STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225048	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Rehabilitation & Skilled Nursing Center	96 Forest Street Peabody, MA 01960

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43846 Based on interviews, observations, and policy review, the facility failed to ensure staff treated residents in a dignified manner during the dining experience. Specifically, for a resident who was dependent on staff for assistance with meals, staff were standing over the resident while providing assistance with feeding, on the first floor unit. Findings include: Review of the facility policy titled Residents' Rights Policy, dated 10/4/23, indicated Respect and dignity- The resident has right to be treated with respect and dignity. On 1/28/25 at 8:26 A.M., the surveyor observed a Certified Nurses Aide (CNA) feeding a resident in his/her room on the first floor. The CNA was observed to be standing over the resident who was in bed. On 1/29/25 from 8:12 A.M. to 8:14 A.M., the surveyor observed a CNA feeding the same resident in his/her room on the first floor. The CNA was observed to be standing over the resident who was in bed. During an interview on 1/30/25 at 8:19 A.M., Nurse #3 said staff should be seated while assisting a resident while eating for dignity. During an interview on 1/30/25 at 8:31 A.M., the Assistant Director of Nurses (ADON) said she expects staff to sit while feeding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on record reviews, observations and interviews, the facility failed to ensure resident centered care plans were developed and/or implemented for three Residents (#28, #96, and #92) out of a total sample of 26 residents. Specifically, 1. For Resident #28, the facility failed to implement bilateral lower extremity booties. 2. For Resident #96, the facility failed to implement a physician's order for a Do Not Resuscitate braclet. 3. For Resident #92, the facility failed implement the fall intervention for a low bed. Findings Include: Review of the facility policy titled Care Planning, dated [DATE], indicated The organization will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This will be developed within 7 days after the MDS and CAA completion. 1. Resident #28 was admitted to the facility in [DATE] with diagnoses including pressure ulcer of the sacral region, obesity, and osteomyelitis of vertebra, sacral and sacrococcygeal region. Review of Resident #28's most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #28 had a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #28 requires dependent assistance with functional daily activities and is at risk for developing pressure ulcers/injuries. On [DATE] at 9:12 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 6:57 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 10:08 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 6:41 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. Review of Resident #28's physician order indicated the following order initiated on [DATE]: - Navy blue booties to bilateral feet as tolerated, every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's skin breakdown care plan interventions indicated the following: - Navy blue booties to bilateral feet as tolerated, effective date [DATE]. Review of Resident #28's medical record failed to indicate he/she refused to wear his/her bilateral lower extremity booties. During an interview on [DATE] at 1:51 P.M., Resident #28 said he/she was asked by staff today if he/she would wear booties if they ordered them for him/her. Resident #28 said he/she has not been wearing booties and doesn't understand why the facility wants him/her to wear them now. During an interview on [DATE] at 7:27 A.M., Unit Manager #2 said Resident #28 has orders for booties and wears them as tolerated. Unit Manager #2 said the Resident gets out of bed every day and wears his/her shoes and was not aware he/she had not been wearing his/her booties while in bed the past few days. Unit Manager #2 said she would expect the physician's order to followed and it to be documented accurately in the medical record. During an interview on [DATE] 7:41 A.M., The Director of Nursing said she would expect the physician's order to be acknowledged by nursing, accurately documented in the medical record, and indicated if the resident refuses. 15016 2. Resident #96 was admitted to the facility in [DATE] and has active diagnoses which include chronic kidney disease and chronic obstructive pulmonary disease. Review of an untitled document, located in Resident #96's medical record and signed by the Resident, indicated the facility, effective [DATE]. adopted the use of the purple color coded Do Not Resuscitate (DNR) wristband alert for patients/residents. Review of Resident #96's plan of care dated [DATE], indicated a DNR code status and A purple DNR bracelet to left wrist, check placement every shift. Review of Resident #96's physician order dated [DATE], indicated DNR Bracelet every shift. Verify DNR Bracelet is in place on left wrist every shift. DNR Bracelet represents a time out, in the event of cardiac arrest. Do not initiate CPR (cardiopulmonary resuscitation) obtain patient MOLST (medical orders for life-sustaining treatment) and verify current DNR order. Review of Resident #96's physician orders dated [DATE], indicated Code Status: Do Not Resuscitate, Do Not Intubate, use noninvasive ventilation. Information only. Transfer to Hospital. Review of Resident #96's Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition and he/she did not refuse to accept care. Review of Resident #96's Medication Administration Record dated [DATE] and [DATE], indicated nursing staff documented the Resident wore a DNR bracelet every shift and every day, while in the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #96 on [DATE] at 12:29 P.M., he/she said his/her DNR bracelet had been missing for approximately six weeks. The Resident said he/she has repeatedly asked nurses and aides to provide a replacement bracelet since it went missing. The surveyor observed that the Resident was not wearing a DNR bracelet. Resident #96 said she had CPR performed on him/her once before at a hospital and did not want to have it ever again. During an interview with Unit Manager #3, she said she was unaware Resident #96 was not wearing a DNR bracelet, and that none of the staff reported this. Unit Manager #3 showed the surveyor a drawer at the nursing station, which held approximately a dozen purple DNR bracelets, and said staff know where to find these if a replacement was needed. During an interview with Resident #96's assigned nurse (Nurse #4), she said she was aware Resident #96 was not wearing a DNR bracelet, but did not know how long he/she had been without it. 43846 3. Resident #92 was admitted to the facility in [DATE] with diagnoses that included aphasia following cerebral infarction, traumatic subarachnoid hemorrhage, hemiplegia and hemiparesis, epilepsy and traumatic brain injury. Review of Resident #92's Minimum Data Set (MDS) assessment, dated [DATE], indicated he/she was assessed by nursing staff to have severe cognitive impairments. On [DATE] at 8:05 A.M. and 2:40 P.M., the surveyor observed Resident #92 in bed, the height of the bed was observed to be about three feet high from the ground. On [DATE] at 8:13 A.M., 9:50 A.M., and 1:00 P.M., the surveyor observed Resident #92 in bed, the height of the bed was observed to be about three feet high from the ground. On [DATE] at 6:52 A.M., the surveyor observed Resident #92 in bed, the height of the bed was observed to be about three feet high from the ground and his/her door was closed. Review of Resident #92's fall care plan, dated [DATE], indicated Low bed when occupied. Review of Resident #92's most recent fall assessment, dated [DATE], indicated the resident had a fall in the past year. Review of Resident #92's active Certified Nurses Aide (CNA) Kardex (from explaining to staff the needs of each resident), indicated Fall interventions: Low bed when occupied. During an interview and observation on [DATE] at 8:14 A.M., Nurse #2 said the Resident has a history of falling and his/her bed is not in a low position, the bed is in a high position. Nurse #2 said nursing staff are expected to follow each residents care plan. During an interview on [DATE] at 8:15 A.M., the MDS Nurse said the expectation is that nursing staff following the Resident's care plan. The MDS Nurse said if a resident has a plan of care of a low bed then the bed should be in the lowest locked position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:31 A.M., the Assistant Director of Nurses (ADON) said the Resident has been a fall risk and staff are expected to follow the Resident's care plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, interview, and record review, the facility failed to ensure that respiratory care and services consistent with professional standards of practice, were provided for two Residents (#227 and #70), out of a total sample of 26 residents. Specifically, 1. For Resident #227, the facility failed to ensure a physicians order was in place for the use of a CPAP (continuous positive airway pressure) is a machine that uses mild air pressure to keep breathing airways open while you sleep. 2. For Resident #70, the facility failed to implement physician's orders for continuous oxygen at the correct flow rate. Findings include: 1. Review of the facility policy titled Non-Invasive Positive Pressure Ventilation, not dated, indicated Non-invasive positive pressure ventilation is the delivery of air pressure and/or mechanically assisted breaths without the application of an artificial airway. Procedure: 1. Verify physician's order. Resident #227 was admitted in January 2025 with diagnoses that included obstructive sleep apnea, acute respiratory failure, chronic obstructive pulmonary disease, hypoxemia, and influenza. Review of Resident #227's most recent Minimum Data Set (MDS) assessment, dated 1/22/25, indicated he/she scored a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. During an interview on 1/28/25 at 7:58 A.M., Resident #227 said he/she has used a CPAP for a long time and has been using it here while at the facility. Review of Resident #227's nursing progress note, dated 1/25/25, indicated patient did use his/her CPAP LAST NIGHT. Review of Resident #227's nursing progress note, dated 1/26/25, indicated compliant with the use of his/her CPAP. Review of Resident #227's nursing progress note, dated 1/27/25, indicated patient CPAP on. Review of Resident #227's nursing progress note, dated 1/28/25, indicated CPAP on during the night. Review of Resident #227's physician orders failed to indicate an order for the use of his/her CPAP. During an interview on 1/29/25 at 9:10 A.M., Nurse #1 said he has taken care of Resident #227 many times and said the Resident has been using their CPAP for at least a week here. Nurse #1 said there should be a doctors order in place for the Residents CPAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 9:55 A.M., the Respiratory Therapist said Resident #227 has been using his/her CPAP for a few days and said there should have been a doctors order in place for nursing to be aware of the use of the CPAP and the settings. 45984 2. Review of the facility policy titled Oxygen Administration, revised and dated November 2016, indicated the following: - Oxygen therapy is administered as ordered by a physician. Oxygen is set up, delivered, and monitored by a licensed nurse or respiratory therapist. - Verify physician's order for oxygen administration or weaning. Resident #70 was admitted to the facility in December 2021 with diagnoses including chronic respiratory failure and congestive heart failure. Review of Resident #70's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of section O of the MDS indicated that the Resident is currently on oxygen therapy. The surveyor made the following observations: - On 1/28/25 at 8:00 A.M., Resident #70 was laying in his/her bed receiving supplemental oxygen via nasal cannula. The oxygen machine was set to 1.5 liters. - On 1/28/25 at 12:17 P.M., Resident #70 was laying in his/her bed. The Resident was not wearing his/her nasal cannula to receive supplemental oxygen. The nasal cannula was on the floor. The oxygen machine was set to 1.5 liters. - On 1/29/25 at 12:12 P.M., Resident #70 was laying in his/her bed receiving supplemental oxygen via nasal cannula. The oxygen machine was set to 1.5 liters. Resident #70 asked the surveyor is air coming out of it (referring to the oxygen tubing), I can't even tell the difference. Review of Resident #70's physician's order dated 9/3/24 indicated the following: Continuous O2 (oxygen) administration every shift. Rate: 4L (liters) via NC (nasal cannula) to maintain O2 sat (saturation) greater than 92%. Review of Resident #70's alteration in respiratory function care plan dated 12/5/24 indicated the following intervention: - Administer oxygen as ordered by MD (medical doctor) if applicable. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/29/25 at 1:18 P.M., Unit Manager #3 said all physician's orders should be followed. The Unit Manager and surveyor reviewed Resident #70's physician's orders, and she said the Resident should be receiving oxygen at a flow rate of 4 liters and should be wearing the nasal cannula. Unit Manager #3 said if a staff member observed Resident #70 not wearing his/her nasal cannula they should encourage him/her to wear it. Unit Manager #3 and the surveyor observed the Resident's oxygen machine and she said it was set to 1.5 liters and not 4 liters. During an interview on 1/30/25 at 9:52 A.M., the Director of Nursing (DON) said she would expect Resident #70's physician's orders to be followed as written and the Resident should have been receiving oxygen at a flow rate of 4 liters. The DON also said staff should encourage the resident to wear his/her nasal cannula if the Resident is not.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, interviews, and record review the facility failed to implement a physician's order to give phosphate binders (a medication to absorb phosphate from the food you eat) at the appropriate time for one Resident (#24) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Dialysis Residents, Coordination of Care, dated and revised November 2018, indicated the following: - A comprehensive person-centered plan of care is developed and implemented based on comprehensive assessment in collaboration with the Dialysis Center, in accordance with professional standards of practice. The plan of care will be evaluated and revised as indicated based on resident's response to interventions. Care plan will include: Medication management before, during or after dialysis per physician's orders. Resident #24 was admitted to the facility in March 2020 with diagnoses including stage 4 chronic kidney disease, dependence on renal dialysis and type 2 diabetes. Review of Resident #24's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition. Further review of the MDS indicated that the Resident receives hemodialysis treatment. Review of Resident #24's physician's order dated 2/19/22 indicated the following: - Renvela 800 MG (milligrams) (Sevelamer Carbonate) (a phosphate binder) 800MG Oral Three Times Daily for Dependence on renal dialysis - Give 800mg PO (by mouth) TID (three times daily) **MUST BE GIVEN W/ MEALS** for scheduled order times at 9:00 A.M., 1:00 P.M., 5:00 P.M. According to DaVita Kidney Care Professional Standards of Practice, phosphate binders help to pass excess phosphorus out of the body in the stool, reducing the amount of phosphorus that gets into the blood. Usually, phosphate binders are taken within 5 to 10 minutes before or immediately after meals and snacks. Review of the facility's breakfast meal delivery schedule for the second-floor unit indicated that the unit receives three breakfast carts at 7:40 A.M., 7:50 A.M. and 8:10 A.M. The surveyor made the following observations: - On 1/29/25 at 8:20 A.M., Resident #24 was observed eating his/her breakfast in his/her room. - On 1/30/25 at 8:04 A.M., Resident #24 was observed eating his/her breakfast in his/her room. At 8:24 A.M., staff removed the Resident's breakfast tray. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 8:32 A.M., and 10:01 A.M., the surveyor observed Resident #24's electronic medication administration record (MAR) and the Resident was not documented as to receiving the Renvela medication. On 1/30/25 at 9:20 A.M., the surveyor observed Resident #24's electronic medication administration record (MAR) and the Resident was not documented as to receiving the Renvela medication. Review of Resident #24's Administration History for Renvela 800MG indicated the following: - Resident #24 was administered the medication at 10:50 A.M. on 1/29/25, 150 minutes after the Resident was observed eating his/her breakfast. - Resident #24 was administered the medication at 9:33 A.M. on 1/30/25, 89 minutes after the Resident was observed eating his/her breakfast. During an interview on 1/30/25 at 9:25 A.M., Nurse #4 said she has not passed medications to Resident #24 yet. Nurse #4 and the surveyor reviewed Resident #24's physician's orders for Renvela, Nurse #4 said the order should be changed for when breakfast arrives so the Resident can take the medication with food. Nurse #4 said 9:00 A.M. is too late for a scheduled time, it should be 7:30 A.M. She continued to say she was not aware the medication needed to be taken with meals because the order description does not match the order administration time. Nurse #4 said other dialysis residents on the unit with the same medication have an earlier administration time. During an interview on 1/30/25 at 9:36 A.M., Unit Manager #3 and the surveyor reviewed Resident #24's physician's orders, Unit Manager #3 said the Resident should be getting Renvela with meals and the administration time needs to be updated for when breakfast comes up at 8:00 A.M. During an interview on 1/30/25 at 9:54 A.M., the Director of Nursing (DON) said she would expect physician's orders to be followed as written. The DON continued to say for Resident #24, if his/her order for Renvela says to be taken with meals then the timing of his medication administration needs to be updated so he/she receives the medication with meals.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45343 Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for two Residents (#28, and #96), out of a total sample of 25 residents. Specifically, 1. For Resident #28, the nurses documented in the Medication Administration Record (MAR) the Resident was wearing his/her bilateral lower extremity booties, when he/she was not. 2. For Resident #96, the nurses documented in the Medication Administration Record (MAR) the Resident was wearing his/her DNR bracelet, when he/she was not. Findings Include: Review of the facility policy titled Documentation-Clinical, dated [DATE], indicated the following: Policy: - Clinical documentation will be recorded according to Integritus Healthcare guidelines, as outlined below. The facility meets DPH (Department of Public Health) requirements for weekly summary of resident condition by ensuring documentation of medication and treatment administration every shift, interdisciplinary progress notes as needed, skin evaluations weekly, and Functional Performance point of care documentation every shift. Resident status, including change in condition, nursing or other services provided and resident response or progress will be documented as warranted. Purpose: - To ensure accuracy and completeness of clinical documentation. Guidelines: -Medication and Treatment: The licensed nurse notes the time and date of all medications and treatments administered on Medication Administration Record and/or treatment record. The nurse who administers the medication and/or treatment must document it on the resident's record. If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the resident receiving the medication and what was done to attempt to administer the medication. 1. Resident #28 was admitted to the facility in [DATE] with diagnoses including pressure ulcer of the sacral region, obesity, and osteomyelitis of vertebra, sacral and sacrococcygeal region. Review of Resident #28's most recent Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #28 had a Brief Interview for Mental Status (BIMS) exam score of 15 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #28 requires dependent assistance with functional daily activities and is at risk for developing pressure ulcers/injuries. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:12 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 6:57 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 10:08 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. On [DATE] at 6:41 A.M., the surveyor observed Resident #28 laying in his/her bed. Resident #28 was not wearing his/her lower extremity booties, and the booties were not visible in his/her room. Review of Resident #28's physician order indicated the following order initiated on [DATE]: - Navy blue booties to bilateral feet as tolerated, every shift. Review of Resident #28's skin breakdown care plan interventions indicated the following: - Navy blue booties to bilateral feet as tolerated, effective date [DATE]. Review of the [DATE] MAR indicated that nursing documented on all shifts on [DATE]th, 29th and day shift on [DATE]th, that Resident #28 was wearing bilateral lower extremity booties, contrary to direct observation that he/she was not. Review of Resident #28's medical record failed to indicate he/she refused to wear his/her bilateral lower extremity booties. During an interview on [DATE] at 1:51 P.M., Resident #28 said he/she was asked by staff today if he/she would wear booties if they ordered them for him/her. Resident #28 said he/she has not been wearing booties and doesn't understand why the facility wants him/her to wear them now. During an interview on [DATE] at 7:27 A.M., Unit Manager #2 said Resident #28 has orders for booties and was not aware he/she had not been wearing his/her booties while in bed the past few days. Unit Manager #2 said she would expect it to be documented accurately in the medical record. During an interview on [DATE] at 7:41 A.M., The Director of Nursing said she would expect the physician's order to be acknowledged by nursing, accurately documented in the medical record, and indicated if the resident refuses. 15016 2. Resident #96 was admitted to the facility in [DATE] and has active diagnoses which include chronic kidney disease and chronic obstructive pulmonary disease. Review of Resident #96's plan of care dated [DATE], indicated a DNR (do not resuscitate) code status and A purple DNR bracelet to left wrist, check placement every shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225048	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Rehabilitation & Skilled Nursing Center	96 Forest Street Peabody, MA 01960

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #96's physician order dated [DATE], indicated DNR Bracelet every shift. Verify DNR Bracelet is in place on left wrist every shift. DNR Bracelet represents a time out, in the event of cardiac arrest. Do not initiate CPR (cardiopulmonary resuscitation) obtain patient MOLST (medical orders for life-sustaining treatment) and verify current DNR order. Review of Resident #96's Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition and he/she did not refuse to accept care. Review of Resident #96's Medication Administration Record (MAR) dated [DATE] and [DATE], indicated nursing staff documented the Resident wore a DNR bracelet every shift and every day while in the facility, including today ([DATE]). During an interview with Resident #96 on [DATE] at 12:29 P.M., he/she said his/her DNR bracelet had been missing for approximately six weeks. The Resident said he/she has repeatedly asked nurses and aides to provide a replacement bracelet since it went missing. The surveyor observed the Resident was not wearing a DNR bracelet. Resident #96 said she had CPR performed on him/her once before at a hospital and did not want to have it ever again. During an interview with Unit Manager #3, she said she was unaware Resident #96 was not wearing a DNR bracelet, and that none of the staff reported this. Unit Manager #3 showed the surveyor a drawer at the nursing station, which held approximately a dozen purple DNR bracelets, and said staff know where to find these if a replacement is needed. Unit Manager #3 said nursing staff should not have documented on the MAR that the Resident was wearing the bracelet when he/she was not, and that this error made the medical record inaccurate. During an interview with Resident #96's assigned nurse (Nurse #4), she said she was aware Resident #96 was not wearing a DNR bracelet, but did not know how long he/she had been without it. Nurse #4 said she did not know staff documented the Resident wore the DNR bracelet even though it was missing.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 43846 Based on observation, record review and interview, the facility failed to regularly inspect bed frames and mattress spacing to identify areas of potential entrapment. Specifically, the facility failed to regularly inspect and document findings regarding the seven zones of bed entrapment of Residents' beds for potential areas of entrapment as evidenced by a bed bolster (an object used to fill gaps between the mattress and headboard/footboard of a bed) that did not fit properly. Findings include: Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/2006, indicated: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in deaths and serious injuries. There are 7 zones of bed entrapment: Zone 1 (within the rail), Zone 2 (under the rail), Zone 3 (between rail and mattress), Zone 4 (Under the rail, at the ends of the rail), Zone 5 (between split bed rails), Zone 6 (between the end of the rail and the side edge of the head or foot board) and Zone 7 (Between the head or foot board and the mattress end). Review of guidance from the FDA titled Recommendations for Health Care Providers about Bed Rails, dated 07/09/2018, included: - Inspect and regularly check the mattress and bed rails to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. - Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. Review of the facility policy titled Bed Safety and Inspection, revised 10/19/17, indicated The facility will conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify area of possible entrapment. Nursing staff will observe the resident in the bed to look for potentially dangerous or uncomfortable situations that could be caused by the resident's weight, movement or bed position. Verify that no gap between the mattress, bed frame or side rail is wide enough to entrap a resident's head or body. -Maintenance staff will refer to the FDA guidelines for each of the seven zones. 1. Resident #117 was admitted to the facility in January 2025 with diagnoses that include acute on chronic diastolic heart failure, chronic kidney disease, and age-related nuclear cataract. At the time of the survey Resident #226 did not have a completed Minimum Data Set (MDS). (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #226's active Certified Nursing Assistant (CNA) Kardex (a form explaining to staff each Residents level off assistance), indicated he/she is supervised or touching assistance for bed mobility, transfer, ambulation, and hygiene. The surveyor made the following observations on Resident #226's bed: - On 1/28/25 at 8:13 A.M., on the Rehab Unit, a resident was observed in bed. There was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the width of the mattress and the gap between the space above the bolster to the footboard was about six and a half inches. - On 1/29/25 at 8:12 A.M., on the Rehab Unit, a resident was observed in bed. There was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the width of the mattress and the gap between the space above the bolster to the footboard was about six and a half inches. Review of the Maintenance Directors entrapment spreadsheet for December 2024 indicated for this Resident's bed that only zones 1, 2 and 6 were checked. Zones 3, 4, 5 and 7 were left blank. Further review of the monthly spreadsheets indicated for November 2024 and December 2024 for first, second and third floors that only zones 1, 2 and 6 were checked. Zones 3, 4, 5 and 7 were left blank. During an interview and observation on 1/29/25 at 11:14 A.M., the Administrator and Maintenance Director observed Resident #226's bed. The Administrator and Maintenance Director said these gaps put the residents at risk for entrapment. The Maintenance Director said this bolster is not big enough for the gap at the end of this bed. 2. Resident #228 was admitted to the facility in January 2025 with diagnoses that included epilepsy, anemia, weakness, and low back pain. At the time of the survey Resident #228 did not have a completed Minimum Data Set (MDS). Review of Resident #228's active Certified Nursing Assistant (CNA) Kardex (a form explaining to staff each Residents level off assistance), indicated he/she required substantial/maximal assistance for bed mobility and partial/moderate assistance for ambulation, toileting and dressing. The surveyor made the following observations on Resident #228's bed: - On 1/28/25 at 7:55 A.M., on the Rehab Unit, a resident was observed in bed. There was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the width of the mattress and the gap between the space above the bolster to the footboard was about six inches. - On 1/29/25 at 8:12 A.M., on the Rehab Unit, a resident was observed in bed. There was a bolster on the foot of the bed between the mattress and the footboard. The bolster was less than half the width of the mattress and the gap between the space above the bolster to the footboard was about six inches. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Maintenance Directors entrapment spreadsheet for December 2024 indicated for this Resident's bed that only zones 1, 2 and 6 were checked. Zones 3, 4, 5 and 7 were left blank. Further review of the monthly spreadsheets indicated for November 2024 and December 2024 for first, second and third floors that only zones 1, 2 and 6 were checked. Zones 3, 4, 5 and 7 were left blank. During an interview and observation on 1/29/25 at 11:15 A.M., the Administrator and Maintenance Director observed Resident #228's bed. The Administrator and Maintenance Director said these gaps put the residents at risk for entrapment. The Maintenance Director said this bolster is not big enough for the gap at the end of this bed and said he does not have bigger bolsters in the facility. During an interview on 1/29/25 at 2:09 P.M., the Maintenance Director said he does a monthly inspection of every bed in the facility, the last completed inspection was done in December 2024 and prior to each admission that comes into the facility. The Maintenance Director said he does not measure the resident beds with extenders on them because they do not need to be measured and said he did not have to measure and assess zones 3, 4, and 5. The Maintenance Director said he uses a small ruler to do his bed measurement checks. During an interview on 1/29/25 at 2:20 P.M., the Administrator said she expects maintenance to do all the zones on each resident bed when he does the entrapment rounds.