STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075418	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bucks Hill	2817 North Main Street Waterbury, CT 06704

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews for the only sampled resident, (Resident #329), reviewed for advance directives, the facility failed to ensure the advance directives consent was signed and available. The findings include: Resident #329's diagnoses included traumatic subdural hemorrhage, history of traumatic brain injury, and epilepsy. The hospital Interfacility Transfer Summary (W-10) dated [DATE] identified Resident #329 had a status of DNR/DNI (do not resuscitate/do not intubate). The physician's order dated [DATE] directed for Resident #329 to be a full code, indicating that cardiopulmonary resuscitation (CPR) was to be performed. The admission Minimum Data Set assessment dated [DATE] identified Resident #329 had a Brief Interview of Mental Status (BIMS) of 9 indicating moderate cognitive impaired and she/he required partial/moderate assistance for eating and substantial/maximal assistance needed for toileting and dressing. The Resident Care Plan dated [DATE] identified Resident #329 was to be provided with CPR (fully coded). Interventions included to provide end of life care per the resident's wishes, discuss code status with resident/family/responsible party, and have the advance directive consent signed. Interview and clinical record review with the Director of Nurses (DNS) on [DATE] at 11:00 AM failed to identify an available signed advance directive. Although the packet was noted to be in the chart, the advance directive form remained blank. The DNS indicated that facility practice was to obtain a code status within 24 hours of admission. A follow up interview with the DNS on [DATE] at 10:08 AM identified the facility policy for advance directives required the supervisor or charge nurse to review the code status paperwork with the resident or responsible party upon admission and then obtain a physician's order to reflect the resident's wishes. She believed the paperwork was not signed because Resident #329's responsible party was not available. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and record review with APRN #1 on [DATE] at 9:40 AM identified resident code status' should be obtained within 24 hours of admission and that she had reviewed the code status with Resident #329 on [DATE]. APRN #1 stated that aside from her/his aphasia (speaking/understanding deficit) Resident #329 was able to make her/his needs known and answered yes when presented with the full code option for resuscitation code status. Review of the hospital W-10 with APRN #1 indicated that although Resident #329 was discharged with a status of DNR, APRN #1 denied talking to Resident #329's responsible party to clarify the advance directive wishes because the phone number on file did not work adding in the world we live in she/he defaults to being a full code just like someone on the street would. An interview on [DATE] at 10:40 AM with Registered Nurse (RN) #1 identified that the facility policy required the RN supervisor to review and obtain signatures on the advance directives paperwork, if a residents BIMS (brief interview of mental status determining cognitive status) was over 13 (intact) then the resident reviewed and signed the advance directives paperwork. If the BIMS was below 13, the advance directive paperwork was signed by the responsible party. RN #1 indicated that Resident #329's paperwork had not been completed because the responsible party had a lot going on, had been going back and forth with the code status decision, but the facility was able to speak to the responsible party on [DATE] verbally confirming Resident #329 DNR/DNI status wishes. Subsequent to surveyor inquiry, the advance directives paperwork was signed by the responsible party, RN supervisor, and APRN, to reflect a code status of DNR/DNI. A phone interview with Person #1 on [DATE] at 12:28 PM identified the facility had not contacted her/him upon the resident's admission to verify Resident #329's resuscitation code status. Person #1 indicated that she/he was the conservator of person for Resident #329 to make healthcare decisions. Although resuscitation paperwork had been sent to Person #1 on [DATE] no one had followed up with him/her regarding the resident's code status, and on [DATE] when she/he visited the facility with the paperwork, there was no one from administration available to speak with regarding the resident preferred code status. Person #1 identified that she/he spoke with RN#1 on [DATE] and approved Resident #329's DNR/DNI code status. Review of the Advance Directives Policy dated 9/2017 directed in part that it is the resident's right to formulate an advance directive, and the facility would identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to advance directives during the care planning process.

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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** Based on interviews, review of clinical record, and facility policy for the only sampled resident, (Resident #27), reviewed for personal property, the facility failed to report the loss of a resident's personal belonging to the State Agency within the 24-hour time requirement. The findings include: Resident #27's diagnoses included Huntington's disease, major depressive disorder, and bilateral cataracts. The annual Minimum Data Set assessment dated [DATE] identified Resident #27 had long and short term memory loss and was dependent with personal hygiene, dressing, and required maximal assistance for chair to bed and bed to chair transfers. The Resident Care Plan (RCP) dated 12/10/23 identified Resident #27 was at risk for impaired visual function related to cataracts. Interventions included the wearing of glasses, and monitoring for signs and symptoms of acute eye problems including changes in ability to perform activities of daily living and blurred vision. A Complaint and Concern Log form dated 12/18/23 identified a family member reported the loss of Resident #27's bracelet. Interviews attached to the form failed to identify the time of the report by the family member. Although the facility conducted a search of the room and shower room, they were not able to locate the bracelet. Social services, nursing, and the Administrator were made aware of the lost bracelet and interview investigation forms were obtained from 9 staff members, 2 of whom provided care for Resident #27 during the time in which the bracelet went missing. An interview with Person #2 on 12/5/24 at 11:38 AM identified Resident #27's bracelet was a thick chain link 14 Karat (K) gold bracelet, measuring 6 ¼ inches in length and engraved with security information and numbers to call if the resident got lost. Person #2 noted the bracelet had a secure clasp and was valued at over $200. He/she further indicated that after reporting the loss of the bracelet to the Supervisor he/she was informed the police could be called if he/she believed it was necessary. An interview with the facility Administrator and DNS on 12/5/24 at 12:06 PM identified that the Administrator was aware of the lost bracelet. If the bracelet was stolen, she would have reported the incident to the police and to the state agency within 2 hours, however the Administrator failed to identify she had any evidence the bracelet had not been stolen. Further, the Administrator indicated that due to the engraving no one would have stolen the bracelet from Resident #27 and the engraving devalued 14K bracelet. Review of the facility's Resident Personal Belongings/Missing Items Policy identified that the facility protects the rights of a resident to possess personal belongings, Although the facility had a missing item policy, the policy failed to identify what action the facility would take upon the identification of a missing item. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Abuse policy identified that in cases of Misappropriation of resident property with no injury a report is to be filed within 24 hours to both the State Agency and law enforcement, and a written follow-up report would be sent to the State Agency within 72 hours of the incident and include a copy of the Accident/Incident report.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of the clinical record for the only sampled resident, (Resident #44), reviewed for Activities of Daily Living (ADL's), the facility failed to prevent a decline in transfer and ambulation (walking) abilities. The findings include: Resident #44's diagnoses included atrial fibrillation, repeated falls, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 had severe cognitive impairment, required substantial/maximum assistance for chair to bed and bed to chair transfers, partial/moderate assistance for sit to stand ability, and had not been ambulating. The Resident Care Plan (RCP) dated 7/10/24 identified Resident #44 had a deficit in ADL self-care performance. Interventions included ambulate with an assist of 1 with a rolling walker (RW) with a wheelchair (WC) to follow twice a day for 200 feet. A physician's order dated 8/14/24 directed staff to ambulate Resident #44 twice a day to prevent a decline in function. Review of the 9/1/24 to 9/30/24 Nurse Aide (NA) flowsheet documentation identified Resident #44 rarely walked in the hallway. Further review identified Resident #44 ambulated in his/her room [ROOM NUMBER] out of 60 opportunities for the month of September (36 missed opportunities). Review of the 10/1/24 to 10/31/24 NA flowsheet documentation identified that Resident #44 did not ambulate in the hallway and that he/she walked in his/her room for a total of 21 out of 62 opportunities for the month of October (41 missed opportunities). Review of the 11/1/24 to 11/30/24 NA flowsheet documentation identified that Resident #44 did not ambulate in the hallway and that he/she walked in his/her room for a total of 4 out of 60 opportunities for the month of November (56 missed opportunities). An interview with NA #3 on 12/4/24 at 10:45 AM identified that Resident #44 had a decline in his/her ability to walk and transfer, and now required increased assistance from staff to wlk and transfer. NA #3 indicated that she had not notified anyone of Resident #44's decline. An Interview with Licensed Practical Nurse (LPN) #2 on 12/4/24 at 1:35 PM identified she did not think Resident #44 was able to ambulate currently and was definitely not ambulating 200 feet according to the RCP. An interview with Rehabilitation Director, Physical Therapist (PT) #1 on 12/4/24 at 12:18 PM identified that Resident #44 had not been evaluated by PT recently and that he/she was due for a routine quarterly evaluation around January of 2025. PT #1 had not been notified that Resident #44 had a decline in his/her ability to walk and transfer. Further PT #1 indicated had he been notified sooner; he would have scheduled Resident #44 for an evaluation to determine Resident #44's status. Re-interview with LPN #2 on 12/5/24 at 2:35 PM identified that subsequent to surveyor inquiry, she had been informed by NA #3 of Resident #44's substantial decline in ambulation and transfers. LPN #2 indicated that while she had known the resident had not been ambulating; after speaking with NA #3 and the surveyor, she had placed a request for PT to evaluate Resident #44 due to his/her decline. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with PT #1, the Director of Nursing Services (DNS), and Registered Nurse (RN) #1 on 12/6/24 at 1:00 PM identified that Resident #44 would be evaluated by PT in the near future due to the resident's decline in ability to ambulate and if there was a decline Resident #44 would be scheduled for rehabilitation services to try and regain lost function.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and the interview for the only sampled resident (Resident #22) reviewed for activities of daily living, the facility failed to maintain clean and trimmed fingernails. The findings include: Resident #22 diagnoses included cerebral vascular accident (CVA), joint derangement, contracture, and left flaccid hemiplegia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #22 had intact cognition and was dependent of 1 for upper/lower body dressing, and personal hygiene. The Resident Care Plan dated 11/28/24 identified Resident #22 had a self-care deficit related to a CVA and was at risk for further contractures. Interventions included to provide assistance of 1 for bathing, check skin, trim nails on bath day, and report any new abnormal skin areas to the charge nurse. A physician's order dated 12/4/24 directed a body audit every week on shower day. Observations on 12/2/24 at 12:38 PM, 12/3/24 at 1:00 PM, and 12/4/24 at 9:20 AM, identified Resident #22 fingernails were soiled with a brownish debris below the nailbeds and nails were abnormally lengthy. Observation on 12/4/24 at 1:10 PM identified Resident #22's fingernails were noted to be soiled with a brownish debris below the nailbeds and lengthy. Additionally, Resident #22 identified his/her nails were lengthy and he/she did not like them to be so long. Resident #22 identified that he/she had not requested his/her nails to be cleaned/trimmed because it was not up to me. Interview with Nurse Aide (NA) #3 on 12/5/24 at 1:54 PM identified that Resident #22 had a bath on 12/3/24 (Tuesday) and should have had nail care done at that time. NA #3 identified that although she did not provide Resident #22 a bath on 12/3/24, she did provide morning care to the resident on 12/4/24 and 12/5/24. NA #3 observed that Resident #22's nailed were long/soiled, should have been cleaned and trimmed, but she did not complete nail care due to being too busy. Interview with the DNS on 12/5/24 at 2:45 PM identified the NA was responsible to cut and clean resident's nails, and the nurse was responsible to oversee the task was completed. Review of the Care of Fingernail and toenails policy directed, in part, directed colleagues to review the resident's care plan to assess for any special needs of the resident. According to the policy, nail care would include cleaning and regular trimming.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, and interviews for the only sampled resident (Resident #5) reviewed for respiratory care, the facility failed to follow a hospital discharge order for specialist consultation. The findings include: Resident #5 's diagnoses included end stage renal disease, urinary tract infection, and heart failure. Review of the hospital Discharge summary dated [DATE] directed that Resident #5 follow up with a nephrologist in 1 week. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was cognitively intact, and dependent with bed mobility, transfers, personal hygiene, bathing, and dressing. Review of the Advance Practice Registered Nurse (APRN) #1 Progress Note dated 10/28/24 identified that Resident #5 had chronic kidney disease and the plan was for the Resident #5 to follow-up with a nephrologist as recommended. Additionally, Resident #5 had experienced a hypotensive (low blood pressure) episode and was supposed to follow-up with a nephrologist after her/his hospital stay in August. Further review of the clinical record failed to identify Resident #5 was seen by a nephrologist until 11/18/24. Following the nephrology consultation, orders directed Resident #5 to avoid nephrotoxins and renal dose medications and that Resident #5 should be seen again in follow-up in 3 months. An interview with Resident #5 on 12/4/24 at 12:10 PM identified that if he/she had known about the hospital discharge instruction to follow up with a nephrologist in 1 week after discharge from the hospital in August, he/she would have requested the consultation to have been scheduled timely. An interview with APRN #1 on 12/4/24 at 1:11 PM identified that Resident #5 was to follow up with a nephrologist after her/his discharge from the hospital on 8/4/24. APRN #1 identified that she did not ask Resident #5 if he/she would like to follow up with the nephrologist and she was not sure if anyone else had spoken to the resident regarding an appointment with the nephrologist. APRN#1 further identified that the hospital discharge orders were recommendations and that the recommendations were reviewed and considered, but that she had felt it was unnecessary for Resident #5 to follow up with the nephrologist and the facility does what's appropriate for the residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for the only sampled resident (Resident #39) reviewed for pressure ulcers, the facility failed to ensure weekly skin checks (body audits) were conducted per the physician orders, and failed to ensure that a Registered Nurse (RN) assessment was conducted for a resident who was readmitted to the facility with a pressure ulcer. The findings include: Resident #39's diagnoses included a stage 4 pressure ulcer, failure to thrive, and dementia without behaviors. A. The quarterly Minimum Data Set (MDS) assessment date 1/17/23 identified Resident #39 was severely cognitively impaired and required assistance of 1 staff member for bed mobility. The Resident Care Plan in effect from 3/1/23 through 4/30/24 identified a stage 4 pressure area to the coccyx, continue with treatments as ordered, and weekly skin checks on shower days. Physician's orders dated 3/1/23 through 4/30/23 directed weekly body audits on shower days. A physician's order dated 3/22/24 directed a body audit on admission, daily for 3 days then once per week on Fridays. An interview and clinical record review with the DNS on 12/4/24 at 12:40 PM, failed to identify documentation that body audits had been completed weekly per the physician orders from 4/7/23 to 6/30/23. Additionally, the clinical record failed to reflect documentation that skin assessments had been completed per the physician orders from 3/23/24 to 4/18/24 daily for 3 days, then weekly. Interview with RN #3 on 12/4/24 at 1:00 PM identified that there was an issue with the lack of weekly body audits being completed from 4/7/23 through 4/18/24, and that per the facility practice, weekly body audits were completed by the charge nurse and any new skin issues were documented weekly on the body assessment form. Re-interview with the DNS on 12/5/24 at 9:45 AM identified that the charge nurses along with Resident #39's assigned NA were responsible for ensuring weekly body audits were completed as ordered on the appropriate weekly body audit form and that most residents had body audits scheduled on their shower days. B. Review of the hospital Discharge summary dated [DATE] identified Resident #39 had a pressure ulcer. A readmission Nursing Assessment completed on 3/22/24 at 10:48 PM by Licensed Practical Nurse (LPN) #5 identified a stage 2 coccyx wound but failed to identify measurements of the wound and failed to describe the wound appearance. Further review of the clinical record, failed to identify that Resident #39's pressure ulcer (coccyx wound) had been assessed by a Registered Nurse (RN). A readmission physician's order dated 3/22/24 directed to cleanse Resident #39's coccyx with normal saline pack wound with Aquacel AG and cover with dry, clean dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Registered Nurse (RN) #2's admission nurse's note dated 3/22/24 at 6:40 PM identified that although Resident #39 had been readmitted with a coccyx pressure ulcer there was no RN assessment or measurement of the wound in the nurse's note or on Resident #39's readmission form. Resident #39's Resident Care Plan dated 3/24/24 indicated he/she returned from the hospital with a stage 4 pressure that was unchanged. Interventions directed to assist with positioning every 2 hours, provide pressure relieving/reducing devices to bed and chair, skin checks on shower days, and treatment to the coccyx as ordered. Review of Resident #39's facility wound physician note dated 3/25/24 identified a stage 4 pressure area (not stage 2 per LPN #5). Additionally, the area was measured and noted to be 1.5 cm long (centimeters) by 1 cm wide and 0.5 cm deep with undermining (separation of skin from underlying tissue). Interview and clinical record review with LPN #5 on 12/4/24 at 3:00 PM identified that LPN #5 had staged Resident #39's wound but failed to document any measurements. LPN #5 stated that there was a lot going on when Resident #39 was admitted and could not recall if RN #2 had come to assess the resident's pressure ulcer. LPN #5 identified that the facility practice was for the RN to assess pressure ulcers and document the results on the admission/readmission assessment. Interview and clinical record review with RN #2 on 12/4/24 at 3:20 PM identified that she was not aware LPN #5 had staged Resident #39's pressure ulcer until reviewing the clinical record with the surveyor. RN #2 indicated that the LPN does not normally stage a pressure ulcer. Although RN #2 stated she must have seen the wound as she had written a note indicating the pressure ulcer was present, she was unable to explain why there was no assessment or measurement of the wound in the clinical record. Interview with the DNS on 12/5/24 at 9:45 AM identified that the nurses (RNs and LPNs) would usually assess resident wounds together upon admission or readmission to the facility. The DNS identified that the RN was responsible for assessing and documenting a pressure ulcer which included measurements and characteristics of the wound. Review of the Pressure Injury Prevention and Management Policy dated 12/15/22 directed, in part, that pressure ulcer monitoring would be completed by the RN Unit Manager or designee to review all relevant documentation including pressure injury risks, progression towards healing and compliance at least weekly and document the summary of findings in the medical record. Additionally, licensed nurses would conduct a full body skin assessment on all new admissions and re-admissions, weekly, and after any newly identified pressure injury and that findings would be documented in the medical record.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policies and interviews for the only sampled resident (Resident #22) reviewed for positioning and mobility, the facility failed to apply a left wrist hand splint as ordered. The findings include: Resident #22's diagnoses included Cerebral Vascular Accident (CVA), contracture of left hand joint, and flaccid hemiplegia affecting left dominant side. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 had intact cognition and was dependent with bed mobility, transfers and activities of daily living including upper body dressing. The Resident Care Plan dated 11/28/24 identified Resident #22 had a self-care deficit related to a CVA and was at risk for further contractures. Interventions included instructions for a left wrist brace to be worn when out of bed and during transfers. A physician's order dated 6/16/20 and currently in effect directed the left-hand splint to be worn from 7:00 AM to 3:00 PM. Further instructions noted for the 7:00 AM to 3:00 PM shift were to don (apply) the left hand splint with morning (AM) care, and doff (remove) the left-hand splint with last rounds on the 7:00 AM to 3:00 PM shift. Observation on 12/2/24 at 12:38 PM identified Resident #22 was lying in bed, alert, verbal and appropriately answering questions. Additionally, Resident #22 was not wearing a left-hand splint. Observation on 12/3/24 at 11:45 AM noted Resident #22 was lying in bed, without the benefit of a left-hand splint being applied. Observation on 12/4/24 at 1:12 PM identified Resident #22 was seated in his/her wheelchair in the hallway. Additionally, it was noted Resident #22 was wearing a left lower leg brace, but a left-hand splint was not applied. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nurse Aide (NA) #3 on 12/4/24 at 1:32 PM identified that she was the NA providing care for Resident #22. NA #3 noted that she usually would put the left-hand splint on Resident #22 for a couple of hours in the afternoon when Resident #22 was out of bed. Further interview with NA #3 and observation at that time, identified instructions for splinting that were taped to the wall in Resident #22's room which indicated to apply a left-hand splint at 7:00 AM, with instructions directing how to apply the left-hand splint. NA #3 stated that the information was in the electronic health record (EHR) directing how to care for Resident #22. Review of the task section (with an original date of 9/7/17 and currently in effect) in the EHR noted splint application/removal. apply to left hand 8:00 AM to 12:00 PM and then 2:00 PM to 6:00 PM daily. Remove 12:00 PM to 2:00 PM and 6:00 PM, check skin for redness and report to charge nurse (which was a discrepancy from the physician orders to wear the left-hand splint from 7:00 AM to 3:00 PM). Further instructions noted for the 7:00 AM to 3:00 PM shift directed to don (apply) the left hand splint with morning (AM) care and doff (remove) the left-hand splint with last rounds on the 7:00 AM to 3:00 PM shift. NA #3 identified she had placed the left hand splint on Resident #22 for a couple of hours in the afternoon because that was what she had been instructed. Interview with Physical Therapist (PT) #1 on 12/5/24 at 1:26 PM indicated Resident #22's left hand splint should be donned on the 7:00 AM to 3:00 PM shift, applied during AM care and doffed on last rounds per the physician orders. PT #1 provided the splinting and orthotics schedule located in the therapy office, which indicated to apply a left hand splint to be worn on the 7:00 AM to 3:00 PM shift and off on last rounds on the 7:00 AM to 3:00 PM shift. Interview with the Director of Nurses (DNS) on 12/6/24 at 10:21 AM identified the NA would know how to care for a resident by referring to the instructions in the EHR. Review of the EHR with the DNS indicated a discrepancy between the instructions on the physician orders and the instructions in the task section of the EHR. Additionally, the DNS determined there was a transcription discrepancy when the physician orders were inputted into the EHR task section by a licensed staff who no longer worked at the facility. Re-interview with PT #1 on 12/6/24 at 10:30 AM noted PT #1 if the left-hand splint was not applied for a day or so, it wouldn't affect the contracture, but not wearing for long durations would not prevent further contractures, which was the purpose for the utilization of the hand splint. Review of the Prevention of Decline in Range in Motion policy dated 1/27/23 directed, in part, a nurse with the responsibility for the resident to monitor for consistent implementation of the care plan interventions. The Assistive Devices and Equipment policy updated in 2019, indicated that staff and volunteers were trained and demonstrate competency on the use of assisted devices prior to assisting residents.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of the clinical record, and review of facility policy for 2 of 5 sampled residents, (Resident #44 and Resident #281), reviewed for nutrition/hydration status, for Resident #44 the facility failed to weigh the resident monthly, failed to reweigh the resident after a 5 pound weight loss, and failed to ensure the dietician re-evaluated the resident after a weight loss and per the physician's order, and for Resident #281 failed to complete and appropriately document weights for a resident who was newly admitted , underweight and malnourished. The findings include: 1. Resident #44's diagnoses included atrial fibrillation, repeated falls, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #44 was moderately cognitively impaired and was independent after set up for eating. The Resident Care Plan (RCP) dated 11/5/24 identified Resident #44 had an actual nutrition risk. Interventions included providing nutritional supplements as ordered and monitoring weights for significant weight loss. The physician orders in effect for September 2024 through December 2024 directed to weigh Resident #44 monthly. Review of Resident #44's weight records identified on 9/27/24 he/she weighed 103.8 pounds (lbs.), the record failed to indicate an October weight, on 11/9/24 Resident #44 weighed 97.2 lbs. (6.6 lbs. a 6.4 % loss) and on 11/27/24 he/she weighed 97.9 lbs. The weight record failed to identify that following weight loss on 11/9/24 or 11/27/24 the resident was re-weighed for accuracy. Advanced Practice Registered Nurse (APRN) #1's progress note dated 11/19/24 indicated a need for the dietician to evaluate Resident #44 for decreased oral intake, weight loss, and protein and calorie malnutrition. Interview with Dietician on 12/6/24 at 12:10 PM identified she was responsible for reviewing all facility resident weights weekly to identify weight changes. The Dietician reported that she was unaware of the facility weight policy for weighing residents who had weight loss as she had never been given a copy. Although the Dietician indicated that she had made recommendations and had physician's orders for interventions for Resident #44's weight loss, she was unable to locate a nutritional assessment that would have re-evaluated calorie needs, fluid needs, intake amounts, and addressed the overall weight loss, but that she had not completed the Nutritional Assessment. The Dietician also indicated she would likely have made a recommendation for weekly weights due to the weight loss for Resident #44 if the evaluation had been completed. Interview with NA #3 on 12/6/24 at 12:25 PM identified the Weight Assessment and Intervention policy and procedure was to be followed for significant weight loss and directed to reweigh residents for accuracy when weight loss occurred. NA #3 reported weights were conducted on shower days during the first week of the month and the policy required notification to the unit nurse when there was a significant weight loss. NA #3 could not recall if notification was made in November. Additionally, NA #3 could not recall why Resident #44 was not weighed at all in October 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DNS and RN #1 on 12/6/24 at 12:35 PM identified they were not aware Resident #44 had a significant weight loss. The DNS indicated the resident should, ideally, be re-weighed after a significant weight loss to verify accuracy of any weight loss within 24-48 hours. The DNS indicated Resident #44 had not been re-weighed in November according to the time frame. 2. Resident #281's diagnoses included dementia, severe sepsis with septic shock, and urinary tract infection. The admission assessment dated [DATE] identified Resident #281 was non-verbal and cognitively impaired. The admission Assessment indicated Resident #281 required substantial/maximal assistance with eating, was a 2-person physical assist/dependent for transfers. The admission Assessment indicated Resident #281's most recent weight to be 120 pounds with a date of 1/4/22. The admission assessment was signed by the Registered Nurse Supervisor on 12/1/24. The Resident Care Plan dated 11/30/24 identified actual nutritional risk secondary to being underweight with total feeding assistance and need for a therapeutic diet. Interventions included to provide diet as ordered, feed/assist with meals and snacks and that the registered dietician was to evaluate and make diet change recommendations as needed. A physician's order dated 11/30/24 directed to weigh Resident #281 on admission then weekly one time a day every Tuesday. A nursing progress note dated Tuesday, 12/3/24 at 8:28 PM indicated the facility was unable to weigh Resident #281 due to a broken scale. A Nutrition Evaluation completed by the dietician dated 12/3/24 identified that Resident #281 was underweight and the most recent weight dated 1/4/22 was 120 pounds. The Nutrition Evaluation indicated that there was no admission weight completed or documented, nursing was made aware, and a weight was requested. Additionally, the Nutrition Evaluation identified Resident #281's weight per the hospital electronic medical records (EMR) was 135 pounds on 11/24/24, the resident had low muscle and fat mass, and had a history of being underweight. Interview with NA #5 on 12/5/24 at 12:45 PM identified that Resident #281 should have been weighed upon admission and weights must be completed for every admission. NA #5 indicated that Resident #281's weight should have been done by the NA assigned to the resident when he/she was admitted to the facility, and she was unsure why a weight was not taken. Interview and record review with LPN #4 on 12/5/24 at 12:53 PM identified that Resident #281's weight should have been obtained by the assigned NA on admission and she was unsure why the weight had not been taken. LPN #4 indicated that she normally would catch that an admission weight was not completed and documented a nurses note, but that she must have missed the omission. Review of the clinical record with LPN #4 failed to identify a weight had been completed and documented for Resident #281 since admission. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with DNS on 12/5/24 at 1:00 PM identified Resident #281 was new to the facility and should have been weighed upon admission. The DNS indicated it would have been up to the NA or nurse assigned to obtain a weight for Resident #281. The DNS identified she was unsure why Resident #281's weight had not been obtained and documented on admission, and had not been informed a scale was broken. Review of the clinical record with the DNS failed to identify a weight had been completed and documented since Resident #281's admission. Subsequent to surveyor inquiry, on 12/5/24 at 1:26 PM Resident #281 was observed being weighed in his wheelchair by a NA with a recorded weight of 114.2 pounds. Interview and record review with the Dietician on 12/6/24 at 10:00 AM identified that when she conducted Resident #281's Nutrition Evaluation on 12/3/24, she informed the nursing supervisor that the resident did not have an admission weight completed and documented in his/her clinical record and requested a weight be obtained. The Dietician indicated that Resident #281 would be classified as malnourished and underweight with low muscle and fat mass with an ideal body weight of 141 pounds. The Dietician identified that if she had known Resident #281 weighed 114.2 pounds and not 135 pounds (per the hospital electronic medical record she accessed from 11/24/24), she would have changed her nutrition recommendations to add fortified super cereal to Resident #281's daily diet. The Dietician indicated that although she needed to complete a new nutritional assessment for Resident #281 due to the weight discrepancy, she would put the resident on her high-risk list for closer monitoring. Review of the Dietician's document titled Dietician On-Site Visit dated 12/3/24 identified Resident #281 had not had an admission weight completed or documented and that the weight entered on his admission Assessment was dated 2022. The Dietician indicated that at the conclusion of her visit to the facility on [DATE], she made copies of her Dietician On-Site document and gave copies to the nursing supervisor and the DNS. The Dietician further identified that she was not aware of the scale being broken and that upon Resident #281's admission to the facility, she would have expected nursing to complete and appropriately document the resident's weight in the clinical record where it could have been accessed by her. Review of the facility policy, Weight Assessment and Intervention, undated, directed that any weight change of 5 lbs. or more since the last weight would trigger that the weight be retaken. If the weight was verified and was determined to be a weight loss, nursing would consult with the dietician, MD, and family/responsible party. Additionally, nursing staff will measure a resident's weight on the day of admission, the day after and weekly for 4 weeks, and weights would be recorded in each resident's medical record. Surveyor: [NAME], [NAME] A.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, facility documentation, interviews, and facility policy , the facility failed to ensure resident food was served at a safe temperature and was appetizing. The findings include: Review of the facility monthly Food Committee Meeting minutes dated 10/30/24 and 11/26/24, identified that residents complained that the soup and coffee was served cold. Interview with Resident Council attendees on 12/4/24 at 11:00 AM indicated food was not served at a safe and appetizing temperature approximately 50% of the time. Observation on 12/5/24 at 12:11 PM identified dietary staff were preparing to plate food. A test tray was requested. The cook indicated the steam tray temperature was 150 degrees Fahrenheit (F) prior to initiating plating. The plates were maintained in a plate warmer until ready for use. After dietary aids put beverages and a desert on the trays, an insulated cover was placed over the plate. All trays were loaded onto a metal serving cart, the test tray was placed as the final tray, and the cart left the kitchen at 12:25 PM. Observation on 12/5/24 at 12:26 PM identified the meal cart was delivered to the Colonial A unit. The first tray was removed by nursing assistant at 12:27 PM and taken to a resident's room. After all other trays had been delivered, the test tray was removed from the cart at 12:39 PM. Both the Food Service Director and Surveyor used calibrated thermometers to check the temperatures of the food as follows: Pork chops with gravy: surveyor temp 118 degrees F/Food Service Temp 118.2 degrees F/Goal 135 degrees F; Mashed Potatoes: surveyor temp 119.4 degrees F/Food Service Temp 120 degrees F/Goal 135 degrees F; Hot beets: surveyor temp 111 degrees F/Food Service Temp 111 degrees F/Goal 135 degrees F; Milk: surveyor temp 46 degrees F/Food Service Temp 46 degrees F/Goal 41 degrees F. The Food Service Director identified that the test tray temperatures were not appropriate according to the set requirement. Review of the facility policy for Food Quality and Palatability identified food and drinks must be served at a safe and appetizing temperature to meet resident's needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, facility documentation, and facility policy during a tour of the Food Services Department, the facility failed to ensure dishwasher temperatures were maintained according to the manufacturer's requirement to adequately sanitize dishware. The findings include: Interview and observation of the dishwashing process with the Director of Food Services and Dietary Aide (DA) #1 on 12/5/24 at 1:37 PM identified a wash cycle temperature of 148 degrees Fahrenheit (F) and a rinse cycle temperature of 150 degrees F. According to a mounted metal NSF Data Plate on the front of the unit, dishwashing temperatures for the hot water sanitizing cycle should have a wash tank minimum temperature of 160 degrees F, and a final sanitizing rinse minimum temperature of 180 degrees F. The observed temperatures failed to meet the manufacturer's requirement to ensure adequate hot water sanitization temperatures. The Director of Food Services identified that sometimes the cycle needed to be run a couple of times to get the temperature up to the minimum manufacturer's requirement, he restarted the cycle several more times on the same tray of dishes (12 plastic bowls) and although during the repeated cycles the rinse cycle rose to 188 degrees F, the wash temperature never reached the required minimum of 160 degrees F. Interview and review of the December 2024 dishwasher temperatures logs with DA #1 identified she recorded a wash temperature of 145 degrees F and a rinse temperature of 160 degrees F as well as all the other recorded wash and rinse temperatures being below the requirement. DA #1 stated that dishwasher temperatures below the required minimums were a common occurrence, and although the dish washing log had the correct temperature parameters listed on the bottom of the page including a directive to stop washing and alert the manager or designee, she stated she had not followed the facility policy. The Director of Food Services indicated that the unit had been scheduled for service the following day and that, going forward, the chemical sanitizing method would be used until the unit was serviced, inspected, and considered operational by the service technician. Subsequent to surveyor inquiry, the Director of Food Services indicated the current dishes as well as the previous 2 loads could not be deemed adequately sanitized based on the wash temperatures not meeting the minimum manufacturer's requirements. The Director of Food Services switched the unit to perform chemical sanitizing, the minimum chemical sanitizing temperatures were noted to be met, and he stated he would start the rewashing process to properly sanitize all 3 loads. Review of the Ware washing policy dated 9/2017 identified, in part, the dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. Further, the policy indicated that all dish machine water temperatures would be maintained in accordance with the manufacturer's recommendations for high temperature or low temperature machines.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 2 of 5 residents (Resident #41 and Resident #59) reviewed for infection control, the facility failed to ensure appropriate Personal Protective Equipment (PPE) use during high contact care for residents who required Enhanced Barrier Precautions (EBP). The findings include: 1. Resident #41's diagnoses included peripheral vascular disease, diabetes, and chronic kidney disease. A physician's order dated 5/31/24 directed EBP to be maintained every shift for chronic wounds. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 was cognitively intact and dependent for toileting, bathing, personal hygiene, transfers, and dressing. The Resident Care Plan in effect from 12/1/24 through 12/4/24 identified that Resident #41 was on EBP for leg lymphedema. Interventions directed to wear gloves and a gown when changing contaminated linens and place soiled linens in bags marked biohazard. Review of the [NAME] dated 12/4/24 identified Resident #41 was on EBP for chronic wounds and directed staff to wear a gown and gloves when performing high contact activities. Observation of Resident #41 and NA #2 on 12/4/24 at 6:50 AM identified visible signage outside the resident's door that directed staff must wear gloves and a gown when performing high contact activities. A cart containing disposable isolation gowns and other PPE was noted outside of Resident #41's room and NA #2 was observed to be providing high contact care. An interview with NA #2 on 12/4/24 at 6:50 AM identified that Resident #41 was on EBP and the blue dot next to the resident's name outside the door indicated that the resident was on EBP. NA #2 stated that staff should wear gloves and a gown when care and treatments were provided for a resident with chronic wounds. NA #2 identified that she should have been wearing PPE, but she was rushing. Additionally, NA #2 indicated she was unaware of the facility policy. An interview with the Director of Nursing (DNS) on 12/4/24 at 8:06 AM identified that she had observed NA #2 not wearing PPE on 12/4/24 at 6:50 AM. The DNS indicated that all staff had been educated on wearing appropriate PPE and educated that the blue dot next to the resident's name directed the use of EBP. The DNS was unable to identify why NA #2 was not wearing proper PPE during the provision of high contact care for Resident #41, she should have been, and further stated that she would provide the facility policy. 2. Resident #59's diagnoses included a stage 3 pressure ulcer, severe obesity, and type 2 diabetes. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was cognitively intact, required maximal assistance with personal hygiene, and was dependent with chair to bed and bed to chair transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 9/30/24 identified a risk for infection requiring EBP use related to a chronic pressure ulcer on the left buttocks. Interventions included EBP and the resident required the use of gown and gloves during dressing, transferring, and wound care. An observation on 12/2/24 at 10:36 AM identified signage posted on Resident #59's door which was visible prior to entry, indicating EBP with directions that providers and staff must wear gloves and a gown for high contact activities. Nurse Aide (NA) #1 was not observed to be wearing any PPE while providing care to Resident #59. An interview with NA #1 on 12/2/24 at 10:40 AM identified she had been bathing Resident #59, using a basin and washcloth, and changed his/her sheets. NA#1 indicated she was aware that PPE should be worn prior to providing care to a resident in a room that was identified to require the use of EBP. NA #1 stated that she had not worn PPE because she had forgotten to do so. Review of the facility's Enhanced Barrier Precautions policy identified that staff members are to wear gloves and a gown during high contact resident care activity (dressing, bathing, transferring, changing linens, etc.) for residents on EBP.

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews for 1 of 2 tub rooms, the facility failed to provide a homelike, sanitary, and safe environment. The findings include: Observation during the initial facility tour on 12/4/24 at 8:00 AM of [NAME] Unit tub room identified the following: 1) Tiles were cracked and broken on the floor and walls. 2) The radiators had stains and were discolored. 3) The vanity cabinet with the sink had broken pieces, was cracked, and discolored. 4) Debris was noted hanging from the fan. An Interview with the Maintenance Director on 12/5/24 at 10:00 AM identified that tiles were cracking and missing, the radiator needed to be painted, and the vanity cabinet had water damage and needed to be replaced. The Maintenance Director indicated that the ceiling fan had dust, needed to be cleaned, and that he was responsible to ensure cleaning. He was unsure when the fan had last been cleaned. Interview with the Administrator on 12/5/24 at 10:30 AM identified that the facility had remodeled certain areas in the building but was unsure if the [NAME] Unit was slated to be remodeled or in what timeframe the remodeling for this area would begin. The Environmental Rounds log was reviewed for 9/24 and failed to identify any concerns with the tub rooms in the facility.