STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. Building B. Wing	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43184 Based on review of the clinical records, facility documentation, facility policy and interview for 21 of 21 residents (Resident #1 - 21) who resided on the Birch & Cedar unit of the 1st floor, the facility failed to immediately notify the physician when all 21 residents did not receive their medications, treatments or monitoring on 7/2/22 between 3:00 PM - 7:00 PM, and of additional medication omissions between 7:00 PM - 11:00 PM. The physician was not notified for 18 days. The findings include: Based on review of facility documentation and interviews the following was identified: On 7/2/22 at 3:00 PM, when the scheduled licensed nurse did not show up for his/her shift on the Birch & Cedar unit, the licensed nurse who was working 7/2/22 during the 7:00 AM - 3:00 PM shift on that unit, LPN #1, without an incoming replacement, left the facility. Further, although the RN Supervisor was directed by the DNS to report to the Birch & Cedar unit to administer medications, she did not and subsequently, the 21 residents on that unit were without a licensed nurse from 3:00 PM - 7:00 PM, 4 hours, and did not receive their ordered evening shift medications, treatments and/or monitoring between 3:00PM - 7:00 PM. Further, additional medications were omitted during the 7:00 PM - 11:00 PM shift. Medications omitted included Insulin, antiseizure, antibiotics, antipsychotics, antihypertensives, and an anti-rejection medication. Additionally, 3 residents with a diagnoses of diabetes and who required fingerstick for blood sugar monitoring did not have their blood sugar checked. Further, one resident with a wound did not have the dressing changed, and one resident who had a medication ordered to be administered once monthly for schizophrenia, missed that monthly dose. Further, 5 significant medication error occurred. Facility documentation indicated the facility became aware of the medication omissions on 7/20/22 and at that point, the physician was notified of the medication omissions, 18 days after the medication omissions occurred . (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #20 on 7/20/22 at 11:31 AM indicated that he/she recalled an incident when he/she did not get Insulin. Additionally, Resident #20 indicated he/she requested the Insulin and was told by the nurse that she would be back, but the nurse never came back. Resident #20 could not recall the exact date that this happened. Resident #20 further indicated that he/she has only refused Insulin on 1 occasion when he/she did not eat anything. Interview with NA #3 on 7/20/22 at 11:49 PM indicated that she worked on the 1st floor Birch & Cedar unit on 7/2/22 during the 3:00 PM - 11:00 PM, and there was not a nurse on the unit for the entire shift. Additionally, NA #3 indicated a nurse from the 2nd floor came to the unit to help after she finished the medications on the 2nd floor. Interview with NA #1 on 7/20/21 at 12:08 PM indicated NA #1 did work on the 1st floor on 7/2/22 for the 3:00 PM - 11:00 PM shift. NA #1 indicated that there was 1 nurse on the floor for the entire floor (2 units/46 residents). Additionally, NA #1 indicated that this was not for the entire shift, but that she was not aware when the supervisor came to the unit due to being busy with her assignment. Interview with RN #2 (RN Supervisor 7:00 AM - 7:00 PM shift) on 7/20/22 at 12:56 PM indicated that she was the supervisor for the facility on 7/2/22 until 7:00 PM. RN #2 identified that there was only 1 nurse working on the 1st floor (46 residents), when there was supposed to be 2, (1 for each unit). Additionally, RN #2 identified that due to the workload (2 admissions and 2 falls), RN #2 indicated she went to the first floor after change of shift to let them know she was involved in other things, but she was unable to get back down to the unit to give the medications. RN #2 further indicated that she worked until the end of her shift at 7:00 PM. Interview with RN #1 (RN supervisor 7:00 PM - 7:00 AM shift) on 7/20/22 at 1:07 PM identified that she did work her scheduled shift on 7/2/22 from 7:00 PM - 7:00 AM. RN #1 identified that when she arrived at the facility, she went to the 1st floor, Birch & Cedar unit and took the unit for medication administration along with LPN #4. Additionally, RN #1 indicated that she did not give any medications that were due between 4:00 PM - 5:00 PM due to them being overdue and not scheduled during her shift. RN #1 further indicated that if a medication is not documented in the electronic medical record (EMR), she would not give the medication because she did not know if it was given. RN #1 identified that she documented some of the 3:00 PM - 7:00 PM medications as refused in the EMR because she had to put something in the system to move forward with the medication pass. RN #1 indicated if a resident does refuse a medication, she would follow up with the APRN to inform them. Interview with LPN #1 on 7/20/22 at 1:54 PM identified that on 7/3/22 during her scheduled 7:00 AM - 3:00 PM shift, when the not administered medications flagged in the EMR from 7/2/22 on the 3:00 PM - 11:00 PM shift that were not documented, she documented in the EMR, not my shift to prevent confusion because the medication will come up twice in the EMR. Additionally, LPN #1 indicated that if a medication is not signed off it indicates that medication was not given or was given but not documented and that is where mistakes can happen, so that is the reason she documents that it was not given so that only the medications due on her shift show up. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/21/22 at 10:45 AM indicated that the free-floating supervisor (RN #2) on the 7:00 AM - 7:00 PM shift did make attempts to replace the staff member that was a no call/no show as well as the scheduler. Additionally, the DNS indicated that RN #2 informed her via text message that she was overwhelmed and not feeling good, but she did not tell the DNS medications had not been given on the Birch & Cedar unit. The DNS further indicated that she directed the RN supervisor (RN #2) to hang in there as it was close to the end of her shift. Interview with Scheduler #1 on 7/21/22 at 10:52 AM identified that RN #2 did reach out to her to let her know that there was a no call/no show on 7/2/22 for 3:00 PM - 11:00 PM, but that it wasn't until approximately 6:00 PM. Additionally, Scheduler #1 indicated that RN #2 did inform her that she did attempt to replace the staff member via a blast text and calls to no avail. Scheduler #1 indicated that she also attempted to call and text staff members to fill in, but she either got a refusal or no answer back. Scheduler #1 indicated that she did inform the DNS, per protocol, that there was a no call/no show and she could not find a replacement. Review of the investigation/interviews conducted by RN #3 (Independent Nurse Consultant) dated 7/21/22 indicated for 7/2/22 3:00 PM - 11:00 PM one licensed staff was a no call/no show for the Birch & Cedar unit. RN #3 further indicated that RN #2 was the supervisor on duty on 7/2/22 from 7:00 AM - 7:00 PM. RN #3 conducted an interview with RN #2 on 7/20/22 at 6:30 PM along with the Administrator and the DNS. RN #2 stated that she did not pass the medications on the Birch & Cedar unit of the 1st floor because she had admissions and 2 fall incident reports to complete and she was overwhelmed. RN #2 stated that she did not convey to the DNS that she didn ' t pass the medications on Birch & Cedar, she only told the DNS that she was overwhelmed. RN #2 also stated she told the oncoming supervisor (RN #1) that the medications were not done. RN #2 stated she left the facility at 7:15 PM. Additionally, RN #3 conducted an interview with RN #1 on 7/20/22. RN #1 stated that when she arrived at the facility at 7:00 PM, RN #2 was not there, and a licensed nurse greeted her at the door and informed her that there was no supervisor in the building. RN #1 indicated that she then went to the supervisor's office where she found the keys, but no report or narcotic count done. RN #1 stated at that time she and LPN #4 went to pass the 7:00 PM medications. RN #1 stated that she did not give the 5:00 PM medications because she did not know if RN #2 gave any medications or what she gave. RN #1 indicated she did attempt to call RN #2 3 times to ask if she gave any medications or what she gave, but RN #2 did not answer the phone. At that time RN #1 documented the medications as refused, to prevent another nurse from signing them off. Additionally, the investigation done by RN #3 identified the DNS was unaware that RN #2 had left the building. Review of the narcotic count sheet reviewed for 7/2/22 identified that RN #2 did not sign in or off that she did a narcotic count at all on 7/2/22. Interview with RN #1, (the 7:00 PM - 7:00 AM RN Supervisor on 7/2/22) on 7/28/22 at 11:35 AM identified that when she arrived at the facility on 7/2/22 for her shift and was informed that there was no RN Supervisor in the building, she called the DNS to discuss the situation with her. RN #1 indicated that the DNS informed her that the previous RN Supervisor (RN #2) had gotten overwhelmed, but the DNS indicated she was not aware that RN #2 had left the building. Additionally, RN #1 indicated that she immediately went to the Birch & Cedar unit and started passing out medications and taking care of the resident's needs. When asked why she did not notify the DNS or the physician that the 21 residents may have missed their medications between 3:00 PM - 7:00 PM, RN #1 indicated that she had too many problems and had to prioritize to ensure resident needs were met. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/28/22 at 11:54 AM identified that on 7/2/22 she was told by RN #1 that she had not received report from the previous RN Supervisor (RN #2) and that she would have to take the 1st floor Birch & Cedar unit. The DNS indicated that she did offer to come to the facility, but RN #1 declined stating by the time the DNS would arrive, she would have it handled. Additionally, the DNS indicated immediately following the call, she attempted to call other staff members to fill in the 3:00 PM - 11:00 PM shift but was unsuccessful. The DNS also indicated that she did talk with the scheduler (Scheduler #1) who also made calls to staff with no success. The DNS identified that when she spoke with the RN Supervisor for the 7:00 AM - 7:00 PM shift (RN #2), she was informed by RN #2 that there were admissions and falls that needed to be done. The DNS indicated at that time she instructed RN #2 to put in the medication orders only for the admissions and to perform the RN assessments for the falls and the paperwork piece could be finished at a later time. The DNS indicated that throughout the 3:00 PM - 7:00 PM shift, she called RN #1 to check on the situation at the facility. The DNS indicated that she was not on-call on 7/2/22 stating that she was never on call on the weekend because she took call 5 days a week and administration was aware of this. The DNS indicated the administration attempted to say she was the back-up on call management staff member, but she was not. Interview with LPN #1 on 7/28/22 at 12:52 PM identified that on 7/2/22 at the end of her 7:00 AM - 3:00 PM shift, she called the nursing supervisor (RN #2) to let her know that her replacement staff had not come in yet. LPN #1 indicated that RN #2 informed her that the replacement staff member would be there in 5 minutes. LPN #1 indicated she waited another 10 - 15 minutes and when no replacement staff came in, she again called RN #2 and asked her to come to the unit to do the narcotic count with her and take report. LPN #1 indicated that RN #2 informed her that she was too busy to come to the unit and directed her to do the narcotic count with the other LPN on the first floor (LPN #3) and to give her report as well. LPN #1 indicated that she did the narcotic count with LPN #3 and then did a written report of the residents on the Birch & Cedar unit. LPN #1 indicated she then gave the keys and the written report to RN #2 and left the facility. LPN #1 indicated that when no replacement staff comes in, it is the protocol to wait to leave the facility until another staff member comes to replace her. Additionally, LPN #1 indicated that she did leave the facility on 7/2/22 because she gave the keys and report to RN #2 and was under the impression that RN #2 was going to cover the unit until the next supervisor came in at 7:00 PM (RN #1). Interview with RN #1 on 8/1/22 at 9:30 AM identified that when she arrived at the facility on 7/2/22 at 7:00 PM, she was told by a nurse aide who was the acting receptionist, that RN #2 was gone. RN #1 indicated that she did not get report from RN #2 and that she did attempt to call RN #2 several times, but RN #2 never answered her phone. RN #1 indicated she immediately went to the supervisor ' s office on the second floor and found keys on the desk and the door to the office ajar. Additionally, RN #1 indicated that due to the keys being present in the unlocked office, she did a narcotic count, on her own, without another staff member present, to ensure the narcotic count matched the narcotic sheets. RN #1 further indicated the keys found were the narcotic keys, the facility/supervisor keys and the 1st floor Birch & Cedar unit keys on the desk in the supervisor ' s office. Review of the controlled substance change of shift accountability log for the Birch & Cedar unit dated July 2022 identified on 7/2/22, there was no signature by the incoming nurse for the 7:00 AM - 3:00 PM shift (LPN #1) or the outgoing nurse for the 3:00 PM - 11:00 PM shift (LPN #1). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Medical Director, (MD #1) on 8/1/22 at 11:30 AM identified he had been informed by the facility on 7/20/22 that on 7/2/22 between 3:00 PM - 7:00 PM, 21 residents on Birch & Cedar did not receive their ordered medications/treatments. MD #1 indicated that staff should notify him immediately, as medication errors/omissions happen as he needs to know what was omitted to determine if any significant medications were missed that he might need to do something about. MD #1 further indicated some medications may be ok to miss a dose, but other medications, for example Insulin or Coumadin may need additional monitoring or 1-time orders. Additionally, MD #1 indicated that outcomes that could have occurred due to the omitted doses depended upon the medication and some medications, for example, thyroid medication or blood pressure medication may not have a serious outcome, but missing a dose of an anticoagulant medication could be significant and may cause problems . Further, missing psychotropic medications can easily result in behavior issues, and missing antiseizure medications can easily result in breakthrough seizures. MD #1 further indicated missing many medications may not affect the resident medically right away, but some of the medications (as talked about above) are more critical and can have an effect medically. MD #1 indicated when resident ' s miss that many medications, it is important to know what was missed immediately to make any special changes. MD #1 further indicated that the expectation would be notification immediately when a medication is omitted with the resident ' s name, the medication(s) that were missed, why they were missed and any follow up assessments that were done. MD #1 indicated that he would expect the nurse who omitted the medications to notify him when medications were missed, but if that nurse did not notify him, the next nurse to coming on to the unit for the next shift or the next nurse who identified medications were omitted should notify him when it is found in order for him to decide what to do for the resident as it happens . Review of the Medication Administration policy identified it was the policy to provide a safe and effective medication framework to help eliminate any harm that could be caused at any level of the medication management process. Additionally, the policy directs in the event of a medication administration error, the licensed nurse will immediately provide care to the resident (if necessary) and notify the provider, supervisor, DNS, or designee. The event will be documented in the resident ' s chart in the EMR and an incident report (A&I) is to be completed and forwarded to the immediate supervisor of the licensed nurse who administered the medication. The incident will be reviewed and may be subject to disciplinary action if necessary, up to and including termination of employment. The facility failed to adequately staff the Birch & Cedar unit on 7/2/22 during the 3:00 PM - 7:00 PM shift to ensure the safe delivery of care according to professional standards. Subsequently, 21 of 21 residents on that unit did not receive medications, treatments and monitoring between 3:00 PM - 7:00 PM. Further, although RN #1, RN #2 and LPN #1 were all aware that medications had been omitted for the 21 residents on the Birch & Cedar unit on 7/2/22 between 3:00 PM - 7:00 PM, they did not report the medication omissions to the physician. Subsequently, the physician was not notified for 18. Please cross reference F658, F684, F725 and F760.

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F 0600 Level of Harm - Minimal harm or potential for actual harm 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** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sampled resident (Resident #31) reviewed for neglect, the facility failed ensure the resident was free of bugs and provided with a clean neck brace timely, and for two of six residents (Resident #26 and #30) reviewed for abuse, the facility failed to ensure the residents were free from verbal mistreatment. The findings include: 1) Resident #31 was admitted on [DATE] with diagnoses that included spinal fusion of the cervical region. The Resident Care Plan (RCP) dated 6/24/2022 identified the resident was at risk for complications (bleeding/infection) and risk for alteration in comfort related to surgical wounds. The admission MDS dated [DATE] identified Resident #31 was alert and oriented and required total dependence with two-person assistance for personal hygiene. Interventions directed to keep the incision site clean and dry. Review of the discharge summary dated 6/23/2022 directed Resident #31's cervical neck incision was to be changed every shift and as needed. Instructions directed to cleans under the cervical collar with soap and water, pat dry. Cleanse incision with normal saline, apply Aquacel AG into the crease of the neck and the lower portion of incision line, secure with blue silicone tape and place an abdominal (ABD) pad between dressing and cervical collar. Resident #31 had a follow-up appointment on 7/5/2022 with MD #2 (Neurosurgery). A physician's order dated 6/24/2022 directed for the cervical neck incision to be cleansed with normal saline, pat dry, apply Aquacel followed by a Telfa dressing and an abdominal (ABD) pad, daily during the evening shift. Review of the nursing progress note date written by LPN #5, dated 6/30/2022 at 1:13 AM identified treatment Resident #31's surgical incision on the back of his/her neck had a foul odor with greenish colored drainage that had seeped onto the neck collar making it moist. The note further indicated LPN #5 cleaned and dried the brace as best as she could, lined it with fresh gauze and indicated Resident #31 would need a new brace. Interview with MD #2 on 8/2/2022 at 10:40 AM identified Resident #31 was seen for a follow-up 6-week visit on 7/5/2022 status post a spinal fusion. MD #2 indicated, upon arrival to the office, MD #2 discovered Resident #31 was covered throughout his/her body with little, tiny bugs including within the surgical neck wound bed that required MD #2 and his medical assistant to kill all the bugs and clean Resident #31 prior to performing an assessment and surgical dressing change. MD #2 indicated the wound was covered only by an ABD pad, without the benefit of any other medical treatment within the wound bed and not according to the discharge physician orders from the hospital. MD #2 further identified the surgical collar brace was covered soiled, unclean, and not in a clean condition for use. MD #2 provided wound care and although he did not believe the wound was currently infected, he started Resident #31 on antibiotic treatment prophylactically (to prevent an infection) due to the bugs and soiled collar. MD #2 recommended to the facility, if the facility could not manage the wound care, to consider transferring Resident #31 to another facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 8/2/22 at 1:25 PM identified although she had identified on 6/30/2022 that Resident #31 needed a new neck collar/brace, she did not obtain one for Resident #31. She further indicated that it was therapy's responsibility to ensure extra equipment was available and provide a new brace. Interview with Occupational Therapist (OT) #1 on 8/2/22 at 1:55 PM identified although LPN #5 did not notify her regarding the situation, she was aware that Resident #31 needed replacement pads for his/her neck brace. OT #1 identified when Resident #31 was admitted , an order was placed for replacement pads, and a shipment was received the week of July 24th to July 30th, and OT #1 was unable to provide documentation that new pads were applied. Interview with RN #5 on 8/2/22 at 3:00 PM identified although the nursing staff are responsibility to ensure care was provided to prevent infection regarding wound management and ensure the brace was clean, RN #5 indicated Resident #31 may not have his/her collar brace pads changed out since admission. Please cross reference F925 finding. Review of the Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property and Retaliation Policy dated November 1, 2021, directed in part, neglect was the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to attain or maintain their highest practicable level of physical, mental, and psychosocial wellbeing. Abuse or neglect may be intentional or unintentional. The Policy further directed that neglect would include inadvertent action which results in physical, emotional, or financial harm due to ignorance, inexperience, or inability to provide proper care. 2) A reportable event dated 8/1/2022 identified during a Resident Council meeting regarding contraband in the facility, Resident #26 became frightened when Employee #99 stated that the residents at the facility would not be accepted at any other home and that they were essentially rejects. Interview with the Recreation Director on 8/2/2022 at 11:25 AM identified she was present during the Resident Council meeting on 8/1/2022 and indicated Employee #99 stated to the residents, when the residents were in the hospital and needed somewhere to go, the facility was the one who took them in because the residents are everyone else's rejects. Interview with the Employee #99 on 8/2/2022 at 11:50 AM identified during the Resident Council meeting on 8/1/2022 he made the statement how many of you have been rejected or are rejects from other facilities. Employee #99 indicated he thought the statement was taken out of context and that he was trying to encourage the residents to come forward with any information or concerns. Employee #99 indicated he was presenting hardships due to resident and staffing issues, was encouraging residents to come forward and report issues to make the building better, and told them if you see something, say something. Employee #99 further identified that one resident stated he/she felt scared that he/she would have no place to go and indicated that he was not trying to be disrespectful or intimidate residents when he made the comment. Interview with Resident #26 on 8/2/2022 at 1:32 PM identified Employee #99 made a statement about residents not having any place to go, and did not elaborate further regarding the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #3 (Independent Nurse Consultant) on 8/2/2022 at 2:19 PM identified during the Resident Council meeting on 8/1/2022 Employee #99 stated to the residents if the Department of Public Health (DPH) shuts us down, who will take you, no one, no one will take you, you are all rejects. Additionally, RN #3 identified that all residents present in the resident council meeting were quietly looking down after this statement and 2 residents mentioned it saying, I am afraid, where will we go. Interview with RN #8 on 8/2/2022 at 2:25 PM identified after the 8/1/2022 Resident Council meeting, several residents were upset and verbalized they were scared they would have no place to go. Additionally, RN #8 was able to specifically identify Resident #26 as one of the residents who were upset but could not recall specifically any other resident name. Interview with Resident #30 on 8/3/2022 at 3:15 PM identified Resident #30 felt Employee #99's comments were derogatory. Additionally, Resident #30 identified Employee #99's comments made him/her feel as thank you for reminding me that I feel like a piece of shit. Review of the minutes from the Resident Council Meeting dated 8/1/2022 identified 34 residents were in attendance. Additionally, the minutes identified Employee #99 stated, when you needed somewhere to go and no one else took you in, we did, this is a very unique facility, we call this/refer to everyone as rejects. The minutes further indicated immediately following this statement RN #7 stepped in and stated, we call ourselves the rejects and motioned to the administration staff. Review of the facility Resident Rights Policy directed in part, residents have the right to be free from verbal or mental abuse. Review of the facility Resident Abuse Policy, dated 11/1/2021, directed in part, Verbal Abuse was defined as the intentional use of oral language that willfully includes disparaging and derogatory terms to residents regardless of their ability to comprehend. 43184

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 documentation, facility policy and interviews, for 1 resident (Resident #35) reviewed for an allegation of verbal abuse, the facility failed to ensure that the allegation of verbal abuse was reported to the State Agency according to established timelines. The findings include: Resident #35 was admitted to the facility in April 2021 with diagnosis included quadriplegia, osteomyelitis of vertebra, intraspinal abscess and granuloma, and pain in thoracic spine. The quarterly MDS dated [DATE] identified Resident #35 was without cognitive impairment and required total 2-person physical assistance with personal hygiene. The physician's orders dated 7/1/22 - 7/28/22 directed to monitor target behavior: (Paranoia, hallucination, delusion, anxiety, restlessness, agitation) striking/hitting/kicking, perseverating/repetitive complaints, spitting cursing, elopement attempts, delusions, psychosis, aggression, refusal of care. At the end of each shift mark frequency-how often behavior occurred & Intensity-how resident responded to redirection. The physician's order dated 7/9/22 directed to get Resident #35 out of bed to a modified customize wheelchair via hoyer lift and staff to assist with wheelchair mobility as needed. A reportable event form dated 7/10/22 at 6:45 AM identified Resident #35 went to the nursing supervisor's office and reported that the nurse threatened him/her. Resident #35 alleged the nurse verbalized; I am going to get on your (explicative) one way. No distress noted, Resident #35 apologized to the nurse. APRN notified. Review of the incident completion checklist dated 7/10/22 identified Resident #35 was angry at the nurse during medication pass. Resident #35 then came to the nursing supervisor's office and reported the nurse for verbally threatening him/her. Nurse to work another unit pending investigation. (LPN #9 was never moved off the unit and continued the medication pass). A written investigation statement by NA #10 dated 7/10/22 identified she did not hear a conversation between Resident #35 and LPN #9. A written investigation statement by NA #2 dated 7/10/22 identified she did not hear or see LPN #9 did anything or said anything that was out of context to Resident #35. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written investigation statement by RN #13 dated 7/10/22 identified LPN #9 called her at 6:30 AM and notified her that Resident #35 was agitated and verbally abusive. RN #13 indicated Resident #35 was at the nurse's desk angry, yelling at LPN #9 to put on gloves when giving him/her his/her medications. Resident #35 telling LPN #9 to put on her face mask. Resident #35 calling LPN #9 names. Resident #35 continued to be insulting and finally took the medication. Resident #35 then came downstairs approximately 10 minutes later and reported LPN #9 threatened him/her. Resident #35 alleged LPN #9 verbalized to the resident I'm going to get your (explicative), one way or the other. RN #13 identified she never heard LPN #9 make any threatening statements. Resident #35 returned to the unit and apologized to LPN #9. The previous DNS, and the on-call APRN was called and updated and told to move LPN #9 off unit pending investigation. (LPN #9 was never moved off the unit and continued the medication pass). A nurse's note dated 7/10/22 at 7:07 AM identified RN #13 was called to unit by LPN #9 because Resident #35 was angry and verbally abusive. Resident #35 was insisting for LPN #9 to wear gloves when giving him/her the medications. Resident #35 calling LPN #9 a name, and mad because LPN #9 was not wearing a mask. Resident #35 eventually took the medications but continued to be insulting and angry. Resident #35 came downstairs and claimed LPN #9 threatened him/her. Resident #35 stated LPN #9 told him/her she would get his/her (explicative). The DNS was notified. Resident #35 later returned to unit and apologized to LPN #9. The on-call APRN awaiting return call. A nurse's note dated 7/10/22 at 7:51 AM identified Resident #35 was verbally abusive to LPN #9 this morning. Resident #35 began screaming racial slurs at LPN #9 calling her names and he/she is tired of all these (explicative) that works here, they are all lazy. LPN #9 indicated she asked Resident #35 why he/she was saying these things and Resident #35 said because he/she can. Resident #35 then told LPN #9 to wear gloves when administering his/her medication. LPN #9 called the supervisor who came immediately and observed Resident #35 continued to be verbally inappropriate to LPN #9. LPN #9 gave Resident #35 his/her medications and then continued the medication pass. The care plan dated 7/11/22 identified Resident #35 exhibits behaviors as evidenced by: inappropriate behavior towards staff. Interventions include approach the resident in a calm, consistent manner. For refusals of care, re-approach resident at another time. Monitor any changes in mood/behavior and report to the physician. Interview with MD #1 on 8/15/22 at 8:31 PM identified he was not aware of the alleged verbal allegation between Resident #35 and LPN #9. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #9 on 8/18/22 at 9:55 AM identified she had been working at the facility since 2020. LPN #9 identified she works on the 7:00 AM - 3:00 PM shift but she does pick up other shifts. LPN #9 indicated she had picked up on 7/9/22 on the 11:00 PM - 7:00 AM shift. LPN #9 indicated Resident #35 came to the medication cart that morning (7/10/22) for his/her medications. LPN #9 indicated as she was preparing the medications Resident #35 said how come you don't have any gloves on, you should be wearing gloves? LPN #9 indicated she explained to Resident #35 she does not wear gloves to prepare the medications. LPN #9 indicated then Resident #35 said how come your mask is not on. LPN #9 indicated she had a mask on, but it was underneath her nose. LPN #9 indicated Resident #35 called her a name and told Resident #35 she was going to call the supervisor. RN #13 was called. LPN #9 indicated she had never seen Resident #35 behave in that manner. LPN #9 indicated Resident #35 said you are (explicative) look at your eyelashes, I'm tired of your (explicative) aides and nurses. RN #13 came to the unit and witness Resident #35 behavior. LPN #9 indicated RN #13 asked Resident #35 would he/she like her to give him/her the medications and the resident said no. Resident #35 then took the medications from LPN #9. LPN #9 indicated Resident #35 went downstairs and told RN #13 that LPN #9 had threatened him/her. LPN #9 indicated RN #13 called her and notified her of the alleged allegation. LPN #9 indicated after passing her medication to the floor she went downstairs to the supervisor's office and the on-coming supervisor indicated he had met with Resident #35 and the resident apologized and Resident #35 said he/she was upset, and that LPN #9 never threatened him/her. LPN #9 indicated Resident #35 came upstairs later and apologized to her. Review of the facility resident abuse, mistreatment, neglect, exploitation, misappropriation of resident property, and retaliation policy identify to ensure that all staff know their responsibility in identifying and reporting any type of abuse, mistreatment, neglect, exploitation, misappropriation of resident property, and retaliation as per state and federal guidelines. Verbal abuse: defined as the intentional use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age; ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see their family again. Allegations of abuse and neglect are to be reported to the state department of public health within two (2) hours of initial allegations

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43184 Based on review of the clinical record, facility documentation, facility policy and interviews for 21 residents who reside on the Birch & Cedar unit (Resident #1 - 21) the facility failed to administer medications as prescribed, failed to notify the DNS and physician when medications were not administered, failed to complete assessments of the residents' condition after medications were omitted, failed to monitor residents who had significant medication omissions and failed to accurately document the medication omissions. Further, the facility failed to ensure licensed staff followed professional standards of practice including report to the oncoming and off going shifts, narcotic count and ensuring the security of the narcotic keys. These failures resulted in a finding of Immediate Jeopardy. The findings include: Based on review of facility documentation and interview the following was identified: On Saturday 7/2/22, the scheduled 7:00 AM - 7:00 PM RN Supervisor called out. Per the on call rotation, RN #2 was called in to cover as 7:00 AM - 7:00 PM RN Supervisor. On 7/2/22 at 3:00 PM, when the scheduled licensed nurse did not show up for his/her shift on the Birch & Cedar unit, the licensed nurse who was working 7/2/22 during the 7:00 AM - 3:00 PM shift on that unit, LPN #1, left the facility without an incoming replacement. Although the RN Supervisor working 7/2/22 between 7:00 AM - 7:00 PM, (RN #2), was aware that the 3:00 PM - 11:00 PM licensed nurse did not show up to cover the Birch & Cedar unit, and she (RN #2) was directed by the DNS to administer medications on the Birch & Cedar unit, RN #2 did not provide coverage of the Birch & Cedar unit, did not administer medications to the 21 residents on the unit, and did not report to the DNS, the physician or the oncoming RN Supervisor that medications and treatments had not been administered/completed between 3:00 PM - 7:00 PM on 7/2/22. Further, RN #2 placed her narcotic keys on the desk in the supervisor office and without giving report, without reporting to anyone that all 21 residents on the Birch & Cedar unit had missed their medications between 3:00 PM - 7:00 PM, and without counting the narcotics or handing the narcotic keys to a licensed nurse, she left the facility at approximately 6:20 PM. This left the facility without an RN in the building for approximately 46 minutes until the 7:00 PM - 7:00 AM RN Supervisor (RN #1) arrived. Subsequently, because LPN #1 left the unit on 7/2/22 at approximately 3:59 PM without coverage, and because RN #2 did not cover the unit or notify the DNS or any physician that the unit (21 residents) was not covered, the 21 residents on the Birch & Cedar unit did not receive any medications or treatments, including blood sugar monitoring and Insulin administration, between 3:00 PM to 7:00 PM on 7/2/22. Further, when the 7:00 PM - 7:00 AM RN Supervisor, (RN #1), arrived on 7/2/22 at approximately 7:06 PM, and she noted that the medications for the 21 residents on the Birch & Cedar unit had not been signed as administered, she failed to notify the DNS and the physician of the omissions, and failed to pass the information on in report. Further, she documented some of the missing medications erroneously as refused. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following day, 7/3/22 during the 7:00 AM - 3:00 PM shift, when the licensed nurse (LPN #1) began her shift, although the EMR alerted her to the missed medications the prior day (7/2/22), she documented all the missed medications for the 21 residents on Birch & Cedar unit as not administered and did not report the missed medications to the DNS or the attending physician's. Because the DNS and the physicians were not aware that all 21 residents had not received their ordered medications and treatments on 7/2/22 between 3:00 PM - 7:00 PM, the facility administration was not able to develop and implement corrective action to address the situation or to prevent a reoccurrence. Interview with RN #2 (RN Supervisor 7:00 AM - 7:00 PM shift) on 7/20/22 at 12:56 PM indicated that on 7/2/22 during 3:00 PM - 11:00 PM, there was only 1 nurse working on the 1st floor when there was supposed to be 2, 1 for each unit. Additionally, RN #2 identified that due to the workload (2 admissions and 2 falls), she was unable to get to the 1st floor to administer medications. Interview with RN #1 (RN supervisor 7:00 PM - 7:00 AM shift) on 7/20/22 at 1:07 PM identified that when she arrived at the facility, she went to the 1st floor, Birch & Cedar unit and took the unit for medication administration along with LPN #4. Additionally, RN #1 indicated that she did not give any medications that had been due between 4:00 PM - 5:00 PM because they were overdue and not due on her shift. RN #1 further indicated that she would not give the missed medication because she did not know if it had already been given. RN #1 identified that she documented some of the 3:00 PM - 7:00 PM medications as refused in the EMR because she had to put something in the system to move forward with the medication pass. RN #1 indicated although she attempted to get in touch with RN #2 to ascertain if the medications had been administered, she could not reach her. Interview with LPN #1 on 7/20/22 at 1:54 PM identified that on 7/3/22 when she came in for the 7:00 AM - 3:00 PM shift, and the medications from the previous night were flagging in the EMR as not administered, she documented not administered, not my shift to prevent the medications from repeatedly popping up and moved forward with the medication pass. Interview with the DNS on 7/21/22 at 10:45 AM indicated that the free-floating supervisor (RN #2) on the 7:00 AM - 7:00 PM shift, as well as the scheduler, did make attempts to replace the staff member that was a no call/no show. Additionally, the DNS indicated that RN #2 informed her via a text message that she was overwhelmed and not feeling good, but she did not tell the DNS that medications for the 21 residents on Birch & Cedar had not been administered. The DNS further indicated that she directed the RN supervisor (RN #2) to hang in there as it was close to the end of her shift. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the investigation/interviews conducted by RN #3 (Independent Nurse Consultant) dated 7/21/22 indicated there was 1 licensed nurse on the 1st floor who was a no call/no show for the 3:00 PM - 11:00 PM shift on 7/2/22. RN #2 was the supervisor on duty on 7/2/22 from 7:00 AM - 7:00 PM. RN #3 conducted an interview with RN #2 on 7/20/22 at 6:30 PM along with the Administrator and the DNS. RN #2 stated that she did not pass the medications on the Birch & Cedar unit of the 1st floor because she had admissions and 2 fall incident reports to complete and she was overwhelmed. RN #2 stated that she did not convey to the DNS that she didn't pass the medications and only told the DNS that she was overwhelmed. RN #2 also stated she told the oncoming supervisor (RN #1) that the medications had not been administered (this is in conflict with other interviews that indicate that RN #2 had left the facility at approximately 6:20 PM without giving report). RN #2 stated she left the facility at 7:15 PM (this is in conflict with other interviews that indicate that RN #2 had left the facility at approximately 6:20 PM). Additionally, RN #3 conducted an interview with RN #1 on 7/20/22. RN #1 stated that when she arrived at the facility at 7:00 PM, RN #2 was not there, and a licensed nurse greeted her at the door and informed her that there was no RN supervisor in the building. RN #1 indicated that she then went to the supervisor's office where she found the narcotic and supervisor keys, but no report or narcotic count done. RN #1 stated at that time she and LPN #4 went to pass the 7:00 PM medications on Birch & Cedar. RN #1 stated that she did not give the 5:00 PM medications because she did not know if RN #2 had given any medications or what she gave. RN #1 indicated she did attempt to call RN #2 several times to ask if she gave any medications or what she gave, but RN #2 did not answer the phone. At that time RN #1 documented some of the medications as refused, to prevent another nurse from signing them off. Review of the narcotic count sheet dated 7/2/22 identified that RN #2 did not sign in or off that the narcotic count was done. Interview with RN #1 on 7/28/22 at 11:35 AM identified that when she arrived at the facility and was informed that there was no supervisor there, she called the DNS. RN #1 stated that the DNS informed her that the previous RN supervisor (RN #2) had gotten overwhelmed but the DNS was not aware that she left the building. Additionally, RN #1 indicated that she immediately started passing out medications on the Birch & Cedar unit, taking care of the residents but because she prioritized, she did not notify the physician or the DNS that medications were omitted. Interview with the DNS on 7/28/22 at 11:54 AM identified that on 7/2/22 she was told by the 7:00 PM - 7:00 AM RN supervisor (RN #1) that she, (RN #1), had not received report from the previous RN supervisor (RN #2). Further RN #1 indicated to the DNS that she, (RN #1), would have to take the first floor Birch & Cedar unit because there was not a nurse there. The DNS indicated that she did offer to come to the facility, but RN #1 declined stating by the time the DNS would arrive, she would have it handled. Additionally, the DNS indicated immediately following the call, she attempted to call other staff members to fill in the 3:00 PM - 11:00 PM shift but was unsuccessful. The DNS also indicated that she did talk with the scheduler (Scheduler #1) who also made calls to staff with no success. The DNS identified that when she spoke with the RN Supervisor for the 7:00 AM - 7:00 PM shift (RN #2), she was informed by RN #2 that there were admissions and falls that needed to be done. The DNS indicated at that time she instructed RN #2 to put in the medication orders in for the admissions and to perform the RN assessments for the falls and the paperwork piece could be finished at a later time. The DNS indicated that throughout the 3:00 PM - 7:00 PM shift, she called RN #1 to check on the situation at the facility. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #1 on 7/28/22 at 12:52 PM identified that on 7/2/22 at the end of her 7:00 AM - 3:00 PM shift, she called the nursing supervisor (RN #2) to let her know that her replacement staff had not come in yet. She again called RN #2 after waiting for her replacement and asked her to come to the unit to do the narcotic count with her and take report. LPN #1 indicated that RN #2 informed her that she was too busy to come to the unit and directed her to do the narcotic count with the other LPN on the first floor (LPN #3) and to give her report as well. LPN #1 indicated she gave the keys and written report to RN #2 and left the facility. LPN #1 indicated that when no replacement staff comes in, it is the protocol to wait to leave the facility until another staff member comes to replace her. Additionally, LPN #1 indicated that she did leave the facility on 7/2/22 because she gave the keys and report to RN #2 and was under the impression that RN #2 was going to cover the unit until the next supervisor came in at 7:00 PM (RN #1). Interview with RN #1 on 8/1/22 at 9:30 AM identified that when she arrived at the facility on 7/2/22 at 7:00 PM, she was told by a nurse aide who was the acting receptionist, that RN #2 was gone. RN #1 indicated that she did not get report from RN #2 and that she did attempt to call RN #2 several times, but RN #2 never answered her phone. RN #1 indicated she immediately went to the supervisor's office on the 2nd floor and found keys on the desk and the door to the supervisor office ajar. Additionally, RN #1 indicated that due to the keys being present in the unlocked office, she did a narcotic count, on her own, without another staff member present, to ensure the narcotic count matched the narcotic sheets. RN #1 further indicated the keys found were the narcotic keys, the facility/supervisor keys and the 1st floor Birch & Cedar unit keys on the desk in the supervisor's office. Interview with the Medical Director, (MD #1) on 8/1/22 at 11:30 AM identified he had been informed by the facility on 7/20/22 that on 7/2/22 between 3:00 PM - 7:00 PM, 21 residents on Birch & Cedar did not receive their ordered medications/treatments. MD #1 indicated that staff should notify him immediately, as medication errors/omissions happen, as he needs to know what was omitted to determine if any significant medications were missed that he might need to do something about. MD #1 further indicated some medications may be ok to miss a dose, but other medications, for example Insulin or Coumadin may need additional monitoring or 1-time orders. Additionally, MD #1 indicated that outcomes that could have occurred due to the omitted doses depended upon the medication and some medications, for example, thyroid medication or blood pressure medication may not have a serious outcome, but missing a dose of an anticoagulant medication could be significant and may cause problems. Further, missing psychotropic medications can easily result in behavior issues, and missing antiseizure medications can easily result in breakthrough seizures. MD #1 further indicated missing many medications may not affect the resident medically right away, but some medications are more critical and can have an effect medically. MD #1 indicated when resident's miss that many medications, it is important for him to be immediately made aware of what was missed to make any special changes. MD #1 further indicated that the expectation would be notification immediately when a medication is omitted with information such as the resident's name, the medication(s) that were missed, why they were missed and any follow up assessments that were done. MD #1 indicated that he would expect the nurse who omitted the medications to notify him when medications were missed, but if that nurse did not notify him, the next nurse coming on to the unit for the next shift or the next nurse who identified that medications were omitted should notify him when aware in order for him to decide what to do for the resident as it happens. Review of the controlled substance change of shift accountability log for the Birch & Cedar unit dated July 2022 identified on 7/2/22, there were no signatures by the incoming nurse for the 7:00 AM - 3:00 PM shift (LPN #1) or the outgoing nurse for the 3:00 PM - 11:00 PM shift (LPN #1). (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Medication Administration policy identified the goal is to provide a safe and effective medication framework to help eliminate any harm that could be caused at any level of the medication management process. Additionally, the policy directs in the event of a medication administration error, the licensed nurse will immediately provide care to the resident (if necessary) and notify the provider, supervisor, DNS, or designee. The event will be documented in the resident's chart, in the EMR, and an incident report (A&I) is to be completed and forwarded to the immediate supervisor of the licensed nurse who administered the medication. The incident will be reviewed and may be subject to disciplinary action if necessary, up to and including termination of employment. Review of the controlled substance policy directs nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the DNS. Please cross reference F580, F684, F725 and F760.

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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** 37293 41682 Based on review of the clinical record, facility documentation, facility policy and interview, the facility failed to ensure a licensed nurse was assigned to the 21 residents (Resident #1 - 21), who resided on the Birch & Cedar unit on 7/2/22, after the scheduled 3:00 PM - 11:00 PM licensed nurse did not show up for his/her shift. Subsequently, those 21 residents did not receive any medications or treatments between 3:00 PM to 7:00 PM. Additionally, for 1 resident (Resident #31) reviewed for a cardiac device and wounds, the facility failed to implement recommendations from the hospital discharge summary, failed to transcribed orders accurately, failed to ensure an initial wound assessment was completed timely, and failed to ensure weekly wound assessments were completed timely. The findings include: 1. Resident #1 was admitted to the facility in April 2022 with the diagnosis that included chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, unspecified kidney failure, hypertension, bipolar disorder, congestive heart failure, glaucoma, and depression. The quarterly MDS dated [DATE] indicated Resident #1 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications: Divalproex delayed release 250 mg three times a day for bipolar disorder, evening dose at 6:00 PM. Midodrine 10 mg every 8 hours for blood pressure with the evening dose at 10:00 PM. Montelukast 10 mg for COPD at 5:00 PM. Dorzolamide-timolol drops 22.3-6.8 mg/ml one drop twice a day for aftercare, evening dose due at 5:00 PM. Ferrosol 325 mg once a day for iron replacement at 5:00 PM. Senna-S 8.6-50 mg 2 tabs once a day at 5:00 PM. Simbrinzia drops 1-0.2% 1 drop into both eyes three times a day for after care, evening dose due at 5:00 pm. Review of the medication compliance report for 7/2/22 between 3:00 PM - 11:00 PM identified staff did not administer the ordered medications due between 3:00 PM - 7:00 PM on 7/2/22, and one medication due at 10:00 PM. Review of the Medication Error Report dated 7/20/22 identified Resident #1's medications were omitted between 3:00 PM - 7:00 PM on 7/2/22 and one medication due at 10:00 PM. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 did not receive the ordered medications, including medications for bipolar disorder, blood pressure and COPD, on 7/2/22 during the 3:00 - 11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 2. Resident #2 was admitted to the facility in July 2019 with the diagnosis that included Huntington's disease, schizoaffective disorder bipolar type, other drug induced movement disorder, anxiety, and depression. The quarterly MDS dated [DATE] indicated Resident #2 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications: Benztropine 0.5 mg for movement disorder twice a day, evening dose due at 6:00 PM. Seroquel 50 mg for schizophrenia three times a day, evening dose due at 6:00 PM. Trazodone 50 mg four times a day for depression, evening dose due at 4:00 PM. Valproic Acid solution 250 mg/ml give 750 mg twice a day for bipolar disorder, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #2's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #2 did not receive the ordered medications, including medications for movement disorder, schizophrenia, depression and bipolar disorder, on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 3. Resident #3 was admitted to the facility in November 2019 with the diagnosis including Type 2 diabetes mellitus, hallucinations, delusional disorder, paranoid schizophrenia, unspecified intellectual disabilities, schizoaffective disorder paranoid type, dementia, major depressive disorder and anxiety disorder. The quarterly MDS dated [DATE] indicated Resident #3 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Insulin Lispro 10 units for diabetes once a day at 5:00 PM. Lantus Insulin 35 units once a day for diabetes at 5:00 PM. Divalproex delayed release 500 mg twice a day for schizoaffective disorder, evening dose due at 7:00 PM. (continued on next page)

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New Haven Center for Nursing & Rehabilitation LLC	181 Clifton Street New Haven, CT 06513

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Haloperidol 10 mg twice a day for paranoid schizophrenia, evening dose due at 5:00 PM. Lorazepam 2 mg every 12 hours for anxiety, evening dose due at 9:00 PM. Xarelto 10 mg once a day for history of pulmonary embolism at 5:00 PM. Oxygen at 3 liters per minute via nasal cannula during sleep with oxygen saturation level. Atorvastatin 20 mg once a day for hypercholesterolemia at 5:00 PM. Gemfibrozil 600 mg twice a day for hyperlipidemia, evening dose due at 7:00 PM. Stimulant laxative plus 8.6-50 mg 2 tablets once a day at 5:00 PM. Boost Glucose control 240 mg three times a day for supplement, evening dose due at 6:00 PM. Pain monitoring every shift with appropriate pain scale. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22 and one medication due at 9:00 PM. Review of the Medication Error Report dated 7/20/22 identified Resident #3's medications were omitted between 3:00 PM-7:00 PM and one medication due at 9:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #3 did not receive the ordered medications, including medications for diabetes, schizoaffective disorder, paranoid schizophrenia, anxiety and history of pulmonary embolism, on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 4. Resident #4 was admitted to the facility in June 2022 with the diagnosis that included acute respiratory failure with hypoxia, liver cell carcinoma, history of cardiac arrest, Methicillin susceptible Staphylococcus aureus infection (MSSA), bacteremia, paralytic syndrome, acute pulmonary edema, viral hepatitis C without hepatic coma, cirrhosis of the liver and acute kidney failure. The discharge MDS assessment dated [DATE] indicated Resident #4 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Amlodipine 10 mg once a day blood pressure at 5:00 PM. Lasix 40 mg once a day for edema at 5:00 PM. Nadolol 20 mg once a day for blood pressure at 5:00 PM. Calcium Acetate 667 mg before meals for digestion before meals at 5:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Famotidine 20 mg once a day for stomach acid at 5:00 PM. Multivitamin with min-folic acid once a day for supplement at 5:00 PM. Senna OTC 8.6 mg twice a day for constipation, evening dose due at 5:00 PM. Vitamin C 500 mg once a day for supplement at 5:00 PM. Check IV site every shift Fluids with med pass twice a day during 3-11:00 PM shift. Flush PICC/midline with 10 ml normal saline before and after medication administration every 8 hours at 4:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #4's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #4 did not receive the ordered medications, including medications for blood pressure and edema on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 5. Resident #5 was admitted to the facility in October 2021 with the diagnosis that included cerebral infarction, hyperkalemia, chronic kidney disease, hypertension, peripheral vertigo, systemic lupus erythematosus, depression and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] indicated Resident #5 had moderately impaired cognition Physician orders dated 7/1/22 directed to administer the following medications: Carvedilol 25 mg twice a day for hypertension, evening dose due at 5:00 PM. Hydralazine 25 mg twice a day for hypertension, evening dose due at 5:00 PM. Levetiracetam 500 mg twice a day for seizures, evening dose due at 5:00 PM. Lokelma 10 gm once a day on Mon, Wed, Fri and Sat for hyperkalemia at 5:00 PM. Mycophenolate mofetil 500 mg twice a day for Lupus, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Error Report dated 7/20/22 identified Resident #5's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #5 did not receive the ordered medications, including medications for hypertension, seizures, hyperkalemia and Lupus on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 6. Resident #6 was admitted to the facility in February 2022 with the diagnosis that included chronic obstructive pulmonary disease (COPD), fluid overload, other psychoactive substance abuse, chronic diastolic heart failure, asthma, acute respiratory failure, somatoform disorder, depression, anxiety and opioid dependence. The quarterly MDS assessment dated [DATE] indicated Resident #6 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Metformin 500 mg twice a day for high blood sugar, evening dose due at 5:00 PM. Suboxone 8-2 mg film three times a day for opioid abuse, evening dose due at 4:00 PM. Oxygen at 2 liters/minute via nasal cannula continuous every shift with Oxygen saturation level. Multivitamin with min-folic acid once a day for supplement at 5:00 PM. Omeprazole 40 mg twice a day for stomach acid, evening dose due at 9:30 PM. Bi-Pap with heated humidifier at bedtime. Check blood sugar before breakfast, lunch, dinner and bedtime. Pain monitoring every shift with appropriate pain scale. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM and one medication due at 9:30 PM. Review of the Medication Error Report dated 7/20/22 identified Resident #6's medications were omitted between 3:00 PM-7:00 PM and one medication due at 9:30 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #6 did not receive the ordered medications, including medications for high blood sugar and opioid dependence on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 7. Resident #7 was admitted to the facility in May 2008 with the diagnosis that included intracranial injury, schizophrenia, anxiety, visual loss, convulsions, hallucinogen dependence, other degenerative diseases of nervous system, opioid abuse, and disorder of brain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly MDS assessment dated [DATE] indicated Resident #7 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications: Divalproex delayed release 250 mg for convulsions twice a day, evening dose due at 5:00 PM. Phenytoin sodium 100 mg twice a day for convulsions, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #7's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #7 did not receive the ordered medications, including medications for convulsions on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 8. Resident #8 was admitted to the facility in September 2001 with the diagnosis that included depression, Vitamin D deficiency, dementia, acute respiratory failure with hypoxia, leiomyoma of uterus, hypertension, other cerebrovascular disease, asthma, schizophrenia and hemiplegia and hemiparesis following unspecified cerebrovascular disease. The quarterly MDS assessment dated [DATE] indicated Resident #8 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medication: Olanzapine 5 mg three times a day for schizophrenia, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #8's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until7/20/22, 18 days later. Resident #8 did not receive the ordered medications, including medications for on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 9. Resident #9 was admitted to the facility in September 2012 with the diagnosis that included chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, vascular dementia, depression, hypertension, anxiety, benign prostatic hyperplasia, other cardiomyopathy, transient cerebral ischemia attach, nontraumatic intracranial hemorrhage and Vitamin B12 deficiency anemia. The quarterly MDS assessment dated [DATE] indicated Resident #9 had moderately impaired cognition. (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 7/1/22 directed to administer the following medications: Labetalol 300 mg three times a day for hypertension, evening dose due at 5:00 PM. Metformin 1000 mg twice a day for diabetes, evening dose due at 5:00 PM. Atorvastatin 20 mg once a day for hypercholesterolemia at 5:00 PM. Potassium Chloride ER 20 mEq once a day for potassium supplement at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #9's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #9 did not receive the ordered medications, including medications for diabetes and hypertension, on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 10. Resident #10 was admitted to the facility in April 2016 with the diagnosis that included Type 1 diabetes mellitus, dementia, extrapyramidal and movement disorder, catatonic schizophrenia, anxiety, hypercalcemia, and depression. The quarterly MDS assessment dated [DATE] indicated Resident #10 had severely impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Eliquis 5 mg twice a day for blood clot prevention, evening dose due at 5:00 PM. Olanzapine 10 mg once a day for schizophrenia at 5:00 PM. Vital signs twice a day. Restasis 0.05% drops once a day for dry eyes at 5:00 PM. Vitamin D3 50 mcg once a day at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #10's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10 did not receive the ordered medications, including medications for blood clot prevention and schizophrenia on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 11. Resident #11 was admitted to the facility in August 2021 with the diagnosis that included Multiple Sclerosis (MS) depression, anxiety, schizoaffective disorder, diabetes insipidus, nontraumatic subdural hemorrhage, hypertension, hyperlipidemia, and chronic kidney disease stage 5. The quarterly MDS assessment dated [DATE] indicated Resident #11 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Artificial Tears 1 drop twice a day for dry eyes, evening dose due at 9:00 PM. Divalproex 125 mg give 2 capsules twice a day for schizoaffective disorder, evening dose due at 5:00 PM. Lactulose 10 gm/15 ml 30 ml twice a day for constipation, evening dose due at 5:00 PM. Remeron 30 mg once a day for depression at 9:00 PM. Renvela 800 mg three times a day for kidney disease, evening dose due at 6:00 PM. Sodium Bicarbonate 650 mg three times a day for stomach acid, evening dose due at 5:00 PM. Stimulant Laxative Plus 8.6-50 mg once a day for constipation at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM and one due at 9:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #11's medications were omitted between 3:00 PM-7:00 PM and one medication due at 9:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #11 did not receive the ordered medications, including medications for depression, kidney disease and schizoaffective disorder on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 12. Resident #12 was admitted to the facility in December 2019 with the diagnosis that included hemiplegia and hemiparesis following cerebral infarction, nontraumatic subarachnoid hemorrhage, glaucoma, depression, emphysema, dysphagia, unspecified mood disorder, constipation, unspecified dementia and hypertension. The quarterly MDS assessment dated [DATE] indicated Resident #12 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Senna S 8.6-50 mg 2 tabs once a day for constipation at 5:00 PM. Sucralfate suspension 100 mg/ml give 10 ml four times a day for digestion, evening dose due at 5:00 PM. Zinc Oxide Diaper Cream 1-10% apply topically three times a day for skin protection, evening dose due at 6:00 PM. Resource 2.0 240 ml administer via g-tube four times a day for supplement if doesn't consume 100% orally, evening dose due at 7:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #12's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #12 did not receive the ordered medications, including medications for constipation and digestion on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 13. Resident #13 was admitted to the facility in February 2022 with the diagnosis that included low vision one eye, corneal ulcer, benign prostatic hyperplasia (BPH), type 2 diabetes mellitus, cocaine abuse, restlessness and agitation, depression, hypertension, cerebral infarction, and gastro-esophageal reflux disease. The quarterly MDS assessment dated [DATE] indicated Resident #13 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Labetalol 200 mg every 8 hours for hypertension, evening dose due at 4:00 PM. Metformin 500 mg twice a day for diabetes, evening dose due at 5:00 PM. Refresh Plus 0.5% 1 drop four times a day for dry eyes, evening dose due at 4:00 PM. Tamsulosin 0.4 mg once a day for BPH at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #13's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13 did not receive the ordered medications, including medications for hypertension, diabetes and BPH on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 14. Resident #14 was admitted to the facility in June 2022 with the diagnosis that included hepatic failure, alcoholic hepatitis without ascites, alcoholic cirrhosis of liver without ascites, inflammatory disorders of scrotum, depression, alcohol abuse, opioid dependence and post-traumatic stress disorder. The entry MDS assessments dated 6/10/22 and 6/19/22 were not completed for Resident #14. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Buprenorphine HCL 8 mg twice a day for opioid dependence, evening dose due at 9:00 PM. Lactulose 10 gm/15 ml 30 ml three times a day for liver disease, evening dose due at 9:00 PM. Polyethylene Glycol 17 gm twice a day for constipation, evening dose due at 9:00 PM. Simethicone 80 mg 2 tabs four time a day for indigestion, evening doses due at 4:00 PM and 8:00 PM. Daily dressing change to surgical incision site on scrotum-cleanse with normal saline and pack with 1-inch packing strip gauze, resident may receive prn Hydromorphone for pain relief prior to dressing change once a day due on the 3-11:00 PM shift. Monitor resident's mood and response to medication three times a day at 7:00 PM for depression symptoms. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM, 1 medication due at 8:00 PM and three medications due at 9:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #14's medications were omitted between 3:00 PM-7:00 PM, one medication due at 8:00 PM and three medications due at 9:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #14 did not receive the ordered medications, including medications for opioid dependence, liver disease, constipation and indigestion and did not receive the ordered treatments on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 15. Resident #15 was admitted to the facility in June 2022 with the diagnosis that included acidosis, opioid dependence, delusional disorders, depression, severe psychotic symptoms, anxiety, chronic venous hypertension with ulcer of right lower extremity, dermatitis and acute respiratory failure with hypoxia. The admission MDS assessment dated [DATE] indicated Resident #15 had intact cognition. (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 7/1/22 directed to administer the following medications/treatments: Folic Acid 400 mcg once a day for supplement at 5:00 PM. Miralax 17 gm twice a day for constipation, evening dose due at 5:00 PM. Myrbetriq extended release 24-hour 25 mg 2 tabs once a day for overactive bladder at 5:00 PM. [NAME] lotion 0.5-0,5% administer 15 ml once a day for dermatitis on the 3-11:00 PM shift. Senna 8.6 mg 2 tablets once a day for constipation at 5:00 PM. Seroquel 25 mg three times a day for depression, evening dose due at 6:00 PM. Trazodone 50 mg 1/2 tab four times a day for depression, evening dose due at 5:00 PM. Boost Breeze 240 ml three times a day for supplement, evening dose due at 6:00 PM. Multivitamin with multimineral supplement once a day for supplement at 5:00 PM. Pain monitoring every shift. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #15's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #15 did not receive the ordered medications, including medications for overactive bladder, depression and constipation on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 16. Resident #16 was admitted to the facility in November 2018 with the diagnosis that included peripheral vascular disease (PVD), persistent mood disorders, anxiety, chronic ulcer of lower leg, dysthymic disorder, opioid dependence, adult failure to thrive, mood disorder, dry eyes, migraine, folate deficiency anemia, contact with and exposure to other viral communicable disease and constipation. The quarterly MDS assessment dated [DATE] indicated Resident #16 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Artificial Tears drops 1% 1 drop four times a day for dry eyes, evening dose due at 4:00 PM. Combigan drops 0.2-0.5% 1 drop every 12 hours for glaucoma, evening dose due at 10:00 PM. Erythromycin ointment 5 mg/gm (0.5%) 1 cm four times a day for bacterial infection of the eye, evening dose due at 10:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Gabapentin 100 mg once a day for mood disorder at 10:00 PM. Moxifloxacin drops 0.5% 1 drop four times a day for bacterial infection of the eye, evening dose due at 10:00 PM. Remeron 30 mg once daily at bedtime for depression at 9:00 PM. Valtrex 1 gram twice a day for anti-viral, evening dose due at 10:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00-7:00 PM On 7/2/22, and one medication due at 9:00 and five medications due at 10:00 PM. Review of the Medication Error Report dated 7/20/22 identified Resident #16's medications were omitted between 3:00 PM-7:00 PM and 1 medication due at 9:00 PM and five medications due at 10:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #16 did not receive the ordered medications, including medications for dry eyes, glaucoma, bacterial infection of the eye, depression and anti-viral on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 17. Resident #17 was admitted to the facility in December 2016 with the diagnosis that included major depressive disorder, recurrent, sever with psychotic symptoms, hypo-osmolality and hyponatremia, acute respiratory failure with hypoxia, contact with and exposure to other viral communicable diseases, alcohol abuse, in remission, anxiety, unspecified psychosis not due to a substance or known physiological condition, psychotic disorder with hallucinations due to known physiological condition, hypothyroidism, hypertension, constipation, Vitamin D deficiency and cataract. The quarterly MDS assessment dated [DATE] indicated Resident #17 had severely impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Atorvastatin 10 mg once a day at 9:00 PM for hyperlipidemia. Benztropine 0.5 mg 2 tabs twice a day for psychotic disorder with hallucinations, evening dose due at 5:00 PM. Clonazepam 0.5 mg four times a day for anxiety, evening dose due at 9:00 PM. Polyethylene Glycol 17 gm once a day for constipation, evening dose due at 5:00 PM. Quetiapine 50 mg three times a day for unspecified psychosis, evening dose due at 9:00 PM. Pain monitoring every shift with appropriate pain scale. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22 and three medications at 9:00 PM. Review of the Medication Error Report dated 7/20/22 identified Resident #17's medications were omitted between 3:00 PM-7:00 PM on 7/2/22 and three medications due at 9:00 PM. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #17 did not receive the ordered medications, including medications for psychotic disorder, anxiety, and psychosis on 7/2/22 during the 3:00 PM-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 18. Resident #18 was admitted to the facility in June 2022 with the diagnosis that included altered mental status, anxiety, restlessness and agitation, alcohol abuse, alcohol dependence with alcohol-inducing dementia, type 2 diabetes mellitus with other specified complications, unspecified dementia with behavioral disturbance, and delirium due to known physiological condition. The admission MDS assessment dated [DATE] indicated Resident #18 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Metformin 500 mg twice a day for diabetes, evening dose due at 5:00 PM. Trazodone 50 mg four times a day for restlessness and agitation, evening dose due at 4:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #18's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 18 days later. Resident #18 did not receive the ordered medications, including medications for diabetes and restlessness and agitation on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 19. Resident #19 was admitted to the facility in February 2018 with the diagnosis that included disease of spinal cord, low back pain, spondylosis with myelopathy thoracic region, paranoid schizophrenia, and depression. The quarterly MDS assessment dated [DATE] indicated Resident #19 had intact cognition. <br [TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on observation, clinical record review, facility documentation review, facility policy review, and interviews for two of two residents (Resident #28 and #29) reviewed for accidents, the facility failed to ensure adequate supervision was provided to ensure residents with a history of substance abuse did not have access to contraband/illicit substances. The findings include: 1. Resident #28 was admitted to the facility during June 2022 with diagnoses that included insulin dependent diabetes and history of substance abuse. Review of Resident #28's admission agreements, including the contraband agreement, identified Resident #28 refused to sign any agreements at the time of admission. The Resident Care Plan (RCP) dated 7/6/2022 identified a history of substance abuse. Interventions directed to refer Resident #28 to psychiatric services on admission and as needed, offer resident the option of attending substance abuse groups, IDT and medical provider evaluation of resident's request for LOA, social work support as needed and nursing support as needed, and upon discharge social services to provide resident with follow-up information as appropriate. The admission MDS dated [DATE] identified Resident #28 was alert and oriented, and was independent with locomotion, eating, and personal hygiene. Review of the clinical record identified a nurse's note dated 7/11/2022 at 1:30 PM identified LPN #6 was called to Resident #28's room by his/her roommate. LPN #6 observed Resident #28 sweating profusely, vomiting, skin cool, clammy with blood sugar of 82, and Resident #28's family member was present. The nursing supervisor was notified and assessed Resident #28. Repeat blood sugar was 62, IM Glucagon (hormone used to treat low blood sugar) with follow up blood sugar 69, and Resident #28 was transported to the hospital for evaluation. Review of facility incident report dated 7/11/2022 at 9:01 PM identified Resident #28 was profusely sweating, cold and clammy, nauseous and vomited. Suspect to be having a reaction, blood sugars were 82, then 61 with Glucagon given and Resident #28 was transferred to the hospital. The report further indicated the hospital emergency notes indicated Resident #28 took Percocet (used for pain) that is not part of Resident #28's medication list. The facility investigation completed by RN #7 identified a family member was visiting, and the family member indicated it was the drugs making Resident #28 sick, and Resident #28 refused hospital transfer. Staff educated the family member regarding low blood sugar, the family called 911, and Resident #28 consented to transfer. RN #7 interviewed the family member regarding access to drugs, and the family member denied providing drugs. The investigation concluded illicit substances may have been received during a family visit, and the visitor and Resident #28 were educated on the facility contraband policy. Review of the hospital drug screen report dated 7/11/2022 from the hospital identified Resident #28 was positive for amphetamine, cannabinoids, and Fentanyl. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse's note dated 7/12/2022 at 6:33 AM identified Resident #28 returned from the hospital and hospital drug toxicology report was positive for amphetamines (mood-altering drug, used illegally as a stimulant), cannabinoids (A type of chemical in Marijuana) and Fentanyl (used to control pain). The note further indicated Resident #28 admitted he/she does smoke Marijuana but denied the use of any other illegal substances. The note further identified Resident #28's name was entered in the psychiatry consult book for follow up. Review of the clinical record failed to identify Resident #28 was prescribed amphetamines, cannabinoids, or Fentanyl. Nurse's note dated 7/15/2022 at 2:03 PM Resident #28 became agitated, screaming at staff and residents, flailing cane, became aggressive, family called and attempted to calm resident without success, and Resident #28 was transferred to the hospital for evaluation. Note at 2:06 PM indicated family picked up Resident #28's personal belongings. Resident #28 did not return to the facility at the time of the survey. Social Services note dated 7/12/2022 at 10:23 AM identified Resident #28's room, person and surrounding areas were searched, and no prohibited items were found, and note at 2:15 PM identified a plan for visitation in public areas. A social service note dated 7/13/2022 at 3:50 PM indicated Resident #28 was issued the contraband agreement, read the agreement and Resident #28 refused to sign the agreement. Interview with RN #7 on 8/2/2022 at 1:14 PM identified the facility did receive a copy from the hospital of the positive toxicology screen for Marijuana, amphetamines, and Fentanyl, and Resident #28 had no previous history of a positive toxicology screen. RN #7 further indicated Resident #28 should not have had access to Marijuana, amphetamines and Fentanyl that were not prescribed for him/her, and she did not know where Resident #28 had obtained the drugs. The facility failed to ensure Resident #28 was free of access to illicit substances. 2. Resident #29 was admitted to the facility with the diagnosis that included drug or chemical induced diabetes mellitus, alcohol abuse, psychoactive substance abuse, and unspecified dementia. Review of facility documentation titled Contraband Agreement indicated Resident #29 signed the document on 4/13/2022. The RCP dated 7/18/2022 a history or active diagnosis of substance abuse, verbally abusive, resistive to care and aggressive behaviors. Interventions directed to refer resident to psych services on admission and as needed, offer resident the option of attending substance abuse groups, upon discharge social services to provide resident with follow-up information as appropriate, IDT and medical provider evaluation of resident's request for LOA, social work support as needed, and nursing support as needed. Additional interventions directed to approach in a calm, consistent manner, psychiatric/psychological consult and follow-up as ordered/necessary, provide the opportunity to express feelings through 1:1 and group visits, monitor for any changes in mood state/routines, report to MD and provide reassurance and emotional support during episodes. The quarterly MDS dated [DATE] identified Resident #29 had moderate cognitive impairment and was totally dependent for personal hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse's note dated 7/23/2022 at 4:01 PM identified Resident #29 was very agitated and arguing with staff; unable to be redirected and very verbally abusive to staff and residents. The note further indicated Resident #29 became very verbally aggressive and hit staff with his/her stick and punched a staff member in the chest. The APRN was notified, and new orders obtained to transfer Resident #29 to the hospital for evaluation. Nurse's note dated 7/25/2022 at 11:28 PM identified Resident #29 was readmitted to the facility, and was alert and oriented. The facility incident report dated 7/26/2022 at 9:49 PM identified during a regular review of hospital readmission paperwork, staff identified Resident #29 tested positive for Fentanyl when at the hospital. The report further indicated Resident #29 returned to facility after transfer to the hospital on 7/23/2022 for aggressive behavior, and Resident #29 was currently on Suboxone (used to treat opioid addiction in adults). Facility investigation identified Resident #29's room was immediately searched with no findings, visitation would be restricted and leave of absence (LOA) would be suspended. The report further identified Resident #29 had not had any visitors, denied use of an illicit substance, and did not give any statement about where the Fentanyl came from. Review of the clinical record failed to identify Resident #28 was prescribed use of Fentanyl prior to transfer to the hospital on 7/23/2022. Interview with RN #7 (Chief Clinical Officer) on 8/2/22 at 12:24 PM identified Resident #29 had no previous history of positive toxicology tests. RN #7 indicated when the facility is informed of a positive toxicology screen, a room search is immediately performed, an investigation is initiated to include if the resident had any visitors, and if so, to investigate if the visitor brought anything into the facility. RN #7 identified that Resident #29 was seen by the substance abuse counselor, group therapy was suggested, which the resident refused stating it was a one-time thing. RN #7 indicated Resident #29 should not have had access to the Fentanyl and was unable to identify where the drug came from. Review of the facility Contraband Policy, directed in part, the purpose of this procedure is to provide appropriate interventions for residents who may violate the contraband admission agreement. Additionally, the policy identified if a resident is found to be in possession of any substances indicated as contraband (per contraband admissions agreement), the facility reserves the right to perform room and/or person searches and an accident and incident report will be completed for each contraband violation. The policy further identified to prevent further violation, the facility will impose person searches/room searches/package after return from every LOA and randomly, ongoing random room searches, and the resident's care plan will be updated to reflect these interventions.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43184 Based on review of the clinical record, facility documentation, facility policy and interviews, the facility failed to ensure sufficient staff (licensed nurses) on 7/2/22 during the 3:00 PM to 11:00 PM shift to provide care and services and to respond to each residents' needs on the 1st floor Birch & Cedar unit (21 residents). Further, when 1 licensed nurse was a no call, no show, the current licensed nurse who had worked on the unit for the 7:00 AM to 3:00 PM shift left without an oncoming nurse to take the unit. Subsequently, all 21 residents on the Birch & Cedar unit did not receive medications, treatments or monitoring on 7/2/22 between 3:00 PM - 7:00 PM, and several medications were omitted between 7:00 PM - 11:00 PM. Further, the RN Supervisor, (RN #1) left the facility at approximately 6:20 PM, without giving report and counting narcotics, and leaving the facility without an RN. This insufficient licensed nurse staffing resulted in a finding of Immediate Jeopardy. The findings include: Based on review of facility documentation and interview the following was identified: On Saturday 7/2/22, the scheduled 7:00 AM - 7:00 PM RN Supervisor called out. Per the on-call rotation, RN #2 was called to cover as 7:00 AM - 7:00 PM RN Supervisor. On 7/2/22 LPN #1 was assigned to the Birch & Cedar unit of the 1st floor for the 7:00 AM - 3:00 PM shift which had a census of 21. LPN #1 left the facility at 3:59 PM on 7/2/22. On 7/2/22 RN #1 was scheduled for the 7:00 PM - 7:00 AM shift as the free-floating RN Supervisor. Facility documentation indicated that on 7/2/22 the nurse scheduled on the Birch & Cedar unit (21 residents) for 3:00 PM - 11:00 PM was a no call no show. Although calls and blast texts for additional staff were attempted, no additional staff came to the facility during the 3:00 PM - 11:00 PM shift. Subsequently, the Birch & Cedar unit (21 residents) were without a licensed nurse from 3:00 PM - 7:00 PM, 4 hours, until RN #1 arrived at approximately 7:06 PM. Facility documentation identified that 21 of 21 residents on the Birch & Cedar unit did not receive their ordered evening shift medications, treatments and/or monitoring between 3:00PM - 7:00 PM, and some additional medications were omitted during the 7:00 PM - 11:00 PM shift. Medications omitted included Insulin, antiseizure, 2 doses of IV antibiotics, antipsychotics, anticoagulants, antihypertensives, and an anti-rejection medication. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Additionally, 3 residents with a diagnoses of diabetes and who required fingerstick for blood sugar monitoring did not have their blood sugar checked. Further, one resident with a wound did not have the dressing changed, and one resident who had a medication ordered to be administered once monthly for schizophrenia, missed that monthly dose. Review of a signed statement dated 7/4/22 by RN #1 (RN Supervisor 7:00 PM - 7:00 AM) identified that when she arrived at the facility on 7/2/22 for her 7:00 PM - 7:00 AM shift, she was informed that there was a staffing issue, and that the 7:00 AM - 7:00 PM RN Supervisor had left and there was no RN Supervisor in the building. Further that there was no nurse on the Birch & Cedar unit. Interview with Resident #20 on 7/20/22 at 11:31 AM indicated that he/she recalled an incident when he/she did not get Insulin. Additionally, Resident #20 indicated he/she requested the Insulin and was told by the nurse that she would be back, but the nurse never came back. Resident #20 could not recall the exact date that this happened. Interview with RN #2 (RN Supervisor 7:00 AM - 7:00 PM shift) on 7/20/22 at 12:56 PM indicated that there was only 1 nurse working on the 1st floor (46 residents), when there should have been 2, (1 for each unit). Additionally, RN #2 identified that due to the workload (2 admissions and 2 falls), RN #2 indicated she went to the first floor after change of shift to let them know she was involved in other things, but she was unable to get back down to the unit to administer medications. Interview with RN #1 (RN supervisor 7:00 PM - 7:00 AM shift) on 7/20/22 at 1:07 PM identified that when she arrived at the facility on 7/2/22, she went to the 1st floor, Birch & Cedar unit and took the unit for medication administration along with LPN #4. Additionally, RN #1 indicated that she did not give any medications that were due between 4:00 PM - 5:00 PM due to them being overdue and not scheduled during her shift. Interview with the DNS on 7/21/22 at 10:45 AM indicated that the free-floating supervisor (RN #2) on the 7:00 AM - 7:00 PM shift as well as the scheduler did make attempts to replace the staff member that was a no call/no show. Additionally, the DNS indicated that RN #2 informed her via a text message that she was overwhelmed and not feeling good, but she did not tell the DNS that medications had not been given on the Birch & Cedar unit. The DNS further indicated that she directed the RN supervisor (RN #2) to hang in there as it was close to the end of her shift. Interview with Scheduler #1 on 7/21/22 at 10:52 AM identified that RN #2 did reach out to her to let her know that there was a no call/no show on 7/2/22 for 3:00 PM - 11:00 PM, but that it wasn't until approximately 6:00 PM. Additionally, Scheduler #1 indicated that RN #2 did inform her that she attempted to replace the staff member via a blast text and calls to no avail. Scheduler #1 indicated that she also attempted to call and text staff members to fill in, but she either got a refusal or no answer back. Scheduler #1 indicated that she did inform the DNS, per protocol, that there was a no call/no show and she could not find a replacement. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the investigation/interviews conducted by RN #3 (Independent Nurse Consultant) dated 7/21/22 indicated for 7/2/22 3:00 PM - 11:00 PM one licensed staff was a no call/no show for the Birch & Cedar unit. RN #3 further indicated that RN #2 was the supervisor on duty on 7/2/22 from 7:00 AM - 7:00 PM. RN #3 conducted an interview with RN #2 on 7/20/22 at 6:30 PM along with the Administrator and the DNS. RN #2 stated that she did not pass the medications on the Birch & Cedar unit of the 1st floor because she had admissions and 2 fall incident reports to complete and she was overwhelmed. RN #2 stated that she did not convey to the DNS that she had not passed the medications on Birch & Cedar unit, she only told the DNS that she was overwhelmed. RN #2 also stated she told the oncoming supervisor (RN #1) that the medications had not been administered between 3:00 PM - 7:00 PM (this is in conflict with interviews that RN #2 had left without giving report and that RN #1 was not aware if medications had been administered between 3:00 PM - 7:00 PM). RN #2 stated she left the facility at 7:15 PM (this is in conflict with interviews that RN #2 left at approximately 6:20 PM). Additionally, RN #3 conducted an interview with RN #1 on 7/20/22. RN #1 stated that when she arrived at the facility at 7:00 PM, RN #2 was not there, and a licensed nurse greeted her at the door and informed her that there was no supervisor in the building. RN #1 indicated that she then went to the supervisor's office where she found the keys, but no report or narcotic count done. RN #1 stated at that time she and LPN #4 went to pass the 7:00 PM medications. RN #1 stated that she did not give the 5:00 PM medications because she did not know if RN #2 gave any medications or what she gave. RN #1 indicated she did attempt to call RN #2 3 times to ask if she gave any medications or what she gave, but RN #2 did not answer the phone. At that time RN #1 documented the medications as refused, to prevent another nurse from signing them off. Interview with RN #1, (the 7:00 PM - 7:00 AM RN Supervisor on 7/2/22) on 7/28/22 at 11:35 AM identified that when she arrived at the facility on 7/2/22 for her shift and was informed that there was no RN Supervisor in the building, she called the DNS to discuss the situation with her. RN #1 indicated that the DNS informed her that the previous RN Supervisor (RN #2) had gotten overwhelmed, but the DNS indicated she was not aware that RN #2 had left the building. Additionally, RN #1 indicated that she immediately went to the Birch & Cedar unit and started passing out medications and taking care of the resident's. When asked why she did not notify the DNS or the physician that the 21 residents may have missed their medications between 3:00 PM - 7:00 PM, RN #1 indicated that she had too many problems and had to prioritize to ensure resident needs were met. Interview with the DNS on 7/28/22 at 11:54 AM identified that on 7/2/22 she was told by the 7:00 PM - 7:00 AM RN supervisor (RN #1) that she (RN #1) had not received report from the previous RN supervisor (RN #2). Further RN #1 indicated to the DNS that she, (RN #1), would have to take the 1st floor Birch & Cedar unit. The DNS indicated that she did offer to come to the facility, but RN #1 declined stating by the time the DNS would arrive, she would have it handled. Additionally, the DNS indicated immediately following the call, she attempted to call other staff members to fill in the 3:00 PM - 11:00 PM shift but was unsuccessful. The DNS also indicated that she did talk with the scheduler (Scheduler #1) who also made calls to staff with no success. The DNS identified that when she spoke with the RN Supervisor for the 7:00 AM - 7:00 PM shift (RN #2), she was informed by RN #2 that there were admissions and falls that needed to be done. The DNS indicated at that time she instructed RN #2 to put in the medication orders for the admissions and perform the RN assessments for the falls and the paperwork piece could be finished at a later time. The DNS indicated that throughout the 3:00 PM - 7:00 PM shift, she called RN #1 to check on the situation at the facility. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #1 on 7/28/22 at 12:52 PM identified that on 7/2/22 at the end of her 7:00 AM - 3:00 PM shift, she called the nursing supervisor (RN #2) to let her know that her replacement staff had not come in yet. LPN #1 indicated she again called RN #2 and asked her to come to the unit to do the narcotic count with her and take report. LPN #1 indicated that RN #2 informed her that she was too busy to come to the unit and directed her to do the narcotic count with the other LPN on the first floor (LPN #3) and to give her report as well. LPN #1 indicated she gave the keys and a written report to RN #2 and left the facility. LPN #1 indicated that when no replacement staff comes in, it is the protocol to wait to leave the facility until another staff member comes to replace her. Additionally, LPN #1 indicated that she did leave the facility on 7/2/22 because she gave the keys and report to RN #2 and was under the impression that RN #2 was going to cover the unit until the next supervisor came in at 7:00 PM. Interview with RN #1 on 8/1/22 at 9:30 AM identified that when she arrived at the facility on 7/2/22 at 7:00 PM, she was told by a nurse aide who was the acting receptionist, that RN #2 was gone. RN #1 indicated that she did not get report from RN #2 and that she did attempt to call RN #2 several times, but RN #2 never answered her phone. RN #1 indicated she immediately went to the supervisor's office on the second floor and found keys on the desk and the door to the office ajar. RN #1 further indicated the keys found were the narcotic keys, the facility/supervisor keys and the 1st floor Birch & Cedar unit keys on the desk in the supervisor's office. The facility failed to ensure sufficient staff on the Birch & Cedar unit on 7/2/22 during the 3:00 PM - 7:00 PM shift to ensure the safe delivery of care according to professional standards. Subsequently, 21 of 21 residents on that unit did not receive medications, treatments and monitoring between 3:00 PM - 7:00 PM. Please cross reference F580, F658, F684 and F760.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **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 #31) reviewed for a cardiac device, the facility failed to ensure that nursing staff (license nurses) had been educated or possessed the competencies necessary to provide care to the resident who was admitted with a CardioMEMS sensor (the CardioMEMS System remotely monitors changes in pulmonary artery (PA) pressure, to reduce heart failure hospitalization s and mortality and increase quality of life). The findings include: Review of the hospital discharge summary dated 6/23/22 identified Resident #31 was admitted to the hospital on 5/25/22 and discharged on [DATE] with diagnosis that included chronic diastolic heart failure, paroxysmal atrial fibrillation, and chronic kidney disease. Resident #31 has a past medical history significant for chronic diastolic heart failure, status post CardioMEMS sensor implantation (the CardioMEMS System remotely monitors changes in pulmonary artery (PA) pressure, to reduce heart failure hospitalization s and mortality and increase quality of life). Resident #31 ' s hospital course was complicated by ventricular tachycardia, acute kidney injury, and acute respiratory failure. Resident #31 has a CardioMEMS sensor in place. The CardioMEMS device is to be interrogated on a daily basis. Resident #31 requires a follow up with a cardiologist (which the name, address, and phone number was provided). Past surgical history includes a cardiac pacemaker placement. Resident #31 was admitted to the facility on [DATE] with diagnoses that diabetes, fusion of spine, cervical region, and sepsis. Resident #31 was admitted to the facility on [DATE]. Review of the clinical record including physician ' s orders and nurse's note dated 6/23/22 - 7/28/22 failed to reflect documentation related to the CardioMEMS or cardiac pacemaker. Resident #31 had been residing at the facility for over a month before staff became aware he/she had CardioMEMS device that required staff to interrogate daily. Interview with the Admission Director on 7/28/22 at 5:08 PM identified she was not aware that Resident #31 had a CardioMEMS device. The Admission Director indicated she received the referral from the hospital, and she sent the referral to the previous DNS. The Admission Director indicated the previous DNS reviewed the referral to make sure the facility could provide medical care. The Admission Director indicated the previous DNS would make the determination if the resident could be admitted and let her know. The Admission Director indicated she reviews the financial aspect, a criminal background check and sex offender registry check. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #10 on 7/28/22 at 5:34 PM identified she was not aware that Resident #31 had a CardioMEMS nor were facility staff. RN #10 indicated the first time she heard about the CardioMEMS was today (7/28/22). RN #10 indicated a specialist from the CardioMEMS company had been at the facility this afternoon regarding the CardioMEMS. RN #10 indicated she took the specialist to Resident #31 room and indicated the specialist educated her and RN #12 on the CardioMEMS. RN #10 indicated the specialist reported that the last time the cardiologist office received a reading from the CardioMEMS was on 6/22/22, over a month prior. Interview with RN #7 on 7/28/22 at 6:54 PM identified she was not aware that Resident #31 had a CardioMEMS and indicated she was made aware today (7/28/22). RN #7 indicated she was not aware of it and the nursing staff was not educated or in-service regarding the CardioMEMS. Interview with RN #7 on 7/29/22 at 8:47 AM identified someone from the company came to the facility yesterday (7/28/22) and in-serviced the supervisor and the infection preventionist regarding the CardioMEMS. RN #7 indicated the company is due to come back today (7/29/22) to in-service the rest of the nursing staff regarding the CardioMEMS and the reading of the device. Interview with the CardioMEMS Clinical Specialist on 7/29/22 at 11:10 AM identified the facility staff had reported that they were not aware that Resident #31 had a CardioMEMS. The CardioMEMS Clinical Specialist indicated he is available for education, in-servicc training for the nursing staff, and also to troubleshoot the device, and for general support with the CardioMEMS. The CardioMEMS Clinical Specialist indicated the cardiologist office finally got in touch Resident #31 and he/she notified them that he/she has been a nursing facility. The CardioMEMS Clinical Specialist indicated the cardiologist office got in touch with him to interface with the facility and he provided education to RN #10 and RN #12 on 7/28/22 during his visit to Resident #31. The CardioMEMS Clinical Specialist indicated he has not been asked to come back to educate or in-service the other nursing staff regarding the CardioMEMS. Interview with the previous DNS on 8/15/22 at 12:45 PM identified she was not aware that Resident #31 had a CardioMEMS, and cardiac pacemaker and indicated she had never reviewed Resident #31's referral from the hospital. She indicated RN #10 did the admission. The previous DNS indicated she and the nursing staff were not in-service regarding the CardioMEMS. Interview with MD #1 on 8/15/22 at 8:31 PM identified he was not aware that the facility had accepted a resident with a CardioMEMS, and he was not aware that Resident #31 had a cardiac pacemaker. MD #1 indicated this is the first time he is hearing of it. MD #1 indicated he was not aware that the nursing staff were not educated on the CardioMEMS before the the resident was accepted for admission to the facility. MD #1 indicated the facility should have provided education and an in-service training for the nursing staff prior to the resident being admitted to the facility. MD #1 indicated he was not aware that a specialist from the CardioMEMS company had come to the facility to assess Resident #31. MD #1 indicated the RN completing the admission should read the hospital discharge thoroughly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with APRN #1 on 8/16/22 at 10:43 AM identified the clinic has been trying to get in touch with Resident #31 but had not been successful. APRN #1 indicated Resident #31 had a pacemaker placement done in 2016, and a CardioMEMS placement was done on 7/22/20. APRN #1 indicated Resident #31 has a diagnosis of chronic diastolic heart failure and the CardioMEMS measures and monitors the pulmonary artery pressure and heart rate for patients with heart failure. APRN #1 indicated it is very important for the cardiologist to receive a reading daily. APRN #1 indicated the data is used by the cardiologist for heart failure management with the goal of the reading to be within normal range a patient. APRN #1 indicated the normal range goal for Resident #31 is (21 - 27) meaning the resident is stable. APRN #1 indicated based on the readings, the cardiologist can make treatment decisions and manage the resident's heart failure, possibly helping these patients get care sooner and avoid heart failure related hospitalization s. APRN #1 indicated the facility should have been monitoring and transmitting the CardioMEMS reading daily. Further, APRN #1 indicated the facility has not scheduled an appointment for Resident #31 to be followed with their cardiac office. The facility failed to ensure that nursing staff had been educated on use of the CardioMEMS and failed ot ensure staff demonstrated competencies on use of the CardioMEMS. Although requested, a facility policy was not provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on review of the clinical record, facility documentation, facility policy and interview for 5 residents, (Residents #3, 4, 7, 19 and 20) the facility failed to ensure the residents were free from significant medication errors due to insufficient licensed nurse staffing. The findings include: 1. Resident #3 was admitted to the facility in November 2019 with the diagnosis including Type 2 diabetes mellitus, hallucinations, delusional disorder, paranoid schizophrenia, unspecified intellectual disabilities, schizoaffective disorder paranoid type, dementia, major depressive disorder and anxiety disorder. The quarterly MDS dated [DATE] indicated Resident #3 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications: Insulin Lispro 10 units for diabetes once a day at 5:00 PM. Lantus Insulin 35 units once a day for diabetes at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the Insulin due between 3:00 PM-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #3's medications were omitted between 3:00 PM-7:00 PM. Additionally, the report indicated the physician was not notified until 7/20/22, 19 days later. Resident #3 did not receive the ordered Insulin on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 2. Resident #4 was admitted to the facility in June 2022 with the diagnosis that included acute respiratory failure with hypoxia, liver cell carcinoma, history of cardiac arrest, Methicillin susceptible Staphylococcus aureus infection (MSSA), bacteremia, paralytic syndrome, acute pulmonary edema, viral hepatitis C without hepatic coma, cirrhosis of the liver and acute kidney failure. The discharge MDS assessment dated [DATE] indicated Resident #4 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medication. Oxacillin in dextrose 2 gm/50 ml via IV every 4 hours for MSSA, evening doses due at 6:00 PM and 10:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered IV antibiotic due at 6:00 PM and 10:00 PM on 7/2/22. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Error Report dated 7/20/22 identified Resident #4's medications were omitted between 3:00 PM-7:00 PM and one medication due at 10:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 19 days later. Resident #4 did not receive the ordered IV antibiotic medication on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 3. Resident #7 was admitted to the facility in May 2008 with the diagnosis that included intracranial injury, schizophrenia, anxiety, visual loss, convulsions, hallucinogen dependence, other degenerative diseases of nervous system, opioid abuse, and disorder of brain. The quarterly MDS assessment dated [DATE] indicated Resident #7 had moderately impaired cognition. Physician orders dated 7/1/22 directed to administer the following medications: Divalproex delayed release 250 mg for convulsions twice a day, evening dose due at 5:00 PM. Phenytoin sodium 100 mg twice a day for convulsions, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered medications due between 3:00-7:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #7's medications were omitted between 3:00 PM-7:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 19 days later. Resident #7 did not receive the ordered medications, including medications for convulsions on 7/2/22 during the 3:00-11:00 PM shift because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 4. Resident #19 was admitted to the facility in February 2018 with the diagnosis that included disease of spinal cord, low back pain, spondylosis with myelopathy thoracic region, paranoid schizophrenia, and depression. The quarterly MDS assessment dated [DATE] indicated Resident #19 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Fluphenazine Decanoate solution 25 mg/ml 3 ml (75 mg) injection on the second of the month for paranoid schizophrenia, dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the once monthly ordered medication (Fluphenazine Decanoate) due at 5:00 PM on 7/2/22. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Error Report dated 7/20/22 identified Resident #19's medication (Fluphenazine Decanoate) was omitted at 5:00 PM on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 19 days later. Resident #19 did not receive the ordered medication, given monthly on the 2nd, on 7/2/22 at 5:00 PM because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. 5. Resident #20 was admitted to the facility in June 2022 with the diagnosis that included other acute osteomyelitis left ankle and foot, type 2 diabetes mellitus with other skin complications, opioid dependence, peripheral vascular disease, depression and unspecified open wound left ankle. The admission MDS assessment dated [DATE] indicated Resident #20 had intact cognition. Physician orders dated 7/1/22 directed to administer the following medications/treatments: Insulin Lispro 100 unit/ml, administer per sliding scale before meals for blood sugar control as follows: < 70 call the physician 200-249 give 2 units 250-299 give 4 units 300-349 give 6 units 350-399 give 8 units greater than 399 give 10 units and call physician. Insulin Lispro 100 units/ml give 14 units subcutaneously before meals for blood sugar control, evening dose due at 5:00 PM. Review of the medication compliance report for 7/2/22 between 3:00 PM-11:00 PM identified staff did not administer the ordered Insulin (before meals) due at 5:00 PM on 7/2/22. Review of the Medication Error Report dated 7/20/22 identified Resident #20's Insulin (before meals) due at 5:00 PM on 7/2/22 was omitted on 7/2/22. Additionally, the report indicated the physician was not notified until 7/20/22, 19 days later. Resident #20 did not receive the ordered Insulin (before meals) due at 5:00 PM on 7/2/22 because there was not a licensed nurse on the Birch & Cedar unit that shift due to insufficient staffing. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #20 on 7/20/22 at 11:31 AM indicated that he/she recalled an incident when he/she did not get Insulin. Additionally, Resident #20 indicated he/she requested the Insulin and was told by the nurse that she would be back, but the nurse never came back. Resident #20 could not recall the exact date that this happened. Resident #20 further indicated that he/she has only refused Insulin on 1 occasion when he/she did not eat anything. Interview with NA #3 on 7/20/22 at 11:49 PM indicated that she worked on the 1st floor Birch & Cedar unit on 7/2/22 during the 3:00 PM - 11:00 PM, and there was not a nurse on the unit for the entire shift. Additionally, NA #3 indicated a nurse from the 2nd floor came to the unit to help after she finished the medications on the 2nd floor. Interview with NA #1 on 7/20/21 at 12:08 PM indicated NA #1 did work on the 1st floor on 7/2/22 for the 3:00 PM - 11:00 PM shift. NA #1 indicated that there was 1 nurse on the floor for the entire floor (2 units/46 residents). Additionally, NA #1 indicated that this was not for the entire shift, but that she was not aware when the supervisor came to the unit due to being busy with her assignment. Interview with RN #2 (RN Supervisor 7:00 AM - 7:00 PM shift) on 7/20/22 at 12:56 PM indicated that she was the supervisor for the facility on 7/2/22 until 7:00 PM. RN #2 identified that there was only 1 nurse working on the 1st floor (46 residents), when there was supposed to be 2, (1 for each unit). Additionally, RN #2 identified that due to the workload (2 admissions and 2 falls), RN #2 indicated she went to the first floor after change of shift to let them know she was involved in other things, but she was unable to get back down to the unit to give the medications. RN #2 further indicated that she worked until the end of her shift at 7:00 PM. Interview with RN #1 (RN supervisor 7:00 PM - 7:00 AM shift) on 7/20/22 at 1:07 PM identified that she did work her scheduled shift on 7/2/22 from 7:00 PM - 7:00 AM. RN #1 identified that when she arrived at the facility, she went to the 1st floor, Birch & Cedar unit and took the unit for medication administration along with LPN #4. Additionally, RN #1 indicated that she did not give any medications that were due between 4:00 PM - 5:00 PM due to them being overdue and not scheduled during her shift. RN #1 further indicated that if a medication is not documented in the electronic medical record (EMR), she would not give the medication because she did not know if it was given. RN #1 identified that she documented some of the 3:00 PM - 7:00 PM medications as refused in the EMR because she had to put something in the system to move forward with the medication pass. RN #1 indicated if a resident does refuse a medication, she would follow up with the APRN to inform them. Interview with LPN #1 on 7/20/22 at 1:54 PM identified that on 7/3/22 during her scheduled 7:00 AM - 3:00 PM shift, when the not administered medications flagged in the EMR from 7/2/22 on the 3:00 PM - 11:00 PM shift that were not documented, she documented in the EMR, not my shift to prevent confusion because the medication will come up twice in the EMR. Additionally, LPN #1 indicated that if a medication is not signed off it indicates that medication was not given or was given but not documented and that is where mistakes can happen, so that is the reason she documents that it was not given so that only the medications due on her shift show up. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/21/22 at 10:45 AM indicated that the free-floating supervisor (RN #2) on the 7:00 AM - 7:00 PM shift did make attempts to replace the staff member that was a no call/no show as well as the scheduler. Additionally, the DNS indicated that RN #2 informed her via text message that she was overwhelmed and not feeling good, but she did not tell the DNS medications had not been given on the Birch & Cedar unit. The DNS further indicated that she directed the RN supervisor (RN #2) to hang in there as it was close to the end of her shift. Interview with Scheduler #1 on 7/21/22 at 10:52 AM identified that RN #2 did reach out to her to let her know that there was a no call/no show on 7/2/22 for 3:00 PM - 11:00 PM, but that it wasn't until approximately 6:00 PM. Additionally, Scheduler #1 indicated that RN #2 did inform her that she did attempt to replace the staff member via a blast text and calls to no avail. Scheduler #1 indicated that she also attempted to call and text staff members to fill in, but she either got a refusal or no answer back. Scheduler #1 indicated that she did inform the DNS, per protocol, that there was a no call/no show and she could not find a replacement. Review of the investigation/interviews conducted by RN #3 (Independent Nurse Consultant) dated 7/21/22 indicated for 7/2/22 3:00 PM - 11:00 PM one licensed staff was a no call/no show for the Birch & Cedar unit. RN #3 further indicated that RN #2 was the supervisor on duty on 7/2/22 from 7:00 AM - 7:00 PM. RN #3 conducted an interview with RN #2 on 7/20/22 at 6:30 PM along with the Administrator and the DNS. RN #2 stated that she did not pass the medications on the Birch & Cedar unit of the 1st floor because she had admissions and 2 fall incident reports to complete and she was overwhelmed. RN #2 stated that she did not convey to the DNS that she didn ' t pass the medications on Birch & Cedar, she only told the DNS that she was overwhelmed. RN #2 also stated she told the oncoming supervisor (RN #1) that the medications were not done. RN #2 stated she left the facility at 7:15 PM. Additionally, RN #3 conducted an interview with RN #1 on 7/20/22. RN #1 stated that when she arrived at the facility at 7:00 PM, RN #2 was not there, and a licensed nurse greeted her at the door and informed her that there was no supervisor in the building. RN #1 indicated that she then went to the supervisor's office where she found the keys, but no report or narcotic count done. RN #1 stated at that time she and LPN #4 went to pass the 7:00 PM medications. RN #1 stated that she did not give the 5:00 PM medications because she did not know if RN #2 gave any medications or what she gave. RN #1 indicated she did attempt to call RN #2 3 times to ask if she gave any medications or what she gave, but RN #2 did not answer the phone. At that time RN #1 documented the medications as refused, to prevent another nurse from signing them off. Additionally, the investigation done by RN #3 identified the DNS was unaware that RN #2 had left the building. Review of the narcotic count sheet reviewed for 7/2/22 identified that RN #2 did not sign in or off that she did a narcotic count at all on 7/2/22. Interview with RN #1, (the 7:00 PM - 7:00 AM RN Supervisor on 7/2/22) on 7/28/22 at 11:35 AM identified that when she arrived at the facility on 7/2/22 for her shift and was informed that there was no RN Supervisor in the building, she called the DNS to discuss the situation with her. RN #1 indicated that the DNS informed her that the previous RN Supervisor (RN #2) had gotten overwhelmed, but the DNS indicated she was not aware that RN #2 had left the building. Additionally, RN #1 indicated that she immediately went to the Birch & Cedar unit and started passing out medications and taking care of the resident's needs. When asked why she did not notify the DNS or the physician that the 21 residents may have missed their medications between 3:00 PM - 7:00 PM, RN #1 indicated that she had too many problems and had to prioritize to ensure resident needs were met. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/28/22 at 11:54 AM identified that on 7/2/22 she was told by RN #1 that she had not received report from the previous RN Supervisor (RN #2) and that she would have to take the 1st floor Birch & Cedar unit. The DNS indicated that she did offer to come to the facility, but RN #1 declined stating by the time the DNS would arrive, she would have it handled. Additionally, the DNS indicated immediately following the call, she attempted to call other staff members to fill in the 3:00 PM - 11:00 PM shift but was unsuccessful. The DNS also indicated that she did talk with the scheduler (Scheduler #1) who also made calls to staff with no success. The DNS identified that when she spoke with the RN Supervisor for the 7:00 AM - 7:00 PM shift (RN #2), she was informed by RN #2 that there were admissions and falls that needed to be done. The DNS indicated at that time she instructed RN #2 to put in the medication orders only for the admissions and to perform the RN assessments for the falls and the paperwork piece could be finished at a later time. The DNS indicated that throughout the 3:00 PM - 7:00 PM shift, she called RN #1 to check on the situation at the facility. The DNS indicated that she was not on-call on 7/2/22 stating that she was never on call on the weekend because she took call 5 days a week and administration was aware of this. The DNS indicated the administration attempted to say she was the back-up on call management staff member, but she was not. Interview with LPN #1 on 7/28/22 at 12:52 PM identified that on 7/2/22 at the end of her 7:00 AM - 3:00 PM shift, she called the nursing supervisor (RN #2) to let her know that her replacement staff had not come in yet. LPN #1 indicated that RN #2 informed her that the replacement staff member would be there in 5 minutes. LPN #1 indicated she waited another 10 - 15 minutes and when no replacement staff came in, she again called RN #2 and asked her to come to the unit to do the narcotic count with her and take report. LPN #1 indicated that RN #2 informed her that she was too busy to come to the unit and directed her to do the narcotic count with the other LPN on the first floor (LPN #3) and to give her report as well. LPN #1 indicated that she did the narcotic count with LPN #3 and then did a written report of the residents on the Birch & Cedar unit. LPN #1 indicated she then gave the keys and the written report to RN #2 and left the facility. LPN #1 indicated that when no replacement staff comes in, it is the protocol to wait to leave the facility until another staff member comes to replace her. Additionally, LPN #1 indicated that she did leave the facility on 7/2/22 because she gave the keys and report to RN #2 and was under the impression that RN #2 was going to cover the unit until the next supervisor came in at 7:00 PM (RN #1). Interview with RN #1 on 8/1/22 at 9:30 AM identified that when she arrived at the facility on 7/2/22 at 7:00 PM, she was told by a nurse aide who was the acting receptionist, that RN #2 was gone. RN #1 indicated that she did not get report from RN #2 and that she did attempt to call RN #2 several times, but RN #2 never answered her phone. RN #1 indicated she immediately went to the supervisor ' s office on the second floor and found keys on the desk and the door to the office ajar. Additionally, RN #1 indicated that due to the keys being present in the unlocked office, she did a narcotic count, on her own, without another staff member present, to ensure the narcotic count matched the narcotic sheets. RN #1 further indicated the keys found were the narcotic keys, the facility/supervisor keys and the 1st floor Birch & Cedar unit keys on the desk in the supervisor ' s office. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration policy identified it was the policy to provide a safe and effective medication framework to help eliminate any harm that could be caused at any level of the medication management process. Additionally, the policy directs in the event of a medication administration error, the licensed nurse will immediately provide care to the resident (if necessary) and notify the provider, supervisor, DNS, or designee. The event will be documented in the resident ' s chart in the EMR and an incident report (A&I) is to be completed and forwarded to the immediate supervisor of the licensed nurse who administered the medication. The incident will be reviewed and may be subject to disciplinary action if necessary, up to and including termination of employment. The facility failed to adequately staff the Birch & Cedar unit on 7/2/22 during the 3:00 PM - 7:00 PM shift to ensure the safe delivery of care according to professional standards. Subsequently, 5 residents on that unit had significant medication errors 3:00 PM - 7:00 PM.

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	075397	A. Building B. Wing	08/03/2022

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37293 Based on observation, review of facility documentation, facility policy, and interviews for 1 of 6 medication carts, the facility failed to ensure the medication cart was locked and clean. The findings include: Observation on 7/28/22 at 10:14 AM with the Administrator, RN #3, RN #11, and RN #9 on the 2nd floor identified an unlocked medication cart in the hallway in front of the nurse's station with an open uncovered bowl of applesauce, 2 orange needle cap covers (insulin needles) on top. LPN #7 was preparing medication at another medication cart on the other side of the nurse's station. At the time of the observation, one resident was sitting in a wheelchair in the area of the unlocked medication cart. Interview with LPN #7 on 7/28/22 at 10:15 AM identified she was the nurse on the 2nd floor for both Spruce and Elm units. LPN #7 indicated she was not in-serviced prior to administration of medication and indicated she is going between 2 medication carts to administer medications. Interview with RN #9 on 7/28/22 at 10:16 AM identified he was not aware that LPN #7 had left the medication cart unlocked. RN #9 indicated LPN #7 should have covered the applesauce, discarded the 2-orange needle cap covers, and locked the medication cart when she left and was not using it. Interview with the Administrator on 7/28/22 at 10:18 AM identified the nurse should have locked the medication cart and the applesauce should have been covered. Review of the facility medication administration policy directed it is the facility policy to provide a safe and effective medication management framework to help eliminate any harm as it relates to the medication management process. Medications must be stored safely and out of reach from residents, either in a locked medication room or a locked medication/treatment cart. The licensed nurse is responsible for managing the security of medications on his/her unit and is expected to keep medication storage locked at all times. The medication cart is to be secured at all times when not in used by the licensed nurse.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37293 Based on observations, review of facility documentation, facility policy, and interviews, the facility failed to maintain the kitchen in a clean and sanitary manner. The findings include: A tour of the kitchen on 7/28/22 at 1:20 PM with the Director of Dietary, Food Service Director, and RN #11 identified the following: a. The wall above the pot sink was noted with a moderate amount of splatter stains and debris. b. The wall underneath of the pot sink was noted with moderate amount of brown stains. c. The sanitizer holder was noted with rust, stains, and dry debris. d. The rubber seal was coming off the doors of the cooler refrigerator (2 doors), all shelves were rusty with dry stains and food debris. e. The ice machine door handle was broken, outside was covered with multiple green and gray stains. g. The hand washing sink was noted with multiple rusty areas. h. The toaster was noted with moderate amount of dry brown stains. i. The microwave was noted with an accumulation of dry food debris inside. j. The convention oven was noted with an accumulation of grease film and food debris. k. The top of the convention oven was noted with a large amount of grease film, dust, and debris. l. The tray line system belt was noted with multiple brown stains, and food debris. m. The pot shelves were noted with a large amount of rust. n. The 2 bottom shelves of the oven were noted with an accumulation of stains, and dry food debris. o. The outside of the 2 oven doors were noted with large amount of stains. p. The walk-in refrigerator bottom shelf was noted with moderate amount of stains. q. The walk-in refrigerator 2 fan covers were noted to be broken, and or damaged. r. The milk cooler gasket was noted striped, torn and coming off. The strip was noted with large amounts of black stains, gasket rusty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	t. The ceiling in the hallway in front of the kitchen was noted with large of amount of moisture with water dripping off the ceiling to the floor. u. The wall in the hallway across from the kitchen was noted with a large hole. Interview with the Director of Dietary on 7/28/22 at 1:30 PM identified she has been employed by the facility for approximately 5 months. The Director of Dietary indicated she was not aware of all the issues identified during tour. The Director of Dietary indicated it is the responsibility of all cooks and dietary staff to make sure the kitchen is clean throughout the day. The Director of Dietary indicated the closing cook and dietary staff members are responsible for making sure the kitchen is clean at the end of the day. Interview with the Food Service Director (FSD) on 7/28/22 at 1:35 PM identified he will address the rust issues, replace the shelves, and address the milk cooler gasket. The FSD indicated he will notify the maintenance department regarding the hole on the wall. Review of the facility general sanitation of kitchen policy identified food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Review of the facility food safety and sanitation policy identified all local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #31) reviewed for wounds, the facility failed to ensure results of blood glucose monitoring was documented consistently in the clinical record. The findings include: Resident #31 was admitted on [DATE] with diagnoses that included spinal fusion of cervical region and type II diabetes mellitus. The admission MDS dated [DATE] identified Resident #31 was alert and oriented and received Insulin injections seven (7) out of the last seven (7) days. The Resident Care Plan (RCP) dated 6/24/2022 identified Resident #31 was at risk for abnormal blood glucose levels (hypo/hyperglycemia) secondary to diabetes mellitus. Interventions include provide diabetic medications and/or insulin as ordered. Evaluate response to medications. Monitor resident during peak action times according to his/her medication regime when applicable. Record and report any negative responses to MD as soon as possible. Provide finger sticks as ordered. Record/report abnormal findings to MD. As applicable, provide sliding scale insulin as per MD order. A physician's order dated 6/23/2022 directed to check blood sugar four times daily (before meals and at bedtime) at 6:15 AM, 11:30 AM, 5 PM and 9 PM. Special instructions: Notify provider if blood sugar is less than 70 or greater than 400. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 6/23 through 8/1/2022, identified although the MAR was marked with a check mark to indicate the blood sugar levels were checked, the results of the blood sugar was not included on the MAR or the clinical notes on the following dates: 7/1 at 6:15 AM and 9:00 PM; 7/3 at 9:00 PM, and on 7/30/2022, at 11:30 AM. Interview and review of the electronic charting system with RN #5 on 8/2/2022 at 3:00 PM identified the nurse who obtains the blood sugar level should document the blood sugar level. Although RN #5 indicated the MAR was marked with a check mark to indicate the blood sugars were obtained, RN #5 was unable to provide documentation as to what the results of the blood sugars were on the dates/times listed. RN #5 identified the results should be documented on the MAR or in the nurses notes and RN #5 did not know why there were not recorded. No facility policy was provided for surveyor review regarding documenting blood sugar results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37293 Based on observation, review of facility documentation and interviews the facility failed to ensure staff wore facility provided Personal Protective Equipment (PPE) according to professional standards. The findings include: a. Observation on 7/28/22 at 10:33 AM identified Housekeeper #1 was wearing a black surgical mask. Interview with Housekeeper #1 identified she was aware that she is not allowed to wear her own personal mask and she was aware that she is required to wear the facility provided Personal Protective Equipment (PPE). Housekeeper #1 indicated the facility provides the employee with Personal Protective Equipment (PPE) surgical mask. b. Observation on 7/28/22 at 12:47 PM identified DA #1 (Dietary Aide) was wearing a black surgical mask. Interview with DA #1 identified he was not aware that he could not wear his own personal surgical mask during working hours. DA #1 indicated he was not aware the facility provided Personal Protective Equipment (PPE). DA #1 indicated the facility did not in-service him on facility Personal Protective Equipment (PPE). c. Observation on 7/28/22 at 12:30 PM identified NA #9 was wearing a black surgical mask. Interview with NA #9 identified she was not aware that she could not wear her own personal surgical mask during working hours and indicated she was not aware that she is supposed to wear the facility provided Personal Protective Equipment (PPE). d. Observation on 7/28/22 at 3:40 PM identified RN #10 was wearing a black surgical mask. Interview with RN #10 identified she was not aware that she could not wear her own personal surgical mask during working hours. RN #10 indicated she was not aware that the facility provided Personal Protective Equipment (PPE). RN #10 indicated she was not in-service regarding facility Personal Protective Equipment (PPE). Interview with the Administrator on 7/28/22 at 4:05 PM indicated he was not aware that staff had been wearing their own masks. The Administrator indicated all staff will be in-serviced on the facility provided Personal Protective Equipment (PPE) according to professional standards. Interview with the previous DNS on 8/15/22 at 1:00 PM identified she was not aware that staff had been wearing their own masks. The previous DNS indicated all employees at the facility was aware to change from their personal face mask to the facility surgical mask. The previous DNS indicated there is a box of surgical mask at the receptionist desk for the employees to utilize. The previous DNS indicated an in-service was given to the nursing staff regarding wearing facility provided Personal Protective Equipment (PPE) according to professional standards. Review of the facility Covid-19 Personal Protective Equipment (PPE) policy identified a facility-provided surgical face mask is required to be worn at all times while in the facility.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 37293 Based on observation, review of facility policy and interviews, the facility failed to ensure that dishwasher was maintain in good repair condition. The findings included: Observation during the tour of the kitchen on 7/28/22 at 1:20 PM with the Director of Dietary, Food Service Director, and RN #11 identified the following: A large amount of thick white steam was emanating from the dishwasher room from the dishwasher. The large amount of thick white steam traveled into the hallway. Interview with the Director of Dietary on 7/28/29 at 1:30 PM identified she was aware of the thick white steam emanating from the dishwasher. The Director of Dietary indicated the maintenance department was made aware that the dishwasher was producing the steam. Interview with the Food Service Director (FSD) on 7/28/22 at 1:35 PM identified he is aware of the large amount of thick white steam emanating from the dishwasher. The FSD indicated this was due to the exhaust fan slowing down and there is a question regarding the belt. The FSD indicated he would have the maintenance department assess the issue with the dishwasher. Interview with the Administrator on 7/28/22 at 3:45 PM identified he was not aware of the issue. The Administrator indicated he would arrange to have the dishwasher repaired. An additional interview with the Director of Dietary on 7/29/29 at 7:40 AM indicated the steam has been emanating from the dishwasher for a couple of weeks. Interview with the previous DNS on 8/15/22 at 12:45 PM identified she was not aware of the steam coming from the dishwasher in the kitchen. Review of the facility restorative maintenance policy identified it is the policy of the facility to make all necessary repairs or replacements to facility equipment as needed. Equipment issues identified by the facility staff will be addressed on an as-needed basis by either repair or replacement as soon as possible. Equipment may be repaired in-house or by contracted vendor. Review of the facility dish machine temperature log policy identified the director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation and interviews the facility failed to maintain an adequate pest control program. The findings include: Review of the pest control invoice dated 7/27/22 at 8:56 AM identified a meeting with the Maintenance Director that morning with the purpose of developing a course of action to combat the Fruit Flies on the basement level and in room [ROOM NUMBER]. The kitchen was inspected and surrounding areas for breeding sites. A number of problem areas were found and reviewed with the Maintenance Director. The pest control company plan includes a deep cleaning followed by nightly applications using a product by the food service staff. Tour of the facility on 7/28/22 at 2:30 PM - 3:30 PM with RN #11 identified numerous winged black insects were observed. Winged black insects flying around were noted in the following areas: The 3rd floor Birch unit in resident rooms, and hallway. The 3rd floor Cedar unit in resident rooms, and hallway. The 3rd floor Elm unit in the shower room. The 3rd floor elevator area. The 2nd floor Spruce unit in resident rooms, hallway, and the shower room. The 2nd floor elevator area. The 1st floor Elm unit in resident rooms, and hallway. The 1st floor Spruce unit in the shower/bathing room. The 1st floor Cedar unit in resident rooms, and hallway. The 1st floor elevator area. The kitchen area, and in the hallway by the kitchen. The winged black insects were noted on bedroom walls, bathrooms, hallways, shower rooms, and the kitchen area. Interview and review of the pest control invoices with the Administrator on 7/28/22 at 3:45 PM identified he was made aware of the issue and the pest control company was at the facility on 7/27/22 addressing the issue of the winged black flying insects. The Administrator indicated a follow up visit by the pest control company for a deep cleaning is due this week. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Maintenance Director on 7/29/22 at 9:45 AM identified he was not aware of the small flying winged black insects issue throughout the facility. The Maintenance Director indicated he was made aware of the issue on Tuesday 7/26/22. The Maintenance Director indicated he placed a call out to the pest control company and notified them of the issue, and a follow up visit was done on 7/27/22. The Maintenance Director indicated a follow up visit by the pest control company for a deep cleaning was done on 7/28/22. Interview with the previous DNS on 8/15/22 at 12:45 PM identified she was aware of the small flying winged black insects. The previous DNS indicated the facility was aware of the issue of the small flying winged black insects in the resident rooms and hallways. The previous DNS indicated the flying winged black insects were discussed in morning meetings. The previous DNS indicated she was not aware of the small flying winged black insects in the kitchen. The previous DNS indicated the Administrator and herself had toured the facility and resident rooms for food left in room uncovered. The previous DNS indicated the Administrator had directed the social service department to educate the residents regarding leaving uncovered food in their rooms. The previous DNS indicated the Maintenance Director had called the pest control company regarding the small flying winged black insects. Review of the facility pest control policy identified the facility maintains an ongoing pest control program. Facility pest control program is ongoing to ensure that the facility is free from insects and rodents. Pest control services are provided by a licensed contractor. Screens are maintained in facility windows. Only approved pest control products will be utilized in the facility. Maintenance services may assist with pest control when appropriate and necessary. Pest control visits may be requested in addition to routine treatment if a problem/issue is identified needing more immediate attention.