STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075434	A. Building B. Wing	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orange Health Care Center	225 Boston Post Rd Orange, CT 06477

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 1Number of residents cited: 1Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 1 of 5 sampled residents (Resident #22) reviewed for non-pressure skin conditions, the facility failed to ensure a significant change in physical status or a need to alter treatment was consulted with the resident's physician in a timely manner. The findings include: Resident #22 was admitted to the facility 6/25/25 with diagnosis that included the presence of an aortocoronary bypass graft, and hypertension. The care plan dated 6/26/25 identified Resident #22 had a surgical incision on the chest and left lower extremity status post coronary artery bypass graft (CABG) with interventions that included: facilitate follow up with surgeon as scheduled and as needed, report any redness, warmth, fever, increased pain or edema to physician, and treatment to surgical site as ordered. Additionally, the care plan identified the potential for bleeding related to antiplatelet therapy with interventions that included: observe for and report immediately and as needed signs and symptoms of antiplatelet complications and signs and symptoms of bleeding. The physician's orders dated 6/27/25 directed to cleanse the left lower extremity surgical incision with wound cleanser, apply bacitracin followed by alginate and apply a dry, clean dressing, change daily. The admission MDS assessment dated [DATE] identified Resident #22 had intact cognition, utilized a walker, required moderate assistance with personal hygiene, upper and lower body dressing and had the presence of a surgical wound. The treatment administration record (TAR) for July 2025 identified Resident #22 received daily wound treatments on 7/1, 7/2, 7/3, 7/4, 7/5, 7/6 and 7/7/25. The nursing progress note dated 7/1/25 identified no signs and symptoms of infection or bleeding on the incision site. The nursing progress note dated 7/2/25 at 6:55 AM identified no signs and symptoms of infection or bleeding on the incision site. The nursing progress note dated 7/2/25 at 10:37 PM identified surgical incisions were open to air, well approximated and without s/s infection.The nursing progress note dated 7/4/25 at 6:34 AM identified the wound dressing on left leg soaked with blood, dressing changed (1st change).The nursing progress note dated 7/4/25 at 3:14 PM by RN#4 identified treatment was done to left lower leg and the old dressing was saturated with bloody drainage (2nd change in one day).The nursing progress note dated 7/4/25 at 10:15 PM identified the dressing to left lower extremity was changed due to drainage (3rd change in one day).The nursing progress note dated 7/5/25 at 6:24 AM identified wound dressing to left leg soaked with blood and dressing changed (1st change). The nursing progress note dated 7/5/25 at 2:16 PM by RN#4 identified treatment was done to left lower leg old dressing saturated with bloody drainage and indicated the wound continued to ooze slowly with bloody drainage. The note also identified Resident #22 was put in the APRN's book for evaluation (2nd change).The nursing progress note dated 7/5/25 at 10:49 PM identified the dressing to left lower extremity changed due to drainage (3rd change). The nursing progress note dated 7/6/25 at 7:21 AM identified the left lower extremity dressing was clean, dry and intact. The nursing progress note dated 7/6/25 at 1:00 PM identified treatment to left lower leg old dressing saturated with bloody drain (1st change).The nursing progress note dated 7/6/25 at 10:50 PM identified dressing to left lower extremity changed due to drainage (2nd change).The nursing progress note dated 7/7/25 at 7:24 AM identified the left lower extremity dressing was clean, dry and intact.The nursing progress note dated 7/7/25 at 9:15 AM identified that the left surgical incision dressing was saturated with blood and was reported to the APRN, who ordered to hold aspirin and Plavix for 24 hours and call the surgeon (1st change). The nursing progress notes identified that the resident had three consecutive days (7/4, 7/5 and 7/6) of excessive bleeding, requiring the dressing to be changed three times a day and not once as ordered. The APRN's notification binder identified Resident #22 had left lower leg oozing bloody drainage saturated dressings that required changing (the notation was dated 7/5/25). The entry was initialized and dated 7/7/25 indicating the resident was seen by the APRN. APRN #2's progress note dated 7/7/25 at 9:59 AM identified she was asked to see Resident #22 due to increased bleeding to the left lower leg surgical wound, starting on 7/4/25, saturation of the dressing with a plan for left lower leg wound to be followed by cardiology and surgeon. Nursing staff to reach out to provider and review current symptoms and hold anticoagulant for 24 hours. The nursing progress note dated 7/7/25 at 3:27 PM by RN #2 identified Resident #22's left lower leg dressing was observed saturated with bloody drainage and wound observed with bloody oozing and 15 minutes pressure applied and treatment applied as ordered and findings reported to APRN and APRN saw resident and gave new orders to hold aspirin and Plavix and call the surgeon (2nd change). The cardiothoracic consultation

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 1Number of residents cited: 1Based on clinical record review, review of facility documentation, and interviews for one sampled resident (Resident #61) reviewed for discharge, the facility failed to ensure the Ombudsman's office was provided with the required notification of the transfer. The findings include:Resident #61's diagnoses included rheumatoid arthritis of multiple sites, anemia, and type 2 diabetes mellitus.The admission MDS assessment dated [DATE] identified Resident #61 had intact cognition, required set-up or clean up assistance with personal hygiene, toileting hygiene, upper body dressing, supervision with bed mobility, transfers and ambulation.The Social Worker (SW#2) progress note dated 4/17/25 at 4:50 PM identified Resident #61 was discharged home with medications and home care services in place. The note further identified that discharged paperwork was reviewed and signed with the resident.A review of the transfer notice sent to the Ombudsmen's office for the month of April 2025 failed to identify that the Ombudsmen's office was notified of Resident #61's discharge to home on 4/17/25. In addition, a review of the transfer notice sent to the Ombudsmen's office from January 2025 to June 2025 failed to identify any discharges that occurred at the facility were reported to the Ombudsmen's office. An email confirmation from the Ombudsmen's office dated 7/17/25 identified that the reports sent to the office monthly by the facility appeared to be only hospitalizations and not of discharges or transfers as the facility is required to report all routine discharges monthly and submit them to the Ombudsman's portal. Review of the facility's discharge report for the past six months identified the following: for the month of January, there were five residents discharged and/or transferred from the facility; for the month of February, there were nine residents discharged and/or transferred from the facility; for the month of March, there were thirteen residents discharged and/or transferred from the facility; for the month of April, there were ten residents discharged and/or transferred from the facility; for the month of May, there were nine residents discharge and/or transferred from the facility; for the month of June, there were nine residents discharge and/or transferred from the facility.Interview with the Director of Social Service (SW #2) on 7/17/25 at 10:00 AM identified that the Director of Admissions was responsible for sending the transfers and discharge reports to the Ombudsmen's office via the portal.Interview with the Director of Admissions (LPN #2) on 7/17/25 at 11:30 AM identified she was responsible for sending the notice to the ombudsmen's office for transfer and discharges of hospitalizations and involuntary discharges. LPN #2 identified she had been sending reports to the ombudsmen's office for at least 5 years and had only sent hospitalizations. She identified she was not aware of having to send discharge notification to the Ombudsmen's office as a requirement or if it is a requirement. She indicated that she would send the hospitalization report monthly for the previous month within the first two weeks of each month to the ombudsmen via the portal and it does not include discharges. Interview with the Administrator on 7/17/25 at 12:20 PM identified she was not aware that transfers and discharges needed to be reported to the ombudsmen's office as the facility had only been sending reports that included residents who were sent to the hospital and any involuntary discharges. The Administrator identified that the facility does not have a policy for transfers and discharges as it is a regulation, so the facility practice is to follow the regulation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 22Number of residents cited: 2Based on clinical record reviews and interviews for two of three sampled residents (Residents #8 and #22) reviewed for care planning, the facility failed to ensure that the care plan meeting was scheduled and completed by the interdisciplinary team following the MDS assessment. The findings include: 1. Resident #8's diagnoses included depression, anxiety, and vascular dementia.The quarterly MDS assessment dated [DATE] identified Resident #8 had severely impaired cognition, required maximal assistance for bed mobility, transfers and required total assistance for personal hygiene, toileting hygiene, lower body dressing. The assessment further identified Resident #8 was non-ambulatory and utilized a wheelchair independently.The Reportable Event Report dated 5/22/25 at 12:15 PM identified Resident #8 was observed on the floor in his/her room lying on his/her left side in front of the wheelchair with no noted injuries. The report further identified that Resident #8 was asked what he/she was trying to do at the time of the fall, and he/she pointed to a head band on the floor. The fall investigation documentation identified a care plan intervention to ensure no objects are on the floor to entice the resident not to reach down to the floor. Review of the care plan dated 5/15/25 identified Resident #8 was at risk for falls related to being impulsive, impaired safety awareness, as resident had an unwitnessed fall on 5/2/25 with an abrasion to nose with an intervention directed for 5/2/25 to encourage or assist the resident to not wear clothing with slippery surface and ensure pant legs are above his/her knees. The care plan did not identify that Resident #8 had an unwitnessed fall on 5/22/25 and did not contain the intervention identified on the fall investigation. Review of Resident #8's nurse aide care card instructions also did not identify the implementation of the new intervention. Interview and review of the record with the DNS on 7/17/25 at 10:10 AM identified the care plan was not updated following Resident #8's fall on 5/22/25. She identified the care plan is usually reviewed and revised after an incident by the MDS Coordinator or herself, but she had failed to provide the information to the MDS Coordinator for the care plan to be revised. The DNS identified the intervention developed was to be added to the care card, but it was not added.Interview and review of Resident #8's clinical record with the MDS Coordinator (RN #1) on 7/17/25 at 12:51 PM failed to identify in the current care plan dated 5/15/25 that Resident #8 had a fall on 5/22/25 with the intervention noted from the investigation was implemented. RN #1 identified the resident's care plan should have been revised to include the intervention developed based on the fall. He identified it was his responsibility to review and revise the resident's care plan, but he had not received information pertaining to the fall from the DNS. In a second interview with the DNS on 7/22/25 at 2:00 PM, she identified that it is the facility's practice to update the resident's care plan within 48 to 72 hours following a fall. Review of the Fall policy identified nursing staff will assess resident, provide care and implement immediate interventions to minimize further injuries. 2. Resident #22 was admitted to the facility on [DATE] with diagnoses that included myocardial infarction, vascular implant, presence of aortocoronary bypass graft, and hypothyroidism.The admission MDS assessment dated [DATE] identified Resident #22 had intact cognition and required assistance with activities of daily living ranging from set up help to substantial assistance from staff. The MDS assessment further identified that the resident triggered and should have a care plan for the following areas: visual function, activities of daily living, urinary incontinence, psychosocial wellbeing, mood state, activities, falls, nutritional status and pressure ulcers. Review of the resident care plan meeting form for Resident #22 identified that the care plan meeting form was blank. The care plan meeting should have been completed within 21 days of the Resident #22's admission date (7/15/25). Interview with RN #1 (MDS Coordinator) on 7/17/25 at 10:30 AM identified that he was responsible for scheduling care plan meetings for long term residents and the social worker was responsible for scheduling the care plan meeting for short term residents. He identified the care plan meeting consists of the multi-disciplinary team, which includes nursing, therapy, social worker, recreation, and resident and/or family member. He further identified that the care plan meetings are documented on the care plan meeting form and the participants of the care plan meeting sign the care plan meeting form to indicate their attendance and participation in the meeting. RN #1 further noted that the form indicated that a meeting had not taken place. Interview with SW #1 on 7/17/25 at 10:55 AM identified that she is responsible for scheduling care plan meetings for short term residents. She identified that she typically would schedule the care plan meeting with the resident and/or family member within one or two weeks from the admission date. She identified that the care plan meeting would include representatives from therapy

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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 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** Number of residents sampled: 5Number of residents cited: 5Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for three of five sampled residents (Residents #14, 22, and #34) reviewed for non-pressure skin conditions (surgical incisions/wounds), the facility failed to ensure the primary care physician managed and monitored the post-surgical wound and acted upon changes to the wound in a timely manner and failed to ensure the alternating pressure mattress was set to the residents’ weights as ordered The findings include: 1. Resident #14’s diagnoses included dementia, and anxiety. The quarterly MDS assessment dated [DATE] identified Resident #14 was severely cognitively impaired, had no behaviors, was dependent for bed mobility, transfers, and personal hygiene, required substantial to maximal assistance with dressing, was non ambulatory, and utilized a wheelchair for mobility. The MDS further identified Resident #14 had no current skin impairments, utilized a pressure reducing device in a chair, and bed and the application of ointments/medications to the feet. The care plan dated 5/13/25 identified Resident #14 was at risk for skin breakdown related to bilateral heels, deep tissue injury, and blisters on gluteal folds. Care plan entry dated 5/21/25 identified the resident had moisture associated skin damage (MASD) to gluteal cleft with interventions that included treatment to gluteal cleft, encourage to reposition and weekly follow up with the wound physician. Physician’s order dated 7/1/25 directed air mattress every shift for wound, check setting every shift (setting is according to weight) for comfort, and proper positioning. Review of Resident #14’s clinical record identified Resident #15’s weight to be 152 pounds as of 7/15/25. The Wound Physician’s (MD#3) note dated 7/16/25 identified Resident #14 had an MASD full thickness wound that was noted to be improving with delayed wound closure, the measurements were noted as 0.5cm in width by 0.5cm in length by 0.1cm in depth, with a small amount of serosanguineous exudate. The note further identified the plan was to optimize nutrition with a registered dietician consultation, avoid friction/sheer/traumatic forces, fingernail hygiene with hygiene assistance/incontinence care, and follow the facility pressure ulcer prevention protocol. Observations on 7/15/25 at 9:40 AM and 2:30 PM and, on 7/16/25 at 9:15 AM and 2:00 PM identified Resident #14 in bed positioned on his/her back with the pressure mattress on and set to a weight of 375 pounds. A review of the medication administration record/treatment administration record (MAR/TAR) for July 2025 identified LPN#3 signed off on 7/15/25 for the checking of the mattress setting (day shift) and LPN#4 signed off on 7/16/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 7/16/25 at 2:15 PM with the DNS identified Resident #14’s air mattress was set to a weight of 375 and DNS noted it was the incorrect setting because the setting should be set according to the resident’s weight, for proper pressure relief and healing. The DNS further identified that signing the MAR/TAR as completed means that the nurse should ensure the mattress is set at the appropriate setting. Interview on 7/17/25 with LPN #3 at 9:48 AM identified she was the nurse on Resident #15’s unit on 7/15/25 and noted that she signed off in the MAR/TAR that she checked the air mattress setting; however, she identified that she went into the resident’s room and checked that the pressure mattress was plugged in and on but did not check what the pressure relieving mattress was set to for weight. She identified that she was rushing around ensuring multiple things were being done at the same time and identified that signing the MAR/TAR means that the order was followed, although she signed off in the MAR/TAR without ensuring the air mattress setting was at a therapeutic level. Interview on 7/17/25 at 10:56 AM with LPN#4 identified that she had not checked the mattress setting on her shift for Resident #14 until after the Surveyor’s observation with the DNS was completed then she went in around 2:45 PM and ensured that the setting was correct. LPN#4 could not identify why she had already signed off that the mattress setting was correct prior to 2:45 PM. Interview on 7/18/25 at 11:40 PM with APRN #1 identified that she orders air mattresses for residents being treated for a MASD and/or for a pressure area with the goal of reducing the risk of worsening or developing a pressure ulcer. There are some standing orders that are in place regarding the mattresses. The mattresses are set according to the resident’s weight and if it is not set to the correct setting and if there is not enough air in the mattress it will not be elevated and if there is too much air it could cause a pressure area. Interview on 7/21/25 at 1:45 PM with MD #3 identified that she monitors and assesses Resident #14’s wound on a weekly basis and expects the orders for the mattress settings be followed. If the mattress is set lower than it should be, the mattress would not be providing the amount of support that it should, and if it inflated too much the resident is more at risk for pressure areas due to the mattress being too hard. She further noted that it was concerning that the mattress settings were not being set and/or monitored as ordered because this could prevent the resident from healing. Review of the Skin Care Policy directed appropriate preventative surfaces to beds and wheelchairs will be implemented on all residents identified at risk. 2. Resident #22 was admitted to the facility from an acute care hospital on 6/25/25 with diagnosis that included the presence of an aortocoronary bypass graft, and hypertension. The admission nursing note dated 6/25/25 identified Resident #22 was admitted with two surgical wounds one located on the sternal area, and another located on the left lower extremity, resulting from a left saphenous vein graft. The note identified the surgical incision had been approximated with wound glue and had slight bloody drainage. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 6/26/25 identified Resident #22 had a surgical incision on the chest and left lower extremity status post coronary artery bypass graft (CABG) with interventions that included: facilitate follow up with surgeon as scheduled and as needed, report any redness, warmth, fever, increased pain or edema to physician, and treatment to surgical site as ordered. Additionally, the care plan identified the potential for bleeding related to antiplatelet therapy with interventions that included: observe for and report immediately and as needed signs and symptoms of antiplatelet complications and signs and symptoms of bleeding. Nursing progress note dated 6/26/25 at 7:51 AM identified surgical incision clean, dry and intact (CDI), sutures intact, no s/s of infection. The physician's orders dated 6/27/25 directed to cleanse the left lower extremity surgical incision with wound cleanser, apply bacitracin followed by Alginate apply a dry clean dressing, and change daily. Review of the treatment administration records for June/2025 and July/2025 identified the resident was administered the wound treatment as ordered. Nursing progress note dated 6/27/25 at 6:17 AM identified the surgical dressing on chest was CDI. Provider progress note dated 6/27/25 at 9:15 AM identified Current surgical site assessment reveals healing sternal incision with hydrocolloid removed, healing chest tube sites, right groin ecchymosis without hematoma, and stable left lower extremity hematoma at vein harvest site - mildly tender but without signs of infection. Review of nursing progress notes from 6/28/25 through7/3/25 identified no signs and symptoms of infection or bleeding to the incision site. The admission MDS assessment dated [DATE] identified Resident #22 had intact cognition, utilized a walker, required moderate assistance with personal hygiene, upper and lower body dressing and had the presence of a surgical wound. The nursing progress note dated 7/4/25 at 6:34 AM identified the wound dressing on left leg soaked with blood, dressing changed (1st change). The nursing progress note dated 7/4/25 at 3:14 PM by RN#4 identified treatment was done to left lower leg and the old dressing was saturated with bloody drainage (2nd change in one day). The nursing progress note dated 7/4/25 at 10:15 PM identified the dressing to left lower extremity was changed due to drainage (3rd change in one day). The nursing progress note dated 7/5/25 at 6:24 AM identified wound dressing to left leg soaked with blood and dressing changed (1st change). The nursing progress note dated 7/5/25 at 2:16 PM by RN#4 identified treatment was done to left lower leg old dressing saturated with bloody drainage and indicated the wound continued to ooze slowly with bloody drainage. The note also identified Resident #22 was put in the APRN's book for evaluation (2nd change). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note dated 7/5/25 at 10:49 PM identified the dressing to left lower extremity changed due to drainage (3rd change). The nursing progress note dated 7/6/25 at 7:21 AM identified LLE DSG CDI the left lower extremity dressing was clean, dry and intact. The nursing progress note dated 7/6/25 at 1:00 PM identified treatment to left lower leg old dressing saturated with bloody drain (1st change). The nursing progress note dated 7/6/25 at 10:50 PM identified dressing to left lower extremity changed due to drainage (2nd change). The nursing progress note dated 7/7/25 at 7:24 AM identified LLE DSG CDI. The left lower extremity dressing was clean, dry and intact. The nursing progress note dated 7/7/25 at 9:15 AM identified that the left surgical incision dressing was saturated with blood and was reported to the APRN, who ordered to hold aspirin and Plavix for 24 hours and call the surgeon (1st change). The nursing progress notes identified Resident #22 had three consecutive days (7/4, 7/5 and 7/6) of excessive bleeding, requiring the dressing to changed three times a day and not once as ordered. The APRN’s notification binder identified Resident #22 had left lower leg oozing bloody drainage saturated dressings that required changing (the notation was dated 7/5/25). The entry was initialized and dated 7/7/25 indicating the resident was seen by the APRN. Review of the clinical record and the APRN’s notification binder identified that the physician and/or APRN was not called and notified of the resident’s increase in drainage and the frequency that the resident’s dressings had to be changed. The notification was only placed in the notification binder. Review of facility documentation identified that there is an APRN on site at the facility Monday through Friday. APRN #2’s progress note dated 7/7/25 at 9:59 AM identified she was asked to see Resident #22 due to increased bleeding to the left lower leg surgical wound, starting on 7/4/25, saturation of the dressing with a plan for left lower leg wound to be followed by cardiology and surgeon. Nursing staff to reach out to the cardiac surgeon and review current symptoms and hold anticoagulant for 24 hours. The nursing progress note dated 7/7/25 at 3:27 PM by RN#2 identified Resident #22’s left lower leg dressing was observed saturated with bloody drainage and wound observed with bloody oozing and 15 minutes pressure applied and treatment applied as ordered and findings reported to APRN and APRN saw resident and gave new orders to hold aspirin and Plavix and call the surgeon (2nd change). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cardiothoracic consultation report dated 7/9/25 identified Resident #22 was seen for a post operative wound check of the left lower extremity harvest site. The wound was noted to have discharge, odor, and depth. Resident #22 was noted to have shortness of breath with concerns for pleural effusion. New orders included Aquacel packing strip twice a day to wound, superficial wound culture today and follow up appointment made for 7/16/25. Additionally, the office ordered the Cephalexin (antibiotic) 500mg twice per day be increased to four times per day. The resident had already been placed on Cephalexin for a diagnosis of urinary tract infection. The nursing progress note dated 7/10/25 at 2:47 PM identified the wound treatment was administered as ordered with noted serosanguinous drainage and no redness or swelling noted. The nursing progress note dated 7/11/25 at 2:25 PM identified the wound was packed with alginate strips as ordered and the old dressing was saturated with bloody drainage. The nursing progress note dated 7/12/25 identified the LLE wound dressing was saturated with bloody drainage and the wound had blood oozing around wound bed, no swelling or redness, no complaints of pain. The nursing progress note dated 7/13/25 at 2:03 PM identified the dressing to the LLE was saturated with bloody drainage and there was blood oozing from the wound and the wound size had an increase in length, width and depth. Redness was noted around the wound, and the resident identified he/she was experiencing tenderness. The note further indicated the treatment was applied as ordered and pressure was applied to the wound and a written note was left for the APRN. The APRN’s notification binder contained an entry dated 7/13/25 that identified Resident #22 had a low blood pressure and the LLE surgical wound had increased length, width, depth and was draining serosanguinous fluid. The entry further noted the resident had a vascular appointment on 7/16. The entry was initialed by the APRN with a date of 7/14/25. Further review of the clinical record failed to identify documentation that the APRN evaluated Resident #22’s left lower leg surgical wound. A review of the treatment administration record (TAR) for July 2025 identified Resident #22 was administered Cephalexin (antibiotic) 500mg by mouth every 12 hours for a urinary tract infection (UTI) on 7/7 (pm dose only), 7/8, and 7/9 (am dose only). Further review identified that Cephalexin 500 mg was administered every 6 hours for UTI/surgical wound infection on 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15 and 7/16 (two doses). The nursing progress note dated 7/14/25 at 6:12 AM identified there was no active bleeding or infection noted on the chest or left leg. APRN #1’s progress note dated 7/16/25 at 2:04 PM identified Resident #22 was seen by cardiac surgery for follow up to LLE surgical wound and indicated that around noon, the cardiac surgery office called the facility to report Resident #22 was sent to the emergency room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/16/25 at 11:18 AM with RN #2 identified she would call the doctor or APRN with any drainage or change to the resident. RN #2 indicated with any change in the presentation of the incision; any redness would need a call to the doctor. RN #2 identified If the wound care order does not contain PRN or as needed dressing changes and needs to be changed more frequently, then the doctor needs to be called. RN#2 indicated there is an on-call number for the weekend but identified she handled it on Monday when she reported to the DNS. The surgeon was called, and we received orders to hold the Plavix and aspirin. Interview on 7/16/25 at 11:29 AM APRN #1 identified there is someone on call over weekends and holidays and indicated she would expect to receive a phone call with any change in presentation. APRN#1 identified the extra wound drainage/bleeding is a change in condition and should not have just been put in the communication binder. APRN#1 indicated Resident #22 was being monitored for low Hemoglobin and hematocrit which is affected by bleeding. APRN#1 identified she reviewed the resident labs on 7/8/25 and was not told that the resident was bleeding. APRN#1 identified that if the wound order didn't contain a PRN change, staff should have called and obtained an order for additional wound care. Interview on 7/16/25 at 12:45 PM with the DNS identified that the surgical wounds are not managed by the facility’s physician, APRN’s, or wound physician. The DNS indicated that the surgeon (outside of the facility) is the who follows the surgical wounds, and the surgical office is who needs to be contacted in order to obtain orders or report changes. The DNS identified that she was in and out of the building on 7/5 and 7/6 and wasn’t notified until 7/7/25 that Resident #22’s wound was bleeding and then she made the phone call to the surgical office. The DNS indicated that the notification should have been made when the change was first noticed. Interview on 7/18/25 at 2:32 PM with MD #1 (Medical Director) identified the wound specialist oversees the surgical wounds. MD#1 indicated she was not wound certified and does not manage the wounds. She also identified that the APRN’s also see the residents. Interview on 7/18/25 at 3:00 PM with RN #4 identified that she placed the entry concerning Resident #22’s wound into the APRN book to be seen on 7/5/25. RN #4 indicated that at the time she did not think the bleeding was an immediate concern and identified that reflecting back on it, she should have called the on-call physician to report the changes with the wound. RN#4 indicated she would not have called the surgical office and that the on call would have been who she would have called. Interview on 7/21/25 at 8:24 AM with LPN #1 identified is the wound care nurse and sees residents with the wound physician. LPN#1 identified that the wound care doctor does not see or monitor surgical wounds. LPN#1 indicated that surgical wounds are managed by the surgical team that performed the surgery (outside of the facility) and she does not see surgical wounds nor document on surgical wounds. Interview on 7/21/25 at 9:38 AM with APRN #2 identified that on 7/7/25 when she went to see Resident #22 in response to the entry placed in the notification book. APRN#2 could not recall if she visualized the wound and indicated that if there is a problem with surgical wounds, they are referred to the surgeon or sent to the hospital to be evaluated. Additionally, she noted that when a resident is admitted , the nurses visualize the surgical wounds and neither the doctor nor the APRNs visualize the surgical wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/21/25 at 11:10 AM with the DNS identified that the wound culture completed by the cardiothoracic surgeon’s office resulted in positive results, but the DNS was unable to say how she came to know this information. Review of the clinical record failed to identify laboratory results with an indication of what the outcome of the wound culture was (the laboratory testing was completed by the surgeon’s office). Interview on 7/21/25 at 11:20 AM with RN #2 identified that she documented what she saw, increased bleeding and need to change the dressing, but did not report her findings to anyone. RN #2 indicated that on 7/13/25 she placed Resident #22’s information in the APRN book to be seen on 7/14, which was a Monday and there is APRN coverage Monday through Friday. She did not identify any follow up with the APRN to ascertain whether or not, the APRN followed up with an evaluation of Resident #22s’s surgical wound. Interview on 7/21/25 at 12:05 PM with the surgical Physician’s Assistant (PA) identified that she spoke with the DNS on 7/7/25 and indicated she was told that the wound had bled through one dressing. The surgical PA identified that the expectation is that if something was different from baseline, a medical change or change of management, the surgical office should be notified immediately. The surgical PA indicated that the 7/7 conversation with the DNS was the only contact the surgical office had with the facility and when Resident #22 was seen on 7/16/25 for the follow up, the wound had tunneled in two spaces, had obvious signs and symptoms of infection and indicated Resident #22 was sent to the hospital to avoid further mismanagement of the wound. Interview on 7/21/25 at 1:39 PM with the Wound Care Physician identified that she does not see surgical wounds in the facility. The Wound Care Physician indicated she might visualize the wound if staff came to her with a problem, but then they would be referred to the surgeon or sent to the hospital. Although requested, wound culture results were not provided by the facility or the wound clinic. The facility skin care policy identified residents with wounds and/or pressure ulcers are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. The policy identified ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The policy identified residents admitted with skin impairments will have appropriate interventions to promote healing and that a physician’s order for treatment will be obtained and wound location and characteristics documented in nurses notes and indicated the wound care treatment protocol was to be used and that the resident will be seen by the wound care specialist weekly and will be documented on regarding size, progress, orders or changes in orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure Resident #22’s left lower leg surgical wound was monitored and changes in the wound reported to the surgeon’s office in a timely manner. The facility ascertained that they do not manage surgical wounds, but the surgical staff do not hold privileges within the facility, which would indicate that a physician and/or APRN must take responsibility for the managing of the wounds which would include consulting with the consultant physician (surgeon) as necessary. There was a delay in treatment/assessment from 7/4/25 to 7/9/25 and there was a second delay in treatment/assessment from 7/13/25 to 7/16/25 when the resident was sent to the surgeon’s office and subsequently sent to the acute care hospital for evaluation and treatment of the left lower extremity surgical wound. 3. Resident #34’s diagnoses included dementia, muscle weakness, and adult failure to thrive. The care plan dated 5/27/25 identified Resident #34 was at risk for skin break down due to bladder incontinence, bowel incontinence, history of skin breakdown, impaired mobility and nutritional deficits. Interventions included air mattress in place every shift, check setting every shift for proper setting according to weight for comfort and proper positioning. The annual MDS assessment dated [DATE] identified Resident #34 was severely cognitively impaired, had no behaviors, was dependent with bed mobility, transfers, dressing, personal hygiene, was non-ambulatory, utilized a wheelchair for mobility, had an open lesion other than ulcers, rashes, cuts, and skin tear and utilized a pressure reducing device for chair and bed, and was on a turning and repositioning schedule. Physician’s order dated 7/1/25 directed air mattress every shift for wound, check setting every shift (setting is according to weight) for comfort, and proper positioning Review of Resident #34’s clinical record identified Resident #34’s weight to be 132lbs as of 7/15/25. The Wound Physician’s (MD#3) note on 7/9/25 identified Resident #34 had a neoplasm that was being monitored status post excision by dermatology and the current plan was to continue the current wound recommendations to include the facility pressure ulcer prevention protocol. Observation on 7/15/25 at 9:45 AM identified Resident #34 lying in bed on his/her side with the pressure mattress on and set to a weight of 375. Observation on 7/15/25 at 2:35 PM identified Resident #34 was out of bed in his/her wheelchair with the pressure mattress on and set to a weight of 375. Observation on 7/16/25 at 9:20 AM identified Resident #34 was lying in bed on his/her back with the pressure mattress on and set to a weight of 375. Observation on 7/16/25 at 2:05 PM identified Resident #34 was out of bed into his/her wheelchair with the pressure mattress on and set to a weight of 375. A review of the medication administration record/treatment administration record (MAR/TAR) for July 2025 identified LPN#3 signed off on 7/15/25 for the checking of the mattress setting (day shift) and LPN#4 signed off on 7/16/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 7/16/25 at 2:15 PM with the DNS identified Resident #14’s air mattress was set to a weight of 375 and DNS noted it was the incorrect setting because the setting should be set according to the resident’s weight, for proper pressure relief and healing. The DNS further identified that signing the MAR/TAR as completed means that the nurse should ensure the mattress is set at the appropriate setting. Interview on 7/17/25 with LPN #3 at 9:48 AM identified she was the nurse on Resident #15’s unit on 7/15/25 and noted that she signed off in the MAR/TAR that she checked the air mattress setting; however, she identified that she went into the resident’s room and checked that the pressure mattress was plugged in and on but did not check what the pressure relieving mattress was set to for weight. She identified that she was rushing around ensuring multiple things were being done at the same time and identified that signing the MAR/TAR means that the order was followed, although she signed off in the MAR/TAR without ensuring the air mattress setting was at a therapeutic level. Interview on 7/17/25 at 10:56 AM with LPN#4 identified that she had not checked the mattress setting on her shift for Resident #34 until after the Surveyor’s observation with the DNS was completed then she went in around 2:45 PM and ensured that the setting was correct. LPN#4 could not identify why she had already signed off that the mattress setting was correct prior to 2:45 PM. Interview on 7/18/25 at 11:40 PM with APRN #1 identified that she orders air mattresses for residents being treated for a MASD and/or for a pressure area with the goal of reducing the risk of worsening or developing a pressure ulcer. There are some standing orders that are in place regarding the mattresses. The mattresses are set according to the resident’s weight and if it is not set to the correct setting and if there is not enough air in the mattress it will not be elevated and if there is too much air it could cause a pressure area. Interview on 7/21/25 at 1:45 PM with MD #3 identified that she monitors and assesses Resident #34’s wound on a weekly basis and expects the orders for the mattress settings be followed. If the mattress is set lower than it should be, the mattress would not be providing the amount of support that it should, and if it inflated too much the resident is more at risk for pressure areas due to the mattress being too hard. She further noted that it was concerning that the mattress settings were not being set and/or monitored as ordered because this could prevent the resident from healing. Review of the Skin Care Policy directed appropriate preventative surfaces to beds and wheelchairs will be implemented on all residents identified at risk.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records, review of facility policy/procedures and interviews for three sampled residents (Residents #4, #8, and #34) reviewed for physician visits, the facility failed to ensure that the physician made alternating visits with the APRN’s every sixty days. The findings include: 1. Resident #4 was admitted to the facility 8/1/22 with diagnoses of type 2 diabetes mellitus, chronic kidney disease (CKD), peripheral vascular disease, and atrial fibrillation. The annual MDS assessment dated [DATE] identified Resident #4 had moderately impaired cognition, was taking anticoagulant, antidepressant, opioid, antiplatelet, hypoglycemic and anticonvulsant medications and was at risk for pressure injuries. The care plan dated 7/10/23 identified Resident #4 had a diagnosis of diabetes with diabetic CKD, with interventions to report signs and symptoms of hypo/hyper glycemia or bleeding to MD, obtain labs as ordered and report results to MD. Additionally, the care plan identified Resident #4 was at risk for skin breakdown with an intervention to notify MD of any sign of skin breakdown. Review of the clinical chart from 7/1/23 through 7/21/25 failed to identify any Physician visits, assessments or documentation that identified Resident #4 was seen by the Physician. Review of the clinical chart from 7/1/23 through 7/21/25 identified Resident #4 was seen by APRN#2 for the 60-day visits and by APRN#1 for other general care visits. No documentation was found to indicate that the attending physician had visited and examined Resident #4 at least once every 120 days after the first 90 days after admission. Interview with the DNS on 7/17/25 at 10:10 AM identified that residents should be seen by the physician every other month and a note should be written in the clinical record of that visit. Review of the clinical record with the DNS failed to identify documentation of physician visits from the Medical Director (MD #1)) who is the resident’s primary care physician at the facility (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/18/25 at 11:56 AM with APRN #1 identified she sees new residents frequently and is responsible for follow up when the residents are placed in the APRN book. APRN#1 indicated that when residents go out to appointments, she is responsible to complete the health and physicals for the visits, and she does the monthly routine visits. APRN#1 identified APRN #2, or the Medical Director (MD #1) does the admissions and indicated she thought MD #1 was supposed to see the residents every 60 days and complete the health and physical (H&P) assessment but was not completely sure. Review of Resident #34’s chart identified there were no physician notes or visits for the time period of 7/1/23 through 7/21/25. Interview with the Medical Director (MD #1) on 7/18/25 at 2:32 PM identified she completes the new admission visit for all the facility residents. The Medical Director identified there are two APRNs that see residents and document their visits, and that it would be redundant for her to also see all the residents after admission and document. The Medical Director indicated that she rounds on residents and collaborates with staff and the APRNs but does not document because of redundancy. The Medical Director identified that if the issue is urgent or the resident has needs then she will see them. She indicated that she is aware of the regulation and requirement for 60-day visits but identified that it was expensive and the facility would need to hire another physician to see the residents at that interval. The Medical Director indicated that both APRNs had been in practice for over 2 years, and can practice independently, so she is able to delegate the H&Ps or the regular visits to them. Interview with APRN #2 on 7/21/25 at 9:38 AM identified that she conducts the annual comprehensive visits and the 60-day interval visits. APRN #2 identified she does what she is asked to do and works for MD #1 and not the facility. APRN #2 indicated that on admissions or re-admissions she reviews the resident chart and looks at laboratory test results and screenings for the annual visits. APRN #2 indicated that the Medical Director completes all the initial admission visits, inclusive of obtaining the history and physical and ordering medications. Although requested, the facility did not provide a policy for physician visits and requirements and annual physical requirements. 2. Resident #8 was admitted to the facility in the month of May/2023 with diagnoses that included major depressive disorder, anxiety, and vascular dementia. The admission MDS assessment dated [DATE] identified Resident #8 had severely impaired cognition, required maximal assistance with upper body dressing, transfers and was dependent on staff for toileting and personal hygiene. The assessment further identified the resident utilized a wheelchair for mobility independently. Review of Resident #8’s clinical record from 7/25/2023 through 7/21/25 failed to identify documented physician visits inclusive of assessments, physician’s orders and/or notes. The last physician documentation noted was dated 5/25/2023. Further review identified only visits from an APRN for the required every sixty-day visits. Interview with the DNS on 7/17/25 at 10:10 AM identified that residents should be seen by the physician every other month and a note should be written in the clinical record of that visit. Review of the clinical record with the DNS failed to identify documentation of physician visits from the Medical Director (MD #1) since 5/25/23, who is the resident’s primary care physician at the facility. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/18/25 at 11:56 AM with APRN #1 identified she sees new residents frequently and is responsible for follow up when the residents are placed in the APRN book. APRN#1 indicated that when residents go out to appointments, she is responsible to complete the health and physicals for the visits, and she does the monthly routine visits. APRN#1 identified APRN #2, or the Medical Director (MD #1) does the admissions and indicated she thought MD #1 was supposed to see the residents every 60 days and complete the health and physical (H&P) assessment but was not completely sure. Review of Resident #8’s chart identified there were no physician notes or visits since 5/25/23. Interview with the Medical Director (MD #1) on 7/18/25 at 2:32 PM identified she completes the new admission visit for all the facility residents. The Medical Director identified there are two APRNs that see residents and document their visits, and that it would be redundant for her to also see all the residents after admission and document. The Medical Director indicated that she rounds on residents and collaborates with staff and the APRNs but does not document because of redundancy. The Medical Director identified that if the issue is urgent or the resident has needs then she will see them. She indicated that she is aware of the regulation and requirement for 60-day visits but identified that it was expensive and the facility would need to hire another physician to see the residents at that interval. The Medical Director indicated that both APRNs had been in practice for over 2 years, and can practice independently, so she is able to delegate the H&Ps or the regular visits to them. Interview with APRN #2 on 7/21/25 at 9:38 AM identified that she conducts the annual comprehensive visits and the 60-day interval visits. APRN #2 identified she does what she is asked to do and works for MD #1 and not the facility. APRN #2 indicated that on admissions or re-admissions she reviews the resident chart and looks at laboratory test results and screenings for the annual visits. APRN #2 indicated that the Medical Director completes all the initial admission visits, inclusive of obtaining the history and physical and ordering medications. Although requested, the facility did not provide a policy for physician visits and requirements and annual physical requirements. 3. Resident #34’s diagnoses included dementia, hyperlipidemia, hypertension, and chronic obstructive pulmonary disease. The annual MDS assessment dated [DATE] identified Resident #34 was severely cognitively impaired, had no behaviors, and was dependent with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident utilized a wheelchair for mobility. The care plan dated 6/23/25 identified Resident #34 was at risk for alteration in respiratory status due to his diagnosis of COPD. Interventions directed to administer respiratory medications as ordered, notify MD if current management of respiratory status ineffective, and report any increase shortness of breath, edema and dyspnea to MD. Review of the clinical record from 7/1/2023 through 7/21/25 failed to identify assessments or documentation to identify that Resident #34 was seen by a physician. Further review identified that the resident was only seen by the APRN for the required visits every 60 days. Interview with the DNS on 7/17/25 at 10:10 AM identified that residents should be seen by the physician every other month and a note should be written in the clinical record of that visit. Review of the clinical record with the DNS failed to identify documentation of physician visits from the Medical Director (MD #1)) who is the resident’s primary care physician at the facility (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/18/25 at 11:56 AM with APRN #1 identified she sees new residents frequently and is responsible for follow up when the residents are placed in the APRN book. APRN#1 indicated that when residents go out to appointments, she is responsible to complete the health and physicals for the visits, and she does the monthly routine visits. APRN#1 identified APRN #2, or the Medical Director (MD #1) does the admissions and indicated she thought MD #1 was supposed to see the residents every 60 days and complete the health and physical (H&P) assessment but was not completely sure. Review of Resident #34’s chart identified there were no physician notes or visits for the time period of 7/1/23 through 7/21/25. Interview with the Medical Director (MD #1) on 7/18/25 at 2:32 PM identified she completes the new admission visit for all the facility residents. The Medical Director identified there are two APRNs that see residents and document their visits, and that it would be redundant for her to also see all the residents after admission and document. The Medical Director indicated that she rounds on residents and collaborates with staff and the APRNs but does not document because of redundancy. The Medical Director identified that if the issue is urgent or the resident has needs then she will see them. She indicated that she is aware of the regulation and requirement for 60-day visits but identified that it was expensive and the facility would need to hire another physician to see the residents at that interval. The Medical Director indicated that both APRNs had been in practice for over 2 years, and can practice independently, so she is able to delegate the H&Ps or the regular visits to them. Interview with APRN #2 on 7/21/25 at 9:38 AM identified that she conducts the annual comprehensive visits and the 60-day interval visits. APRN #2 identified she does what she is asked to do and works for MD #1 and not the facility. APRN #2 indicated that on admissions or re-admissions she reviews the resident chart and looks at laboratory test results and screenings for the annual visits. APRN #2 indicated that the Medical Director completes all the initial admission visits, inclusive of obtaining the history and physical and ordering medications. Although requested, the facility did not provide a policy for physician visits and requirements and annual physical requirements.