff to answer the call bell, it happens all the time, it goes on all the time. The resident stated he/she many times has had to urinate right in his/her bed and lay in the urine, screaming for help because no one comes, and he/she indicated the bed gets cold because it's wet. The resident indicated he/she has had to call 911 in the past when staff don't answer the call bell. The resident indicated he/she rings for the bedpan and will urinate on the bedpan, but if no one comes, he/she has no choice and cannot hold it, so will urinate in the bed. If staff answer his/her call light in a timely manner, he/she uses the bed pan. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #4, (Resident #79's roommate), on 8/16/21 at 1:12 PM identified he/she does not remember the exact date but does remember an incident when he/she was woken up by Resident #79 screaming for help at approximately 5:00 AM. Resident #4 indicated the night shift did not come to answer the call bell or come in the room to help Resident #79. It wasn't until the day shift arrived that Resident #79 received help. Interview with NA #1 on 8/16/21 at 1:30 PM identified she does not remember exactly the day or date, but it happened when Resident #79 came back from the hospital recently. NA #1 indicated when she came in at 7:00 AM, Resident #79's light was ringing, and she answered the call light. NA #1 indicated Resident #79 was crying and stated that the nurse aide (lady) on the night shift did not provide care. NA #1 indicated Resident #79 and his/her bed and linens were saturated with urine, so she provided Resident #79 a bed bath and changed the bed linen. NA #1 indicated after she provided care to Resident #79, she notified RN #2 and LPN #1 of Resident #79's complaint that the night shift had not provided care and that Resident #79 was soiled and saturated and left in a urine-soaked bed. Interview with LPN #1 on 8/16/21 at 3:47 PM identified he is the regular nurse on the B unit and assigned to Resident #79. LPN #1 indicated he does not remember NA #1 reporting to him that Resident #79 was complaining about the night shift not answering the call light or providing the resident the bed pan, and subsequently the resident soiled and saturated the bed with urine. LPN #1 indicated that one time during the day shift, he does remember an incident when Resident #79's family member called the facility and reported that if someone does not go into the resident room to provide toileting assistance that he/she was going to call 911. Interview with RN #4 on 8/16/21 at 4:00 PM identified she does not remember NA #1 informing her that Resident #79 complained that the night shift did not provide care during the shift and that the resident was left in a urine-soaked bed. Interview with Social Worker #1 on 8/17/21 at 9:53 AM identified she was not aware of the resident's complaint regarding the night shift not providing him/her with care during the night. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was not aware of the alleged complaint by Resident #79 that the 11:00 PM - 7:00 AM shift did not provide care for 2 hours and that the resident was left in a urine-soaked bed. Review of the abuse and neglect policy identified residents have the right to be free from abuse, corporal punishment, involuntary seclusion, and psychosocial harm. Resident will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Neglect - any failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. Reporting mechanism: Facility in-house reporting - whenever there is a witnessed or alleged report of a resident abuse action, as defined above, the following is initiated. The Administrator or on-call designee and Director of Nursing Services are to be notified immediately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An investigation of the witnessed or alleged abusive action will be initiated within 2 hours of its discovery. A reportable event form will be started by the RN Supervisor or designee. A complete investigation will begin. This may include but not limited to statements from witnesses and staff, consultation with family, physician, DPH and Ombudsman. The facility failed to investigate the allegations of neglect when 9 residents (Resident #5, 23, 32, 35, 39, 40, 47, 53, 63) who were found by staff on 8/19/21, at the beginning of the 11:00 PM - 7:00 AM shift, saturated with urine and feces, which was reported to the administrator, and when Resident #79, who was alert, oriented and continent, reported to NA #1 that staff had not answered his/her calls to use the bed pan for 2 hours, during the night shift, and that he/she had urinated in the bed which was saturated with urine.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, and interviews for 1 resident (Resident #23) reviewed for discharge, the facility failed to ensure that the information regarding the resident being on the sex offender registry was communicated with the receiving facility upon discharge. The findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, cognitive deficits and post-traumatic stress disorder. Review of the State of Connecticut Department of Emergency Services & Public Protection Division of State Police Sex Offender Registry dated 7/12/21 identified Resident #23 was listed as a registered sex offender. The significant change MDS dated [DATE] identified Resident #23 had intact cognition and required total assistance with personal hygiene. Review of the September 2021 social service notes failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the September 2021 MAR identified Resident #23 was being monitored for anti-depressant (specific behaviors): Depressed, sad, crying, tearfulness, withdrawn, and mood changes every shift. The behavior monitoring record failed to identify that Resident #23 was being monitored for inappropriate sexual behaviors. A social service note dated 9/20/21 at 11:16 AM identified Resident #23 and Person #8 requested a referral be sent to skilled nursing facilities in 3 other towns so that Resident #23 could be closer to Person #8. Referrals were sent on 9/1/21. Review of the referral documentation dated 9/22/21 sent to one of the skilled nursing facilities failed to reflect that Resident #23 was on the Sex Offender Registry. A physician's order dated 9/27/21 directed to discharge Resident #23 to the facility closer to home on 9/28/21. Reviewed of the Inter-Agency Patient Referral Report (W-10) dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the interdisciplinary discharge summary dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. The social service note dated 9/28/21 at 2:07 PM identified the social worker assisted Resident #23 to notify the Connecticut Sex Offender Registry of his/her change of address in writing. The social worker spoke to the social worker at the receiving skilled nursing facility to update on Resident #23 status. Resident #23 was discharged at 2:00 PM via ambulance with belongings. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service note dated 9/28/21 at 6:00 PM identified the facility received a phone call from the receiving skilled nursing facility indicating they were sending Resident #23 back to the facility because they were not aware that Resident #23 was on the Sex Offender Registry. Resident #23 arrived back at the facility at 6:00 PM in a wheelchair, indicating he/she had no idea why they were sent back. After Resident #23 was returned to his/her room, the Social Worker explained to Resident #23 the reason why he/she had been sent back, and the resident became weepy and upset. A nurse's note dated 9/28/21 at 9:21 PM identified Resident #23 returned to the facility at approximately 6:00 PM. Admission to the new facility was refused related to a past indiscretion. Resident #23 was visibly upset and crying about reason for refusal. Resident #23 became calmed after allowing him/her to talk and showing compassion. Resident #23 was monitored throughout the shift and he/she was able to go to sleep around 9:30 PM. Review of the care plans dated 9/30/21 failed to reflect Resident #23 was a registered sex offender and/or interventions to address such. Interview with the Social Worker on 10/1/21 at 1:27 PM identified she became aware that Resident #23 was on the Sex Offender Registry on 9/2/21 when another facility that she had placed a referral to called and notified her that Resident #23 was on the Sex Offender Registry. The Social Worker indicated she did not share the information with the Administrator or the DNS and indicated she had not discussed the issue with the interdisciplinary team during the morning meeting. The Social Worker indicated she failed to document in the resident clinical record or initiate a care plan regarding Resident #23 being on the Sex Offender Registry. The Social Worker identified she informed the Administrator and the DNS on 9/28/21 when Resident #23 was in route back to the facility. Interview with the Administrator on 10/1/21 at 1:45 PM indicated she was not aware or does not recall Resident #23 being on the Sex Offender Registry. The Administrator indicated it is the Admission Director responsibility to do a background check on the new resident applicants. The Administrator indicated she cannot answer why a care plan was not initiated. The Administrator identified the Social Worker did not inform her that Resident #23 was on the Sex Offender Registry. The Administrator indicated she found out on 9/28/21 when the receiving facility, that Resident #23 had been discharged to, called and stated the resident is in route back to the facility because he/she was listed on the Sex Offender Registry. Interview with the DNS on 10/1/21 at 2:44 PM identified she was not aware that Resident #23 was on the Sex Offender Registry. She indicated she learned of it on 9/28/21 when the receiving facility was sending Resident #23 back to the facility. The DNS indicated the social worker had not informed her that Resident #23 was on the Sex Offender Registry. The DNS indicated she was aware Resident #23 did not have a care plan addressing his/her history. Although requested, a facility discharge policy was not provided. The facility failed to ensure that information regarding the resident being listed on the sex offender registry was communicated to the receiving facility upon discharge.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37002 Based on observation, interview, and record review for 1 residents (Resident #14) reviewed for resident assessment, the facility failed to complete and transmit the annual MDS assessment per the RAI. Resident #14 was readmitted to the facility on [DATE] with diagnoses included osteoarthritis. Review of the clinical record on 9/15/21 identified the annual MDS assessment due 8/14/21 was not completed (18 days overdue). Interview with the MDS coordinator on 9/15/21 at 1:00 PM identified that the annual assessment should have been completed on 8/14/21 but he/she was behind in his/her work and is having a difficult time catching up.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on clinical record reviews and interviews for one of four sampled residents (Resident #349) who was reviewed for urinary continence or urinary catheters, the facility failed to correctly code the admission Minimum Data Set assessment related to an indwelling urinary catheter. The findings include: Resident #349's admission diagnoses included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee, pacemaker implant, and Type II Diabetes Mellitus. Review of the Hospital Discharge Summary and Inter-agency Referral Report dated 12/30/20 failed to reflect documentation that Resident #349 had a urinary catheter on discharge from the hospital. The facility admission nursing assessment dated [DATE] identified Resident #349 had an indwelling urinary catheter on admission. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #349 had an indwelling urinary catheter. Interview and review of the admission nursing assessment, care plan, hospital discharge summary, dehydration assessment, and MDS with the MDS Coordinator on 9/13/21 at 1:42 PM identified the documentation failed to reflect Resident #349 had an indwelling catheter at the time of admission and the coding of an indwelling urinary catheter in Section H Bladder and Bowel of the admission MDS dated [DATE] was made in error.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on clinical record reviews, review of facility policy, and interviews for one of four sampled residents (Resident #349) who was recently admitted , the facility failed to develop a comprehensive person-centered care plan to meet the resident's needs related to toileting and supplemental oxygen use. And for 1 resident (Resident #23) who was listed on the Sex Offender Registry, the facility failed to develop a comprehensive care plan to address the resident's history of such. The findings include: 1. Resident #349's admission diagnoses included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee, pacemaker implant, and Type II Diabetes Mellitus. The admission nursing assessment dated [DATE] identified Resident #349 had an indwelling urinary catheter on admission. a. Review of the Hospital Discharge Summary and Inter-agency Referral Report dated 12/30/20 failed to reflect documentation that Resident #349 had a urinary catheter on discharge from the hospital. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #349 made consistent and reasonable decisions regarding tasks of daily life, required extensive assistance of two (2) staff with turning and repositioning in bed, was totally dependent on two (2) staff for toileting, extensive assistance of one (1) staff for personal hygiene and had an indwelling urinary catheter. Review of the admission Resident Care Plan (RCP) failed to reflect documentation that Resident #349's urinary status, an indwelling catheter problem, or interventions related to the restoration of bladder continence had been developed. Review of the facility undated Bowel and Bladder policy identified, in part, that residents who are incontinent on admission will have a care plan developed and revised as needed. b. The Hospital Discharge Summary dated 12/30/20 identified Resident #349 was unable to be weaned off supplemental oxygen, the respiratory status was stable and Resident #349 was discharged on two (2) Liters per Minute of oxygen via nasal canula to the rehabilitation facility. Review of the facility Nursing Admission assessment dated [DATE] failed to identify Resident #349 required oxygen. The admission Resident Care Plan (RCP) dated 12/31/20 failed to address Resident #349's respiratory status and oxygen requirements. The Vitals Summary dated 12/31/20, 1/1/21, 1/2/21, and 1/4/21 identified Resident #349 was receiving supplemental oxygen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Resident #349's care plan from 12/30/20 through 1/15/21 with the MDS Coordinator, Registered Nurse (RN) #6, on 9/13/21 at 1:42 PM identified a comprehensive care plan was not developed related to bladder status. RN #6 indicated that although Resident #349 was using oxygen intermittently from the date of admission, a care plan for oxygen use was not developed until 1/5/21 when a physician's order to titrate the oxygen was obtained. RN #6 indicated that since Resident #349 was identified as incontinent and had been using supplemental oxygen on admission, a care plan should have been developed directing the resident's care for both incontinence and oxygen use. 37293 2. Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, cognitive deficits and post-traumatic stress disorder. Review of the State of Connecticut Department of Emergency Services & Public Protection Division of State Police Sex Offender Registry dated 7/12/21 identified Resident #23 was listed as a registered sex offender. The significant change MDS dated [DATE] identified Resident #23 had intact cognition and required total assistance with personal hygiene. Review of the September 2021 social service notes failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the September 2021 MAR identified Resident #23 was being monitored for anti-depressant (specific behaviors): Depressed, sad, crying, tearfulness, withdrawn, and mood changes every shift. The behavior monitoring record failed to identify that Resident #23 was being monitored for inappropriate sexual behaviors. A social service note dated 9/20/21 at 11:16 AM identified Resident #23 and Person #8 requested a referral be sent to skilled nursing facilities in 3 other towns so that Resident #23 could be closer to Person #8. Referrals were sent on 9/1/21. Review of the referral documentation dated 9/22/21 sent to one of the skilled nursing facilities failed to reflect that Resident #23 was on the Sex Offender Registry. A physician's order dated 9/27/21 directed to discharge Resident #23 to the facility closer to home on 9/28/21. Reviewed of the Inter-Agency Patient Referral Report (W-10) dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the interdisciplinary discharge summary dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. The social service note dated 9/28/21 at 2:07 PM identified the social worker assisted Resident #23 to notify the Connecticut Sex Offender Registry of his/her change of address in writing. The social worker spoke to the social worker at the receiving skilled nursing facility to update on Resident #23 status. Resident #23 was discharged at 2:00 PM via ambulance with belongings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service note dated 9/28/21 at 6:00 PM identified the facility received a phone call from the receiving skilled nursing facility indicating they were sending Resident #23 back to the facility because they were not aware that Resident #23 was on the Sex Offender Registry. Resident #23 arrived back at the facility at 6:00 PM in a wheelchair, indicating he/she had no idea why they were sent back. After Resident #23 was returned to his/her room, the Social Worker explained to Resident #23 the reason why he/she had been sent back, and the resident became weepy and upset. A nurse's note dated 9/28/21 at 9:21 PM identified Resident #23 returned to the facility at approximately 6:00 PM. Admission to the new facility was refused related to a past indiscretion. Resident #23 was visibly upset and crying about reason for refusal. Resident #23 became calmed after allowing him/her to talk and showing compassion. Resident #23 was monitored throughout the shift and he/she was able to go to sleep around 9:30 PM. Review of the care plans dated 9/30/21 failed to reflect Resident #23 was a registered sex offender and/or interventions to address such. Interview with the Social Worker on 10/1/21 at 1:27 PM identified she became aware that Resident #23 was on the Sex Offender Registry on 9/2/21 when another facility that she had placed a referral to called and notified her that Resident #23 was on the Sex Offender Registry. The Social Worker indicated she did not share the information with the Administrator or the DNS and indicated she had not discussed the issue with the interdisciplinary team during the morning meeting. The Social Worker indicated she failed to document in the resident clinical record or initiate a care plan regarding Resident #23 being on the Sex Offender Registry. The Social Worker identified she informed the Administrator and the DNS on 9/28/21 when Resident #23 was in route back to the facility. Interview with the Administrator on 10/1/21 at 1:45 PM indicated she was not aware or does not recall Resident #23 being on the Sex Offender Registry. The Administrator indicated it is the Admission Director responsibility to do a background check on the new resident applicants. The Administrator indicated she cannot answer why a care plan was not initiated. The Administrator identified the Social Worker did not inform her that Resident #23 was on the Sex Offender Registry. The Administrator indicated she found out on 9/28/21 when the receiving facility, that Resident #23 had been discharged to, called and stated the resident is in route back to the facility because he/she was listed on the Sex Offender Registry. Interview with the DNS on 10/1/21 at 2:44 PM identified she was not aware that Resident #23 was on the Sex Offender Registry. She indicated she learned of it on 9/28/21 when the receiving facility was sending Resident #23 back to the facility. The DNS indicated the social worker had not informed her that Resident #23 was on the Sex Offender Registry. The DNS indicated she was aware Resident #23 did not have a care plan addressing his/her history. Review of the care planning - interdisciplinary team policy identified an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The facility failed to ensure a care plan was developed after the facility was informed that resident was on the Sex Offender Registry.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, and interviews for 1 resident (Resident #23) who was listed on the Sex Offender Registry, the facility failed to ensure that information regarding the residents listing on the registry was documented on the discharge information sent with the resident to the receiving facility upon his/her discharge. The findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, cognitive deficits and post-traumatic stress disorder. Review of the State of Connecticut Department of Emergency Services & Public Protection Division of State Police Sex Offender Registry dated 7/12/21 identified Resident #23 was listed as a registered sex offender. The significant change MDS dated [DATE] identified Resident #23 had intact cognition and required total assistance with personal hygiene. Review of the September 2021 social service notes failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the September 2021 MAR identified Resident #23 was being monitored for anti-depressant (specific behaviors): Depressed, sad, crying, tearfulness, withdrawn, and mood changes every shift. The behavior monitoring record failed to identify that Resident #23 was being monitored for inappropriate sexual behaviors. A social service note dated 9/20/21 at 11:16 AM identified Resident #23 and Person #8 requested a referral be sent to skilled nursing facilities in 3 other towns so that Resident #23 could be closer to Person #8. Referrals were sent on 9/1/21. Review of the referral documentation dated 9/22/21 sent to one of the skilled nursing facilities failed to reflect that Resident #23 was on the Sex Offender Registry. A physician's order dated 9/27/21 directed to discharge Resident #23 to the facility closer to home on 9/28/21. Reviewed of the Inter-Agency Patient Referral Report (W-10) dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the interdisciplinary discharge summary dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. The social service note dated 9/28/21 at 2:07 PM identified the social worker assisted Resident #23 to notify the Connecticut Sex Offender Registry of his/her change of address in writing. The social worker spoke to the social worker at the receiving skilled nursing facility to update on Resident #23 status. Resident #23 was discharged at 2:00 PM via ambulance with belongings. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service note dated 9/28/21 at 6:00 PM identified the facility received a phone call from the receiving skilled nursing facility indicating they were sending Resident #23 back to the facility because they were not aware that Resident #23 was on the Sex Offender Registry. Resident #23 arrived back at the facility at 6:00 PM in a wheelchair, indicating he/she had no idea why they were sent back. After Resident #23 was returned to his/her room, the Social Worker explained to Resident #23 the reason why he/she had been sent back, and the resident became weepy and upset. A nurse's note dated 9/28/21 at 9:21 PM identified Resident #23 returned to the facility at approximately 6:00 PM. Admission to the new facility was refused related to a past indiscretion. Resident #23 was visibly upset and crying about reason for refusal. Resident #23 became calmed after allowing him/her to talk and showing compassion. Resident #23 was monitored throughout the shift and he/she was able to go to sleep around 9:30 PM. Review of the care plans dated 9/30/21 failed to reflect Resident #23 was a registered sex offender and/or interventions to address such. Interview with the Social Worker on 10/1/21 at 1:27 PM identified she became aware that Resident #23 was on the Sex Offender Registry on 9/2/21 when another facility that she had placed a referral to called and notified her that Resident #23 was on the Sex Offender Registry. The Social Worker indicated she did not share the information with the Administrator or the DNS and indicated she had not discussed the issue with the interdisciplinary team during the morning meeting. The Social Worker indicated she failed to document in the resident clinical record or initiate a care plan regarding Resident #23 being on the Sex Offender Registry. The Social Worker identified she informed the Administrator and the DNS on 9/28/21 when Resident #23 was in route back to the facility. Interview with the Administrator on 10/1/21 at 1:45 PM indicated she was not aware or does not recall Resident #23 being on the Sex Offender Registry. The Administrator indicated it is the Admission Director responsibility to do a background check on the new resident applicants. The Administrator indicated she cannot answer why a care plan was not initiated. The Administrator identified the Social Worker did not inform her that Resident #23 was on the Sex Offender Registry. The Administrator indicated she found out on 9/28/21 when the receiving facility that Resident #23 had been discharged to, called and stated the resident is in route back to the facility because he/she was listed on the Sex Offender Registry. Interview with the DNS on 10/1/21 at 2:44 PM identified she was not aware that Resident #23 was on the Sex Offender Registry. She indicated she learned of it on 9/28/21 when the receiving facility was sending Resident #23 back to the facility. The DNS indicated the social worker had not informed her that Resident #23 was on the Sex Offender Registry. The DNS indicated she was aware Resident #23 did not have a care plan addressing his/her history. Although requested, a facility discharge policy was not provided. The facility failed to ensure that information regarding the resident being listed on the Sex Offender Registry was communicated to the receiving facility upon discharge.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41683 Based on clinical record reviews, review of facility documentations, and interviews for one of two sampled residents (Resident # 348) who was reviewed for quality of life, the facility failed to provide interpretive services to a non- English- speaking Resident in accordance with the facility's policy. The finding includes: Resident # 348's diagnoses included Motor Neuron disease and spastic hemiplegia. Review of Resident # 348's clinical records identified Resident #348 was his/her Responsible party. A review of the Admission/Readmission Evaluation dated 10/24/19 identified resident #348's language as Pashto (Eastern Iranian language) and identified that the resident provided very little information due to language. The admission Minimum Data Set assessment (MDS) dated [DATE] identified Resident #348 was cognitively intact and was of the Asian race/ethnicity. The MDS failed to trigger communication as a care area. Review of the facility's documentation of the Resident's Care Conference for Resident #348 dated 2/5/20 failed to identify documentation that Resident #348, a resident's family member, or the resident's emergency contact participated in the Conference. Further review of the facility's documentation failed to identify the resident and or a family member was invited to participate in the resident's care conference. In an interview with Person #1 on 9/8/21 at 10:00 AM, Person #1 stated he/she was working with Resident #348 in the facility and identified that the resident did not speak or understand spoken English. Person #1 stated that Resident #348 had a new diagnosis and indicated he was not sure how this diagnosis was communicated to the Resident. Person #1 indicated he/she was informed by the social worker that the facility did not have a language line available for the resident. In an interview with Social Worker #1 on 9/8/21 at 10:24 AM, the Social Worker identified it was the practice of the facility to use a staff or family member to interpret for Residents who were non- English speaking. The social worker further stated that family members of non -English speaking Residents would be asked to provide a communication board with common phrases from the resident's spoken language. The Social worker indicated that if the facility did not have an employee available to interpret for the resident and the resident did not have a family member available, she would use Google translate or similar applications. The social worker stated she had no knowledge whether the facility had access to a language line. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LPN #1 (Charge Nurse) on 9/8/21 at 11:15 AM, LPN #1 indicated that when communicating with a Non - English speaking resident he would interpret the resident's body language, facial expression or use a family member to interpret when available. LPN #1 indicated that if a resident did not have a family member to assist in interpreting for the resident, he would download and use a translation application. LPN #1 stated he could not recall participating in any educational offerings on the use of any specific cites or equipment used in language interpreting for a non- English-speaking resident. In an interview with Nurse Practitioner #1 on 9/8/21 at 11:23 AM, she identified that she was unsure how she would proceed if a case arose where she had to communicate pertinent information such as a change in medication to a non- English Speaking Resident when there were no family members or staff available to translate. In an interview with the Administrator on 9/8/21 at 11:30 AM, the Administrator identified the facility did not currently have an active interpreter line in place. Review of the Communication with Persons with limited English Proficiency policy directed that if local or staff resources are not available for a particular language, the Administrator shall provide foreign language interpreter through the Language Line.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31357 35682 Based on observations, review of the clinical record, facility policy, and interviews for 4 residents (Resident #28, 29, 40 and 349) who were reviewed for ADL's, the facility failed to provide shaving, nail care, facial and timely care. The findings include: 1. Resident # 28's diagnoses included bilateral wrist contractures, hypertension and diabetes mellitus. The quarterly MDS dated [DATE] identified Resident #28 had intact cognition and required total 1 person assistance with bathing and grooming. The care plan dated 8/11/21 identified Resident #28 had a self-care performance and mobility deficit related to contractures of both wrists and impaired mobility. Interventions included to provide assistance with care and mobility and encourage the resident to participate as able. The September 2021 monthly physician's orders directed to provide extensive assistance of one for all ADL tasks. Review of the resident's Visual/Bedside Kardex Report directed to provide assistance with ADL's and mobility and encourage the resident to participate in ADLs as able. Intermittent observations on 9/8, 9/9, 9/10 and 9/13/21 identified Resident #28 was unshaven with heavy facial hair on the beard and mustache area. Interview and observation with LPN #1 and RN #3 (RN #3 who was working as the resident's nurse aide) on 9/13/21 at 8:30AM identified Resident #28 was lying in bed. LPN #1 asked the resident if he/she wanted a shave. Resident #28 identified that yes, he/she would like to be shaved. LPN #1, who was the resident's regular 7:00 AM - 3:00 PM nurse identified that the nurse aide should always offer to shave the resident even if the resident does not ask. After surveyor inquiry, Resident #28 was clean shaven by RN #3. Review of the policy on ADL Care identified that residents will be provided activity of daily living support and assistance as needed. Personal hygiene includes bathing/showering, grooming, nail care and oral care and ADL's will be given daily. 2. Resident #29 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, polyneuropathy, diabetes, and hypertension. The care plan dated 3/24/21 identified Resident #29 had an ADL performance and mobility deficit related to limited mobility. Interventions included to encourage the resident to participate in ADL's. A physician's order dated 5/21/21 directed ADL for Resident #29 requires assistance of 1 staff with supervision. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual MDS dated [DATE] identified Resident #29 had intact cognition, required supervision for activities of daily living and assist of 1 for transfers, personal hygiene, and toileting. Interview with Resident #29 on 9/8/21 at 10:00 AM indicated he/she has been asking the staff almost daily to be shaved for over 2 weeks. The staff keep telling the resident they are too busy and do not have time to shave the resident because they are short staffed. Resident #29 indicated he/she would ask again today. Observations on 9/8/21 at 10:00 AM and 2:00 PM, and on 9/9/21 at 10:00 AM and 1:50 PM identified Resident #29 had unshaven facial hair across most of the chin area approximately 1/2 inch long. Interview with NA #12 on 9/9/21 at 1:55 PM indicated Resident #29 did ask to be shaved this morning but it would take time to shave him/her, so NA #12 indicated she told Resident #29 if she did not get to shave him/her today she would do it tomorrow on 9/10/21. NA #12 indicated she was busy trying to get residents out of bed before lunch and then lunch trays came and she never had time today to shave Resident #29 and was now heading home. NA #12 indicated she came in at 9:30 AM and was leaving at 2:00 PM today. Interview with LPN #1 on 9/9/21 at 2:50 PM indicated he was aware Resident #29 had some facial hair and had asked to be shaved but could not recall when. LPN #1 did not recall if it was in the past week or two. LPN #1 indicated the nursing aids are responsible to shave the residents with morning care. LPN #1 indicated NA #12 was assigned to Resident #29 did not come in to work until 9:30 AM and was leaving early at 2:00 PM and that was why Resident #29 did not get shaved today but noted he had spoken with NA #12 who indicated she would do it tomorrow. Interview and observation with the DNS on 9/13/21 at 10:20 AM indicated shaving Resident #29's facial hair should be done daily with morning care if needed or at least weekly on shower day by the nurse aids. The DNS indicated when Resident #29 first asked to be shaved it should have been done. The DNS indicated if the resident refused to be shaved that the nurse aide would tell the charge nurse. Interview with Resident #29 on 9/13/21 at 11:00 AM indicated he/she was finally shaved on Saturday (9/11/21). Review of the Shaving a Patient policy identified the purpose was to promote cleanliness and to provide skin care. 3. Resident #40 was admitted to the facility on [DATE] with diagnoses that included vascular dementia and mild cognitive impairment. The quarterly MDS dated [DATE] identified Resident #40 had severely impaired cognition and required extensive assistance with personal hygiene. The care plan dated 7/13/21 identified Resident #40 has a self-care performance deficit related to limited mobility. Interventions included to report to the nurse any decline in ADL self-performance or mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 8/4/21 identified Resident #40 is resistive to care at times related to dementia. Interventions included to give clear explanation of all care activities prior to and as they occur during each contact. Review of nurse's notes dated 8/1/21 through 9/13/21 failed to reflect documentation that Resident #40 was resistive or refused shaving or fingernail grooming. Intermittent observations during the 7:00 AM - 3:00 PM shift on 9/9, 9/10 and 9/13/21 identified Resident #40 was noted with brown debris under his/her untrimmed fingernails and was unshaven. Review of the nurse aide care card did not address how staff should provide assistance regarding Resident #40 activity of daily living (ADL's). Interview with the Administrator on 9/14/21 at 12:19 PM identified that it is the responsibility of the nurse aide to trim and clean nails, and shave during morning care and as needed. Additionally, if a resident refuses care, the nurse aide is responsible to notify the nurse. Interview with NA #13 on 9/13/21 at 9:00 AM identified she was assigned to Resident #40 today and she will trim and clean nails and shave the resident. Interview with the DNS on 9/15/21 at 11:32 AM identified she was not aware of the issue and indicated it is the responsibility of the nurse aides to provide nail care and shave residents during morning care, on shower days and as needed. Review of the ADL care policy directed residents will be provided activity of daily living support and assistance as needed. Personal hygiene - bathing/showering, grooming, nail care, and oral care. ADL's will be given daily. If a resident refuses ADL care, the charge nurse should be notified. Review of the nails care policy identified to clean the nail bed, to keep nails trimmed, to prevent infection, to prevent scratching. Residents with no medical contraindications of the facility shall receive nail care, including care of nails, on a regularly scheduled basis. 4. Resident #349's diagnoses included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee and Type II Diabetes Mellitus. A physician's order dated 12/31/20 directed to get out of bed into a wheelchair as tolerated, slide board transfer with assistance and precautions. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #349 made consistent and reasonable decisions regarding tasks of daily life, required extensive assistance of two (2) staff with turning and repositioning in bed, was totally dependent on two (2) staff for toileting, extensive assistance of one (1) staff for personal hygiene and utilized a wheelchair for mobility. The Resident care plan (RCP) dated 12/31/20 identified a self-performance and mobility deficit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions directed to discuss with resident and/or the responsible party any concern related to loss of independence or decline in function, encourage participation to promote independence, and physical and occupational therapy evaluations and treat as indicated. Upon further review, the care plan failed to reflect documentation that Resident #349 had refused care, was non-compliant, or required bedrest. A physician's order dated 1/5/20 directed to provide the extensive assistance of one staff with upper/lower body dressing, toilet transfers and limited assistance with personal hygiene. Review of the nurse aide flow sheets from 1/1/21 through 1/11/21 identified failed to reflect documentation that the daily task record had been completed to include the number of staff required to assist the resident. The nurse's note dated 1/2/21 at 9:14 PM identified Resident #349 was maintained on bedrest. The nurse's note dated 1/3/21 at 9:53 PM identified bedrest per resident's choice. The nurse's note dated 1/5/21 at 1:41 PM identified that Resident #349 remained on bedrest per choice. The nurse's notes on 1/4/21, 1/6/21 and 1/11/21 identified Resident #349 was only out of bed with physical therapy. Interview with the Recreation Director on 9/13/21 at 10:20 AM identified that she did not see Resident #349 out of bed during her limited interactions with the resident, except when Resident #349's picture was taken for the clinical record on 1/14/21. Interview with the Director of Nursing (DON) on 9/13/21 at 10:34 AM identified the nurse aide flow sheets dated 12/30/20 through 12/31/21 could not be located and there was no documentation of Resident #349's care from 1/1/21 through 1/11/21 except for the nurse's notes. Interview with Person #7 on 9/16/21 at 1:08 PM identified that he/she had been at the facility to visit on fifteen (15) or seventeen (17) days, and that for approximately fourteen (14) of those days Resident #349 was in bed and for approximately seven (7) of those days Resident #349 was dressed in a hospital gown. Person #7 indicated he/she had visited at various times of the day, on the weekends from early morning to just before lunch and on weekdays between 3:30 PM and 7:00 PM. Person #7 stated that he/she had been there once during a physical therapy session, had seen Resident #349 doing wheelchair push-ups and that following the session Resident #349 was placed back to bed. In a Resident Care Conference, held on 1/8/21, Person #7 identified that Resident #349 had complained of not moving for hours and he/she inquired as to why the resident was not left in the chair after therapy, but that the facility did not give him/her an explanation. 37293 42117

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14528 Based on review of the clinical record, facility documentation, facility policy, and interviews for 7 residents (Residents #29, 37, 77, 79, 81, 88 and 349) the facility failed to ensure care and services according to physician's order, facility policy and professional standards of practice related to treatments for edema, wounds and neurologic vital signs. The findings include. 1. Resident #29 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, polyneuropathy, diabetes, and hypertension. The care plan dated 3/24/21 identified Resident #29 had an activities of daily living performance and mobility deficit related to limited mobility. Interventions included encourage the resident to participate in activities of daily living. Additionally, the care plan identified an altered cardiovascular status related to hypertension and hyperlipidemia. Interventions included to observe for and report any signs or symptoms of dependent edema. Further, the care plan identified Resident #29 had the potential for fluid overload with interventions to administer medications as ordered. The annual MDS dated [DATE] identified Resident #29 had intact cognition, was always continent of bowel and bladder and required supervision for activities of daily living and assist of 1 for transfers, personal hygiene, and toileting. A physician's order dated 7/27/21 directed to apply tubi grips to bilateral lower extremities in the morning and remove at bedtime every 12 hours for edema. The nurse's progress notes dated 8/1/21 - 9/13/21 failed to reflect any refusals to wear tubi grips or that the APRN/ MD were notified of refusals to wear tubi grips. An interview with Resident #29 on 9/8/21 at 10 :00 AM indicated the charge nurse had not put on his/her tubi grip stocking for over a month. Resident #29 noted he/she would wear them if the nurse had asked but hasn't ask. Observations on 9/8/21 at 10:00 AM and 2:00 PM identified Resident #29 was sitting in the wheelchair dressed in residents' room and only had on nonskid socks and did not benefit from tubi grips to bilateral lower extremities with bilateral lower extremity edema present. Observations on 9/9/21 at 10:00 AM and 1:50 PM identified Resident #29 was dressed in the wheelchair and only had on grippy socks without the benefit of the tubi grip stocking for the edema to bilateral lower extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #1 on 9/9/21 at 2:25 PM identified he was responsible to apply the tubi grips to Resident #29's bilateral lower extremities per the physician order, because of the dependent edema that was present. LPN #1 indicated he had been documenting Resident #29 was refusing the tubi grips per the physician order, but because Resident #29 had a long time ago refused them, LPN #1 assumed Resident #29 would refuse them and had not asked. LPN #1 indicated he had not asked Resident #29 in a while except maybe once or twice even though he was documenting in the medical record that she was refusing daily. Review of medical record LPN #1 indicated the month of August and September 2021 he had put Resident #29 had refused the tubi grips but probably only ask a couple of times. LPN #1 indicated he had not asked Resident #29 this week or last week if she/he would wear them. LPN #1 did a thorough room search in the nightstand, drawers, closet, and bathroom and was not able to locate a pair of tubi grips to apply to Resident #29's swollen legs in the residents room. LPN #1 approached Resident #29 and offered the tubi grips to bilateral lower extremities if he got a pair and Resident #29 was agreeable to put them on. LPN #1 indicated if Resident #29 had refused the tubi grips he would be responsible to notify the APRN or physician of the refusals by the second day and document it in the progress notes. Observation on 9/13/21 at 11:00 AM identified Resident #29 was wearing white ted stockings (Anti Embolism Stockings) to bilateral lower extremities. Resident #29 indicated he/she liked having them on because it makes his/her legs feel better and helps with the swelling. Interview and observation with LPN #1 on 9/13/21 at 10:25 AM indicated he had put the white ted stockings (Anti Embolism Stockings) on Resident #29 on 9/10/21 and 9/13/21 (without a physician order) LPN #1 indicated Resident #29 was agreeable to put them on to bilateral lower extremities. LPN #1 indicated he did not know what tubi grips were, so he decided to use ted stockings (Anti Embolism Stockings) instead because that was all central supply had the large size Anti Embolism Stockings, so LPN #1 noted he tried them on Resident #29. LPN #1 indicated he did not measure the resident's legs prior to applying the Anti Embolism Stockings on 9/10/21 and 9/13/21 without a physician order. LPN #1 indicated he had a physician order for tubi grips, and he thought the ted stockings (Anti Embolism Stockings) were the same thing. LPN #1 questioned if he needed a new order for the ted stockings (Anti Embolism Stockings). Interview and observation with the DNS on 9/13/21 at 2:15 PM indicated Resident #29 had on ted stockings (Anti Embolism Stockings) to bilateral lower extremities and the facility does not have a physician order for the ted stockings (Anti Embolism Stockings), they have a physician order only for the tubi grips and they are not the same. The DNS indicated prior to putting on the Anti Embolism Stockings someone had to measure Resident #29's calves to get the right size and document that in a progress note prior to putting them on. The DNS was not aware LPN #1 had placed Resident #29 in the Anti Embolism Stockings on 9/10/21 and 9/13/21 until the surveyor brought this to the DNS attention. Interview and clinical record review with LPN #1 and the DNS on 9/13/21 at 2:15 PM the DNS indicated if a resident refuses a medication or a treatment the APRN or physician have to be notified and a progress note written to explain why the resident refuses and the physician was notified. LPN #1 indicated he had been documenting that Resident #29 was refusing the tubi grips but did not ask Resident #29 daily. LPN #1 indicated he had assumed Resident #29 would refuse them, so he didn't ask. The DNS indicated LPN #1 must follow the physician order and was expected to ask Resident #29 every day prior to documenting that Resident #29 had refused without even asking. The DNS indicated her expectation was that LPN #1 would ask every day and document accurately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record dated August 1-31, 2021 identified that LPN #1 indicated Resident #29 had refused the tubi grips on the 20 days he worked. The Medication Administration Record dated September 1-13, 2021 identified that LPN #1 indicated Resident #29 had refused the tubi grips on 7 days that the tubi grips were not offered. The Medication Record nor the Treatment Record dated September 2021 reflected the new order 9/13/21 for ted stockings. Review of facility Charge Nurse Job Description identified the major duties and responsibilities included follow the physician's orders, review resident records daily to assure accuracy and completeness, document comprehensive and complete nursing notes, document and report any unusual or significant findings and contact the physician, and follow facility policies and procedures. Review of facility policy Documentation in Resident Records identified the medical record shall be legible, factual, signed and dated. Review of facility Policy Change of Condition in a Resident Status identified The RN supervisor will assess the residents change in condition and document their findings in the medical record. The charge nurse will record in the residents' medical record information relative to change in the residents' medical condition or status. Review of facility brochure for Anti Embolism Stockings identified are specifically designed to provide a controlled level of compression to your legs. This graduated compression helps your vascular system return blood from the veins in your lower legs to your upper body. These compression stockings effects help reduce the chance that a blood clot (DVT) may form. Compression also helps decrease swelling and discomfort in your lower legs. A proper fit is essential to proper function. Although requested, a policy for the use of tubi grips was not provided. 2. Resident #37 was admitted to the facility on [DATE] with diagnoses that included epilepsy with seizures, acute and chronic respiratory failure, heart failure, hypertension, orthostatic hypotension. The annual MDS dated [DATE] identified Resident #37 had intact cognition, was always continent of bowel and bladder and required supervision with toileting. Additionally, Resident #37 required extensive assistance for dressing and limited assistance for personal hygiene. a. A reportable event form dated 4/3/21 at 6:00 AM identified Resident #37 had unwitnessed fall and in the shower. Abrasion noted to back of head, right knee in front, and left knee. Subsequent to physician notification, neurological checks were ordered. b. A reportable event form dated 4/4/21 at 5:50 AM indicated Resident #37 was found lying on the floor in his/her room. c. A Reportable event form dated 7/10/21 at 6:00 AM indicated Resident #37 reported he/she had fallen and hit right his/her great toe on the base of the table. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on 9/14/21 at 1:00 PM noted she was not able to locate the Neurological Evaluation Flow Sheet after the falls on 4/3, 4/4, and 7/10/21. Interview and review of the clinical record with the DNS on 9/14/21 at 2:30 PM failed to reflect that neurological vital signs had been completed after the falls on 4/3, 4/4, and 7/10/21 per the facility protocol. The DNS indicated her expectation was the nursing staff would have completed the fall packet checklist including doing the neurologic vital signs. Review of the Falls Management policy identified in the event of a fall, the following measures will be instituted: if the resident fall was unwitnessed or if head injury is suspected, neurological signs will be monitored. Document in the medical record. Review of the Neurological Assessments policy identified the goal is to evaluate the residents for complications of neurologic dysfunction. The procedure is to perform neurological checks as follows unless otherwise ordered by the physician: every 15 minutes for 1 hour, every 30 minutes for 2 hours, every 2 hours for 8 hours, every 4 hours for 16 hours, and every 8 hours for 48 hours. Additionally, evaluate the resident's level of consciousness and document appropriate code per key on the Neurological Evaluation Flow Sheet. Furthermore, evaluate the resident's pupils, motor function, hand grasps, and extremity strength, blood pressure, temperature, pulse, respirations and document on the Neurological Evaluation Flow Sheet. The physician will be notified of adverse clinical findings. 3. Resident #77 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, multiple pressure areas, contractures of the right and left knee, contractures of the right and left ankle, cognitive deficit, and communication deficit. A physician's order dated 8/8/21 directed to get daily weights and if weight gain 2-3 pounds or more in a day, or worsening of swelling in ankles, legs, or abdomen, call the physician. The admission MDS dated [DATE] identified Resident #77 had severely impaired cognition, was frequently incontinent of bowel and bladder and required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. An interview with LPN #1 on 9/13/21 at 9:40 AM indicated Resident #77's daily weights are scheduled at 6:00 AM and he was not told that Resident #77 had refused or asked to try to get the weight on day shift. LPN #1 indicated if Resident #77 had refused a weight there should be a progress note explaining why the resident refused the weight and the second refusal the APRN would be notified. An interview and medical record review with the DNS on 9/13/21 at 9:45 AM indicted the nursing staff are responsible to get the daily weights per the physician order. The DNS indicated the daily weights were scheduled at 6:00 AM daily, but review of medical record indicated there were only 2 weights done (on 8/8/21 and 8/20/21) from 8/8/21- 9/13/21. The DNS indicated there was not a progress note indicating there was any refusals from Resident #77 since admission and there weren't any progress notes indicating the responsible party, APRN or physician were notified of the weights not being done or refused. The DNS indicated she would expect the responsible party, APRN would be notified if the weights were not done on the second day. The DNS indicated she expects the nurses to follow the physician orders and if there was a reason why they don't let the APRN or physician now. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with APRN #2 on 9/14/21 at 12:25 PM indicated Resident #77 was on daily weights since admission from the hospital because Resident #77 had an echo performed that was questionable for diastolic heart failure and ejection fraction of 55%. APRN #2 indicated she only saw 2 weights done since admission and was not notified that the weights were not being done or the resident was refusing the weight. APRN #2 indicated she should have been notified if Resident #77 was refusing weights or why they were not done. APRN #2 indicated she will decrease the weights to 3 times a week to try to get a baseline and better compliance by staff. The TAR dated 8/9/21 - 8/31/21 for daily weights reflected incomplete documentation as 15 days were without documentation. There were 5 days with check marks indicating the weight was done but was not available in the clinical record. There were 2 weights documented during this time frame on 8/8/21 and 8/20/21. The TAR dated 9/1/21-9/14/21 for daily weights reflected 12 days were blanks out of 14 days, and 2 days were noted as 'refused drug'. Review of the Weight Measurement Policy indicated the goal was to ensure residents maintain acceptable parameters of nutritional status. Weights will be obtained on all residents on admission. 4. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. Review of the May 2021 physician's orders directed to transfer the resident via a mechanical lift with the assistance of 3 staff. Review of the weight's summary dated 5/18/21 identified Resident #79 weighed 402.1 lbs. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, and transfer activity occurred only once or twice during the reference period. Additionally, the MDS identified transfers occurred with 2 person plus physical assistance. The care plan dated 6/2/21 identified Resident #79 had a self-performance and mobility deficit related to deconditioning and weakness. Interventions included to encourage the resident to participate in ADLs to promote independence. The care plan failed to reflect the physician's order for transfers via mechanical lift with the assistance of 3 staff. Review of the nurse aide care card failed to reflect the that the resident required the assistance of 3 staff during mechanical lift transfers. Interview with Resident #79 on 8/16/21 at 1:05 PM identified that sometime in May 2021, during a mechanical lift transfer from the bed to the wheelchair, with NA #1 and NA #23, the lift tilted to the side with the resident in it, and the nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she was upset that the incident happened and was scared and thought that he/she was going to fall on the floor. Resident #79 indicated that during the incident they were all screaming as the nurse aides were trying to get him/her into the wheelchair. Resident #79 indicated that both nurse aides are small and short, and during the incident, part of the lift hit the resident in the head and the resident landed in the wheelchair in a slouching position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with RN #1 on 8/16/21 at 4:00 PM identified she was aware of the incident on 5/28/21 with Resident #1. RN #4 indicated Resident #79 did not fall on the floor and was not injured and that is why she did not complete a reportable event form. RN #4 indicated she assisted in helping to properly position Resident #79 in the wheelchair after the incident. RN #4 indicated she assessed Resident #79 but did not document the assessment or notify the physician or conservator. RN #4 indicated she was not aware of the physician's order to have 3 staff transfer Resident #79 with the mechanical lift and was not aware that the nurse aide care card did not include that information. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was on vacation during when the incident happened and indicated she would have expected RN #4 or LPN #1 to assess Resident #79, document the incident in the clinical record and complete a reportable event form. Although on 5/28/21, Resident #79 was involved in an incident in which the mechanical lift tilted during a transfer, causing the lift to hit the resident in the head, the licensed staff failed to complete a comprehensive assessment of the resident's condition, including ongoing neurological vital signs, and document such, according to professional standards. 5. Resident #81's diagnoses included intracapsular fracture of right femur, spondylosis and dementia. The quarterly MDS dated [DATE] identified Resident #81 had severely impaired cognition and required extensive assistance with bathing, dressing, grooming and toilet use. Resident #81 required limited assistance with bed mobility and transfers, and supervision of 1 person with ambulation in room and corridor. Resident #81 was not steady, but able to stabilize without human assistance related to balance during transitions and walking and used a walker for mobility. The care plan dated 7/14/21 (revised on 8/13/21 after a fall with fracture) identified the resident was at risk for falls related to gait/balance problems, hearing problems and confusion. Interventions included to anticipate and meet resident needs, ensure call light was within reach, encouraging use and to respond promptly to all requests for assistance. Physician's order dated 8/17/21 directed toe touch weight bearing right lower extremity. A reportable event form dated 8/21/21 at 5:45 AM identified Resident #81 had an unwitnessed fall in the room. The report indicated neurological checks to be done per protocol. Actions taken indicated to monitor for change in condition and re-educate on use of call bell. Review of nurse's note dated 8/21/21 identified the resident was assessed by a registered nurse after the fall at 5:45 AM. Review of the Fall Checklist, which indicates the To Do List after a fall occurs and was attached to the Reportable Event Form dated 8/21/21, was blank. The checklist identified if this fall was unwitnessed or if there is a head injury, neurological checks are to be initiated every 15 minutes times 4, every 30 minutes times 4, every 1 hour times 4 and then every shift times 8 shifts. The clinical record failed to reflect neurological vital signs were initiated and completed per the facility policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 9/13/21 at 3:35PM identified that although the actual reportable event form had been completed, the Fall Checklist was not done. The DNS identified that the purpose of the checklist was to trigger the nurse to complete all the components of the fall investigation, including neurological checks, updating the resident care plan and care card, staff huddle, etc. The DNS indicated neurological assessments should have been initiated but was unable to explain why they were not done. Review of the Falls Management policy identified if the resident fall was unwitnessed or if a head injury is suspected, neurological signs will be monitored. 6a. R #88's diagnoses included Cerebral Vascular Accident (CVA) and heart disease. The annual minimum data assessment dated [DATE] identified that R #88 had mildly impaired cognition and hearing was adequate. Physician orders dated 8/2/21 at 9:00 PM directed Debrox Solution 6.5 % instill 5 drops in left ear twice a day for 4 days. APRN #1's progress noted dated 8/2/21 indicated that R #88 had left ear pain, with impacted cerumen noted in the left ear and the tympanic membrane could not be visualized. A follow- up progress note by APRN #1 dated 8/4/21 at 2:29 PM identified that P #88 was sent to the ED on 8/3/21 (9:00 PM) for left ear pain and had not yet received the Debrox ear drops due to unavailability. The medication administration record dated 8/2/21 to 8/4/21 conflictingly noted that the Debrox was administered at 9:00 PM on 8/2/21 and 8/3/21 and at 9:00 AM on 9/3/21 and 9/4/21. The pharmacy disposition sheet identified that Debrox was sent to the facility on [DATE] with the evening delivery. Interview with the Medical Supply staff member via phone with the Administrator on 9/15/21 at 9:53 AM indicated that Debrox was ordered a month ago as a stock item because the facility did not have the item in stock. Interview with RN #8 on 9/15/21 at 9:49 AM noted although Debrox was ordered as a stock item, the ordered stock was now in use for other residents and additional Debrox needed to be ordered. R #88 was unavailable for interview on 9/15/21 at the time of this investigation. Interview with APRN #1 on 9/15/21 at 9:41 AM identified that although R #88 was forgetful at times, for the most part R #88 was reliable and was the person who informed her that the medication was not administered. The facility job description entitled Charge Nurse Job Description identified a major responsibility to follow physician orders. The facility policy entitled Medication Ordering and Prescribing identified the nurse will fax the actual physician orders to the pharmacy. The facility policy entitled Documentation in Resident Record identified that the records be factual. b. R #88's diagnoses included Cerebral Vascular Accident (CVA) and heart disease. The annual minimum data assessment dated [DATE] identified that R #88 had mildly impaired cognition and hearing was adequate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders dated 8/2/21 through 8/9/21 directed oral pain, antibiotic or steroidal medication administration and ear drops for left ear pain for diagnosed otitis media (ear infection). Physician orders dated 8/17/21 directed Ear Nose and Throat (ENT) consult for persistent left ear pain. APRN #1's notes dated 8/30/21 identified that R #88 admitted to using Q-tips in his/her left ear with subsequent perforated ear drum. Scheduling documentation indicated that P #88's ENT appointment was scheduled for 9/23/21. Interview with Scheduler #1 on 9/14/21 at 9:45 AM identified that the ENT office informed her that the ENT appointment was made by the facility on 8/24/21 (1 week after the order was written). Interview with the Administrator on 9/14/21 at 9:50 AM indicated that the facility did not have a scheduler at the time R #88's consult was ordered and when it came to her attention, she had the receptionist make the appointment. The facility failed to call for the consult appointment timely which led to a delay in the appointment date. c. R #88's diagnoses included Cerebral Vascular Accident (CVA), heart disease, history of obesity and Diabetes Mellitus. The quarterly minimum data set (MDS) assessment dated [DATE] and annual MDS dated [DATE] identified that R #88 had mildly impaired cognition and did not have a history of weight loss. Physician orders in place from 4/22/21 to 9/14/21 directed weekly weights on Wednesdays. The weights and vitals summary noted that weekly weights were missing for Wednesday 7/14/21, 8/4/21 and 8/18/21. In addition, P #88's weight decreased from 166.5 pounds on 7/28/21 to 158.6 pounds on 8/11/21 (by 7.9 pounds within 2 weeks). The facility staff failed to monitor R #88's weight per physician order and a weight loss was identified. Progress notes by Dietician #1 dated 8/17/21 indicated that R #88 was seen for weight discrepancy/decline and will continue to work with resident on nutritional adequacy. Interview with Dietician #1 on 9/16/21 at 8:27 AM identified that she would be reasonable to expect a weight discrepancy to be followed up with a reweight at least within one week. The facility policy entitled Weight Measurements identified residents with a weight variance of 5 pounds more or less than the previous month will be reweighed and did not specify the timeframe for the reweight. The facility job description entitled Charge Nurse Job Description identified a major responsibility to follow physician orders. The facility job description entitled Certified Nursing Assistant Job Description identified a major responsibility to complete resident assignments effectively and promptly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Resident #349 was admitted to the facility with diagnoses that included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee and Type II Diabetes Mellitus. a. The Hospital Discharge Summary and Inter-Agency Patient Referral Report (W-10) dated 12/30/20 identified Resident #349 was discharged with a diagnosis of cellulitis of the left lower extremity. Discharge instructions directed to provide wound care to the left lower extremity, cleanse with normal saline, apply Aquaphor to the peri-wound skin, apply silver alginate to the wound base, cover with abdominal pad and wrap with gauze three (3) times per week. The summary identified Resident #349's last hospital dressing change was noted to be on 12/28/20. The admission nursing assessment dated [DATE] identified a left lower leg diabetic ulcer measuring 8.0 centimeters (cm) x 4.0 cm x 0.2 cm. The admission Minimum Data Set assessment dated [DATE] identified Resident #349 made consistent and reasonable decisions regarding tasks of daily life, required extensive assistance of two (2) staff with turning and repositioning while in the bed, was totally dependent on two (2) staff for toileting, required extensive assistance with one staff for personal hygiene, and had one (1) arterial venous ulcer present. Review of the physician's orders, nurse's notes, and Treatment Administration Records (TAR) from 12/30/20 through 1/4/21 failed to reflect a physician's order to change the left lower extremity dressing or that dressing changes had been performed to Resident #349's left lower extremity wound. The Resident Care Plan dated 1/4/21 identified a diabetic ulcer of the left lower extremity related to a history of ulcer and uncontrolled diabetes mellitus. Interventions directed to provide weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and other notable changes or observation. A physician's order dated 1/4/21 directed to cleanse the left lower extremity ulcer with normal saline, apply calcium alginate with silver and dry protective dressing daily. The nurse's note dated 1/5/21 at 10:04 PM identified that Resident #349's dressing to the left lower extremity had been changed earlier on the 7:00 AM to 3:00 PM morning shift. The Physical Therapy Treatment Encounter Note dated 1/8/21 identified Resident #349 reported the left leg wound dressing had not been changed since Tuesday (1/5/21) when wound rounds had occurred. Interview and clinical record review with the MDS Coordinator, Registered Nurse (RN) #6, on 9/13/21 at 1:42 PM identified the clinical record failed to reflect documentation Resident #349's dressing had been changed from admission on 12/30/20 until 1/5/21 or that subsequent dressing changes had occurred on 1/6/21, 1/7/21, 1 [TRUNCATED]

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37002 Based on interview, review of the clinical record, and review of facilty policy for 1 esident (R #342) reviewed for missing items, the facility failed to assist the resident to locate or replace his/her glasses. The findings include: Resident # 342's diagnoses included dementia with behavior disturbance. The admission MDS assessment dated [DATE] identified Resident #342 was severely cognitively impaired and required supervision with transfers and walking, extensive assistance with dressing and hygiene, and supervision with eating. The care plan dated 1/15/21 identified Resident #342 has impaired visual function. Interventions included arrange consultation with eye care practitioner as required, and observe and report for signs and symptoms of acute changes. Review of Resident #342's clinical record identified documentation in the daily notes the resident's glasses were missing starting on 1/23/21 through the resident's discharge on 3/1/21. Interview with Person #2 on 9/10/21 at 10:30 AM identified she was not aware that Resident #342's glasses were missing until he/she went into the facility after the resident's discharge to collect the resident's belongings. Interview with the administrator on 9/10/21 at 11:30 AM identified if a resident's glasses were missing a missing items report would be completed, a thorough search of the resident's room would be done, then a facility wide search would be conducted, and if it the glasses still weren't found the resident's name would be added to the list to be seen by optometry to replace the glasses. The administrator identified he/she was not aware that Resident #342's glasses were missing and could not find a missing items report or documentation that the resident was added to the optometry list. Interview with LPN #4 on 9/14/21 at 4:00 PM identified Resident #342's glasses went missing soon after admission and he/she does not recall if it was reported to the supervisor. LPN #4 identified if a resident's glasses are missing first the resident's room and unit are searched and if they are unable to find them it is reported to the supervisor and a missing items form is completed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on observation, review of clinical records, facility documentation, interviews, and policies, for one of three residents at risk for elopement, (Resident #45), the facility failed to provide the necessary supervision when the resident was left unattended outside by staff on two occasions resulting in a finding of Immediate Jeopardy. In addition, the facility failed to check the placement and function of the resident's wander guard in accordance with facility policy. Additionally, for 2 of 7 residents (Resident #37 and 79) reviewed for accidents, the facility failed to ensure a safe environment resulting in injury. The findings include: The findings include: 1. Resident #45 had a diagnosis of an intracranial hemorrhage and encephalopathy. Review of the State of Connecticut court of probate paperwork dated 5/28/21 identified that the resident had been involuntarily conserved due to inability to make decisions even with appropriate assistance and was unable to meet essential requirements for personal needs. A quarterly Minimum Date Set dated 6/21/21 identified that the resident had severe cognitive impairment, required limited assist with activities of daily living, and required supervision with locomotion while in a wheelchair on and off the unit. A nurse's note dated 7/4/21 at 3:49 PM identified that the resident was sitting at the front door and when the door opened the resident bolted through the door and the staff were unable to stop him. A nurse's note dated 7/13/21 at 11:01 AM identified that the resident was able to remove the wander guard, two (2) wander guards were found in the Resident's drawer, and the wander guard was moved to the underside of the resident's wheelchair. A care plan dated 7/14/21 identified that the resident was an elopement risk with repeated attempts to exit the building, and has a history of cutting the wander guard off with interventions that included distracting the resident from exit seeking behavior, staff to sit with the resident while outside, and a wander guard which will be checked for placement twice a shift, and function will be checked daily. A nurse's note dated 7/17/21 at 6:31 PM identified that the resident had wheeled past a family member who was coming into the building, and was able to exit the building, the resident was yelling that h/she was going home and proceeded in the wheelchair to the end of the sidewalk . A nurse's note dated 7/21/21 at 3:46 PM identified that the resident packed up belongings and then attempting to get out the locked front door, h/she was positioned at the front door waiting for a staff or visitor to enter the facility so h/she could get out the door. The resident had attempted to enter the code into the door lock unsuccessfully. (continued on next page)

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	075057	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note dated 7/28/21 at 8:32 PM identified that the resident wanted to go outside after dinner, it was explained to the resident that someone needed to be with h/her, and that someone would go out with h/her around 6:00 PM. At 5:45 PM the resident was observed climbing out of the window in the dining room, and only had one foot inside the building. A nurse had gone outside and was able to steady the resident so h/she would not fall. The resident was difficult to redirect and sat in the middle of the road for 15 minutes. The resident was subsequently placed on one to one supervision until psychiatric services could evaluate h/her. Psychiatric services made some medication changes, determined that the resident was not a threat to self or others and the one to one was discontinued. A nurse's note dated 8/12/21 at 7:10 PM identified that the resident asked to go outside, and h/she was told it would be a minute or so. The resident immediately became aggressive then opened the window in the dining room, but did not go out the window, was redirected and then taken to sit on the secured patio outside of B wing (the secured patio is surrounded by a white fence). a. A nurse's note dated 8/26/21 at 6:25 PM written by Registered Nurse (RN) #2 identified that the resident was observed in the back of the building and found in a rut by the C wing exit door. The resident stated that h/she left the unsecured patio area in the front of the building because h/she wanted to go for a ride. It was explained to the resident that it was a safety issue because there was a hill on the property which put him/her at risk for injury. The resident refused to come back into the building and was left sitting in front of the glass door on the unsecured patio by RN #2 . Interview with RN #2 on 9/8/21 at 1:16 PM identified that she was the nursing supervisor on 8/26/21 and was alerted by a Nurse Aide (NA) that the resident was out on the sidewalk by the C wing door. RN #2 immediately ran to the area and helped the resident to get h/her wheelchair out of the rut. The resident refused to go back inside, therefore; the Supervisor placed the resident in front of the glass door so h/she could be seen by the Receptionist. RN #2 identified that she was uneasy leaving the resident outside, however, she was told by Administration that it was OK if the Receptionist watched the resident. Interview with Receptionist #1 on 9/6/21 at 6:00 PM stated that she let Resident #45 out onto the unsecured patio in front of the building on 8/26/21 and on that particular day there were many residents out front therefore she was not able to maintain the resident in her line of vision. Receptionist #1 stated that she left the front desk area to use the bathroom and when she came back she was notified that the resident had been found on the sidewalk in front of the C wing exit door. The Receptionist identified that she is not required to find coverage for her breaks, and although she knew that she was supposed to watch the resident and was aware that the resident wore a wander guard device, she was not aware that the resident was an elopement risk. Interview with the Director of Nurses on 9/6/21 at 6:30 PM identified that the resident gets agitated at times when he cannot go outside, and does not like to sit on the secured patio, therefore, the resident is allowed to sit outside on the unsecured patio in front of the building as long as the receptionist is at the front desk and can supervise h/her. However, on 8/26/21 the resident was out on the unsecured patio in front of the building and not in the direct line of sight of the Receptionist as h/she should have been. The DON identified that the receptionist should have placed the resident where she could see h/her and alerted a staff member if she needed to go on a break to provide coverage for the supervision of Resident #45 . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On 9/6/21 at 4:08 PM, the surveyor observed Resident #45 in his/her wheelchair on the front patio of the facility unsupervised. As the surveyor entered the building the resident followed the surveyor through the front door and the wander guard alarm sounded, there were no staff readily visible upon entry into the building. Interview with the Director of Nurses on 9/6/21 at 4:20 PM verified that the resident did have a wander guard on and was an elopement risk. The DON further stated that the resident was usually let outside to sit in the front of the building and the Receptionist watches the resident through the glass door. (Receptionist was not present at the time of the observation). The DON identified that the resident must have been let outside by a staff member because a code must be entered into the keypad to allow the door to open and silence the alarm. The DON was unable to identify which staff member allowed the resident to sit outside unsupervised. Interview with Receptionist #2 on 9/6/21 at 5:00 PM identified that Resident #45 was not outside when she left for the day at 3:00 PM. She further identified that when the resident does go outside she keeps an eye on him through the glass window. Interviews with staff throughout the building on 9/6/21 at 4:40 PM failed to identify which staff member disarmed the wander guard and let the resident out of the building unsupervised. Review of the elopement policy identified that safe environment is provided for Residents who are at risk to wander. c. Review of Resident #45's August 2021 Treatment Administration Record (TAR) identified that 7 out of 31 days the wander guard function was not checked, and the placement was not checked for 30 times out of a possible 186 times for the month. d. Review of the July 2021 TAR identified that Resident #45's the wander guard function was not checked on 2 days out of 31 and the placement was not checked for 19 times out of possible 92 times for the month. e. Review of the June 2021 TAR identified that Resident #45's wander guard function was not checked for 7 days out of 30 days, and the placement was not checked 13 times out of a possible 90 times. Interview with the DON on 9/7/21 identified that the wander guard function should be checked daily, and per the physician's order, placement should be checked 2 times a shift. Review of the wander guard policy identified that the wander guard function will be checked once daily and the placement will be checked once a shift. On 9/7/21 the facility submitted an immediate action plan to include facility wide education of staff to ensure the safety of Residents that require wander guard monitoring. All Residents who wear wander guards that request to sit outside will be supervised by a staff member. A facility wide audit of Residents with wander guards will be completed to ensure placement and function are being monitored and that physician's orders and care plans are up to date. Wander guard audits will be completed weekly for 4 weeks, and monthly for 3 months or until the Quality Insurance and Performance Improvement (QAPI) committee determines resolution. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an onsite visit on 9/8/21, the action plan was verified as implemented, therefore, the Immediate Jeopardy was abated. 42117 2. Resident #37 was admitted to the facility on [DATE] with diagnoses that included epilepsy with seizures, acute and chronic respiratory failure, heart failure, hypertension, orthostatic hypotension. The annual MDS dated [DATE] identified Resident #37 had intact cognition, was always continent of bowel and bladder and required supervision with toileting. Additionally, the resident required extensive assistance for dressing and limited assist for personal hygiene. The Occupation Therapy note dated 4/13/21 indicated Resident #37 had a raised toilet seat/commode for transfers and toileting. The reportable event form dated 5/8/21 at 2:30 PM indicated Resident #37 was in the bathroom and caught his/her left outer lower leg on the raised toilet seat. A laceration noted which was Y shaped measuring 4.0 cm x 2.5 cm x 0.4cm wound. The laceration was from the raised toilet seat front knob. Blood was noted all over it and the leg was caught on it causing laceration. Interventions included the raised toilet seat to be changed and a pressure dressing applied to Resident #37's leg and ice until transferred to hospital for stitches. The care plan indicated the intervention to have maintenance change the raised toilet seat in bathroom, on maintenance book to be done on Monday 5/10/21. The APRN note dated 5/8/21 at 8:37 AM noted Resident #37 had a left leg open area due to knob on the raised toilet seat with large amount of blood noted. Resident #37 was on Eliquis and area looks deeply impacted. Send resident to the emergency room for further evaluation. The nurses note dated 5/8/21 at 6:54 PM noted Resident #37 returned from the hospital with 9 stitches to the laceration of the left outer lower leg. Attempted to call emergency room because no information on stitches or tetanus shot on discharge paperwork. The nurses note dated 5/8/21 at 7:02 PM indicated put in maintenance book to have raised toilet seat removed and another one reapplied due to knob in front caused laceration. The hospital discharge paperwork dated 5/8/21 indicated Resident #37 went to the emergency room for a laceration to the left lower leg. An interview with the Administrator on 9/15/21 at 9:00 AM indicated she did not recall if she went and looked at the raised toilet seat that caused the laceration to Resident #37's leg. An interview with the Director of Maintenance on 9/15/21 at 9:40 AM indicated he did not have any of the maintenance logs prior to 7/21/21. The DOM indicated he was not at the facility in May 2021. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with DNS #2 on 9/15/21 at 9:45 AM indicated she did recall the incident. DNS #2 indicated she did not see the raised toilet seat until after it was changed. DNS #2 indicated the supervisor informed her there was something very sharp on the leg of the raised toilet seat that caused the laceration and the supervisor told her she put in the maintenance book to have it changed. DNS #2 indicated the first raised toilet seat was like a commode with legs but the new one was just the plastic that screws onto the top of the toilet. DNS #2 indicated she did not ask the DOM at that time to see the commode because all she cared was that it had already been changed. Interview with RN #2 on 9/15/21 at 10:00 AM indicated she did remember looking at the raised toilet seat that was like a commode with metal legs over the toilet and on one of the legs where there was a bolt, it had a very sharp edge, and there was blood on it so she knew that was where Resident #37 had received the laceration to his/her left lower leg on the outside. RN #2 noted the bolt stuck out and was not covered and was not flush. RN #2 indicated she sent Resident #37 to the hospital and he/she returned with 9 stitches. RN #2 indicated she put it in the maintenance book, but she removed it with maintenance later on that shift and maintenance put a new raised toilet seat on. 3. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. Review of the May 2021 physician's orders directed to transfer the resident via a mechanical lift with the assistance of 3 staff. Review of the weight's summary dated 5/18/21 identified Resident #79 weighed 402.1 lbs. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, and transfer activity occurred only once or twice during the reference period. Additionally, the MDS identified transfers occurred with 2 person plus physical assistance. The care plan dated 6/2/21 identified Resident #79 had a self-performance and mobility deficit related to deconditioning and weakness. Interventions included to encourage the resident to participate in ADLs to promote independence. The care plan failed to reflect the physician's order for transfers via mechanical lift with the assistance of 3 staff. Review of the nurse aide care card failed to reflect that the resident required the assistance of 3 staff during mechanical lift transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #79 on 8/16/21 at 1:05 PM identified that sometime in May 2021, during a mechanical lift transfer from the bed to the wheelchair, with NA #1 and NA #23, the lift tilted to the side with the resident in it and the nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she was upset that the incident happened and was scared because he/she thought that he/she was going to fall onto the floor. Resident #79 indicated that during the incident they were all screaming as the nurse aides were trying to get him/her into the wheelchair. Resident #79 indicated that both nurse aides are small and short and during the incident, the lift hit the resident in the head. Resident #79 indicated that the nurse aides could have gotten really hurt. Both nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she landed in the wheelchair in a slouching position. Resident #79 indicated after the incident, NA #23 was pinned in back of the wheelchair against the wall, and the lift flipped backwards and fell on to NA #1 and she got hurt. Resident #79 indicated NA #1 and NA #23 started yelling for LPN #1. Resident #79 indicated LPN #1 came into the room and helped to reposition him/her properly in the wheelchair and help the 2 nurse aides. Interview with Resident #4 on 8/16/21 at 1:12 PM identified he/she was in the room and witnessed the incident with Resident #79 when the mechanical lift tilted, and the 2 nurse aides got hurt. Resident #2 indicated the incident happened in May 2021. Resident #4 indicated the privacy curtain was not pulled for privacy and he/she could see everything that happened. Resident #4 indicated NA #1 and NA #23 were getting Resident #79 out of the bed with the lift and when NA #1 started turning the lift around to put Resident #79 into the wheelchair, the lift tilted and both nurse aides were doing their best to prevent Resident #79 from falling and to get him/her into the wheelchair. Resident #2 indicated the 2 nurse aides managed to get Resident #79 into the wheelchair, but NA #23 got pinned between the back of the wheelchair and the wall, and the tilted lift fell on NA #1. Both nurse aides started yelling for help. Interview with NA #1 on 8/16/21 at 1:30 PM indicated she was not aware that Resident #79 required the assistance of 3 staff with mechanical lift transfers and indicated the nurse aide care card did not reflect that information. NA #1 indicated on 5/28/21 she and NA #23 were transferring Resident #79 from the bed to the wheelchair in the lift, and the lift tilted. NA #1 indicated she and NA #23 tried as hard as they could to prevent the lift from fully tipping over and to get the resident into the wheelchair. NA #1 identified she was afraid that Resident #79 would land on the floor. As they turned the lift toward the wheelchair, it tilted, and she and NA #23 did everything they could to prevent Resident #79 from falling onto the floor in the lift and to get the resident into the wheelchair safely. When they managed to place the resident into the wheelchair, NA #23 got pinned behind the wheelchair and the wall, and the mechanical lift fell on NA #1. NA #1 indicated she and NA #23 started yelling for LPN #1. LPN #1 came into the room to help properly position Resident #79 into the wheelchair. Both nurse aides were doing everything possible to prevent the resident from falling on the floor as the lift was tilted. NA #1 indicated it is the facility policy to have 2 nurse aides at all times when the mechanical lift is being used on a resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #23 on 8/16/21 at 3:26 PM identified that a couple of months ago, she and NA #1 were transferring Resident #79 from the bed to the wheelchair via a mechanical lift and indicated they are required to have 2 staff members when using the mechanical lift. NA #23 indicated she was not aware that Resident #79 needed the assistance of 3 staff with transfers using the mechanical lift. NA #23 indicated the 600-pound capacity mechanical lift was used, the resident was properly position on the lift pad, and the base was opened. As the resident was being transferred to the wheelchair, the lift tipped over. NA #23 was positioned in back of the wheelchair guiding the resident into the wheelchair. NA #23 identified when the lift tipped, Resident #79 fell into the wheelchair and NA #23 was pinned between the wheelchair and the wall. Both she and NA #1 started screaming for help. NA #23 indicated Resident #79 was crying and cursing during and after the incident. Interview with LPN #1 on 8/16/21 at 3:47 PM identified he was aware of the mechanical lift incident involving Resident #79. LPN #23 indicated he heard yelling and he ran into Resident #79's room and observed Resident #79 slouching in the wheelchair. LPN #1 indicated he assessed Resident #79 but failed to document the assessment in the clinical record and failed to notify the physician, APRN or the conservator of the incident. LPN #1 indicated Resident #79 did not fall or was injured, and that was why he didn't document the incident in the clinical record or notify the physician or the conservator. LPN #1 indicated the 2 nurse aides did get hurt. Interview with RN #4 on 8/16/21 at 4:00 PM identified she was aware of the incident on 5/28/21 with Resident #. RN #4 indicated Resident #79 did not fall on the floor and was not injured and that is why she did not complete a reportable event form. RN #4 indicated she assisted in helping to properly position Resident #79 in the wheelchair after the incident. RN #4 indicated she assessed Resident #79 but did not document the assessment or notify the physician or conservator. RN #79 indicated she was not aware of the physician's order to have 3 staff transfer Resident #79 with mechanical lift and was not aware that the nurse aide care card did not include that information. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was on vacation when the incident happened and indicated she would have expected RN #4 and LPN #1 to assess Resident #79, document the incident in the clinical record and complete a reportable event form. Interview with the Director of Physical Therapy on 8/17/21 at 2:42 PM indicated he was not aware of the incident with the mechanical lift on 5/28/21. The Director of Physical Therapy indicated the nursing department did not notify the rehabilitation department and identified the rehabilitation department recommend that Resident #1 have the assistance of 3 staff during mechanical lift transfers. Interview with MD #2 on 8/17/21 at 4:06 PM identified the facility did not notify her of the mechanical lift incident that took place on 5/28/21 with Resident #79 but she would have expected to be made aware even if the resident was not injured. MD #2 indicated the facility staff should have followed the order that directed to provide the assistance of 3 staff with mechanical lift transfers. Review of the mechanical lift procedure policy identified the mechanical lift will be used to transfer patient/resident for whom manual transfer is not recommended. Because of mechanical lift models may vary in weight capacity, check the manufacture's specifications before attempting patient/resident transfer. Make sure the bed and wheelchair wheels are locked before beginning the transfer. Always have two people to perform this procedure; one to operate the lift and one to observe and reassure the patient/resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to provide 3 staff during a mechanical lift transfer on 5/28/21 with Resident #79. Subsequently, there was an incident in which the lift tilted with the resident in it and he/she was hit in the head with the lift, and 2 nurse aides were injured.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on clinical record reviews, review of facility policy, and interviews for one of four sampled residents (Resident #349) who was recently admitted , the facility failed to conduct urinary bladder function assessments and failed to provide services to attempt to restore bladder function. The findings include: Resident #349's admission diagnoses included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee, pacemaker implant, and Type II Diabetes Mellitus. The admission nursing assessment dated [DATE] identified Resident #349 had an indwelling urinary catheter on admission. Review of the Hospital Discharge Summary and Inter-agency Referral Report dated 12/30/20 failed to reflect documentation that Resident #349 had a urinary catheter on discharge from the hospital. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #349 made consistent and reasonable decisions regarding tasks of daily life, required extensive assistance of two (2) staff with turning and repositioning in bed, was totally dependent on two (2) staff for toileting, extensive assistance of one (1) staff for personal hygiene and had an indwelling urinary catheter. Review of the clinical record failed to reflect documentation a urinary incontinence evaluation, a bowel retaining evaluation or a three (3) day continence management diary had been completed on admission. Review of the Resident Care Plan (RCP) failed to reflect documentation that Resident #349's urinary status, an indwelling catheter problem, or interventions related to the restoration of bladder continence. Review of the Physical Therapy (PT) and Occupational Therapy (OT) Evaluation and Plans of Treatment dated 12/31/20 identified Resident #349's prior level of functioning was to transfer via slide board and pivot transfer with assistance to the toilet. Interview and review of the clinical record with the MDS Coordinator, Registered Nurse (RN) #6, on 9/13/21 at 1:42 PM failed to reflect documentation that Resident #349 had a catheter at the time during his/her admission at the facility. RN #6 indicated that due to the error in coding on the MDS, Resident #349 was not assessed/reassessed for bladder function and did not receive any services to restore incontinence to his/her prior level of function. Review of the facility undated Bowel and Bladder policy identified, in part, that residents who are incontinent on admission will have a urinary incontinence evaluation and/or bowel retaining evaluation and three (3) day continence management diary completed, and a care plan would be developed and revised as needed.

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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** 37002 Based on clinical record review, review of facility documentation, review of facility policy, and interviews for 1 of 5 sampled residents (Resident #342) reviewed for nutrition, the facility failed to weigh the resident per the physician's order, and monitor the resident's fluid and meal intake to prevent dehydration and weight loss. The findings include: 1.Resident # 342's diagnoses included dementia with behavior disturbance. The Resident Care Plan (RCP) dated 1/12/21 identified Resident #342 has a potential nutrition problem and to provide and serve diet as ordered. Interventions included provide and serve diet as ordered, encourage good nutrition, and document meal intake. The admission MDS assessment dated [DATE] identified Resident #342 was severely cognitively impaired and required supervision with transfers and walking, extensive assistance with dressing and hygiene, and supervision with eating. a.Review of the clinical record identified on 1/12/21 Resident #42's weight was 166 lbs (6 days after admission). The clinical record failed to identify Resident #342 was weighed on admission. The physician's order dated 1/13/21 (7 days after admission) directed to weigh on admission and then weekly. Review of Resident #342's weight record identified the resident's weight on 1/13/21 was 164 lbs (4lb loss) and no further weights were documented until 21 days later on 2/3/21 when a weight of 153 lbs (9lb loss) was documented. Review of the clinical record identified the resident was discharged to the hospital on 2/10/21 and diagnosed with dehydration and returned to the facility on [DATE]. Review of the weight record identified a weight of 155 lbs on 2/14/21 and a weight of 156 lbson 2/17/21. The resident was discharged 14 days later on 3/2/21 with no additional weights documented. Interview with Dietitian #1 on 9/9/21 at 2:00 PM identified he/she was not notified of Resident #342's weight loss until he/she ran the weight report on 2/9/21. Dietitian #1 identified if he/she was notified of the weight loss he/she would have done an assessment on 2/3/21 to determine if the resident required an intervention. Dietitian #1 identified he/she requested a reweight and reported the resident's weight to APRN #1 on 2/9/21 and obtained an order for a daily nutrition supplement. The facility was unable to obtain a reweight because the resident was transferred to the hospital on 2/10/21. Interview with the DNS on 9/10/21 at 1:45 PM identified Resident #342 should be have been weighed on admission on 1/6/21 and weekly on his/her shower day for 4 weeks. The DNS identified the charge nurse is responsible for ensuring weights are completed and reported to the dietitian and APRN. (continued on next page)

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	075057	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated April 2017 identified to ensure that resident maintained acceptable parameters of nutritional status, a weight will be obtained on all residents on admission and readmission, weekly times 4 weeks then monthly. Residents with a weight variance of 5lbs more or less will be reweighed. b. Review of the weight record dated 1/12/21 identified Resident #342's weight was 166 lbs. The initial dietitian assessment dated [DATE] identified resident with good PO intake noted and labs are within normal limits. Fluid goal 1400-1700 ml per day. Resident appears well nourished, currently 123% IBWR (ideal body weight), will monitor intakes and weights for adequacy and need for intervention. Review of the Resident #342's meal intake flowsheet documentation for January 2021 identified that percentage of the meals the resident consumed was only documented on 8 out of 72 opportunities. All 8 meals documented were identified as 100% of meal consumed, the remaining meal intakes were not documented. The resident weight record identified Resident #342's weight on 2/3/21 was 153 lbs, a 13 pound weight loss from 1/12/21. Review of Resident #342's meal intake flowsheet documentation for February 2021 identified the percentage of meals the resident consumed was only documented on 8 out of 72 opportunities. Four meals were documented as 25% consumed, three meals at 50% consumed and one meal was 100% consumed. The physician's order dated 2/16/21 directed 1:1 supervision to feed the resident. Review of the TAR identified the resident was supervised for eating but no intakes were documented. Interview with the APRN on identified on 9/9/21 at 1:00 PM he/she was notified of the resident's weight loss on 2/9/10 ordered labs and a nutrition supplement. Interview with the DNS on 9/10/21 at 1:30 PM identified the percentage of the meal tray including fluids should be documented on the meal intake flowsheet to determine how well the resident is eating to assess if any additional interventions need to be put in place to increase the resident's intake to prevent weight loss. The DNS identified that the charge nurse should review the meal intake flowsheets and report it to the supervisor if the resident is not eating to the dietitian, and the doctor or APRN. Interview with LPN #4 on 9/14/21 at 4:00 PM identified Resident #342 had poor po intake and was difficult to feed due to the resident's behaviors. LPN #4 identified nurses are responsible for documenting supplements and NAs are responsible for documenting meal intakes. LPN #4 identified that the percentage of the meal tray the resident consumed should be documented on the meal intake flowsheets located at the nurses desk by the NAs, but it was frequently not done and he/she did not check the documentation to ensure it was complete or how much the resident ate. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Dietitian on 9/15/21 identified that the meal intake flowsheet documentation is not reliable so he/she usually observes residents eating when he/she is in the building weekly. The dietitian identified that if he/she was aware of the poor PO intake he/she would have assessed the resident for the need for an additional intervention. The dietitian identified that the facility has changed their practice and now the meal and fluid intakes are documented in the electronic medical record rather than a paper flowsheet, and missing documentation is no longer an issue. The weight assessment and measurement policy identified weights are obtained on admission and weekly for 4 weeks. If there is weight change of 5% or more the dietitian will be notified in writing for analysis of the approximate calorie, protein, and other nutrient needs compared with the residents current intake. c. The admission dehydration risk screener dated 1/6/21 identified the Resident #342 was at low risk for dehydration. The initial dietitian assessment dated [DATE] identified resident with good PO intake noted and labs were within normal limits. Fluid goal 1400-1700 ml per day. Resident appears well nourished, currently 123% IBWR (ideal body weight), will monitor intakes and weights for adequacy and need for intervention. Review of Resident #342's meal intake flowsheet documentation for January 2021 identified that percentage of the meal tray the resident consumed was only documented on 8 out of 72 opportunities. All eight meals documented were identified as 100% of meal consumed, the remaining meal intakes were not documented. The physician's order dated 1/16/21 directed Resident #42's fluid goal 1400ml-1700ml. Review of Resident #342's meal intake flowsheet documentation for February 2021 identified that percentage of the meal tray the resident consumed was only documented for 8 out of 75 opportunities. Four meals were documented as 25% consumed, three meals at 50% consumed and one meal was 100% consumed. The lab results report dated 2/2/21 identified the resident's BUN was 67 (10-24). The APRN note dated 2/3/21 identified patient routine labs resulted in BUN 67, unable to receive IVF due to mentation status, will encourage 250 ml additional fluids with all meals. The physician's order dated 2/4/21 directed to encourage additional 250 ml of fluids with each meal for 7 days. Review of the TAR for February 2021 identified and additional 250 ML of additional fluids was encouraged but the TAR failed to identify how much was consumed. The lab results report dated 2/5/21 identified the resident's BUN was 62 (10-24). The physician's order dated 2/6/21 directed strict intake and output (IO) every shift for three days. Review of the clinical record identified Resident #342 consumed 1080 ml on 2/6-2/7/21 1080 ml 2/7/21 and 1220 ml 2/8-2/9/21. Resident #342's fluid goal was 1400-1700ml. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The APRN note dated 2/8/21 identified Resident #342 was dehydrated with BUN 67 and creatinine 1.4. Unable to receive IV hydration due to mentation, resident will not allow IV placement as he/she pull off clothes and plays with telephone cord and wires. Continue strict IO. Review of the clinical record failed to identify that I&O was documented beyond day shift on 2/9/21. Review of the clinical record failed to identify a dehydration risk assessment was completed subsequent to the Resident #34's elevated BUN per facility policy. The APRN note dated 2/10/21 identified resident continues with lethargy, unable to get medication or fluids in the resident. Friday's (2/5/21) labs signified acute dehydration. Noted sunken eye sockets. Needing assistance to walk this morning, Resident #342's baseline is independent without device. Send to ER for evaluation. Review of the clinical record identified Resident #342 was transferred to the ED on 2/10/21 and diagnosed with dehydration and acute kidney injury. The resident was readmitted to the facility on [DATE]. Review of the clinical record failed to identify Resident was placed on I&O upon readmission or that a dehydration risk screener was completed. The lab results report dated 3/1/2021 identified the resident's BUN was 100 (10-24). Interview with the APRN on 9/10/21 was aware that the resident's PO intake including fluids was poor based on labs and ordered I&Os, and encourage fluids. APRN #1 identified he/she usually does call the family to discuss treatment options but did not provide an explanation for why the family was not called. Interview with Dietitian #1 on 9/9/21 at 2:00 PM identified he/she was not aware of Resident #342's poor fluid intake but he/she identified that when a resident has poor fluid intake there is not much he/she can do. Dietitian #1 identified poor fluid intake requires a medical intervention from doctor or APRN to determine if the resident is appropriate for IV fluids or a feeding tube. Interview with LPN #3 on 9/10/21 at 12:30 PM identified prior to the facility documenting food and fluid in the electronic medical to record food and fluid intakes the NA would verbally to the charge nurse if a patient was not drinking. The charge nurse would pass it on to the supervisor to notify the family and the doctor. Interview with LPN #4 on 9/14/21 at 4:00 PM identified the percentage of the meal tray the residents consumed should be documented by the NAs on the meal intake flowsheets located at the nurses desk, but it was frequently not done and he/she did not check the documentation to ensure it was complete or how much the resident ate. LPN #4 identified there was no system in place to determine if the resident was meeting their fluid goals other than getting verbal report if the resident was not drinking. Interview with the DNS identified residents should have a dehydration assessment and intakes and outputs documented for three days upon admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DNS identified the NA should document the total percentage of the meal tray consumed including fluids with every meal to determine if a resident is meeting their fluid goals. If fluid goals are not met the dietitian, APRN or doctor, and family should be notified. The lab results report dated 3/1/2021 identified the resident's BUN was 100 (10-24). The APRN note dated 3/1/21 at 11:10 AM identified nursing reports poor PO intake and refusing to drink, ordered labs, encourage additional 250 ml fluids with meals, monitor intake. The lab results report dated 3/1/2021 identified the resident's BUN was 100 (10-24). The nurse's note dated 3/2/2021 at 12:00 AM identified lab results obtained, critically high BUN and creatinine. The MD was notified and directed to transfer the resident to the ED. The hydration policy dated April 2017 identified a dehydration risk assessment will be completed on Admission, Readmission, Quarterly, and with a significant change in condition. Intake and Output monitoring is indicated for, but not limited to admission/readmission for 72 hours, or decreased oral intake, prior to discontinuing the resident should be consistently meeting fluid goals and consuming food at meals. Residents will have daily recommended fluid goals as established by the dietitian. These goals will serve as a guideline to determine if a resident is at risk for dehydration. Any residents who do not meet their fluid goals for three consecutive days will be assessed for signs/symptoms of dehydration.

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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** 31357 Based on clinical record reviews, review of facility policy, and interviews for one of two sampled residents (Resident #349) who required oxygen therapy for a respiratory condition, the facility failed to ensure a physician's order that directed supplemental oxygen was implemented on admission and failed to consistently monitor the resident's oxygen saturation levels per the physician's order. The findings include: Resident #349's diagnoses included acute on chronic congestive heart failure, acute respiratory failure, non-pressure ulcer of left lower extremity, absence of right leg above the knee and Type II Diabetes Mellitus. The Hospital Discharge Summary dated 12/30/20 identified Resident #349 was unable to be weaned off supplemental oxygen, the respiratory status was stable, and Resident #349 was discharged on two (2) Liters per Minute (LPM) of oxygen via nasal canula to the rehabilitation facility. Review of the facility Nursing Admission assessment dated [DATE] failed to identify Resident #349 required oxygen. The Admission Resident Care Plan (RCP) dated 12/31/20 failed to address Resident #349's respiratory status and oxygen requirements. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #349 made consistent and reasonable decisions regarding tasks of daily life, required extensive assistance of two (20 staff with turning and repositioning while in the bed, was totally dependent on two (2) staff for toileting, required extensive assistance with one staff for personal hygiene, was noted to have shortness of breath and was receiving supplemental oxygen therapy. Review of the December 2020 and January 2021 Medication Administration Records (MAR) and the December 2020 and January 2021 Treatment Administration Records (TAR) records failed to reflect a physician's order for a specific liter flow of supplemental oxygen or when oxygen saturation levels were to be conducted. Review of the nurse's notes dated 12/30/21 through 1/4/21 failed to identify that Resident #349 was receiving supplemental oxygen. The Vitals Summary dated 12/31/20, 1/1/21, 1/2/21, and 1/4/21 identified Resident #349 was receiving supplemental oxygen. Review of the oxygen saturation documentation from12/30/20 through 1/5/21 identified that out of twenty (20) opportunities, the facility had performed oxygen saturation levels eight (8) times, three (3) of the eight (8) recorded oxygen saturation levels, Resident #349 was noted to be on room air (no supplemental oxygen) and for the remaining five (5) oxygen saturation levels, no oxygen liter flow rate was indicated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/5/21 directed to titrate the oxygen flow rate to maintain oxygen saturation levels greater than or equal to 92% every shift. The Advanced Practice Registered Nurse (APRN) note dated 1/9/21 identified a telehealth visit was conducted due to Resident #349 becoming acutely hypoxic, the oxygen saturation was in the low 90's requiring supplemental oxygen, and Resident #349 denied shortness of breath. The note indicated Resident #349 was noted to recover with supplemental oxygen at two (2) liters via nasal cannula and a STAT (immediate) chest x-ray to rule out infectious process was ordered. The APRN note dated 1/9/21 at 6:25 PM identified Resident #349 was in congestive heart failure per the chest x-ray, was on supplemental oxygen at five (5) liters, the resident denied shortness of breath or congestion, to monitor closely and to provide an additional dose of Lasix. A physician's order dated 1/11/21 directed to attempt to wean the oxygen flow back to two (2) via nasal cannula and document in the computer program, Point Click Care. Upon further review, the clinical record from 1/5/21 through Resident #349's discharge on 1/15/21 failed to reflect documentation that oxygen saturation levels were consistently performed and lacked the liter flow rates. Interview and clinical record review with the MDS Coordinator, Registered Nurse (RN) #6, on 9/13/21 at 1:42 PM identified the clinical record failed to reflect documentation an order for oxygen at two (2) liters on discharge from the hospital was transcribed on admission. Review of the oxygen saturation rates with RN #6 identified that Resident #349 was being administered oxygen at times, but other times documentation reflected Resident #349 was on room air, and the only reference to liter rates was intermittently in the nurse's notes. RN #6 identified that since the physician's order directed oxygen titration every shift, oxygen saturations should have been monitored and documented as directed. RN #6 identified the facility did not have an oxygen titration policy. Interview and clinical record review with the Medical Director, MD #1, on 9/15/21 at 12:56 PM identified if Resident #349 was on oxygen at two (2) liters from the hospital the facility should have transcribed the order or contacted the physician to amend the order. MD #1 indicated since the prescribing physician had ordered the titration of oxygen every shift on 1/5/21, the facility should have documented an oxygen saturation level every shift with the corresponding liter rate. Review of facility Oxygen Administration policy identified, in part, that a physician's order shall be required for administering oxygen and that the concentrator flow meter should be set to the flow rate ordered by the physician. Review of the Medication Reconciliation Policy dated 4/2017 identified that reconciliation of medications will be performed upon admission by comparing the preadmission medication list with the medications ordered in order to identify and resolve discrepancies.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on a review of facility documentation, interviews, and policy review, the facility failed to ensure that staffing levels were adequate to meet the needs of four (4) of thirty three (33) residents on the B wing (Residents #4, #17, #44, and Resident #77) in accordance with the plan of care which resulted in a finding of Immediate Jeopardy. Additionally, for 2 out of 3 wings reviewed for staffing, the facility failed to ensure there was sufficient nurse staffing to meet the needs of the residents on 9/3/21 at the beginning of the 7:00 AM to 3:00 PM shift and for 1 resident (Resident #79), reviewed for an allegation of neglect, the facility failed to have sufficient nursing staff to maintain the residents highest practicable physical, mental, and psychosocial well-being. The findings include: Please cross reference F 600 The findings include: 1. Review of the schedule for B wing dated 9/6/21 for the 7:00 AM to 3:00 PM shift identified the census was 33 and there was one (1) charge nurse, and two (2) Nurse Aides (NA) assigned. NA #5 worked 7:00 AM until 12:00 PM, and NA#1 worked 8:00 AM until 2:00 PM. B wing was staffed with 1 NA from 7:00 to 8:00 AM (NA #5), 2 NA from 8:00 AM until 12:00 PM (NA #1 & 5), and 1 NA from 12:00 PM until 2:00 PM (NA #1). There were no NA ' s on the unit from 2:00 PM until 3:00 PM. Interview with Nurse Aide (NA) #1 on 9/6/21 at 7:40 PM identified that she was unable to provide incontinent care, bathing and turning and repositioning to Resident #4, Resident #17, Resident #44, and Resident #77. NA #1 stated that she didn't have time to provide care to all of the residents, because there were 2 NA for 33 residents (approximately 17 residents each) and then at noon she was the only NA for 33 residents. NA #1 further identified that she was able to set up and provide the meals for Resident #4, Resident #17, Resident #44 and Resident #77, but she was unable to provide any other care for the 7:00 AM to 3:00 PM shift. NA #1 identified that she had worked on 9/6/21, although it was her day off, she had informed the facility ahead of time that she could only work until 2:00 PM. Multiple attempts to contact NA #5 were unsuccessful. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Director of Nurses on 9/6/21 at 6:36 PM identified that she had been in the building since 11:00 AM on 9/6/21 and was unaware of that there were only 2 NA on the B wing. The DON stated she was also unaware that there was only 1 NA on the B wing from 12:00 to 2:00, and that there were no Aides on the B wing from 2:00 PM to 3:00 PM. Review of the 7:00 AM to 3:00 PM schedule for 9/6/21 with the DON identified that there had been one agency NA that was a no call, no show and one call out for the 7:00 AM to 3:00 PM shift on 9/6/21, leaving only 2 NA to work the unit. The DON identified that the residents are heavy care on B wing and the wing should have 4 NA on the 7:00 AM to 3:00 PM shift. The DON identified that the residents should have been provided with bathing, incontinent care, and repositioning every 2 hours, and the NA should have asked for help if she could not do so. Interview with LPN #1 on 9/7/21 who was the charge nurse on B wing on 9/6/21 at 4:14 AM identified that the staffing on 9/6/21 for the 7:00 AM to 3:00 PM shift on 9/6/21 was not unusual. LPN #1 stated that when NA#5 came to work on 9/6/21, it was identified that she was not on the schedule, however she agreed to stay until 12:00 PM. Interview with Registered Nurse (RN) #1 on 9/7/21 at 10:30 AM identified that she was the nursing supervisor on 9/6/21 for the 7:00 Am to 3:00 PM shift and was aware of the staffing issue on the B wing, and stated that she had tried to contact all of the staffing agencies and called all of the staff and no one was able to come in that day. Interview with the Staffing Coordinator (SC) on 9/7/21 at 1:00 PM identified that she was not in the building on 9/6/21 because it was a holiday. The SC identified that there is no staffing policy, but the B wing should have at least 3 NA, but ideal staffing would be 4 NA on the 7:00 Am to 3:00 PM shift. The SC further identified that the facility has contracts with four (4) staffing agencies and when she calls, they usually don't have anyone available. The staffing coordinator identified that the facility is also having a job fair to recruit staff, and the facility offers bonuses in an attempt to get staff to work extra shifts. The SC further identified that at times when there are not enough NA's licensed staff will work as NA's. The facility submitted and action plan to the Department on 9/7/21 that identified that nursing management, department heads and staff that have a NA certification, temporary NA's, and agency staff will be utilized when the staffing is inadequate. The nursing scheduler and nursing supervisors were educated on notifying Administration and the Director of Nurses when staffing levels do not meet the State Agency Public Health Code for staffing. Staffing audits will be conducted daily for a week, weekly for a month, and monthly for 3 months. During an onsite visit on 9/8/21, the action plan was verified as implemented, therefore, the Immediate Jeopardy was abated. 2. Review of the census list on 9/3/21 identified the facility capacity is 97 beds and the census was 85 residents in the facility. There were 22 residents on A wing, 31 residents on B wing, and 32 residents on C wing. Tour of the wings on 9/3/21 at 7:05 AM identified the following: A wing had 2 nurse aides on the 7:00 AM - 3:00 PM shift, (22 residents). B wing had zero nurse aides and one LPN, (31 residents). C wing had zero nurse aides and ne LPN, (32 residents). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #3 on 9/3/21 at 7:20 AM on C wing identified she was aware that the 11:00 PM - 7:00 AM nurse aides had left, and that there were no nurse aides on during the 7:00 AM - 3:00 PM shift on C wing. LPN #3 indicated the facility has been short of staff for a very long time. LPN #3 indicated that some nurse aides come in at 8:30 AM or 9:00 AM or 9:30 AM. LPN #3 indicated that it is very difficult to try and pass out the medications and answer the call lights until a nurse aide comes in. Observation between 7:30 AM - 7:40 AM identified the following: A wing had 2 nurse aides and one LPN, (22 residents). B wing had zero nurse aides and one LPN, (31 residents). C wing had zero nurse aides and ne LPN, (32 residents). Interview with LPN #1 on 9/3/21 at 7:33 AM on B wing identified he was aware that the 11:00 PM - 7:00 AM nurse aides had left, and there were no nurse aides on the 7:00 AM - 3:00 PM shift when he made round at the beginning of the shift, and there were still no staff on the wing at 7:30 AM. LPN #1 indicated that a nurse aide should have stayed on the unit until the 7:00 AM - 3:00 PM shift came in. On 9/3/21 at 7:44 AM identified NA #5 arrived on C wing. Interview with NA #5 identified she punched in at 7:21 AM and she is the only nurse aide on the C wing. Observation on 9/3/21 at 7:57 AM identified NA #22 coming from A wing to B wing. Interview with NA #22 identified she was asked to go to B wing and monitor the call lights and pass out the breakfast trays until a nurse aide came in. Observation between 8:00 AM - 8:30 AM identified the following: A wing with one nurse aide and one LPN on the wing, (22 residents). B wing with one nurse aide and one LPN on the wing, (31 residents). C wing with one nurse aide and one LPN on the wing, (32 residents). On 9/3/21 at 8:41 AM, NA #24 went to the Human Resource (HR) office. Interview with NA #24 identified she punched in at 8:30 AM. NA #24 indicated today was her day off and the facility called her to come in because they needed help. NA #24 indicated she was directed to go to C wing. On 9/3/21 at 8:44 AM, NA #25 arrived. Interview with NA #25 identified she was supposed to be at the facility at 8:00 AM and she is from an agency. NA #25 indicated she notified HR that she cannot be at work at 8:00 AM for personal reasons and indicated when she arrived, she was directed to go to B wing. On 9/3/21 at 8:50 AM, NA #26 arrived. Interview with NA #26 identified she was schedule to come in at 9:00 AM. She indicated she was directed to go to B wing until another nurse aide comes in and then she will become the half between B and C wing. (continued on next page)

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	075057	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator on 9/3/21 at 9:00 AM identified she was not aware that the 11:00 PM - 7:00 AM staff had left the facility before the 7:00 AM - 3:00 PM staff came in. She indicated the facility has been experiencing some staffing challenges at times. She indicated the facility supplement with three agencies for nurse aides. The Administrator indicated in-services will be given to the nurse's aide. Interview with Human Resource Director on 9/3/21 at 1:00 PM identified she was not aware that some of the nurse aides were not on the wings. She indicated staffing has been challenging for all shifts. Human Resource Director indicated the facility has placed an ad for nurse aide. Interview with the DNS on 9/3/21 at 2:34 AM identified she was not aware of the schedule issues this morning. The DNS indicated the supervisor called her and notified her that DPH was at the facility, but they did not inform her that there were only 2 nurse aides in the facility at the time of the call. She indicated that the 11:00 PM - 7:00 AM staff should have remained on the wing until the 7:00 AM - 3:00 PM staff came in. Review of the regulations of Connecticut State Agencies identified the facility's administrator and director of nurses shall meet at least once every 30 days to determine the number, experience, and qualifications of staff necessary to comply with this section. The facility shall maintain written and signed summaries of actions taken and reasons, therefore. In a chronic and convalescent nursing home, there shall be at least one licensed nurse on duty on each patient always occupied floor. In no instance shall a chronic and convalescent nursing home have staff below the following standards: The facility failed to ensure there was sufficient staffing to meet residents needs on 9/3/21 at the beginning of the 7:00 AM to 3:00 PM shift. 3. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. Review of the May 2021 physician's orders directed to transfer Resident #79 via a mechanical lift with the assistance of 3 staff as the resident is unable to ambulate. Additionally, the orders identified Resident #79 requires the assistance of 2 staff (extensive assistance) for upper/lower body dressing, and toilet transfers and limited assistance for personal hygiene. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, required extensive two-person physical assistance with toilet use and extensive one-person physical assistance with personal hygiene. Additionally, the MDS indicated Resident #79 was always continent of urine. The care plan dated 6/2/21 identified Resident #79 had a self-performance and mobility deficit related to deconditioning and weakness. Interventions included to encourage the resident to participate in ADLs to promote independence. The care plan did not address how staff should provide assistance regarding Resident #79's bowel and bladder needs. Interview with Resident #79 on 8/16/21 at 1:05 PM identified that usually when he/she rings the call bell, it takes the nurse aides 40 minutes to an hour to answer. Resident #79 indicated that sometime in June 2021, during the 11:00 PM - 7:00 AM shift, he/she needed help and rang the call bell for approximately 4 hours, but the staff did not answer or come to his/her room. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In another incident, Resident #79 indicated recently, after returning from a hospitalization , during an 11:00 PM - 7:00 AM shift, the resident rang the call light because he/she had to urinate. Resident #79 could not remember the exact time but was also yelling for help. The staff on the night shift never came into his/her room to help or provide care so he/she had to urinate in the bed and lay in it. Resident #79 indicated that when the 7:00 AM - 3:00 PM shift arrived, the nurse aide answered the call light a little after 7:00 AM. Resident #79 indicated at that time, NA #1 provided care and the resident reported to NA #1 that he/she had been ringing for help since 5:00 AM and had been laying in urine because no one came to help. Resident #79 indicated he/she lays in bed waiting for staff to answer the call bell, it happens all the time, it goes on all the time. The resident stated he/she many times has had to urinate right in his/her bed and lay in the urine, screaming for help because no one comes, and he/she and the bed gets cold because it's wet. The resident indicated he/she has had to call 911 in the past when staff don't answer the call bell. The resident indicated he/she rings for the bedpan and will urinate on the bedpan, but if no one comes, he/she has no choice and cannot hold it, so will urinate in the bed. If staff answer his/her call light in a timely manner, he/she uses the bed pan. Interview with Resident #4, (Resident #79's roommate), on 8/16/21 at 1:12 PM identified he/she does not remember the exact date but does remember an incident when he/she was woken up by Resident #79 screaming for help at approximately 5:00 AM. Resident #4 indicated the night shift did not come to answer the call bell or come in the room to help Resident #79. It wasn't until the day shift arrived that Resident #79 received help. Interview with NA #1 on 8/16/21 at 1:30 PM identified she does not remember exactly the day or date, but it happened when Resident #1 came back from the hospital recently. NA #1 indicated when she came in at 7:00 AM, Resident #79's light was ringing, and she answered the call light. NA #1 indicated Resident #79 was crying and stated that the nurse aide (lady) on the night shift did not provide care. NA #1 indicated Resident #79 and his/her bed and linens were saturated with urine, so she provided Resident #79 a bed bath and changed the bed linen. NA #1 indicated after she provided care to Resident #79, she notified RN #2 and LPN #1 of Resident #79's complaint that the night shift had not provided care and that Resident #79 was soiled and saturated and left in a urine-soaked bed. Interview with LPN #1 on 8/16/21 at 3:47 PM identified he is the regular nurse on the B unit and assigned to Resident #79. LPN #1 indicated he does not remember NA #1 reporting to him that Resident #79 was complaining about the night shift not answering the call light or providing the resident the bed pan, and subsequently the resident soiled and saturated the bed with urine. LPN #1 indicated that one time during the day shift, he does remember an incident when Resident #79's family member called the facility and reported that if someone does not go into the resident room to provide toileting assistance that he/she was going to call 911. The facility failed to provide sufficient nursing staffing to ensure Resident #79, who was alert, oriented and continent, was free from neglect during the 11:00 PM - 7:00 AM shift, when staff did not provide assistance with toilet use when requested, and subsequently the resident urinated in the bed, was left in a urine saturated bed and found in a urine saturated bed by the day shift over 2 hours later. 37293

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, and interviews for 1 resident (Resident #23) reviewed for discharge, and who was listed on the Sex Offender Registry, the facility failed to provide medically related social services to meet the resident's needs. The findings include: Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, cognitive deficits and post-traumatic stress disorder. Review of the State of Connecticut Department of Emergency Services & Public Protection Division of State Police Sex Offender Registry dated 7/12/21 identified Resident #23 was listed as a registered sex offender. The significant change MDS dated [DATE] identified Resident #23 had intact cognition and required total assistance with personal hygiene. Review of the September 2021 social service notes failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the September 2021 MAR identified Resident #23 was being monitored for anti-depressant (specific behaviors): Depressed, sad, crying, tearfulness, withdrawn, and mood changes every shift. The behavior monitoring record failed to identify that Resident #23 was being monitored for inappropriate sexual behaviors. A social service note dated 9/20/21 at 11:16 AM identified Resident #23 and Person #8 requested a referral be sent to skilled nursing facilities in 3 other towns so that Resident #23 could be closer to Person #8. Referrals were sent on 9/1/21. Review of the referral documentation dated 9/22/21 sent to one of the skilled nursing facilities failed to reflect that Resident #23 was on the Sex Offender Registry. A physician's order dated 9/27/21 directed to discharge Resident #23 to the facility closer to home on 9/28/21. Reviewed of the Inter-Agency Patient Referral Report (W-10) dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the interdisciplinary discharge summary dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. The social service note dated 9/28/21 at 2:07 PM identified the social worker assisted Resident #23 to notify the Connecticut Sex Offender Registry of his/her change of address in writing. The social worker spoke to the social worker at the receiving skilled nursing facility to update on Resident #23 status. Resident #23 was discharged at 2:00 PM via ambulance with belongings. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social service note dated 9/28/21 at 6:00 PM identified the facility received a phone call from the receiving skilled nursing facility indicating they were sending Resident #23 back to the facility because they were not aware that Resident #23 was on the Sex Offender Registry. Resident #23 arrived back at the facility at 6:00 PM in a wheelchair, indicating he/she had no idea why they were sent back. After Resident #23 was returned to his/her room, the Social Worker explained to Resident #23 the reason why he/she had been sent back, and the resident became weepy and upset. A nurse's note dated 9/28/21 at 9:21 PM identified Resident #23 returned to the facility at approximately 6:00 PM. Admission to the new facility was refused related to a past indiscretion. Resident #23 was visibly upset and crying about reason for refusal. Resident #23 became calmed after allowing him/her to talk and showing compassion. Resident #23 was monitored throughout the shift and he/she was able to go to sleep around 9:30 PM. Review of the care plans dated 9/30/21 failed to reflect Resident #23 was a registered sex offender and/or interventions to address such. Interview with the Social Worker on 10/1/21 at 1:27 PM identified she became aware that Resident #23 was on the Sex Offender Registry on 9/2/21 when another facility that she had placed a referral to called and notified her that Resident #23 was on the Sex Offender Registry. The Social Worker indicated she did not share the information with the Administrator or the DNS and indicated she had not discussed the issue with the interdisciplinary team during the morning meeting. The Social Worker indicated she failed to document in the resident clinical record or initiate a care plan regarding Resident #23 being on the Sex Offender Registry. The Social Worker identified she informed the Administrator and the DNS on 9/28/21 when Resident #23 was in route back to the facility. Interview with the Administrator on 10/1/21 at 1:45 PM indicated she was not aware or does not recall Resident #23 being on the Sex Offender Registry. The Administrator indicated it is the Admission Director responsibility to do a background check on the new resident applicants. The Administrator indicated she cannot answer why a care plan was not initiated. The Administrator identified the Social Worker did not inform her that Resident #23 was on the Sex Offender Registry. The Administrator indicated she found out on 9/28/21 when the receiving facility that Resident #23 had been discharged to, called and stated the resident is in route back to the facility because he/she was listed on the Sex Offender Registry. Interview with the DNS on 10/1/21 at 2:44 PM identified she was not aware that Resident #23 was on the Sex Offender Registry. She indicated she learned of it on 9/28/21 when the receiving facility was sending Resident #23 back to the facility. The DNS indicated the social worker had not informed her that Resident #23 was on the Sex Offender Registry. The DNS indicated she was aware Resident #23 did not have a care plan addressing his/her history.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32738 Based on observation and staff interview for 1 of 4 dietary staff observed for hair coverings, the facility failed to ensure staff ' s hair was covered while working with food. The findings include: Observations during a tour of the kitchen identified Dietary Aide # 2 walking around the serving area while food was being served with half of her head of hair not covered with a hairnet. Interview at that time stated that she did not realize her hair was not covered. After surveyor inquiry, the dietary aide applied a new hair restraint.

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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** 14528 Based on clinical record review, review of facility policies and interviews for 3 residents (Residents #23, 29, 79 and 88), the facility failed to ensure that the medical record was complete. The finding includes: 1. Resident #23 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, cognitive deficits and post-traumatic stress disorder. Review of the State of Connecticut Department of Emergency Services & Public Protection Division of State Police Sex Offender Registry dated 7/12/21 identified Resident #23 was listed as a registered sex offender. The significant change MDS dated [DATE] identified Resident #23 had intact cognition and required total assistance with personal hygiene. Review of the September 2021 social service notes failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the September 2021 MAR identified Resident #23 was being monitored for anti-depressant (specific behaviors): Depressed, sad, crying, tearfulness, withdrawn, and mood changes every shift. The behavior monitoring record failed to identify that Resident #23 was being monitored for inappropriate sexual behaviors. A social service note dated 9/20/21 at 11:16 AM identified Resident #23 and Person #8 requested a referral be sent to skilled nursing facilities in 3 other towns so that Resident #23 could be closer to Person #8. Referrals were sent on 9/1/21. Review of the referral documentation dated 9/22/21 sent to one of the skilled nursing facilities failed to reflect that Resident #23 was on the Sex Offender Registry. A physician's order dated 9/27/21 directed to discharge Resident #23 to the facility closer to home on 9/28/21. Reviewed of the Inter-Agency Patient Referral Report (W-10) dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. Review of the interdisciplinary discharge summary dated 9/28/21 failed to reflect any documentation that Resident #23 was on the Sex Offender Registry. The social service note dated 9/28/21 at 2:07 PM identified the social worker assisted Resident #23 to notify the Connecticut Sex Offender Registry of his/her change of address in writing. The social worker spoke to the social worker at the receiving skilled nursing facility to update on Resident #23 status. Resident #23 was discharged at 2:00 PM via ambulance with belongings. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	A social service note dated 9/28/21 at 6:00 PM identified the facility received a phone call from the receiving skilled nursing facility indicating they were sending Resident #23 back to the facility because they were not aware that Resident #23 was on the Sex Offender Registry. Resident #23 arrived back at the facility at 6:00 PM in a wheelchair, indicating he/she had no idea why they were sent back. After Resident #23 was returned to his/her room, the Social Worker explained to Resident #23 the reason why he/she had been sent back, and the resident became weepy and upset. A nurse's note dated 9/28/21 at 9:21 PM identified Resident #23 returned to the facility at approximately 6:00 PM. Admission to the new facility was refused related to a past indiscretion. Resident #23 was visibly upset and crying about reason for refusal. Resident #23 became calmed after allowing him/her to talk and showing compassion. Resident #23 was monitored throughout the shift and he/she was able to go to sleep around 9:30 PM. Review of the care plans dated 9/30/21 failed to reflect Resident #23 was a registered sex offender and/or interventions to address such. Interview with the Social Worker on 10/1/21 at 1:27 PM identified she became aware that Resident #23 was on the Sex Offender Registry on 9/2/21 when another facility that she had placed a referral to called and notified her that Resident #23 was on the Sex Offender Registry. The Social Worker indicated she did not share the information with the Administrator or the DNS and indicated she had not discussed the issue with the interdisciplinary team during the morning meeting. The Social Worker indicated she failed to document in the resident clinical record or initiate a care plan regarding Resident #23 being on the Sex Offender Registry. The Social Worker identified she informed the Administrator and the DNS on 9/28/21 when Resident #23 was in route back to the facility. Interview with the Administrator on 10/1/21 at 1:45 PM indicated she was not aware or does not recall Resident #23 being on the Sex Offender Registry. The Administrator indicated it is the Admission Director responsibility to do a background check on the new resident applicants. The Administrator indicated she cannot answer why a care plan was not initiated. The Administrator identified the Social Worker did not inform her that Resident #23 was on the Sex Offender Registry. The Administrator indicated she found out on 9/28/21 when the receiving facility that Resident #23 had been discharged to, called and stated the resident is in route back to the facility because he/she was listed on the Sex Offender Registry. Interview with the DNS on 10/1/21 at 2:44 PM identified she was not aware that Resident #23 was on the Sex Offender Registry. She indicated she learned of it on 9/28/21 when the receiving facility was sending Resident #23 back to the facility. The DNS indicated the social worker had not informed her that Resident #23 was on the Sex Offender Registry. The DNS indicated she was aware Resident #23 did not have a care plan addressing his/her history. The facility failed to ensure complete documentation in clinical record. 2. Resident #29 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, polyneuropathy, diabetes, and hypertension. The care plan dated 3/24/21 identified an altered cardiovascular status related to hypertension and hyperlipidemia. Interventions directed to observe for and report any signs or symptoms of dependent edema. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The care plan dated 3/24/21 identified a potential for fluid overload related to diuretic use. Interventions directed to administer medications as ordered. The annual MDS dated [DATE] identified Resident #29 had intact cognition, was always continent of bowel and bladder and required supervision for activities of daily living and assist of 1 for transfers, personal hygiene, and toileting. A physician's order dated 7/27/21 directed to apply tubi grips to bilateral lower extremities in the morning and remove at bedtime every 12 hours for edema. The nurse's progress notes dated 8/1/21 - 9/13/21 did not mention any refusals to wear tubi grips or that the APRN/ MD were notified of refusals to wear tubi grips and they were not offered to Resident #29 per the physician order. An interview with Resident #29 on 9/8/21 at 10 :00 AM indicated the charge nurse had not put on his/her tubi grip stocking for over a month. Resident #29 noted he/she would wear them if the nurse had asked but hasn't ask. Observations on 9/8/21 at 10:00 AM and 2:00 PM identified Resident #29 was sitting in the wheelchair dressed in residents' room and only had on nonskid socks and did not benefit from tubi grips to bilateral lower extremities with bilateral lower extremity edema present. Observations on 9/9/21 at 10:00 AM and 1:50 PM identified Resident #29 was dressed in the wheelchair and only had on grippy socks without the benefit of the tubi grip stocking for the edema to bilateral lower extremities. Interview with LPN #1 on 9/9/21 at 2:25 PM identified he was responsible to apply the tubi grips to Resident #29's bilateral lower extremities per the physician order, because of the dependent edema that was present. LPN #1 indicated he had been documenting Resident #29 was refusing the tubi grips per the physician order, but because Resident #29 had a long time ago refused them, LPN #1 assumed Resident #29 would refuse them and had not asked. LPN #1 indicated he had not asked Resident #29 in a while except maybe once or twice even though he was documenting in the medical record that she was refusing daily. Review of medical record LPN #1 indicated the month of August and September 2021 he had put Resident #29 had refused the tubi grips but probably only ask a couple of times. LPN #1 indicated he had not asked Resident #29 this week or last week if she/he would wear them. LPN #1 did a thorough room search in the nightstand, drawers, closet, and bathroom and was not able to locate a pair of tubi grips to apply to Resident #29's swollen legs in the residents room. LPN #1 approached Resident #29 and offered the tubi grips to bilateral lower extremities if he got a pair and Resident #29 was agreeable to put them on. LPN #1 indicated if Resident #29 had refused the tubi grips he would be responsible to notify the APRN or physician of the refusals by the second day and document it in the progress notes. LPN #1 indicated he did not notify an APRN or a physician and did not document anything. Interview and observation with Resident #29 on 9/13/21 at 11:00 AM indicated she/he was wearing white ted stockings (Anti Embolism Stockings) to bilateral lower extremities. Resident #29 noted she/he liked having them on because it makes his/her legs feel better and helps with the swelling. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview and observation with LPN #1 on 9/13/21 at 10:25 AM indicated he had put the white ted stockings (Anti Embolism Stockings) on Resident #29 on 9/10/21 and 9/13/21 he indicated Resident #29 was agreeable to put them on to bilateral lower extremities. LPN #1 indicated he did not know what tubi grips were, so he decided to use ted stockings (Anti Embolism Stockings) indicated central supply only had the large size Anti Embolism Stockings, so LPN #1 noted he tried them on Resident #29. LPN #1 indicated he did not measure the resident's legs prior to applying the Anti Embolism Stockings on 9/10/21 and 9/13/21 without a physician order. LPN #1 indicated he had a physician order for tubi grips, and he thought the ted stockings (Anti Embolism Stockings) were the same thing. LPN #1 questioning if he needed a new order for the ted stockings (Anti Embolism Stockings). Interview and observation with the DNS on 9/13/21 at 2:15 PM indicated Resident #29 had on ted stockings (Anti Embolism Stockings) to bilateral lower extremities and the facility does not have a physician order for the ted stockings (Anti Embolism Stockings) they have a physician order only for the tubi grips and they are not the same. The DNS was not aware LPN #1 had placed Resident #29 in the Anti Embolism Stockings on 9/10/21 and 9/13/21 until the surveyor brought this to the DNS attention. Interview and clinical record review with LPN #1 and the DNS on 9/13/21 at 2:15 PM the DNS indicated if a resident refuses a medication or a treatment the APRN or physician have to be notified and a progress note to explain by the resident refuses and that the physician was notified. LPN #1 indicated he had been documenting that Resident #29 was refusing the tubi grips but did not ask Resident #29 daily. LPN #1 indicated he had assumed Resident #29 would refuse them, so he didn't ask. The DNS indicated LPN #1 must follow the physician order and was expected to ask Resident #29 every day prior to documenting that Resident #29 had refused without even asking. The DNS indicated her expectation was that LPN #1 would ask every day and document accurately. The Medication Administration Record dated August 1-31, 2021 identified that LPN #1 indicated Resident #29 had refused the tubi grips on the 20 days he worked. The Medication Administration Record dated September 1-13, 2021 identified that LPN #1 indicated Resident #29 had refused the tubi grips on Review of facility Charge Nurse Job Description dated 5/2019 identified the major duties and responsibilities included follow the physician's orders, review resident records daily to assure accuracy and completeness, document comprehensive and complete nursing notes, document and report any unusual or significant findings and contact the physician, and follow facility policies and procedures. Review of facility policy Documentation in Resident Records identified the medical record shall be legible, factual, signed and dated. Review of facility Policy Change of Condition in a Resident Status identified the charge nurse will notify the resident physician when there was a refusal of a medication or a treatment. The RN supervisor will assess the residents change in condition and document their findings in the medical record. The charge nurse will record in the residents' medical record information relative to change in the residents' medical condition or status. Notifications will be made within 24 hours of a change occurring in the residents medical condition or status. 3. Resident #79 was admitted to the facility on [DATE] with diagnoses that included severe morbid obesity, reduced mobility, anxiety disorder and major depressive disorder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the May 2021 physician's orders directed to transfer the resident via a mechanical lift with the assistance of 3 staff. Review of the weight's summary dated 5/18/21 identified Resident #79 weighed 402.1 lbs. The quarterly MDS dated [DATE] identified Resident #79 had intact cognition, and transfer activity occurred only once or twice during the reference period. Additionally, the MDS identified transfers occurred with 2 person plus physical assistance. The care plan dated 6/2/21 identified Resident #79 had a self-performance and mobility deficit related to deconditioning and weakness. Interventions included to encourage the resident to participate in ADLs to promote independence. The care plan failed to reflect the physician's order for transfers via mechanical lift with the assistance of 3 staff. Additionally, the care plan identified Resident #79 was at risk for falls related to polypharmacy and weakness. Interview with Resident #79 on 8/16/21 at 1:05 PM identified that sometime in May 2021, during a mechanical lift transfer from the bed to the wheelchair, with NA #1 and NA #23, the lift tilted to the side with the resident in it and the nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she was upset that the incident happened and was scared because he/she thought that he/she was going to fall onto the floor. Resident #79 indicated that during the incident they were all screaming as the nurse aides were trying to get him/her into the wheelchair. Resident #79 indicated that both nurse aides are small and short and during the incident, the lift hit the resident in the head. Resident #79 indicated that the nurse aides could have gotten really hurt. Both nurse aides had to struggle to keep the resident from falling onto the floor in the lift. Resident #79 indicated he/she landed in the wheelchair in a slouching position. Resident #79 indicated after the incident, NA #23 was pinned in back of the wheelchair against the wall, and the lift flipped backwards and fell on to NA #1 and she got hurt. Resident #79 indicated NA #1 and NA #23 started yelling for LPN #1. Resident #79 indicated LPN #1 came into the room and helped to reposition him/her properly in the wheelchair and help the 2 nurse aides. Additionally, interview with Resident #79 on 8/16/21 at 1:05 PM identified that usually when he/she rings the call bell, it takes the nurse aides 40 minutes to an hour to answer. Resident #79 indicated that sometime in June 2021, during the 11:00 PM - 7:00 AM shift, he/she needed help and rang the call bell for approximately 4 hours, but the staff did not answer or come to his/her room. In another incident, Resident #79 indicated recently, after returning from a hospitalization , during an 11:00 PM - 7:00 AM shift, the resident rang the call light because he/she had to urinate. Resident #79 could not remember the exact time but was also yelling for help. The staff on the night shift never came into his/her room to help or provide care so he/she had to urinate in the bed and lay in it. Resident #79 indicated that when the 7:00 AM - 3:00 PM shift arrived, the nurse aide answered the call light a little after 7:00 AM. Resident #79 indicated at that time, NA #1 provided care and the resident reported to NA #1 that he/she had been ringing for help since 5:00 AM and had been laying in urine because no one came to help. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #79 indicated he/she lays in bed waiting for staff to answer the call bell, it happens all the time, it goes on all the time. The resident stated he/she many times has had to urinate right in his/her bed and lay in the urine, screaming for help because no one comes, and he/she and the bed gets cold because it's wet. The resident indicated he/she has had to call 911 in the past when staff don't answer the call bell. The resident indicated he/she rings for the bedpan and will urinate on the bedpan, but if no one comes, he/she has no choice and cannot hold it, so will urinate in the bed. If staff answer his/her call light in a timely manner, he/she uses the bed pan. Interview with Resident #2, (Resident #79's roommate), on 8/16/21 at 1:12 PM identified he/she does not remember the exact date but does remember an incident when he/she was woken up by Resident #79 screaming for help at approximately 5:00 AM. Resident #2 indicated the night shift did not come to answer the call bell or come in the room to help Resident #79. It wasn't until the day shift arrived that Resident #79 received help. Additionally, Resident #2 indicated he/she was in the room and witnessed the incident with Resident #79 when the mechanical lift tilted, and the 2 nurse aides got hurt. Resident #2 indicated the incident happened in May 2021. Resident #2 indicated the privacy curtain was not pulled for privacy and he/she could see everything that happened. Resident #2 indicated NA #1 and NA #23 were getting Resident #79 out of the bed with the lift and when NA #1 started turning the lift around to put Resident #79 into the wheelchair, the lift tilted and both nurse aides were doing their best to prevent Resident #79 from falling and to get him/her into the wheelchair. Resident #2 indicated the 2 nurse aides managed to get Resident #79 into the wheelchair, but NA #23 got pinned between the back of the wheelchair and the wall, and the tilted lift fell on NA #1. Both nurse aides started yelling for help. Resident #79 indicated NA #1 and NA #23 started yelling for LPN #1. Interview with NA #1 on 8/16/21 at 1:30 PM indicated she was not aware that Resident #79 required the assistance of 3 staff with mechanical lift transfers and indicated the nurse aide care card did not reflect that information. NA #1 indicated on 5/28/21 she and NA #23 were transferring Resident #79 from the bed to the wheelchair in the lift, and the lift tilted. NA #1 indicated she and NA #23 tried as hard as they could to prevent the lift from fully tipping over and to get the resident into the wheelchair. When they managed to place the resident into the wheelchair, NA #23 got pinned behind the wheelchair and the wall, and the mechanical lift fell on NA #1. NA #1 indicated she and NA #23 started yelling for LPN #1. LPN #1 came into the room and help to properly positing Resident #79 into the wheelchair. NA #1 identified she was afraid that Resident #79 would land on the floor. As they turned the lift toward wheelchair, it tilted, and she and NA #23 did everything they could to prevent Resident #79 from falling onto the floor in the lift and to get the resident into the wheelchair safely. Both nurse aides were doing everything possible to prevent the resident from falling on the floor as the lift was tilted. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with NA #23 on 8/16/21 at 3:26 PM identified that a couple of months ago, she and NA #1 were transferring Resident #79 from the bed to the wheelchair via a mechanical lift and indicated they are required to have 2 staff members when using the mechanical lift. NA #23 indicated she was not aware that Resident #79 needed the assistance of 3 staff with transfers using the mechanical lift. NA #23 indicated the 600-pound capacity mechanical lift was used, the resident was properly position on the lift pad, and the base was opened. As the resident was being transferred to the wheelchair, the lift tipped over. NA #23 was positioned in back of the wheelchair guiding the resident into the wheelchair. NA #23 identified when the lift tipped, Resident #79 fell into the wheelchair and she was pinned between the wheelchair and the wall. Both she and NA #1 started screaming for help. NA #23 indicated Resident #79 was crying and cursing during and after the incident. Interview with RN #4 on 8/16/21 at 4:00 PM identified she was aware of the incident on 5/28/21 with Resident #79. RN #1 indicated Resident #79 did not fall on the floor and was not injured and that is why she did not complete a reportable event form. RN #4 indicated she assisted in helping to properly position Resident #79 in the wheelchair after the incident. RN #1 indicated she assessed Resident #79 but did not document the assessment or notify the physician or conservator. RN #4 indicated she was not aware of the physician's order to have 3 staff transfer Resident #79 with mechanical lift transfers and was not aware that the nurse aide care card did not include that information. Interview with the Former DNS on 8/17/21 at 2:05 PM identified she was on vacation during when the incident happened and indicated she would have expected RN #4 and LPN #1 to assess Resident #79, document the incident in the clinical record and complete a reportable event form. Review of the clinical record failed to reflect information regarding the incident of 5/28/21 when the mechanical lift tilted, with Resident #79 in it, during a transfer, failed to reflect the resident was hit in the head during that incident, and failed to reflect an assessment of the resident's condition at the time of the incident. Additionally, the clinical record failed to reflect the allegation by Resident #79 to NA #1 that he/she had been ringing the call bell for 2 hours and had to urinate in his/her bed because no one came to provide care. Subsequently, NA #1 in an interview indicated the resident was found in a urine saturated bed. 4. R #88's diagnoses included Cerebral Vascular Accident (CVA) and heart disease. The annual minimum data assessment dated [DATE] identified that R #88 had mildly impaired cognition and hearing was adequate. The annual minimum data set (MDS) assessment dated [DATE] identified that R #88 had mildly impaired cognition. Transfer documentation dated 8/3/21 and 8/22/21 identified that R #88 was transferred to the ER. Nursing narratives dated 8/4/21 noted that R #88 returned from the ER with a new order for Neomycin Polymyxin ear drops to the left ear. Nursing narratives dated 8/23/21 identified that R #88 returned from the ER with no new orders. Review of the electronic medical record and paper record for P #88 and interview with RN #6 on 9/14/21 at 10:50 AM indicated that the return transfer documentation for both ER admissions could not be located. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The missing transfer documentation did not allow for verification that orders were transcribed correctly or that care was provided per discharge instructions. The facility policy entitled Documentation in Resident Records identified that records shall be maintained for each client receiving nursing services and kept in good order. The facility policy entitled Transfer Acute Care identified that detailed information regarding acute care transfers will be reviewed at regular intervals as part of the overall quality assurance and performance improvement plan. 37293 42117

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on observations, review of the clinical record, facility documentation, interviews, and policy review, the facility failed to ensure that visitors were screened for symptoms of COVID-19 upon entry into the facility in accordance with facility policy, failed to maintain compliance with the submitted action plan to address screening of visitors, failed to ensure the COVID-19 observation unit had proper signage posted at the entrance of the unit, failed to ensure staff utilized Personal Protective Equipment (PPE) while caring for Residents on the observation unit, and that PPE was properly discarded after use, resulting in a finding of Immediate Jeopardy. Additionally, the facility failed to ensure an adequate number of gloves were readily available to staff for care, and for 1 resident, (Resident #48) the facility failed to ensure infection control measures were implemented related to respiratory and G tube care. The findings include: 1. On 9/4/21 at 10:53 AM, the surveyor entered the building and remained in the entryway until 11:00 AM. During that time staff were observed in the hallways and walking by but did not approach the surveyor to provide screening for COVID-19. Further observation noted four (4) visitors in the dining room visiting with R#25 and R #78. At 11:00 AM the surveyor walked to the A/B wing nurse's station to ask for the person in charge. The RN Supervisor greeted the surveyor and upon inquiry was told they had no one to sit at the front desk to monitor visitors who entered the building. As of 11:10 AM, no staff had inquired if the surveyor was screened. Further interview with the RN Supervisor at 11:10 AM stated that the Receptionist was not available until 2:00 PM and people will not be screened. The RN Supervisor stated that she does not have enough staff in the building to have someone sit at the front desk to screen people, so she will screen them if she sees them. Observations at 11:23 AM noted the RN Supervisor went to the dining room where the four (4) visitors were and had them complete the COVID-19 screening questions and the RN Supervisor was observed to take each visitors temperature. Interview with R #78 visitors at 11:30 AM stated they arrived at 10:40 AM and they were not screened until now when the RN Supervisor came into dining room. Interview with R #25's visitors at 11:30 AM stated they arrived at 11:10 AM and they were also not screened until now when the RN Supervisor came into room. Interview with the Administrator on 9/4/21 at 12:40 PM stated the facility policy directed that all people who enter the building are to be screened prior to going anywhere in the building. The Administrator stated that the person who was supposed to be the weekend Receptionist was currently working in the kitchen as a dietary aide because they are short of help. Review of the indoor visitation policy dated 4/2021 identified that all visitors will have their temperature taken and be screened for COVID-19 symptoms. On 9/4/21, the facility provided the Department with an action plan that identified all visitors would be screened for COVID-19 symptoms including temperature prior to visitation. The on-duty Receptionist will screen all visitors, and in the absence of the Receptionist, the Nursing Supervisor or designee will perform visitor screening and temperature. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Upon surveyor entrance into the facility on [DATE] at 7:30 AM there were no staff in the lobby to screen for symptoms of COVID-19 in accordance with facility policy and the submitted action plan dated 9/4/21. The surveyor entered the dining room adjacent to the entrance to the facility, and ten (10) minutes later (7:40 AM) the Administrator entered the facility. Subsequent to surveyor request, the surveyor was screened for COVID-19 symptoms. Interview with the Administrator on 9/7/21 at 7:40 AM identified that the Supervisor should have screened the surveyor, however, there was no way to identify when a visitor entered the front entrance because the door is unlocked at 6:30 AM. The Administrator stated that the front door would now remain locked until 8:00 AM when the Receptionist arrives. This intervention was added to the action plan originally submitted on 9/4/21 . 3. Interview with the Director of Nurses (DON) on 9/6/21 at 5:30 PM identified that the C wing was the COVID-19 observation unit (quarantined unit) because a Nurse Aide who worked on 9/3/21 had tested positive for COVID-19 on 9/5/21. a. Observation on 9/6/21 at 6:00 PM of the C wing unit identified that although the doors to the entrance of the unit were closed, the doors lacked signage to identify what type of PPE was necessary to be worn on the unit. Interview with the Director of Nurses on 9/6/21 at 6:00 PM identified that she was unaware that the entrance to the unit required signage to alert those who enter of what type of PPE is required. Review of CDC Guidelines (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) directed in part to place signage at the entrance to the COVID-19 unit that instructs staff they must wear personal protective equipment (PPE). b. Tour of the COVID-19 observation unit on 9/6/21 at 6:15 PM with the Director of Nurses and the Administrator identified that room [ROOM NUMBER] had a yellow precautions sign outside the door indicating that the resident required droplet and contact precautions (gloves, gown, eye protection, and a face mask). Further observation identified that Nurse Aide (NA) #1 and NA #2 were in the room preparing to take the resident to the bathroom, both were in close proximity to the resident, and only wearing a surgical mask and gloves, and lacked the necessary face shield and isolation gown. Interview with NA#1 and NA#2 at the time of the observation identified that they did not know that the unit was a COVID-19 observation unit, and that they were required to wear PPE. NA#1 and NA#2 further identified that they had been providing personal care such as toileting, incontinent care, and repositioning for several residents since the beginning of their shift at 3:00PM without the benefit of face shields or isolation gowns. NA#1 and NA#2 identified that they did not see the yellow isolation signs posted outside of every room. Interview with Licensed Practical Nurse (LPN) #2 on 9/6/21 at 6:25 PM, who was the charge nurse on the observation unit, identified that she had given all of the residents their medications and was not aware that she needed to wear anything else but a face mask while administering medications, she thought that full PPE needed to be worn when only giving personal care . CDC Guidance identified that HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON at the time of the observation identified that she did not think that the PPE was necessary because the residents were all negative when they had their rapid COVID tests on 9/5/21 (2 days after the potential exposure to COVID-19). Interview with the Administrator at the time of the observation identified that the facility had a plentiful supply of PPE, and that the residents were to be on observation for COVID-19 for 14 days and PPE is required until the 14 days has concluded, regardless of what the COVID test results were. c. On 9/6/21 at 8:30 PM on the COVID-19 observation unit, NA #1 was observed to exit out of a droplet precaution room, removed her isolation gown while in the hallway, crumbled it in her gloved hands then walked half the length of the hallway to dispose of the isolation gown. Review of the Centers for Disease Control Guidelines for the removal of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) identified that all PPE must be removed prior to exiting the resident's room. Review of the facility policy for PPE on a COVID-19 observation unit dated 12/2020 identified that a face mask, eye protection, gloves, and an isolation gown were necessary to provide care to residents on the observation unit. Subsequent to observations, on 9/6/21, the facility provided the Department with an immediate action plan that included staff education regarding the requirements of PPE use on the COVID-19 in accordance with CDC guidelines. d. On 9/7/21 at 10:30 AM, the doors to the COVID-19 observation unit lacked signage to inform staff/visitors that the unit was under quarantine, despite the same observation the day prior. Interview with the Administrator on 9/7/21 at 10:30 AM identified that she would ensure signage was added to the doors of the COVID observation unit. Subsequent to this observation, signage was placed on the doors at the entrance of the COVID-19 observation unit which indicated that the unit was quarantined. e. Further observation on 9/7/21 at 10:32 AM identified a droplet and contact precaution sign outside of room [ROOM NUMBER]. Physical Therapist (PT) #1 was identified to be in the room repositioning Resident #53 in bed, the resident was noted to cough several times while being repositioned. PT #1 was wearing gloves and a face mask; however, he lacked a face shield and an isolation gown while providing care to the resident. Interview with PT #1 at the time of the observation identified that he was unaware that the unit was under observation for COVID-19, and he had not seen the yellow isolation sign upon entering the room. Interview with the Administrator on 9/7/21 at 10:30 AM identified that PT#1 should have been wearing a face shield and gown in addition to the face mask and gloves while caring for the resident. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. During tour of the COVID-19 observation unit on 9/7/21 at 10:55 AM, Resident #25 was sitting on h/her bed without a face mask and was speaking to a visitor who also lacked a face mask. Interview with the visitor at the time of the observation identified that he worked at a group home where the Resident resided previously, and visited the resident daily, however he did not know that Resident #25 was on observation for COVID-19 exposure. Interview with LPN #2 on 9/7/21 at 11:00 AM, who was Resident #25's nurse, identified that she was aware that the visitor was in Resident #25's room, and did not inform him that the entire unit was on observation for COVID-19 exposure, nor offer him any PPE. g. Further tour of the COVID-19 observation unit on 9/7/21 at 11:00 AM identified that a visitor was observed coming out of Resident #80's room. Interview with the visitor at the time of the observation identified that she was from the Resident's group home and was not informed that the Resident was on an observation unit for COVID-19 exposure. The visitor was observed wearing a face mask upon exiting the room and identified to the surveyor that she was not wearing any other PPE besides the face mask while visiting the resident. Interview with the Administrator on 9/7/21 at 11:05 AM identified that Resident #25 and Resident #80 did not qualify for compassionate care visits and she thought that the visitors from the group home were allowed because they were included in the Resident's plan of care. Review of the plan of care for Resident #25 and Resident #80 failed to reflect any interventions including visits from group home staff. Review of the facility visitation policy dated 4/2021 identified that indoor visitation should be limited solely to compassionate care visits for vaccinated and unvaccinated residents that are in quarantine until they have met the criteria for release from quarantine. h. Further tour of the COVID-19 observation unit on 9/7/21 at 11:00 AM identified that NA #8 came out of a droplet precaution room and took her gown off, crumpled it up in her un-gloved hands and walked down the hallway to dispose of the gown. Interview with the Administrator on 9/7/21 at 12:00 PM identified that the gowns should be offed prior to leaving the room and that she would be obtaining more receptacles for the used PPE so the Nurse Aide's don't have to walk down the hallway to dispose of them. Over the course of multiple days, the facility failed to ensure infection control practices were implemented in accordance with policies despite immediate action plans submitted to the Department resulting in Immediate Jeopardy. On 9/7/21 the facility submitted an immediate action plan that included: The front door will remain locked until the Receptionist reports to work. All visitors will be screened by the Receptionist, Nursing Supervisor or designee to include screening questions and temperature with results recorded in a log. Facility wide re-education on proper use of PPE, audits daily for seven days and weekly for 4 weeks and monthly for 3 months, and audits will be forwarded to the QAPI Committee for further review and recommendations for a three-month period or until the committee determines resolution. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an onsite visit on 9/8/21, the action plan was verified as implemented, therefore, the Immediate Jeopardy was abated. 37293 2. Observation on 9/2/21 at 9:05 AM on C wing identified RN #4 left a resident's room and went in and out of 4 different other rooms looking for gloves. No gloves were found in the 4 rooms. RN #4 asked a nurse aide for gloves and the nurse aide pulled a pair of gloves out of her scrub pocket. Tour of A wing, B wing, and C wing on 9/2/21 at 9:15 AM with RN #4 identified the following; Of the 13 rooms on A wing, gloves were not available in 10 rooms/bathrooms: rooms 3, 4, 5, 6, 7, 9, 10, 11, 13, and 15. Of the 17 rooms on B wing, gloves were not available in 11 rooms/bathrooms: rooms #16, 17, 19, 20, 21, 23, 24, 25, 26, 29, and 31. Of the 17 rooms on C wing, gloves were not available in 16 rooms/bathrooms: rooms 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, and 49. Interview with NA #9 on 9/2/21 at 10:05 AM on C wing identified she was aware that there were no gloves in the resident rooms. NA #9 identified that she must go and get one box of gloves from the supervisor's office at the beginning of her shift (7:00 AM - 3:00 PM) and place the box of gloves on the railing in the hallway. NA #9 indicated that one box of gloves is to be used among all the staff on the whole unit for the shift. NA #9 indicated that she must put extra gloves in her scrub pocket. NA #9 indicated that the DNS informed the staff that the facility will not be putting gloves in the resident rooms anymore. Interview with LPN #3 on 9/2/21 at 10:08 AM identified she was not aware that the resident rooms did not have gloves and indicated she uses the gloves on the medication cart and at times the nurse's aides will get gloves from the medication cart. Interview with NA #6 on 9/2/21 at 10:12 AM identified she was aware there were no gloves in the resident rooms. NA #6 identified there have not been gloves in the rooms for a very long time and she does not know why. NA #6 indicated when she needs gloves, she must stop resident care, leave the room, and get the gloves in the hallway. Observation with RN #4 on C wing on 9/2/21 at 10:15 AM identified one box of gloves on the railing in the hallway. Interview with LPN #5 on 9/2/21 at 10:25 AM identified she was aware that the resident rooms did not have gloves and identified that when she needs gloves, she gets them from the medication cart. LPN #5 indicated she does not know who is responsible to replenish the rooms with gloves. Interview with RN #4 on 9/2/21 at 10:35 AM identified she was not aware that the resident rooms and bathrooms did not have boxes of gloves available. RN #4 indicated central supply staff is to supply the rooms with gloves. RN #4 indicated that she was not aware that the DNS notified the staff that gloves will not be provided in the resident rooms. (continued on next page)

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	075057	A. Building B. Wing	09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 9/2/21 at 10:43 AM of Physical Therapist (PT) #3 on the B wing leaving the residents room, walking approximately 10 feet to the medication cart to obtain gloves, and re-entering the resident's room to continue therapy. Interview with PT #3 identified gloves had not been readily available for staff in the resident rooms for a very long time (months), which resulted in the staff having to search for gloves prior to caring for a resident or having to leave a resident's room to obtain additional gloves during care. Interview with LPN #1 on 9/2/21 at 10:45 AM on the B wing identified he was aware that there are no gloves in the resident rooms. LPN #1 indicated the facility does not put gloves in the room, and the facility does not want gloves in the rooms. LPN #1 indicated it has been this way for a while. LPN #1 indicated that the medication cart has gloves, and the nurse's aide must go to the supervisor office for gloves, and they are allowed one box for the wing and shift. Interview with NA #5 on 9/2/21 at 10:50 AM on the B wing identified she was aware that there are no gloves in the resident rooms. NA #5 indicated at the beginning of the shift (7:00 AM - 3:00 PM) she must go to the supervisor's office and get one box of gloves and place the box of glove on the railing in the hallway. She identified that the one box of glove is to be used among the staff for the wing for the shift. NA #5 indicated that she put multiple gloves in her scrub pocket because it's difficult to be in the middle of care and have to stop and go and get gloves out in the hallway. Observation on B wing on 9/2/21 at 10:51 AM one box of gloves on the railing in the hallway. Interview with NA #20 on 9/2/21 at 10:52 AM on the B wing identified she was aware that there are no gloves in the resident rooms. She identified that one staff must get one box of glove from the supervisor's office at the beginning of the shift (7:00 AM - 3:00 PM) and place the box of glove on the railing in the hallway. She indicated that one box of glove is to be used among the staff on the unit for the shift. She indicated during care if she needs glove, she must stop and go into the hallway and get another pair of gloves. Interview with Housekeeping Director on 9/2/21 at 10:59 AM identified she was not aware of the resident rooms not having gloves available to the staff. She indicated central supply is responsible to put gloves in the resident rooms. She indicated the Administrator asked her to go and put a box of gloves in all the rooms right now. Interview with the Administrator on 9/2/21 at 11:07 AM identified she was aware that the resident rooms did not have gloves available to the staff. She indicated since 8/2020 during the Covid-19 pandemic, the facility did not have gloves in the resident rooms. The gloves have been controlled in the supervisor office since she has been at the facility (8/2020). The Administrator identified that was the procedure that was in place at the facility when she was employed. She indicated when a resident is positive Covid-19 a box of gloves is put in the rooms or on the isolation cart. Interview with DNS on 9/2/21 at 11:10 AM identified she was aware that the resident rooms did not have gloves. She identified gloves are kept in the supervisor's office and the staff is to get a box at the beginning of each shift due to excessive use, control and to prevent overuse. The DNS indicated it is the company's rule. The DNS indicated gloves should have been readily available to staff for resident care and universal standard precaution. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with NA #12 on 9/2/21 at 12:05 PM identified she was aware that there were no gloves in the resident rooms. NA #12 identified there has been no gloves in the resident room since her employment in 1/2021. She indicated she get a used box of gloves from the previous shift or searches for a box of gloves. She indicated that she keeps the box of gloves with her going from resident room to resident room. Interview with NA #21 on 9/2/21 at 12:19 AM on A wing identified she was aware of the resident rooms not having gloves. She indicated it has been like this for a very long time. NA #21 indicated she must search for gloves or go to the supervisor's office for one box of gloves. And she places the one box of gloves on railing in the hallway for the staff on the wing. Interview with the former DNS on 9/2/21 at 2:06 PM identified she was aware of the resident rooms not having gloves. The former DNS identified that this was the procedure for the facility for approximately a year. She identified that gloves should have been readily available for staff in the resident's room for care not having to go out into the hallway when needed. The former DNS indicated that is not the correct universal standard precaution. Interview with NA #2 on 9/2/21 at 4:21 AM identified she was aware that the resident rooms did not have gloves. She indicated that she gets one box of gloves from the supervisor's office and stuff her pocket with gloves. NA #2 indicated she places the box in the linen closet for the rest of the shift. NA #2 indicated the facility stop putting gloves in the resident rooms since the beginning of the year. Interview with RN #2 on 9/2/21 at 4:44 PM identified she was aware that there were no gloves in the resident rooms and the bathrooms. RN #2 identified that the staff is supposed to come to the supervisor's office, and they are provided with one box of gloves for the whole wing. She indicated that gloves had not been readily available in resident rooms since the beginning of the year. She indicated universal precaution is gloves are available in resident rooms for care. Interview with Central Supplies staff on 9/8/21 at 12:38 PM identified she was told by the Administrator last year not to put any gloves in the resident's rooms and bathrooms. She indicated the Administrator directed her to put gloves in the supervisor's office only. She indicated she was only doing what she was told by the Administrator. Subsequently to surveyor inquiry, the facility's Housekeeping Director brought additional boxes of gloves to A, B, and C wings and stocked the resident rooms with gloves. Review of the facility gloving policy identified to prevent the transmission of infectious organisms between residents, staff and visitors. Protective gloves should be worn by all personnel during any procedure that may involve handling secretions and excrements of blood or bodily fluids. Gloves should only be worn once and then discarded. Gloves must be changed in between resident contact. Gloves must be changed any time their integrity is compromised. It is the policy of this facility that gloves be worn with reasonable anticipation of contact or handling of blood or body fluids, mucous membranes, non-intact skin, potentially infectious materials, when performing vascular access procedures, and/or touching contaminated surfaces. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the CDC (Center for Disease Control) guidelines for PPE for Isolation Precautions identified to wear gloves when it is anticipated that contact with potentially infectious materials could occur on the patient or the patient's surrounding environment and change gloves during patient care when the hands move from a contaminated body-site to a clean body site. Standard Precautions: infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents. Furthermore, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. Standard precautions include but are not limited to hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; safe injection practices, and respiratory hygiene/cough etiquette. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, properly clean and disinfect or sterilize reusable equipment before use on another patient). The use of PPE during resident care is determined by the nature of staff interaction and the extent of anticipated blood, body fluid, or pathogen exposure to include contamination of environmental surfaces. Furthermore, appropriate use of PPE includes but is not limited to the following: o Gloves worn before and removed after contact with blood or body fluid, mucous membranes, or non-intact skin; o Gloves changed, and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care. The facility failed to ensure an adequate number of gloves (personal protective equipment) were readily available to staff accordance to universal standard precautions and infection control policies. 3. Resident #48 was admitted to the facility on [DATE] with diagnoses that included tracheostomy, malignant neoplasm of bronchus or lung, malignant neoplasm of upper lobe, right bronchus or lung, artificial openings of gastrointestinal tract. Physician's order dated originally 7/4/21 and current through 9/13/21 directed to change disposable oxygen supplies every week and as needed on (Saturday 11:00 PM - 7:00 AM) shift. Label and date all supplies every Saturday night. Physician's orders dated originally dated 7/4/21 and current through 9/13/21 directed to suction tracheostomy as needed. Suctioning is a sterile procedure, and a new sterile gloves and suction catheter should be used each time. Physician's orders dated originally 7/4/21 and current through 9/13/21directed to administer cool mist aerosol via air compressor with 2 Liters of oxygen via liquid or concentrator to trach mask to equal 28% oxygen every shift. The admission MDS dated [DATE] identified Resident #48 had intact cognition and required extensive assistance with personal hygiene. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan dated 7/21/21 and currently in effect identified Resident #48 has a tracheostomy. Interventions included to provide trach care as needed, suction as necessary, and use universal precautions as appropriate. Additionally, Resident #48 requires a J-tube. Interventions included to provide local care to J-tube site as ordered and monitor for sign and symptoms of infection. Further, Resident #48 has Chronic Obstructive Pulmonary Disease (COPD). Interventions included to administered oxygen per physician's order. Review of the July 2021 MAR identified to change disposable oxygen supplies every week and as needed. Label and date all supplies every Saturday night. Documentation on 7/10/21, 7/17/21, and 7/24/21 identified oxygen supplies were changed with nurses' initials. Review of the August 2021 MAR identified to change disposable oxygen supplies every week and as needed. Label and date all supplies every Saturday night. Documentation on 8/7/21, 8/14/21, 8/21/21, and 8/29/21 identified oxygen supplies were changed with nurses' initials. Review of the September 2021 MAR identified to change disposable oxygen supplies every week and as needed. Label and date all supplies every Saturday night. Documentation on 9/4/21 identified oxygen supplies were changed with nurse initial. Observation with LPN #3 on 9/9/21 at 11:15 AM identified the following: a. Used suction tubing with no cover lying on table. b. Nebulizer handheld with no cover lying on the table, c. Oxygen nasal cannula tubing with a piece of tape around tubing dated 7/25/21. (Resident #48 was on continuous cool mist aerosol via air compressor with 2 Liters of oxygen via liquid or concentrator to trach mask to equal 28% oxygen every shift). d. Catheter syringe with no cover lying on the table. Interview with LPN #3 on 9/9/21 at 11:16 AM identified she was not aware of the issue until now and she was not the charge nurse on duty. LPN #3 indicated it was the 11:00 PM to 7:00 AM nurse's responsible to change the oxygen tubing weekly per the physician's order. LPN #3 indicated the equipment's should have been covered with the plastic bags. Interview with RN #9 on 9/14/21 at 8:21 AM identified she was the charge nurse on duty on 9/9/21 from 9:00 AM - 11:30 AM and she was not aware of the issue. RN #9 indicated she does not recall if the respiratory equipment's was covered or not in the plastic bags. Interview with the DNS on 9/15/21 at 11:31 AM identified she was not aware of the issue. The DNS indicated the nurse's should have changed the oxygen tubing per physician's order and placed the plastic covers after each equipment usage. Subsequent to surveyor inquiry, Resident #48's oxygen tubing was changed and dated 9/9/21. Additionally, the suction tubing, handheld nebulizer, and catheter syringe was discarded and replaced. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the provide clean nebulizer equipment policy identified to ensure clean nebulizer treatments. It is the policy of the facility to provide clean nebulizer treatments. Place nebulizer tubing & accessories in plastic bag. Review of the facility replace oxygen tubing & set up policy identified it is the policy of this facility to provide a clean oxygen delivery system. Replace oxygen tubing weekly. Record date & initials. Place oxygen tubing & accessories in plastic bag that is dated & initials. Review of the facility gastrostomy/jejunostomy site care policy identified to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection. Review of the facility per nasal cannula policy identified nasal cannula shall be changed every week. The facility failed to ensure infection control practices were maintained related to respiratory and g-tube equipment and facility failed to change oxygen tubing per physician's orders.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32738 Based on observation, facility documentation and staff interview the facility failed to monitor dishwasher temperatures prior to use. The findings include: Observations during a tour of the kitchen on 9/4/21 at 12:05PM identified the Dish Machine Temperature Log for 9/4/21 for breakfast was not completed. Interview Dietary Aide #1 at that time stated that she did not do the temperatures because there was a lot going on. Interview with the Administrator at that time stated that the Dish Machine temperatures need to be checked before use to ensure the dish machine is at appropriate temperature to sanitize the dishes. Upon surveyor request a copy of the dish machine temperature log was provided and the morning temperatures were filled in.