STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed to obtain informed consent for the administration of a psychotropic medication for one Resident (#7), out of a total sample of 26 residents. Findings include: Resident #7 was admitted to the facility in April 2021 and had diagnoses that included but not limited to basal cell carcinoma of skin of other parts of face, unspecified dementia, localized edema, moderate protein calorie malnutrition, venous insufficiency (chronic) (peripheral), and paranoid schizophrenia. Review of Resident #7's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #7 had a score of 0 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment and requires substantial/maximal assistance with activities of daily living including bathing and dressing. Review of Resident #7's physician's orders indicated the following: - Lorazepam (benzodiazepine medication) tablet 0.5 mg (milligrams) give one tablet by mouth every four hours as needed for anxiety, insomnia, nausea, dated 8/9/24. Review of Resident #7's medical record failed to indicate a verbal or written informed consent including risk and benefits for the use of the Lorazepam was obtained by the Resident's Health Care Proxy. During an interview on 9/4/24 at 1:25 P.M., the Social Worker said informed consent is required from the resident or resident's health care proxy for the use of psychotropic medications. During a subsequent interview on 9/4/24 at 1:50 P.M., the Social Worker said she reviewed Resident #7's record and that there was no informed consent for the use of the as needed Lorazepam.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review, policy review, and interview, the facility failed to ensure Advance Directives (written documents that instructs health care providers of the decisions for specific medical treatment if a person was unable to speak or lacked the capacity to make decisions for themselves) were consistently documented in the medical record for three Residents (#23, #38 and #21), out of a total sample of 26 residents. Findings include: Review of the facility policy titled Advanced Directives, dated [DATE], indicated the plan of care will be consistent with his or her documented treatment preferences and/or advance directive. 1. Resident #23 was admitted to the facility in [DATE] with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. Review of Resident #23's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 5 out of a possible 15 on the Brief Interview for Mental Status exam (BIMS) indicating he/she has severe cognitive impairment. Further review of the MDS indicated advanced directives DNR (do not resuscitate) and DNI (do not intubate). Review of Resident #23's active physician orders, dated [DATE], indicated: - CPR (Cardiopulmonary Resuscitation). - Full code. - Follow MOLST (Medical Orders for Life-Sustaining Treatment) instructions. Review of Resident #23's advanced directives care plan, dated [DATE], indicated per MOLST: DNR/DNI. Review of Resident #23's MOLST, dated [DATE], indicated DNR, DNI, transfer to hospital, no dialysis, no artificial nutrition, and use artificial hydration short term only. During an interview on [DATE] 8:13 A.M., the Social Worker said that Resident #23's MOLST should match his/her physician orders. During an interview on [DATE] at 9:08 A.M., the Consulting Nurse said the MOLST and physician order should always match. The Consulting Nurse said Resident #23's physician order should not say CPR, full code if the MOLST says DNR and DNI. 2. Resident #38 was admitted [DATE] with diagnoses that included cerebral infarction, presence of automatic defibrillator, and anorexia. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #38's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of a possible 15 on the Brief Interview for Mental Status exam (BIMS) indicating he/she had severe cognitive impairments. Review of Resident #38's active physician orders, dated [DATE], indicated Full Code. CPR (Cardiopulmonary Resuscitation). Review of Resident #38's advanced directives care plan, dated [DATE], indicated He/she is a full code status. Initiate CPR as needed. Review of Resident #38's active physician orders, dated [DATE], indicated DNR, DNI, DNH comfort care only. Review of Resident #38's MOLST, dated [DATE], indicated DNR, DNI, DNH. Review of Resident #38's medical record, indicated Advance Directives: CPR (Cardiopulmonary Resuscitation), Full Code. Review of Resident #38's Nurse Practitioner (NP) note, dated [DATE], indicated Advance care planning notes: MOLST form reviewed signed in chart. During an interview on [DATE] 8:13 A.M., the Social Worker said that Resident #38's MOLST should match his/her physician orders. During an interview on [DATE] at 9:08 A.M., the Consulting Nurse said the MOLST and physician order should always match. The Consulting Nurse said Resident #38's physician order should not say CPR, full code if the MOLST says DNR and DNI. 48671 3. Resident #5 was admitted to the facility in [DATE] with diagnoses including paranoid schizophrenia, major depressive disorder, hypertension and muscle weakness. Review of Resident #21's most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 9 out of a possible 15 indicating the Resident has moderate cognitive impairment. Review of Resident #21's [DATE] physician's orders indicated the following: - Haloperidol (an antipsychotic medication) tablet 10 mg (milligrams), give 1 tablet by mouth one time a day for paranoid schizophrenia. Start date [DATE]. Review of the medical record indicated that the Resident has a legal guardian and a [NAME] monitor. Further review of Resident #21's medical record indicated a [NAME] treatment plan with permission from court to treat the Resident with Haloperidol 10 mg. The treatment plan was approved on [DATE]. The treatment plan further indicated that that it would be reviewed one year from [DATE] on [DATE] and shall expire at 4:00 P.M., on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #21's Medication Administration Record (MAR) dated [DATE] through [DATE], indicated that Resident #21 was administered Haloperidol 10 mg once daily as ordered from [DATE] to [DATE]. During an interview on [DATE] at 8:55 A.M., the Social Worker said the treatment plan expired in [DATE] and that she reached out in August of 2024 for an update. The Social Worker said treatment plans must be updated before expiration. During an interview on [DATE] at 9:09 A.M., the Consulting Nurse said the Social Worker is responsible for tracking all [NAME] treatment plans and start the renewal process in advance before they expire. The Consulting Nurse said residents are required to have up to date signed documents prior to receiving antipsychotic medications.

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record reviews and interviews the facility failed to ensure the physician/nurse practitioner were notified of the recommendations made by the consulting wound physician for two Residents (#23, #26) out of four applicable residents and failed to notify the physician/nurse practitioner of a change in condition for two Residents (#6, #7). Specifically, 1. For Resident #23, the facility failed to notify the provider of the consultant wound physician's treatment recommendations resulting in the wound treatments not being implemented. 2. For Resident #26, the facility failed to notify the provider of the consultant wound physician's treatment recommendations resulting in the wound treatments not being implemented. 3a. For Resident #6, the facility failed to notify the provider that Resident #6 was not provided oxygen therapy resulting in the resident's oxygen saturation to drop to 77% resulting in respiratory distress. 3b. For Resident #6, the facility failed to notify the provider of significant weight loss resulting in a 12% weight loss in one month. 4. For Resident #7, the facility failed to report to the Nurse Practitioner (NP) or physician that Resident #7's right lower extremity's skin was open, discolored, and weeping. Further, the facility failed to report the Resident's left lower extremity had scabs and swelling. Findings include: Review of the facility's policy entitled, 'Change in a Resident's Condition or Status or Injury of Unknown Origin' not dated indicated the following: The facility shall promptly notify the resident, his or Attending Physician and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The nurse will notify the resident's attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discover of injuries of unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional condition; e. need to alter the resident's medical treatment significantly. f. refusal of treatment or medication two (2) or more consecutive times); (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	g. need to transfer the resident to the hospital/treatment center; h. discharge without proper medical authority; and/or; i. specific instructions to notify the Physician of changes in the resident's condition. 8. the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 1. Resident #23 was admitted to the facility in January 2013 with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated he/she scored a 5 out of a possible 15 on the Brief Interview for Mental status exam indicating he/she has severe cognitive impairment. Further review of the MDS indicated he/she is at risk for developing pressure ulcers. Review of Resident #23's wound doctor evaluation and management summary dated 8/22/24 and 8/29/24, indicated the Resident has a stage two pressure wound of the left lateral heel with partial thickness. Further review of the wound summary indicated the wound dressing treatment plan: apply calcium alginate once a day cover with ABD (large wound dressing) pad and then gauze roll daily. Off-load wound and float heels in bed. The summary further indicated the Resident's plan of care was discussed with a nursing staff member. Review of Resident #23's skin evaluation, dated 8/23/24, indicated seen by wound md (Medical Doctor) new order for wash with normal saline pat dry apply calcium alginate cover with ABD pad and kerles [sic] until healed. Review of Resident #23's wound doctor evaluation and management summary dated 9/5/24, indicated stage two pressure wound to the left lateral heel treatment plan: skin prep apply twice daily. Off-load wound, float heels in bed. The summary further indicated the Resident's plan of care was discussed with a nursing staff member and patient. Review of Resident #23's physician orders failed to indicate that a treatment was put in place for his/her stage two pressure ulcer of the left heel. During an interview on 9/3/24 at 2:17 P.M., Nurse #7 said Resident #23 does not have left heel wound orders in place. During an interview on 9/5/24 at 7:46 A.M., the Consultant Wound Physician said Resident #23 has a pressure ulcer on his/her left heel. The Wound Consultant said he expects for nursing to call and relay his recommendations to the provider at the facility. The Wound Consultant said he would expect their to be treatment and interventions put into place Resident #23's left heel wound. During an interview on 9/5/24 at 12:04 P.M., Medical Doctor (MD) #1 said she was not told by nursing staff that the resident had a wound nor did they tell her they had wound doctor recommendations. MD #1 said she would expect to be called by nursing staff when the Resident was found with a new pressure area and to be told the wound doctor recommendations but was not. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	45984 2. Resident #26 was admitted to the facility in July 2024 with diagnoses including pressure ulcer of left buttock stage 2, pressure ulcer of right upper back, non-pressure chronic ulcer of skin of other sites and dementia. Review of Resident #26's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of Resident #26's MDS under section M indicated that the Resident is at risk for developing pressure ulcers and has one or more unhealed pressure ulcers/injuries. Review of Resident #26's physician's orders indicated the following: - Dated 8/1/24: weekly skin assessment on Thursday 7-3 (7:00 A.M. through 3:00 P.M.) shift one time a day every Thu (Thursday). - Dated 7/30/24: May be seen by the wound doctor. Review of Resident #26's document titled Braden Scale for Predicting Pressure Ulcer Risk, dated 7/18/24 indicated that the Resident was at a Moderate Risk for developing pressure ulcers. Review of Resident #26's assessment titled Admit/Readmit Screener, dated 7/18/24 under Section C. Skin Integrity indicated the following: - Site: left mid-back, Type: Pressure, Length: 3, Width: 3, Stage: II - Site: Coccyx, Type: Pressure, Length: 4, Width: 5, Stage: IV - Site: Left Heel, Type: Scar, Length: 4, Width: 4, Stage: IV - Site: Right Heel, Type: Scar, Length: 3, Width: 3, Stage: Unstageable - Site: Ischial Chronic Wound, Type: Pressure, Length: 1, Width: 1, Depth: 2,3, Stage: IV - Details/Comments: Tunneling 7.2 cm (centimeters) nsw (normal saline wash) aquacel AG (silver- helps with preventing infection in the wound) rope packing 3x (three times) a week cover with boder [sic] gauze. Bilateral heel escar apply skin prep daily cover with boarder from dgs (dressings). Review of Resident #26's Wound Evaluation & Management Summary developed by the wound doctor during his weekly visits with Resident #26 indicated the following: - Dated 8/1/24: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	-Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 2x2x0.2 cm, surface area: 4.00 cm, exudate: light serous, slough: 50%, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days. - Wound of left foot, fourth toe, etiology: infection, wound size: 1x1xnot measurable, surface area: 1.00 cm, exudate: light purulent, thick adherent devitalized necrotic tissue: 40%, granulation tissue: 60%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver (with silver) apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr (border) apply once daily for 30 days. - Dated 8/8/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3.2x3x0.2 cm, surface area: 9.60 cm, exudate: light serous, slough: 50%, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): ABD pad apply once daily for 23 days; Gauze roll (kerlix) 4.5 apply once daily for 23 days. - Wound of left foot, fourth toe, etiology: infection, wound size: 1x1xnot measurable, surface area: 1.00 cm, exudate: light serous, thick adherent devitalized necrotic tissue: 40%, granulation tissue: 60%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.5x1x0.2, surface area: 0.50 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-pressure wound of the right, second toe, etiology: trauma/injury, wound size: 1x1xnot measurable, surface area: 1.00 cm, blister: blood filled. Dressing Treatment Plan - Primary Dressing(s): Skin prep once daily for 30 days. - Non-pressure wound of the right shin, etiology: trauma/injury, wound size: 1.2x0.5x0.1, surface area: 0.60 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days. - Dated 8/14/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3x2.2x0.2 cm, surface area: 6.60 cm, exudate: light serous, slough: 20%, granulation tissue: 80%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver apply once daily for 17 days. Secondary Dressing(s): ABD pad apply once daily for 17 days; Gauze roll (kerlix) 4.5 apply once daily for 17 days. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	- Wound of left foot, fourth toe, etiology: infection, wound size: 0.3x0.5xnot measurable, surface area: 0.15 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver apply once daily for 17 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 17 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.5x0.5x0.2, surface area: 0.25 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 17 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 17 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.5x0.3x0.1, surface area: 0.15 cm, exudate: light serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver once daily for 17 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 17 days. - Non-pressure wound of the right shin, etiology: trauma/injury, wound size: 1.2x0.5x0.1, surface area: 0.60 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 24 days; Hydrogel gel w/silver apply once daily for 24 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 24 days. - Dated 8/22/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 1.6x1.2x0.2 cm, surface area: 1.92 cm, exudate: light serous, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver apply once daily for 9 days. Secondary Dressing(s): ABD pad apply once daily for 9 days; Gauze roll (kerlix) 4.5 apply once daily for 9 days. - Wound of left foot, fourth toe, etiology: infection, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver apply once daily for 9 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 9 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 9 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 9 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver once daily for 9 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 9 days. - Dated: 8/29/24: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	-Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3x3x0.2 cm, surface area: 9.0 cm, cluster wound: open ulceration area of 4.50 cm exudate: light serous, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days. - Wound of left foot, fourth toe, etiology: infection, wound size: 0.2x0.2x0.1, surface area: 0.04 cm, exudate: light serous, slough: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: light serous, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver once daily for 30 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. - Dated 9/5/24: - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3x not measurable, surface area: 0.09 cm, cluster wound: open ulceration area of 0.05 cm exudate: light serous, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver once daily for 23 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 23 days. - Non-Pressure wound of the right knee, etiology: trauma/injury, wound size: 2x1.4x not measurable, surface area: 2.80 cm, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; TRIPLE FOLDED. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. - Non-Pressure wound of the left knee, etiology: trauma/injury, wound size: 1x1.3x0.1, surface area: 1.30 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Triple Folded. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. Review of Resident #26's active, discontinued and completed physician's orders in the facility's electronic medical record failed to indicate that the facility implemented or updated any of Resident #26's treatment orders as recommended by the consultant wound physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/3/24 at 1:11 P.M., Nurse #6 and the surveyor reviewed Resident #26's active physician's orders. Nurse #6 said there are no orders for the Resident's buttock or back wound. When asked how are the nurses supposed to know what treatment Resident #26 should be getting she said we would have no way of knowing without an order. During an observation on 9/3/24 at 1:20 P.M., the surveyor observed Resident #26's wounds with Nurse #6, the buttock and back wounds were treated and covered with gauze despite no active treatment orders. During an interview on 9/4/24 at 6:41 A.M., Nurse #2 said when the wound doctor puts in a treatment recommendation it first gets sent to the Director of Nursing (DON) and then the Nurse Practitioner (NP) will review the treatment orders and approve them and will then tell nursing staff to put the orders in the electronic medical system. Nurse #2 said he only completed the active order for Resident #26's heel treatment and did not treat the other wounds because there was no order in. Nurse #2 said he would not do a treatment without an order because he would not know how to treat the area. During an interview on 9/4/24 at 8:48 A.M., Nurse #5 said he treated Resident #26's buttock and back wounds with a gauze pad despite no active order, he said he used his best nursing judgement so the wounds do not get worse. Nurse #5 said he does rounds with the wound doctor each week and the wound doctor will let the DON know his treatment recommendations and the NP will approve them and put the orders in. Nurse #5 said he is not sure how the ordering process works with the DON absence from the facility. During an interview on 9/4/24 at 10:02 A.M., the NP said any new treatment orders will get flagged in a binder for her to approve and then the nurses will put the orders in the electronic medical record. The NP said a nurse rounds with the wound doctor and then that nurse should reach out to her with any new wound recommendations so she can review and approve them. The NP continued to say if the wound doctor were to make a recommendation she would approve it. When asked if she was aware of any of the recommendations the wound doctor has made for Resident #26, she said she was unaware and staff never brought them to her for review. During an interview on 9/5/24 at 8:11 A.M., the Consultant Wound Physician said he comes in weekly and he would expect all of his recommendations to be followed by nursing. He continued to say since the DON's absence, none of his wound treatment orders have not been communicated. The Wound Doctor continued to say that he communicates with Nurse #5 about his wound treatments, and he would expect them to be implemented. The Wound Doctor said his treatments clearly have not been implemented and there is a problem with transcribing his recommendations. The Wound Doctor then said Resident #26's active order for Santyl Ointment for his/her left heel is an old order and the Resident should not be treated with that. During an interview on 9/5/24 at 12:44 P.M., the facility's Medical Director said he would expect all the wound doctor's treatment recommendations to be followed and put into the electronic medical system so all staff know what they are so they can be completed as ordered. 48671 3a. Resident #6 was admitted to the facility in March 2022 with diagnoses including chronic obstructive pulmonary disease (COPD), acute respiratory failure, dysphagia, and anxiety. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #6 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 a possible 15 indicating an intact cognitive status. Further review of the MDS indicated that the Resident requires assistance with activities of daily living and receives respiratory care. On 9/3/24 at 10:01 A.M., Resident #6 was observed sitting in a wheelchair in the dining room. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached, the nasal cannula was placed around the Residents head but was not placed in his/her nostrils. Staff could be seen walking around the dining room and one staff member remained seated in the doorway. The Resident's back was to the staff member. Review of Resident #6's physician's orders dated 11/10/23 indicated the following: - O2 (Oxygen) at 2L (liters/minute) via nasal cannula continuously to maintain O2 saturation greater than 90% every shift for interstitial lung disease. Review of Resident #6's care plan for oxygen therapy dated 7/6/22 indicated the following intervention: - Monitory oxygen sat (saturation) every shift. - If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to nasal cannula). Return resident to usual oxygen delivery method after the meal. - Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, [NAME] oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. - OXYGEN SETTINGS: I have, O2 via nasal prongs/mask @ 2L continuously as needed. For sob (shortness of breath) respiratory distress. Review of Resident #6's care plan for Emphysema (lung condition causing shortness of breath)/COPD (Chronic Obstructive Pulmonary Disease)/asthma (airway disease) dated 7/6/22 indicated the following intervention: - Give oxygen therapy as ordered by the physician - Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0580 Level of Harm - Actual harm Residents Affected - Some	During an observation and interview on 9/3/24 at 10:04 A.M., Nurse #1 said Resident #6 is on 2L of oxygen and wears a nasal cannula. Nurse #1 said he/she is using a portable concentrator in the dining room. Resident #6 was observed sitting in the wheelchair in the dining room, with his/her back facing another staff member sitting at the doorway to the dining room. A portable oxygen concentrator was observed hanging off the back of the wheelchair, the dial was turned to 2.5L of oxygen, oxygen tubing was attached, the nasal cannula was placed around the Residents head, but was not placed in his/her nostrils. The surveyor continued to make the following observations in the dining room with Nurse #1 present: - At 10:06 A.M., Nurse #1 observed the Resident with the surveyor. The surveyor observed Resident #6 to be uncomfortable and could visualize the use of accessory muscles, as he/she was leaning forward with his/her mouth open. The surveyor observed the portable oxygen tank on empty as indicated by the arrow pointing to the red indicator section labeled 0 zero, the dial was set at 2.5L. Nurse #1 said He/she is doing good and proceeded to walk out of the dining room. The surveyor stopped Nurse #1 from leaving the dining room and asked Nurse #1 to visualize Resident #6's nasal cannula. - At 10:08 A.M., Nurse #1 checked the nasal cannula by observing it on the Resident's face and then checked the concentrator level and said, Yes she is getting oxygen. Nurse #1 proceeded to walk away from the Resident and the surveyor had to stop Nurse #1 for a second time, from leaving the dining room. The surveyor asked Nurse #1 to again visualize the Resident, and Nurse #1 looked over the Resident and said he was going to get a pulse oximeter machine because he/she is having difficulty breathing. The surveyor asked Nurse #1 to visualize the nasal canula placement and Nurse #1 said he was sorry and said Resident #6 is not wearing the nasal canula correctly, and he adjusted the nasal cannula and placed the prongs into the Residents nose. Nurse #1 visualized the oxygen gauge at 0 zero. Nurse #1 told the surveyor that the machine is not empty and that he will check for air bubbles. Nurse #1 obtained a small plastic cup of water, removed the nasal canula from Resident #6's nostrils and submerged the nasal canula prongs into the water. Nurse #1 said there should be bubbles coming out of the nasal cannula prongs, to indicate the oxygen tank is not empty. Nurse #1 then observed the oxygen concentrator set at level at 2.5L and said the Resident should be on 2 liters. Nurse #1 and the surveyor observed very few bubbles and Nurse #1 said the tank is empty and said he/she is not getting any oxygen. - At 10: 15 A.M., Nurse #1 then exited the dining room leaving Resident #6 without oxygen, to obtain a vital sign machine. Nurse #1 placed the pulse oximeter on to the Residents finger and was unable to obtain a reading. Nurse #1 said the machine was not working or turning on and exited the dining room again to obtain a portable pulse oximeter. - At 10:16 A.M., Resident #6 said I'm having a little bit of trouble but not too bad as Nurse #1 placed the pulse oximeter on the Residents finger. Resident #6's oxygen saturation level was 77%. Nurse #1 said he/she is having difficulty breathing and gasping for air. I need to get him/her on oxygen and left the dining room. Resident #6 continued to remain off oxygen. - At 10:18 A.M Nurse #1 said I will be back I'm going to check something to confirm orders are for 2 liters and get an oxygen tank. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0580 Level of Harm - Actual harm Residents Affected - Some	- At 10:20 A.M., another staff member wheeled Resident #6 to his/ her room and Nurse #1 carried a new oxygen tank and oxygen tubing into the Residents room. Nurse #1 attached a new nasal cannula to a concentrator that was already set up in Resident #6's room. Resident #6 continued to have difficulty breathing and his/her pulse oxygenation level was 76 %. Nurse #1 said I need to get shorter tubing and the surveyor had to tell Nurse #1 that the he must place the nasal cannula onto the Resident's nose as it was on the Residents bed. The Nurse placed the nasal canula prongs appropriately into the Resident's nose. Nurse #1 said he/she is in respiratory distress and the oxygen is not working and proceeded to recheck the Residents oxygenation status, and its was 78%. - At 10:24 A.M., Nurse #1 said his/her color does not look good and he/she is gasping. Nurse #1 proceeded to unhook the oxygen tubing from the concentrator in the bedroom and connected it to the new portable tank he brought into the room. Resident #6 continued to have labored breathing with the use of accessory muscles as Nurse #1 re-checked the oxygenation levels. Resident #6 continued to receive 2L oxygen via nasal canula and his/her oxygen saturation level went to 80%, 86%, and 93% and remained at 93% during the remainder of the observation. Nurse #1 said the Resident is doing much better and his/her color has improved, and he/she is no longer in respiratory distress. Nurse #1 said the Resident needed oxygen and should not have been using an empty tank and said the nasal canula needs to be applied to the nose correctly. During an interview on 9/3/24 at 10:25 A.M., Nurse #1 said he will check for respiratory treatment orders and call the doctor to report what happened. During an interview on 9/4/24 at 9:47 A.M., Nurse Practitioner (NP) said she was not aware that Resident #6 had respiratory distress yesterday and that she was not notified by the nurse or anyone in the building. During an interview on 9/5/24 at 12:26 P.M., the Medical Director said staff should have notified the NP right away and said he was notified this morning by the NP. The MD said a process needs to be in place in the absence of the Director of Nursing to make sure systems are followed. During an interview on 9/5/24 at 1:35 P.M., the Administrator said he was not aware that the NP or MD was not notified regarding the issue with Resident #6 and said he was told that the Nurse notified the NP. The Administrator said staff should notify the NP because the facility does not have a DON. During an interview on 9/9/24 at 9:56 A.M., the Consulting Nurse said staff must report clinical concerns and medical issues to the NP or MD right away in order to care for the Residents appropriately. 3b. Review of the facility policy titled Weight Management, revised and dated 10/21/19, indicated the following: - In the event where a resident shows a significant weight loss of 3 lbs (pounds) or more or the weight appears inaccurate, the resident shall be weighed again as soon as possible. If the weight loss is verified the following are completed: - Weights are recorded weekly and taken by a Certified Nursing Assistants. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0580 Level of Harm - Actual harm Residents Affected - Some	- Charge nurses are responsible to ensure that weights are documented appropriately. - Nursing will report weight loss to the Dietitian within 24 hours. - Report weight loss to the physician during physicians next visit. - If weight loss is verified, the Dietitian will seek the appropriate care plan adjustments to include snacks and supplements in order to curtail the weight loss. - Weight losses and gains are addressed quarterly at the QA (Quality Assurance) meeting. - Weights are performed weekly unless weights have been discharged . - If the weight loss is over the CMS guidelines, then a full assessment will be required and performed by the Dietitian. - When nutritional interventions such as supplements and recommended for weight loss, the orders for those interventions will be written within 7 days. Review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, undated, indicated the following: Assessment and Recognition - The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time. - The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of the weight loss and or impaired nutrition. - The staff will report to the physician significant weight gains or losses or food intake. - The physician will review for medical causes of weight gain, anorexia and weight loss before ordering interventions. - For individuals with recent or rapid weight gain or loss (for example a more than a pound a day), the staff and will review for possible fluid and electrolyte imbalance as a cause. - The physician and staff will monitor nutritional status, an individual's response to interventions and possible complications of such interventions. Resident #6 was admitted to the facility in March 2022 with diagnoses including dysphagia, vitamin B12 deficiency anemia, vitamin D deficiency, and dementia. Review of Resident #6 most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 indicating no cognitive impairment. Further review of the MDS indicated that the Resident is at risk for malnutrition and requires a mechanically altered diet. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #6's weight log indicated the following: - 6/7/24: 91.2 lbs. - 6/14/2

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	225049	A. Building B. Wing	09/26/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 43846 Based on observations and interviews, the facility failed to ensure resident protected health information (PHI) was secure and not visible to others on three of three nursing units. Findings include: Review of the facility policy titled Health Insurance Portability and Accountability Act (HIPPA), dated 4/15/22, indicated it is the policy of the facility that all staff preserve the integrity an the confidentiality of protected health information (PHI) pertaining to our residents. The surveyor made the following observations: - On 9/3/24 at 8:05 A.M., the surveyor observed on the Central Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/3/24 at 10:07 A.M., the surveyor observed on the Central Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/4/24 at 9:28 A.M., the surveyor observed on the [NAME] Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/4/24 at 10:40 A.M., the surveyor observed on the [NAME] Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/5/24 at 8:46 A.M., the surveyor observed on the Central Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/5/24 at 11:48 A.M., the surveyor observed on the [NAME] Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/6/24 at 10:13 A.M., the surveyor observed on the Central Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. - On 9/9/24 at 9:19 A.M., the surveyor observed on the [NAME] Unit, a medication cart unattended with the Medication Administration computer screen open displaying a resident's medication screen with his/her medical information. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/3/24 at 11:27 A.M., Nurse #1 said resident medical information should not be displayed on the computer while the medication cart is unattended. During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said the medication administration computer screen should never be left on display with resident medical information in view of anyone walking by while the medication cart is unattended by nursing staff. 45984 The surveyor made the following observations: - On 9/3/24 at 11:27 A.M., on the North unit, a medication cart was unattended in the North hallway. The computer monitor was left on displaying medical medical information. - On 9/5/24 from 7:50 A.M. to 8:01 A.M., on the North unit, Nurse #5 left the medication cart unattended. The computer monitor was left on displaying medical medical information. During an interview on 9/3/24 at 11:27 A.M., Nurse #1 said resident medical information should not be displayed on the computer while the medication cart is unattended.

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	225049	A. Building B. Wing	09/26/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36431 Based on observation, record review and interview the facility failed to ensure a homelike environment for one Resident (#5), out of a total sample of 26 residents. Specifically, Resident #5 was sleeping on a mattress that was torn and not in good condition. Findings include: On 9/3/24 at 9:01 A.M., Resident #5 was observed in bed. He/she threw the pad from the bedside rail off the bed, then began to pull at fabric on the top of the mattress. The fitted sheet on top of the mattress was off, exposing the mattress which was observed to be open/torn exposing a thin fabric and foam. On 9/4/24 at 3:35 P.M., Resident #5 was observed resting in bed. The fitted sheet was in place and the top of the mattress that was visible had exposed foam. On 9/5/24 at 8:07 A.M., Resident #5 was observed resting in bed. The top of the mattress was observed to be torn with foam from inside of the mattress exposed. During an interview on 9/5/24 at 8:11 A.M., Certified Nursing Assistant #5 said the Resident has behaviors of throwing items and picking at the top of the mattress. CNA #5 said the mattress has been replaced in the past and that she recently told maintenance staff the mattress was ripped. CNA #5 said they have a maintenance binder on the unit, but she did not use it. During an interview on 9/5/24 at 8:14 A.M., the Director of Maintenance said this was the first he heard about Resident #5's ripped mattress. CNA #5, Director of Maintenance, the Assistant Maintenance staff, and the surveyor observed Resident #5's mattress which was torn on the top. The Assistant Maintenance staff said he replaced it 2 to 3 months ago and will replace it again now.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on record review and interview, the facility failed to protect three Residents (#20, #23, #26), from neglect, out of a total sample of 26 residents. Specifically, 1. For Resident #20, the facility neglected to a.) implement wound treatments as recommended by the Consultant Wound Physician resulting in the deterioration of a closed unstageable pressure injury to a Stage 4 pressure injury and b.) failed to follow up on a progress note indicating right hip redness dated 8/28/24, and implement the use of an air mattress. 2. For Resident #23, the facility neglected to implement treatment recommendations by the Wound Consultant Physician for wound care. 3. For Resident #26, the facility neglected to implement the treatments as recommended by the Consultant Wound Physician resulting in treatment being implemented without active physician's orders resulting in undocumented wound treatment being implemented and not implementing the Consultant Wound Physician's treatment orders on a newly identified pressure ulcer to the right hip and trauma area to the right, second toe. It was determined the Immediate Jeopardy began on 7/16/24 and was identified on 9/6/24. The Department of Public Health sent a Notice of Determination of Immediate Jeopardy to the Facility Administrator on 9/6/24, including the Immediate Jeopardy Templates. Findings include: Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The American Nurses Association (ANA), Scope of Nursing Practice, Third Edition, indicated Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. Review of the facility's policy Pressure Ulcer/Injury Risk Assessment undated, indicated the following: - The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure ulcers/injuries. The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Conduct a comprehensive skin assessment with every risk assessment. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments. The effects of the interventions must be evaluated. 1. Resident #20 was admitted to the facility in June 2024 with diagnoses including Alzheimer's disease, anemia, vitamin D deficiency, overactive bladder and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 6/23/24, indicated that Resident #20 had severely impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, and required assistance with activities of daily living. Further review of the MDS indicated that Resident #20 was at risk for developing pressure injuries and indicated the use of a pressure reducing device for chair and pressure reducing device for bed. Review of Resident #20's Braden Scale for Predicting Pressure Injury Risk, dated 6/17/24, indicated a score of 15 indicating the resident is at risk for pressure injury development. On 9/3/24 at 8:58 A.M. and 9/4/24 at 8:05 A.M., the surveyor observed Resident #20 laying in bed with one prevalon boot (Prevalon Heel Protectors help reduce the risk of bedsores by keeping the heel floated, relieving pressure), placed on the right heel. His/her left heel was directly on the mattress and not elevated. There was no air mattress applied to the bed. Review of the facility document titled Skin Only Evaluation (Assessment tool used to evaluate resident's skin for any abnormalities, including the presence of any open areas or lesions) dated 7/3/24, indicated that Resident #20's skin was intact, no issues noted. Further review of the medical record indicated physician orders were implemented on 7/16/24 which included obtain pedal pulse every shift for wound ulcer and booties while in bed every shift for wound. The medical record failed to indicate any further documentation that a wound was identified on Resident #20, including the assessment, location, size of wound. Review of the facility document titled Skin Only Evaluation dated 7/17/24, indicated that Resident #20 had open lesions of the foot with a Right heel area measuring 2 cm(centimeters) x 2.5cm, with documented granulation, exudate, purulent, thin, thick, opaque, tan/yellow drainage, erythema. Tissue documented as painful and warm. The skin note indicated Right heel area with open wound injury 2cm x 2.5cm. Stage 3. New order: Wash with NS (normal saline). Apply Xeroform every day then cover with dry dressing and wrap as ordered. Booties at Hs (hour of sleep). Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician, on 7/18/24, and indicated one right heel unstageable DTI (Deep Tissue Injury), closed, surface area 30 cm, length 5 cm, width 6 cm, no depth, intact with purple/maroon discoloration. Treatment plan: Alginate calcium cover with ABD pad and kerlix daily. Off-load wound, float heels in bed. Review of the medical record failed to indicate the facility notified the attending providers of the recommendations from the wound consultant and failed implement the above wound treatment recommendations of the newly identified pressure injury on the right heel until 7/24/24; six days after the wound consultant first saw the Resident. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Nurse Practitioner #1's (NP) progress note dated 7/24/24, (nine days after the right heel pressure injury was first identified and six days after the Resident was first seen by the Consultant Wound Physician) indicated the following: Suspected deep tissue injury to right heel. Acute on chronic Right heel due to elevated wbc (white blood cells) with wound odor swelling. I will order Keflex 500mg by mouth for wound infection X 10 days, Probiotic 250 mg capsule twice daily X 15 days. Repeat lab 7/30 for CBC, CMP. continue in house wound team follow up. Review of the medical record indicated orders for Celphalexin 500 mg every 12 hours for infected right heel wound were not implemented until 8/2/24; 10 days after NP #1's note. Review of Resident #20's Skin Only Evaluation, dated 7/24/24, (the same date of NP's assessment and progress note indicating right heel infection) indicated no signs and symptoms of infection. The assessment further indicated wound exudate: purulent thin, thick, opaque, tan/yellow drainage. Peri wound condition: Erythema Dressing saturation moderate 26-75%. Tissue: Painful, warm. Skin note indicated Right heel area with open wound injury 2cm x 2.5cm. Stage 3. New order: Wash with NS. Apply Xeroform every day then cover with dry dressing and wrap as ordered. Booties at Hs. The skin only evaluation dated 7/24/24 indicated a new order for Xeroform dressing every day for the right heel pressure injury, however, this order had already been implemented on 7/17/24 and was inconsistent with the Wound Consultant recommendations for the use of Alginate Calcium on 7/18/24. Review of the Consultant Wound Physician note dated 7/25/24 indicated: undefined, exacerbated, wound is unstageable with necrosis (the death of tissues of the body due to lack of blood flow or oxygen) thick adherent devitalized necrotic tissue 100%. The progress of this wound and context surrounding the progress were considered in greater detail today. Patient not following repositioning or offloading recommendations and counseling provided. Reviewed off-loading surfaces and discussed surfaces care plan. Treatment plan: Apply hydrogel with silver and xeroform gauze cover with ABD pad and kerlix daily. Off-load wound, float heels in bed. Review of the medical record failed to indicate nursing implemented the above wound treatment recommendations until 7/27/24; two days after the recommendation was made. Review of the physician order, dated 7/27/24 through 9/3/24, indicated: right heel full thickness wash with NS, pat dry, apply xeroform gauze then hydrogel with silver change daily then ABD pad wrap with kerlix change daily. Off load wound, float heel in bed one time a day for wound care. Review of the NP's's note dated 7/29/24, indicated the following: Right heel cellulitis. Patient was recently evaluated for new right heel DTI infection and elevated WBC Keflex was added to medication list. Today follow up visit reviewed inhouse wound team visit summary agreed with plan. Review of the Resident #20's Skin Only Evaluation, dated 7/31/24, indicated: skin was warm/dry and indicated a Stage 4 wound to the right heel with copious drainage, no foul odor. The skin only evaluation failed to indicate any measurements or any further assessment of the wound. The medication administration record contained two active physician orders in place for the same right heel wound from 7/31/24 through 9/2/24 as follows: (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-right heel full thickness unstageable wash with normal saline padded dried apply xerofoam gauze then hydrogel with silver change daily then abd pad wrap with kerlix change daily offload wound float heel in bed one time a day for wound care. Dated (7/27/24-9/3/24). -site unstageable due to necrosis of the right heel full thickness wash with normal saline apply xerofam gauze hydrogel one daily Abd bad [SIC] wrap with kling [NAME] [SIC] daily one time a day for tage [SIC] 4 wound in right heel. Dated (7/31/24-9/3/24). Further review of the MAR (Medication Administration Record) indicated the nursing staff documented both orders as administered to Resident #20's right heel for 34 days. (One order containing hydrogel with silver and one order containing hydrogel only- both being signed off on the same day). Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/1/24, and 8/8/24, and indicated Stage 4 pressure wound of the right heel full thickness. Treatment recommendation is: Apply hydrogel with silver and xeroform gauze cover with ABD pad and kerlix daily. Review of NP's note dated 8/5/24, indicated the following: Nursing report poor appetite with poor wound healing. Pt (patient) recently completed antibiotic for right heel cellulitis with good effect. Today follow up visit reviewed inhouse wound team visit summary agreed with plan. Notify provider with acute suspected deep tissue injury. Acute on chronic site unstageable due to necrosis of the right heel full thickness. This documentation was inconsistent as the Resident now has a Stage 4 right heel wound as documented by the Consultant Wound Physician on 8/1/24 and 8/8/24. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/14/24, 8/22/24, and 8/29/24, which indicated granulation, stage 4 pressure injury. Treatment recommendation indicated: Start Alginate calcium once daily cover with ABD pad and kerlix. Off load wound, float heels in bed. Review of the medical records indicated that the Wound Consultant's recommendations for the use of alginate calcium was not implemented until 9/4/24; a total of 22 days since his/her recommendations. Additionally, staff continued to document the administration of the two additional orders for the use of hydrogel with and without silver. During an interview on 9/4/24 at 9:01 A.M. Nurse #5 said Resident #20 has a right heel wound and that measurements are done weekly by the Wound Consultant. Nurse #5 said there is no unit manager or Director of Nurses (DON) currently and he does not have access to the wound recommendations and visit notes. Nurse #5 said the DON is the only one who had access to the wound recommendations and treatments visit notes. During an interview on 9/4/24 at 9:28 A.M Project Manager #1 said the DON is the only person with access to the Consultant Wound Physician visit and recommendation visit notes and that she has been out of the building since 8/22/24. Project Manager #1 said he would need to call the company to get access to the visit notes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/5/24 at 8:12 A.M., the Consultant Wound Physician said he expects recommendations to be followed, and that Resident #20 should not have duplicate treatment orders for the same wound because hydrogel and hydrogel with silver are two different treatment orders. The Consultant Wound Physician said Hydrogel with silver helps to stop the growth of microorganisms and regular hydrogel does not contain the antimicrobial barrier. The Consultant Wound Physician said Resident #20 requires and air-mattress and prevalon booties to both heels because he/she is at risk for pressure areas and requires turning and repositioning. The Consultant Wound Physician said he has recommended these preventative measures to the nursing staff and clinical management and expects them to be implemented and said Residents who are high risk for pressure ulcers require off-loading interventions. During an interview on 9/5/24 at 12:25 P.M., the Medical Director (MD) said he expects the wound treatment recommendations and orders to be implemented and followed. MD #1 said he expects a tracking system to be in place and reviewed by clinical management to update the plan of care and to track wound progression. MD #1 said he expects senior management to be diligent and implement measures for clinical oversight for all residents. MD #1 said clinical oversight is needed and must have access to the wound treatment recommendations and status of wounds. During an interview on 9/5/24 at 11:56 A.M., the Administrator said he has no knowledge of wounds, infections, or any recommendations not being followed and that he was not aware that Resident #20 had an infected wound that progressed to a Stage 4. The Administrator said the DON should have known orders were not followed and treatment recommendations not implemented correctly and said he would not be notified of wounds unless its relevant and that wounds and infections are discussed only if there are concerns during the quarterly QAPI meeting. The Administrator said nursing staff should have access to the wound recommendations and that orders should be updated. 1b. Resident #20 developed a right hip wound as indicated on a skin check dated 9/11/24. The facility failed to implement the use of an air mattress and failed to follow up on a progress note indicating right hip redness dated 8/28/24. Review of the facility policy titled Bed Safety-Air Mattress-Side Rails undated, indicated but was not limited to the following: - It is the policy of the facility to provide air mattress, with a physician's order, to residents who are bedridden, have limited mobility, are at high risk for pressure sores on the buttocks/hips or who are recovering from a wound. Nursing will follow these procedures: - Obtain a physicians order for an air mattress. - Apply air mattress to residence bed. - Follow manufacturers instructions for use in care of the mattress. - The mattress should be pumped in accordance with their residence weight. - Document all skin assessments. - Maintenance will audit quarterly or as needed to determine proper usage of the air mattress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of medical record indicated Resident #20 was being followed weekly by the Wound Consultant Physician as of 7/18/24, for the development of a DTI to the right heel. Further review of the medical record indicated the Wound Consult Physician made recommendations to off load wound, float heels while in bed and the use of pressure relieving boots and an air mattress. Review of the Care Plan's for Resident #20 included but was not limited to the following: - I need heels kept off bed by and prevent direct contact between bony prominences keep heels off load. - Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. 7/25/24 prevalon boot at all times keep elevated at all times keep feet off load feet off load keep elevated and off load. (Dated: 7/26/24). - Booties while in bed (Dated 7/16/24) - ADL Self- Care Performance Deficit, included the following interventions dated 7/10/24, and revised on 8/31/24: - Bed Mobility: I required, 2 staff participation to reposition and turn in bed. I required an Air Mattress d/t (due to) stage 4 ulcer on my heel, and I am at risk for further skin breakdown. - Skin Inspection: I required, SKIN inspection daily. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. - Wound Management due to DTI care plan, initiated on 8/2/24 and last revised 8/31/24: - Provide wound care per treatment order. I require an air mattress. (Dated 8/2/24). On 9/3/24 at 8:58 A.M., 9/4/24 at 8:05 A.M., 9/4/24 at 1:03 P.M., 9/6/24 at 8:05 A.M., and 9/9/24 at 8:00 A.M. , the surveyor observed Resident #20 lying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. The observations made by the surveyor during the survey revealed that Resident #20's care planned interventions related to the use of prevalon boots to bilateral feet, offloading and the use of an air mattress were not implemented. Review of the physician's orders for Resident #20 indicated the following: - May use prevalon boot every shift for use for skin protection (7/26/24). - May have booties all the time every shift (9/5/24). Further review of the medical record failed to indicate an order was in place for the use of an air mattress. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of NP's note dated 8/28/24, indicated the following: Nursing requested right hip redness, and in house wound visit with rec (recommendation). Pt (patient) recently completed antibiotic for right heel cellulitis with good effect. Today follow up visit reviewed in house wound team visit summary agreed with plan. Cellulitis right heel suspected DTI. Further review if the medical record failed to indicate Nurse #4 documented the right hip redness to Resident #20 hip, despite being reported to NP. Review of Resident #20's Skin Only Evaluation, dated 9/11/24, (15 days after right hip redness was first documented in NP #1's note) indicated the following: - Pressure Ulcer/ Injury Right Hip, Stage 2 (Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible). -Pressure Ulcer / injury Right Heel, Stage 4 Full thickness tissue loss. Area on right heel, moderate serosanguineous drainage on old dressing, no foul odor, wound measuring 3. 8cm x 2.6cmx no depth; wound bed remains red with healthy tissues surrounding the area; skin pink. Wound washed with NS, applied Calcium Alginate, cover with ABD and wrap with Kerlix as ordered. Further review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 9/12/24, and indicated the following: - Wound 1 Stage 4 Pressure Right Heel - Wound 2 Unstageable (due to necrosis) of Right Hip Full Thickness - Wound 3 Unstageable DTI of the Right, First Toe Undetermined Thickness - Wound 4 Unstageable DTI of the Right Ankle Undetermined Thickness The nursing skin assessments completed on 9/11/24 and 9/12/24 indicated Resident #20 developed three additional areas on right 1st toe, right ankle and right hip. Resident #20 had a total of 4 wounds identified, 3 identified as new wounds. During an interview on 9/5/24, at 8:09 A.M., Certified Nurse's Aide (CNA) #7 said that he was not aware that Resident #20 should have his/her legs elevated and that Resident #20 does not have an air-mattress. During an interview on 9/5/24 at 8:11 A.M., Nurse #5 said Residents with skin issues will have an air mattress and heel botties in place to prevent skin breakdown and the plan of care will be updated so staff know what the resident needs for care. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/4/24 at 9:44 A.M., NP said she was notified by staff that Resident #20 had right hip redness and that she did not visualize the resident's skin. NP said she was not aware that Resident #20 did not have an air mattress in place and said Residents at high risk for pressure ulcers should have an air mattress and heel booties in place and she expects staff to notify her of any new skin issues or if wounds are getting worse and that she expects preventative measures to be implemented and followed to prevent the wounds from deteriorating. The NP said she would expect the orders and care plan interventions be followed and said resident #20 requires and air mattress and prevalon booties to both feet. During an interview on 9/5/24 at 8:02 A.M., Nurse #4 said if a new skin area is observed there should be a skin check indicating the new area and the NP or MD will be notified. Nurse #4 said she notified NP #1 that Resident #20 had redness to his/her right hip and that he/she was seen by the wound physician but was not aware of any new orders or follow up because the DON has been out. During an interview on 9/5/24 at 8:09 A.M., the Consultant Wound Physician said Resident #20 requires an air mattress and prevalon boots to both heels because he/she is high risk for wounds and has wounds that need preventative measures. The Consultant Wound Physician said wound recommendations have not been implemented on admission and said he expects recommendations and preventative measures to be followed. The Consultant Wound Physician said Resident #20 is high risk for more pressure areas and prevalon booties, air-mattress and elevation of the legs at all times are needed and should have been implanted because he/she is dependent on staff and can't turn and reposition without staff assistance. During an interview and observation on 9/16/24 at 7:47 A.M., the surveyor along with Nurse #8, The MDS Nurse, and Nurse #6 observed Resident #20 during a wound dressing change. Nurse #8 said Resident #20 has wounds to his/her right hip, right heel, and right toe. Nurse #6 said the resident does not have any other skin areas and that a skin check was completed, and these new areas were identified. The surveyor asked Nurse #8 and the Nurse #6 to turn and reposition the Resident to look observe the Residents skin. The Resident was repositioned and the surveyor asked Nurse #8 to open the brief covering the left hip, observed was intact pink/maroon skin with a localized area of non-blanchable erythema. The Nurse #6 said the area is a pressure area on his/her left hip bone in the same location as the pressure area to the right hip bone. Upon further skin inspection, Resident #20 was observed to have an open skin area to the left ankle, with pink and red drainage. Nurse #6 said the area to the left ankle is a Stage 2 wound that should have a dressing in place due to drainage. During an interview on 9/16/24 at 8:05 A.M., the Nurse #6 said the open wound is a Stage 2 and the area on the left hip bone is pressure that needs to be reported and documented. Nurse #6 said staff should have reported and documented any new areas observed when providing care and during any skin checks or dressing changes. 43846 2. Resident #23 was admitted to the facility in January 2013 with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 indicating he/she has severe cognitive impairment. Further review of the MDS indicated that the Resident is at risk for developing pressure ulcers. Review of Resident #23's Braden Scale for Predicting Pressure Ulcer Risk, dated 2/21/24, indicated the Resident scored 12 indicating he/she is at high risk for developing pressure ulcers. On 9/3/24 at 8:10 A.M., the surveyor observed Resident #23 in bed with his/her heels directly on the mattress, no dressing was observed to be on the Resident's left heel. Resident #23 said his/her heels hurt. On 9/3/24 at 12:14 P.M., the surveyor observed Resident #23 in the dining room without socks on wearing sneakers on both feet. Review of Resident #23's wound doctor evaluation and management summary, dated 8/22/24 and 8/29/24, indicated the Resident has a stage two pressure wound of the left lateral heel with partial thickness, measured 2.5 cm by 2.5 cm. Further review of the wound summary indicated the wound dressing treatment plan: apply calcium alginate once a day cover with ABD (large wound dressing) pad and then gauze roll daily. Off-load wound and float heels in bed. The summary further indicated the Resident's plan of care was discussed with nursing staff member. Review of Resident #23's skin evaluation, dated 8/23/24, indicated seen by wound md (medical doctor) new order for wash with normal saline pat dry apply calcium alginate cover with ABD pad and kerles [sic] until healed. Review of Resident #23's physician orders failed to indicate that a treatment was put in place for his/her stage two pressure ulcer of the left heel. On 9/5/24 at 7:39 A.M., the surveyor with Certified Nurse Aide (CNA) #1 observed the Resident's heels, the surveyor observed a round wound with a dark center on the Resident's left heel. No dressing was observed to be on the left heel wound. CNA #1 said his/her wound has been there for a few weeks and she cannot remember seeing a dressing on the Resident's left heel. Resident #23 was observed in bed with his/her heels directly on the mattress the Resident said his/her heels hurt. Review of Resident #23's wound doctor evaluation and management summary dated 9/5/24, indicated stage two pressure wound to the left lateral heel treatment plan: skin prep apply twice daily. Off-load wound, float heels in bed. The summary further indicated the Resident's plan of care was discussed with nursing staff member and patient. Review of Resident #23's physician orders failed to indicate that a treatment was implemented for his/her stage two pressure ulcer of the left heel. On 9/6/24 at 7:54 A.M., the surveyor observed Resident #23 in bed with his/her heels directly on the mattress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/3/24 at 2:17 P.M., Nurse #7 said Resident #23 does not have wound orders in place for his/her left heel wound. Nurse #7 said the Wound Physician comes to the facility weekly and provides new treatment orders for wound care. During an interview on 9/5/24 at 7:46 A.M., the Consultant Wound Physician said Resident #23 has a pressure ulcer on his/her left heel. The Consultant Wound Physician said he expects for nursing to call and relay his recommendations to the provider at the facility. The Consultant Wound Physician said Resident #23 should be wearing a boot on his/her left foot and not sneakers without socks as that would cause more pressure. The Consultant Wound Physician said he would expect there to be treatment and interventions put into place for Resident #23's left heel wound. During an interview on 9/5/24 at 12:04 P.M., Medical Doctor (MD) #1 said she was not told by nursing staff that the resident had a wound nor did they tell her they had wound recommendations. MD #1 said she would expect to be called when the Resident was found with a new pressure area. 45984 3. Resident #26 was admitted to the facility in July 2024 with diagnoses including pressure ulcer of left buttock stage 2, pressure ulcer of right upper back, non-pressure chronic ulcer of skin of other sites and dementia. Review of Resident #26's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of Resident #26's MDS under section M indicated that the Resident is at risk for developing pressure ulcers and has one or more unhealed pressure ulcers/injuries. Review of Resident #26's physician's orders indicated the following: - Dated 8/1/24: weekly skin assessment on Thursday 7-3 shift one time a day every Thu (Thursday). - Dated 7/30/24: May be seen by the wound doctor. - Dated 7/31/24: wash left wound heel with normal saline apply Santyl Ointment cover with 4x4 then wrap with kling as of 7/19/24. Review of Resident #26's assessment titled Admit/Readmit Screener, dated 7/18/24 under Section C. Skin Integrity indicated the following: - Site: left mid-back, Type: Pressure, Length: 3, Width: 3, Stage: II - Site: Coccyx, Type: Pressure, Length: 4, Width: 5, Stage: IV - Site: Left Heel, Type: Scar, Length: 4, Width: 4, Stage: IV - Site: Right Heel, Type: Scar, Length: 3, Width: 3, Stage: Unstageable - Site: Ischial Chronic Wound, Type: Pressure, Length: 1, Width: 1, Depth: 2,3, Stage: IV (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Details/Comments: Tunneling 7.2 cm (centimeters) nsw aquacel AGrope packing 3x week cover with boder [sic] gauze. Bilateral heel escar apply skin prep daily cover with boarder from dgs (dressings). Review of Resident #26's document titled Braden Scale for Predicting Pressure Ulcer Risk, dated 7/18/24 indicated that the Resident was at a Moderate Risk for developing pressure ulcers. Review of Resident #26's Wound Evaluation & Management Summary developed by the Consultant Wound Physician during his weekly visits with Resident #26 indicated the following: - Dated 8/1/24: -Stage 3 Pressure Wound of the Left Heel, Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days - Wound of left foot, fourth toe, Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr (border) apply once daily for 30 days - Dated 8/8/24: -Stage 3 Pressure Wound of the Left Heel, Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): ABD pad apply once daily for 23 days; Gauze roll (kerlix) 4.5 apply once daily for 23 days - Wound of left foot, fourth toe, Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-Pressure Wound of left buttock, Primary Dressing(s): Alginate Calcium apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-pressure wound of the right, second toe, Dressing Treatment Plan - Primary Dressing(s): Skin prep once daily for 30 days. - Non-pressure wound of the right shin, etiology: Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days - Dated 8/14/24: -Stage 3 Pressure Wound of the Left

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	225049	A. Building B. Wing	09/26/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interviews, the facility failed to complete a Significant Change in Status (SCSA) Minimum Data Set assessment (MDS) for one Resident (#7), out of a total sample of 26 residents, when the Resident was admitted to hospice services. Findings include: Resident #7 was admitted to the facility in April 2021 and has diagnoses that include but not limited to basal cell carcinoma of skin of other parts of face, unspecified dementia, localized edema, moderate protein calorie malnutrition, venous insufficiency chronic peripheral, and paranoid schizophrenia. Review of the MDS dated [DATE] indicated Resident #7 had a score of 0 out of 15 on the Brief Interview for Mental Status exam indicating severe cognitive impairment and requires substantial/maximal assistance with activities of daily living including bathing and dressing. Review of Resident #7's medical record indicated the following: - A physician's order dated 8/5/24, may be admit [sic] on hospice care and services. During an interview on 9/4/24 at 1:10 P.M., the Hospice Representative said Resident #7 signed on to hospice services on 8/9/24. Further review of the MDS assessments failed to indicate a Significant Change in Status assessment was completed. During an interview on 9/5/24 at 9:55 A.M., the Consulting Nurse said a significant change MDS should be completed within 24 to 48 hours after a resident goes on hospice services During an interview on 9/5/24 at 11:15 A.M. the Administrator said he would have expected a significant change MDS be completed timely after the Resident was admitted to hospice.

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, record review and interview, the facility failed to maintain an accurate Minimum Data Set Assessment for one Resident (#67) out of a total sample of 26 residents. Specifically, the facility documented that Resident #67 does not use bed rails while the resident has an active physician's order for the use of bed rails. Findings include: Resident #67 was admitted to the facility in May 2024 with diagnoses including unspecified dementia, incontinence without sensory awareness and anxiety disorder. Review of the Resident's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the resident had a Brief Interview for Mental Status score of 12 out of 15 indicating moderator cognitive impairment. Further review of section P of the MDS indicated that bed rails are not used for Resident #67. During observations on 9/3/24 at 8:07 A.M., 2:20 P.M.; 9/4/24 at 7:19 A.M., 9/5/24 at 6:59 A.M. and 9/6/24 at 7:01 A.M., Resident #67 was sleeping in his/her bed. The sides of the bed had side rails attached to the bed. Review of Resident #67's physician's order dated 5/25/24 indicated the following: 2 1/2 siderails elevated when in bed every shift. Review of Resident #67's falls care plan dated 5/29/24 indicated the following intervention: - The Resident will have 2 top 1/2 siderails to define bed parameters and aide in repositioning. During an interview on 9/6/24 at 11:11 A.M., the MDS Nurse said it is her second day working in the facility. She said she expects the MDS to be coded accurately and it should say Resident #67 uses side rails if there is a physician's order for them. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said she would expect the MDS to be accurate.

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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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** 43846 Based on observations, record review and interview the facility failed to develop a comprehensive resident centered care plan for two Residents (#38, #67) out of a total sample of 26 residents. Specifically, 1. For Resident #38, the facility failed to develop a comprehensive pacemaker care plan, 2. For Resident #67, the facility failed to develop an activities of daily living (ADL) for dependent residents care plan. Findings include: Review of the facility policy titled Comprehensive Care Plan, revised 9/15/22 indicated the following: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility policy Care of a Resident with a Pacemaker, not dated, indicated the following: 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification care upon admission: a. The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant; g. Paced rate. 2. When the resident's pacemaker is monitored by the Physician, document the date and results of the pacemaker surveillance, including: a. How the resident's pacemaker was monitored; (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Type of heart rhythm. c. Functioning of the leads; d. Frequency of utilization and e. Battery life. 1. Resident #38 was admitted [DATE] with diagnoses that included cerebral infarction, presence of automatic defibrillator, and anorexia. Review of Resident #38's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. Review of Resident #38's physician order, dated 2/22/24, indicated Monitor the pacemaker site every shift located in the left upper chest. Further review of Resident #38's physician's orders failed to indicate any further orders pertaining to the management of his/her pacemaker. Review of Resident #38's nursing progress note, dated 8/23/24, indicated Pacemaker in the left side of the chest in place, area clean and intact. Review of Resident #38's pacemaker care plan, dated 4/25/24, indicated the Resident will maintain heart rate within acceptable limits as determined by MD/NP (medical doctor/nurse practitioner) pacemaker settings. Pacemaker checks (Frequency) and document in chart: Heart rate, Rhythm, Battery check. Further review of the care plan was left blank, Resident Pacemaker information: Manufacturer: Model: Serial #: Date implanted: Name of cardiologist: During an interview on 9/3/24 at 8:45 A.M., Nurse #5 said Resident #38 does have a pacemaker, but he is not sure what his/her paced rate is to monitor the Resident's heart rate. Nurse #5 said he is unsure how the pacemaker is monitored because the Resident does not have a bedside device in place for monitoring. Nurse #5 said all he knows is that the battery was replaced around the time the Resident admitted to the facility and that is all that nursing monitors is the healed pacemaker site. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said a detailed care plan should have been developed for Resident #38's pacemaker, so nursing is aware of how to care for this Resident, but it was not. 45984 2. Resident #67 was admitted to the facility in May 2024 with diagnoses including unspecified dementia, incontinence without sensory awareness and anxiety disorder. Review of Resident #67's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident had a Brief Interview for Mental Status score of 12 out of 15 indicating moderator cognitive impairment. Further review of the MDS indicated that the Resident needs assistance with all activities of daily living (ADLs) and is frequently incontinent of bladder. Review of Section V - Care Area Assessment (CAA) of Resident #67's admission MDS dated [DATE] indicated the following under the Functional Abilities (Self-Care and Mobility) section: - He/she requires staff assistance for most ADL care needs and ambulation. - Care Plan Considerations: Proceed to care plan for supportive and protective equipment. Review of Resident #67's active care plans failed to indicate that a care plan for ADLs for a dependent resident was developed. Review of Resident #67's Assessment section of the electronic medical record indicated that an ADL evaluation was 103 days overdue. During an interview on 9/4/24 at 1:16 P.M., Certified Nursing Assistant (CNA) #3 said it is her first day working in the facility. She said she would expect a census sheet listing all the resident's care needs but did not get one and is just winging it and asking all the residents what type of care they need. During an interview on 9/5/24 at 7:42 A.M., CNA #4 said he knows all the residents and does not need to look at care plans or the Kardex (a resident care card). CNA #4 says Resident #67 does okay with ADLs and sometimes he/she will make it to the bathroom and sometimes he/she does not. During an interview on 9/5/24 at 8:33 A.M., Nurse #5 said all residents should have a care plan describing what level of ADL care they need. During an interview on 9/6/24 at 11:11 A.M., the MDS Nurse said it is her second day in the facility. She said it is her expectation that if the Care Area Assessment (CAA) says to proceed with care planning then either the MDS Coordinator or a floor nurse would develop a care plan. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said all residents should have an ADL care plan with resident-focused interventions.

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	225049	A. Building B. Wing	09/26/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review, and interviews, for two Residents (#63 and #23) of 26 sampled residents, the facility failed to ensure nursing provided services in accordance with the comprehensive care plan that met professional standards of quality. Specifically, 1. For Resident #63, the facility failed to ensure nursing implemented the Neurologist's recommended medication that was verified and ordered by the Resident's Nurse Practitioner (NP), 2. For Resident #23, the facility failed to ensure nursing implemented a physician order to obtain a stool sample for colon cancer screening. Findings include: 1. Resident #63 was admitted to the facility in October 2022 with diagnoses that included dementia, dysphagia, aphasia, hemiparesis and hemiplegia, and cerebrovascular disease. Review of Resident #63's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. Review of Resident #63's neurology consult, dated 5/14/24, indicated start Memantine (medication used to treat moderate to severe dementia) titrate up: - week one: take one tablet 5 mg (milligrams) in the morning - week two: take one tablet 5 mg in the morning and 5 mg in the evening for a total dose of 10 mg - week three: take two tablets 10 mg in the morning and one tablet 5 mg in the evening for a total dose of 15 mg - week four and after: take 10 mg two times a day. Review of Resident #63's medical record failed to indicate an active physician's order for Memantine. Review of the Nurse Practitioner (NP) note, dated 5/24/24, indicated reviewed the Neurology visit summary with recommendation to titrate up his/her Memantine agreed with plan. During an interview and record review on 9/4/24 at 11:13 A.M., NP #1 said Resident #63 should have an active order in place for the Memantine and does not. During an interview and record review on 9/4/24 at 11:28 A.M., Nurse #4 said Resident #63 does not have an active physician's order in place for Memantine. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #23 was admitted to the facility in January 2013 with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. Review of Resident #23's most recent Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 indicating he/she has severe cognitive impairment. Review of Resident #23's physician order, dated 8/2/24, indicated Cologuaic (an at home colon cancer screening test) times one for colon cancer screening, D/C (discontinue) when specimen is obtained. Review of Resident #23's bowel movement record indicated the Resident had a bowel movement on 8/4/24, 8/5/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/10/24, 8/25/24, 8/26/24, 8/27/24, 8/29/24, 8/30/24, 8/31/24, and 9/1/24. During an interview on 9/5/24 at 7:50 A.M., Nurse #3 said she in unaware that Resident #23 needs a stool sample and said she works almost every night at the facility. During an interview on 9/5/24 at 7:54 A.M., Certified Nurse Aide (CNA) #2 said she takes care of Resident #23 often and said nursing did not tell her that Resident #23 needed a stool sample. During an interview on 9/6/24 at 8:04 A.M., Medical Doctor (MD) #1 said nursing should have obtained the stool sample by now and should have been aware that the physician's order was in place to obtain the Resident's stool sample. During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said if the Resident has bowel movements regularly then the stool sample should have been obtained by now. The Consulting Nurse said the expectation is that nursing follows the physician's order.

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	225049	A. Building B. Wing	09/26/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for two Residents (#23 and #38) out of a total sample of 26 residents. Specifically, the facility failed to provide assistance with meals as per the plan of care for Resident #23 and for Resident #38. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), not dated, indicated Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Including appropriate support and assistance with: d. Dining (meals and snacks). 1. Resident #23 was admitted to the facility in January 2013 with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated he/she scored a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she has severe cognitive impairment. Further review of the MDS indicated the Resident needs partial/moderate assistance for eating. Review of Resident #23's decline in self-care care plan, dated 5/29/24, indicated the Resident needs assistance with eating. On 9/3/24 from 8:10 A.M. to 8:17 A.M., the surveyor observed Resident #23 in bed asleep with his/her breakfast tray set up for consumption. No staff were present in the room. On 9/3/24 from 12:14 P.M. to 12:21 P.M., the surveyor observed Resident #23 in the dining room not initiating eating. No staff were assisting the Resident with his/her meal. On 9/5/24 from 8:01 A.M. to 8:06 A.M., the surveyor observed Resident #23 in the dining room not initiating eating. The Resident was observed to be distracted by other residents in the dining room. No staff were assisting the Resident with his/her meal. Review of Resident #23's active Certified Nurse Aide (CNA) Kardex (form explaining each residents assistance level or needs), indicated the Resident requires assistance with meals. Review of Resident #23's August 2024 CNA flow sheet indicated for each shift the Resident required limited assist for eating. During an interview on 9/5/24 at 7:38 A.M., Nurse #7 said Resident #23 does need assistance with meals and said staff should be providing that assistance. Nurse #7 said the expectation is that staff follow the CNA care card, care plan or the nurse gives a verbal report to the CNA's. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/24 at 7:54 A.M., CNA #2 said the staff should be following Resident #23's care card and be providing assistance at each meal. 2. Resident #38 was admitted [DATE] with diagnoses that included cerebral infarction, presence of automatic defibrillator, and anorexia. Review of Resident #38's most recent Minimum Data Set (MDS) assessment, dated 6/7/24, indicated he/she scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had severe cognitive impairment. Further review of the MDS indicated he/she required substantial/maximal assistance for eating. On 9/3/24 at 8:19 A.M., the surveyor observed Resident #38 in bed with his/her breakfast tray using his/her hands to try to feed himself/herself. No staff were present assisting the Resident. On 9/3/24 from 12:17 P.M. to 12:22 P.M., the surveyor observed Resident #38 in the dining room using his/her hands attempting to fed him/herself. No staff were present assisting the Resident. On 9/4/24 from 8:10 A.M. to 8:16 A.M., the surveyor observed Resident #38 in the dining room not initiating eating. The Resident was observed to try to open a condiment packet instead of initiating eating. On 9/5/24 from 8:20 A.M. to 8:30 A.M., the surveyor observed Resident #38 in the dining room using his/her hands attempting to fed him/herself. No staff were present assisting the Resident. Review of Resident #38's ADL care plan and CNA Kardex failed to indicate what level of assistance he/she required for eating. Review of Resident #38's September 2024 CNA flow sheets indicated staff coded his/her eating as extensive assist for each shift from 9/1/24 through 9/4/24. During an interview on 9/5/24 at 7:38 A.M., Nurse #7 said the expectation is that staff follow the CNA care card, care plan or the nurse gives a verbal report to the CNA's. During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said if a resident is coded on the MDS as needing substantial/maximal assistance for eating then staff should be providing hands on feeding support. The Consulting Nurse said the level of assistance for eating for each resident should be on the ADL care plan at minimum.

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure standards of quality of care to maintain a resident's highest level of well-being for three Residents (#7, #26, #67), out of a total sample of 26 residents. Specifically, 1. For Resident #7, the facility staff failed to document, and assess the alteration of the skin on his/her lower extremities to determine if the areas were healing or worsening and failed to report the condition of Resident #7's lower extremities to the medical provider resulting in the Resident requiring the treatment with an oral antibiotic for the condition of his/her right and left lower extremities. 2a. For Resident #26, the facility failed to implement the treatments for pressure wounds and non-pressure wound injuries as recommended by the wound physician. 2b. For Resident #26, the facility failed to document thorough and complete weekly skin checks and perform weekly skin checks as ordered by the physician. 3. For Resident #67, the facility failed to perform weekly skin checks as ordered by the physician. Findings include: 1. Resident #7 was admitted to the facility in April 2021 and had diagnoses that included but are not limited to age-related osteoporosis, vitamin D deficiency, moderate protein calorie malnutrition, paranoid schizophrenia, localized edema, unspecified dementia, basal cell carcinoma of the skin of other parts of face, and venous insufficiency (chronic) (peripheral). Review of the most recent Minimum Data Set assessment (MDS) dated [DATE] indicated Resident #7 scored 0 out of 15 on the Brief Interview for Mental Status Exam indicating the Resident has severe cognitive impairment, required substantial/maximal assistance with shower/bathing and dressing, and had no venous/arterial ulcers. Further the MDS indicated that Resident #7 had behaviors of rejection of care 4 to 6 days but less than daily. On 9/3/24 at 8:29 A.M., Resident #7 was observed in his/her room. Resident #7 was sitting in a wheelchair, not dressed from the waist down, eating his/her breakfast. Resident #7 did not respond to the surveyor's greeting. Resident #7's lower right leg was observed to have raised whiteish, yellow pieces of slough, over 1/2 inch size in areas, pulling away from and extending down the front of the lower leg/shin with open reddened and pink areas scattered on the leg and areas of dark scabbing. The left leg had scaly skin and two dark areas consistent with scabbing. Further observations made by the surveyor on 9/3/2024 revealed Resident #7 sitting in his/her room without clothes on from the waist down with his/her legs exposed and visible at 10:44 A.M., 10:58 A.M., and 12:57 P. M. At 1:03 P.M. a Certified Nursing Assistant (CNA) entered Resident #7's room with apple juice. Resident #7's right lower leg was observed as discolored, reddened, with yellow peeling slough, glistening with moisture, with opened areas of pink and red. The left leg had dark areas consistent with scabbing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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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 - Some	Review of Resident #7's medical record indicated the following: - A physician's order dated 5/1/24 apply A and D ointment (an all-purpose ointment rich in Vitamin A and D, used to sooth, heal skin from multiple irritations, prevents dry, rough, scaly, itchy skin, treats minor skin irritations including burns, cuts, and scrapes) BID (two times a day) to lower extremities and prn (as needed) for dry skin. Observations made by the surveyor of Resident #7's lower extremities were not consistent with dry skin. Further review of Resident #7's medical record indicated the following: - A care plan, 'I have, impaired circulation r/t (related to) dependent edema related to my venous ulcers, dated 5/23/22. Goal: I will be free from s/sx (signs/symptoms) of complications of poor circulation through next review date revised 4/2/24, target date 9/12/24. Interventions/task included but not limited to Inspect foot/ankle/calf skin daily for changes: maceration (white, wrinkly, moist), redness purple tinge, blue, rust coloring (sic), weeping, edema, puffiness, tenderness areas with no sensation, date initiated 5/23/22. Monitor pedal pulses every shift and as needed report abnormalities to MD (medical doctor) prn (as needed), date initiated 5/23/22. - A care plan 'I have arterial/ischemic ulcer of the right calf and shin r/t (related to) arteriosclerosis, dated 12/15/2023. Goal, I will be free from infection or complications related to arterial/venous ulcer through review date, revision 4/2/2024, target date 9/12/2024. Interventions include but are not limited to Monitor/document wound Size: Depth, Margins: peri wound, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated, dated 12/15/2023, Monitor/document/report to MD PRN and s/sx of infection: [NAME] drainage, Foul odor, Redness and swelling, Red lines coming from wound, excessive pain, Fever, dated initiated 12/15/23. Review of Resident #7's Skin Only Evaluations documents dated 7/3/2024, 7/10/2024, 7/17/2024, 7/24/2024, 7/31/2024 indicated the following: Skin baseline: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal, were all documented by nursing staff as 'Met.' Does resident have current skin issues? Was left blank. Skin note: open wound on forehead remains. Review of Resident #7's Skin Only Evaluations documents dated 8/7/24, 8/14/2024, 8/21/2024, indicated the following: Skin baseline: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal, was documented by nursing staff as 'Met.' Does Resident have skin issues? Was blank, Skin Note: Resident refused. Review of Resident #7's Skin Only Evaluation document dated 8/28/2024 indicated the following: Skin baseline: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal, was documented by nursing staff as 'Met.' Does Resident have skin issues? Was blank, Skin Note: Resident refused. Scar remained in his/her forehead area. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's Skin Only Evaluation document dated 9/4/2024 indicated Skin Baseline: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal, was documented by nursing staff as 'Met.' Does Resident have skin issues? Was blank, Skin Note: Resident right leg upper skin areas old scar Nickel size and dime size below. Refused. Left leg old scar as well Nickel size both areas fading out. Bloody scar remained in his/her forehead area. Resident #7's weekly Skin Only Evaluations dated for July and August failed to indicate any description of Resident #7's lower extremities including wound size, depth, or width, peri wound, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene per the plan of care intervention. Review of the document titled 'Skilled Nursing Visit Note' from the hospice provider dated 8/9/24 indicated Resident #7's hospice Start of Care (SOC) as 8/9/24. Further review of the Skilled Nursing Visit Note indicated the following: Wound Assessment and Care: Left upper anterior shin dime sized circular black closed wound/other. Right Anterior Lateral Leg shin/Venous Stasis Ulcer assessment: wound bed slough moist, bed color/percentage other: White. Review of the hospice documents titled 'Skilled Nursing Visit Note dated 8/14/24, 8/19/24, 8/23/24, and` 8/30/24 indicated the presence of a right anterior lateral leg shin/venous stasis ulcer on Resident #7. The weekly skin evaluation completed by the facility dated 8/7/24, 8/14/24, 8/21/24, and 8/28/24 failed to indicate the presence of a venous stasis ulcer which conflicts with the skilled nursing documentation/assessment provided by the hospice services provider. Review of the Nurse Practitioner Note dated 8/14/2024 late entry indicated Resident Notes: supportive care hospice consults, refusing TED stockings, refusing treatment A % D ointment BID to lower extremities and prn for dry skin. Review of the Medication Administration Record dated for 8/2024 indicated nursing staff documented the A % D ointment was administered BID (twice a day) from 8/1/24 through 8/31/24. Review of the MAR dated for 9/2024 indicated the nursing staff documented the A & D ointment was administered BID through 9/4/24. Review of the MAR dated for 8/2024 indicated the following: - Day shift: Nursing staff documented Resident #7 refused care eleven shifts out of thirty-one shifts. - Evening Shift: Nursing staff documented Resident #7 refused care 3 out of thirty-one shifts and, - Night Shift: Nursing documented thirty out of thirty-one refusals of care. During an interview on 9/3/24 at 1:26 P.M., Certified Nursing Assistant (CNA) #2 said Resident #7 did not want to be dressed from the waist down today. CNA #2 observed Resident #7 and asked him/her if he/she wanted to be covered. Resident #7 called CNA #2 by name and said 'no' to the offer. CNA #2 said the Resident's legs were red, and peeling. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/3/24 at 2:17 P.M., Nurse #7 said Resident #7 has behaviors of refusing treatments, scratches at his/her forehead lesion and legs, has an order for A and D ointment which he/she will often refuses. Nurse #7 said Resident #7 is now on hospice care. Nurse #7 said there is one nurse that the Resident will allow to provide the A and D ointment. Nurse #7 and the surveyors went to Resident #7's room and observed his/her lower legs. Resident #7 willingly moved his/her legs so they could be observed. Nurse #7 said the right leg had scars and was scaly and there was not much we can do about Resident #7's fragile skin. Upon leaving Resident #7's room Nurse #7 said Resident #7 did have open areas and staff are to report changes in a Resident's skin status. Nurse #7 said when a skin area is identified on a resident, the area should be documented and measured to track the area. Nurse #7 said Resident #7 refuses most care and treatments offered but that Resident #7's lower legs are visible and nursing can observe his/her legs. Review of a Nursing Progress note dated 9/3/2024 at 17:10 (5:10 P.M.), written by Nurse #7 indicated: Resident is alert and responsive. Continue to be non compliant with care. Right leg skin warm, dry and scaly color within normal limits, unable to measure upper shin area with old scar? (Nickel size and dime size below). Left leg below the knee area old scar Nickel size. Will continue to apply A and D as ordered Family and NP aware. Safety maintained. The note conflicts with the observations made by Nurse #7 and the surveyors. During an interview on 9/3/24 at 2:25 P.M., Certified Nursing Assistant #1 observed Resident #7's lower legs and said Resident #7's lower legs have open areas and have been that way on and off for about three months. On 9/4/24 at 1:46 P.M., Resident #7's skin remained red with open areas, the yellowed slough was not present. The left leg was observed with dark red areas consistent with scabbing. During an interview on 9/4/24 at 2:59 P.M., Nurse #7 said what was observed yesterday by herself and the surveyors was old scarring that had been there but could not say how long. Nurse #7 said they were able to wash Resident #7's lower legs this morning. Nurse #7 said the Resident is non-compliant, will refuse to see anyone and refuses most care and treatment. Nurse #7 said the open areas were from old scars. Nurse #7 said the NP was in today. During an interview on 9/5/24 7:45 A.M., Nurse #9 said Resident #7 has flaky dry skin on his/her lower legs and when he/she agrees to the A and D cream it makes a difference. Nurse #9 said the Resident has behaviors of picking at his/her skin, refuses treatments, refuses physical assessments. Nurse #9 and the surveyors went to Resident #7's room. Resident #7 said his/her legs hurt. Resident #7 moved his/her legs so Nurse #9 could observe them. Nurse #9 said the right leg is open and weeping, that there is something going on with him/her and that the NP needs to be called. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/4/24 at 3:51 P.M., the Nurse Practitioner (NP) said the nurses will update her on any concerns when she is in the facility and will call her when she is not there. The NP said she was in the facility yesterday (9/3/24) and that no one talked with her about Resident #7. The NP said Resident #7 is a challenge, has behaviors of disrobing, does not like to be touched. The NP said Resident #7 does have bilateral edema, will not keep his/her legs elevated, has seen the wound doctor in the past and kicked him out, refuses to use TED's (thrombo-embolic deterrent) stockings. The NP said she does not review the skin evaluations and relies on the nursing staff to provide her with information regarding the resident's status. The NP said she has treated Resident #7 in the past for cellulitis and even though the Resident has established behaviors she would expect to be notified of any changes in his/her legs including open areas or seeping. During an interview on 9/05/24 at 12:45 P.M. the Medical Director who is Resident #7's attending physician said what the surveyors observed on Resident #7's lower right extremity does not sound like it is just dry skin. The Medical Director said he would expect the NP or physician to be called for any acute issues or changes in a resident. During a subsequent interview on 9/5/24 at 1:44 P.M., the Medical Director said Resident #7 allowed him to examine his/her lower legs. The Medical Director said there were islands of dried secretions, the left leg had scabs and swelling due to venous insufficiency. The Medical Director said he ordered a short dose of antibiotics for the condition of the lower legs. Review of the physician's order indicated the following: Cephalexin (antibiotic) Capsule 500 mg (milligrams) give 1 capsule by mouth three times a day for infection until 9/9/24, Start Date - 9/5/24. 45984 2. Resident #26 was admitted to the facility in July 2024 with diagnoses including pressure ulcer of left buttock stage 2, pressure ulcer of right upper back, non-pressure chronic ulcer of skin of other sites and dementia. Review of Resident #26's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of Resident #26's MDS under section M indicated that the Resident is at risk for developing pressure ulcers and has one or more unhealed pressure ulcers/injuries. 2a. Review of Resident #26's physician's orders indicated the following: - Dated 8/1/24: weekly skin assessment on Thursday 7-3 shift one time a day every Thu (Thursday). - Dated 7/30/24: May be seen by the wound doctor. - Dated 7/31/24: wash left wound heel with normal saline apply Santyl Ointment cover with 4x4 then wrap with kling as of 7/19/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's assessment titled Admit/Readmit Screener, dated 7/18/24 under Section C. Skin Integrity indicated the following: - Site: left mid-back, Type: Pressure, Length: 3, Width: 3, Stage: II - Site: Coccyx, Type: Pressure, Length: 4, Width: 5, Stage: IV - Site: Left Heel, Type: Scar, Length: 4, Width: 4, Stage: IV - Site: Right Heel, Type: Scar, Length: 3, Width: 3, Stage: Unstageable - Site: Ischial Chronic Wound, Type: Pressure, Length: 1, Width: 1, Depth: 2,3, Stage: IV - Details/Comments: Tunneling 7.2 cm (centimeters) nsw aquacel AGrope packing 3x week cover with boder [sic] gauze. Bilateral heel escar apply skin prep daily cover with boarder from dgs (dressings). Review of Resident #26's document titled Braden Scale for Predicting Pressure Ulcer Risk, dated 7/18/24 indicated that the Resident was at a Moderate Risk for developing pressure ulcers. Review of Resident #26's Wound Evaluation & Management Summary developed by the Consulting Wound Physician during his weekly visits with Resident #26 indicated the following: - Dated 8/1/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 2x2x0.2 cm, surface area: 4.00 cm, exudate: light serous, slough: 50%, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days - Wound of left foot, fourth toe, etiology: infection, wound size: 1x1xnot measurable, surface area: 1.00 cm, exudate: light purulent, thick adherent devitalized necrotic tissue: 40%, granulation tissue: 60%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr (border) apply once daily for 30 days - Dated 8/8/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3.2x3x0.2 cm, surface area: 9.60 cm, exudate: light serous, slough: 50%, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): ABD pad apply once daily for 23 days; Gauze roll (kerlix) 4.5 apply once daily for 23 days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Wound of left foot, fourth toe, etiology: infection, wound size: 1x1xnot measurable, surface area: 1.00 cm, exudate: light serous, thick adherent devitalized necrotic tissue: 40%, granulation tissue: 60%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.5x1x0.2, surface area: 0.50 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-pressure wound of the right, second toe, etiology: trauma/injury, wound size: 1x1xnot measurable, surface area: 1.00 cm, blister: blood filled. Dressing Treatment Plan - Primary Dressing(s): Skin prep once daily for 30 days. - Non-pressure wound of the right shin, etiology: trauma/injury, wound size: 1.2x0.5x0.1, surface area: 0.60 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days - Dated 8/14/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3x2.2x0.2 cm, surface area: 6.60 cm, exudate: light serous, slough: 20%, granulation tissue: 80%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver apply once daily for 17 days. Secondary Dressing(s): ABD pad apply once daily for 17 days; Gauze roll (kerlix) 4.5 apply once daily for 17 days - Wound of left foot, fourth toe, etiology: infection, wound size: 0.3x0.5xnot measurable, surface area: 0.15 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver apply once daily for 17 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 17 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.5x0.5x0.2, surface area: 0.25 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 17 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 17 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.5x0.3x0.1, surface area: 0.15 cm, exudate: light serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 17 days; Hydrogel gel w/silver once daily for 17 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 17 days. - Non-pressure wound of the right shin, etiology: trauma/injury, wound size: 1.2x0.5x0.1, surface area: 0.60 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 24 days; Hydrogel gel w/silver apply once daily for 24 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 24 days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dated 8/22/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 1.6x1.2x0.2 cm, surface area: 1.92 cm, exudate: light serous, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver apply once daily for 9 days. Secondary Dressing(s): ABD pad apply once daily for 9 days; Gauze roll (kerlix) 4.5 apply once daily for 9 days - Wound of left foot, fourth toe, etiology: infection, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver apply once daily for 9 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 9 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 9 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 9 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: none, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 9 days; Hydrogel gel w/silver once daily for 9 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 9 days. - Dated: 8/29/24: -Stage 3 Pressure Wound of the Left Heel, wound size (LxWxD): 3x3x0.2 cm, surface area: 9.0 cm, cluster wound: open ulceration area of 4.50 cm exudate: light serous, granulation tissue: 50%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): ABD pad apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days. - Wound of left foot, fourth toe, etiology: infection, wound size: 0.2x0.2x0.1, surface area: 0.04 cm, exudate: light serous, slough: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days. - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 30 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 30 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, exudate: light serous, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Hydrogel gel w/silver once daily for 30 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dated 9/5/24: - Non-Pressure Wound of left buttock, etiology: trauma/injury, wound size: 0.3x0.3x0.2, surface area: 0.09 cm, exudate: moderate serous, granulation tissue: 100%, abnormal granulation present within the wound margins. Dressing Treatment Plan - Primary Dressing(s): Alginate Calcium apply once daily for 23 days. Secondary Dressing(s): Gauze Island w/ bdr apply once daily for 23 days. - Non-Pressure Wound of the Right, Second Toe, etiology: trauma/injury, wound size: 0.3x0.3xnot measurable, surface area: 0.09 cm, cluster wound: open ulceration area of 0.05 cm exudate: light serous, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 23 days; Hydrogel gel w/silver once daily for 23 days. Secondary Dressing(s): Gauze island w/bdr apply once daily for 23 days. - Non-Pressure wound of the right knee, etiology: trauma/injury, wound size: 2x1.4xnot measurable, surface area: 2.80 cm, thick adherent devitalized necrotic tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; TRIPLE FOLDED. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. - Non-Pressure wound of the left knee, etiology: trauma/injury, wound size: 1x1.3x0.1, surface area: 1.30 cm, exudate: none, granulation tissue: 100%. Dressing Treatment Plan - Primary Dressing(s): Xeroform gauze apply once daily for 30 days; Triple folded. Secondary Dressing(s): Gauze island w/bdr apply once daily for 30 days. Review of Resident #26's active, discontinued and completed physician's orders in the facility's electronic medical record failed to indicate that the facility implemented or updated any of Resident #26's treatment orders as recommended by the Consultant Wound Physician . During an interview on 9/3/24 at 1:11 P.M., Nurse #6 and the surveyor reviewed Resident #26's active physician's orders. Nurse #6 said there are no orders for the Resident's buttock or back wound. When asked how are the nurses supposed to know what treatment Resident #26 should be getting she said we would have no way of knowing without an order. During an observation on 9/3/24 at 1:20 P.M., the surveyor observed Resident #26's wounds with a nurse, the buttock and back wounds were treated and covered with gauze despite no active treatment orders. During an interview on 9/4/24 at 6:41 A.M., Nurse #2 said when the wound doctor puts in a treatment recommendation it first gets sent to the Director of Nursing (DON) and then the Nurse Practitioner (NP) will review the treatment orders and approve them and will then tell nursing staff to put the orders in the electronic medical system. Nurse #2 said he only completed the active order for Resident #26's heel treatment and did not treat the other wounds because there was no order in. Nurse #2 said he would not do a treatment without an order because he would not know how to treat the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/4/24 at 8:48 A.M., Nurse #5 said he treated Resident #26's buttock and back wounds with a gauze pad despite no active order, he said he used his best nursing judgement so the wounds do not get worse. Nurse #5 said he does rounds with the wound doctor each week and the wound doctor will let the DON know his treatment recommendations and the NP will approve them and put the orders in. Nurse #5 said he is not sure how the ordering process works with the DON absence from the facility. During an interview on 9/4/24 at 10:02 A.M., the NP said any new treatment orders will get flagged in a binder for her to approve and then the nurses will put the orders in the electronic medical record. The NP said a nurse rounds with the wound doctor and then that nurse should reach out to her with any new wound recommendations so she can review and approve them. The NP continued to say if the wound doctor were to make a recommendation she would approve it. When asked if she was aware of any of the recommendations the wound doctor has made for Resident #26, she said she was unaware and staff never brought them to her for review. During an interview on 9/5/24 at 8:11 A.M., the Consultant Wound Physician said he comes in weekly and he would expect all of his recommendations to be followed by nursing. He continued to say since the DON's absence, none of his wound treatment orders have not been communicated. The Consultant Wound Physician continued to say that he communicates with Nurse #5 about his wound treatments, and he would expect them to be implemented. The Consultant Wound Physician said his treatments clearly have not been implemented and there is a problem with transcribing his recommendations. The Consultant Wound Physician then said Resident #26's active order for Santyl Ointment for his/her left heel is an old order and the Resident should not be treated with that. During an interview on 9/5/24 at 12:44 P.M., the facility's Medical Director said he would expect all the wound doctor's treatment recommendations to be followed and put into the electronic medical system so all staff know what they are so they can be completed as ordered. Review of Resident #26's Wound Evaluation & Management Summary developed by the Consultant Wound Physician during his weekly visits with Resident #26 indicated the following: - Dated 9/18/24: - Non-Pressure Wound of the right, second toe full thickness - Etiology: Trauma/injury, duration >1 days, wound size (L x W x D): 0.2x0.2xnot measurable (depth unmeasurable due to presence of nonviable tissue and necrosis). Dressing Treatment Plan: Primary Dressing - Xeroform gauze apply once daily for 24 days; Hydrogel gel w/ silver apply once daily for 24 days, Secondary Dressing(s) - Gauze island w/ bdr apply once daily for 24 days. - Unstageable (due to necrosis) of the right hip full thickness - Etiology: pressure, MDS 3.0 stage: Unstageable Necrosis, Duration: >1 days, wound size (L x W x D): 1.1x1xnot measurable (depth unmeasurable due to presence of nonviable tissue and necrosis), Dressing Treatment Plan: Primary Dressing - Xeroform gauze apply once daily for 24 days; Hydrogel gel w/ silver apply once daily for 24 days, Secondary Dressing(s) - Gauze island w/ bdr apply once daily for 24 days. Review of Resident #26's physician's orders indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dated 9/19/24: Non-pressure wound of the right, second toe full thickness - wash with NS, pat dry, apply hydrogel gel w/ silver, xeroform gauze and cover with Gauze island w/bdr dressing - offload wound - Dated 9/19/24L Unstageable (due to necrosis) of the right hip full thickness - wash with NS, pat dry, apply; hydrogel gel w/ silver, xeroform gauze and cover with Gauze island w/ brd dressing - off-load wound - Monitor closely for amount of necrotic tissue and signs of infection - Dated and revised 9/21/24: For unstageable (due to necrosis) of the right hip full thickness - off-load the wound - monitor closely for amount of necrotic tissue and signs of infection Review of Resident #26's electronic medical record indicated that his/her last documented skin check conducted by the facility nursing staff was on 9/13/24. During an observation on 9/24/24 at 7:42 A.M., Nurse #6 and CNA #5 observed Resident #26's skin with the surveyor. Nurse #5 said Resident #26 has new wounds on his/her right hip and right second toe. Nurse #5 said Resident #26 should have dressings and treatments on these areas but does not. Nurse #5 said the surrounding skin around the right hip wound is very red and has an unstageable wound bed. Nurse #5 said she is not sure if the areas are worse because she does not do his/her wound care daily but said the Resident is incontinent which can make the wound worse without having a dressing on it. Further review of Resident #26's skin indicated that the Resident's right foot had no treatments or dressings and his/her right knee had no dressings on it. Nurse #5 said all skin areas should have dressings and treatments on them. During an interview on 9/24/24 at 7:44 A.M., CNA #4 said he has not provided ADL care to Resident #26 or dressed him/her yet. During a su

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, interviews, and record review, the facility failed to provide care and treatment to prevent the development and worsening of pressure injury's (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the coccyx, hips, heels, or elbows) for three Residents (#20, #23, and #26) out of a total sample of 26 residents. Specifically, 1a. For Resident #20 the facility failed to implement treatments and physician orders recommended by the Consultant Wound Physician resulting in the wound requiring antibiotic therapy resulting in the deterioration of an unstageable pressure wound progressing to a Stage 4 pressure injury. 1b. For Resident #20 the facility failed to implement the use of an air mattress and failed to follow up on a progress note indicating right hip redness dated 8/28/24 resulting in the development of a right hip wound as indicated on a skin check dated 9/11/24. 2. For Resident #23, the facility failed to implement treatment recommendations by the Wound Consultant Physician for wound care. 3. For Resident #26, the facility failed to implement treatment recommendations by the Wound Consultant Physician for wound care. Findings include: According to the National Pressure Injury Advisory Panel, a Stage 4 Pressure Injury is defined as a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in injury. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and /or tunneling often occur. Depth varies by anatomical location. Review of the facility's policy Pressure Injury/Injury Risk Assessment, undated, indicated the following: - The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing pressure injurys/injuries. The risk assessment should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. - Conduct a comprehensive skin assessment with every risk assessment. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments. The effects of the interventions must be evaluated. - The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Contact the Medical Director for updated orders. Contact the Wound Doctor for a scheduled visit. Documentation in medical record addressing (MD) notification if new skin alteration noted with change of plan of care, if indicated. Notify attending (MD) if new skin alteration noted. Review of the facility policy, titled Decubitus Prevention, revised 2/4/21, indicated but was not limited to the following: It is the policy of the facility to prevent the formation of pressure sores and other skin breakdowns. - All residents shall be assessed upon admission, quarterly and periodically for the risk of skin breakdown by a licensed staff member. This assessment shall be done using the Norton Scale and by careful review of history, health conditions, environment, medications, nutrition, as well as visualization of the resident's body. The Norton Score will indicate a resident's risk for skin breakdown. To avoid breakdowns a preventative program shall be instituted by the Unit Manager which will include a repositioning schedule, a consult with the Dietician, notification of the attending physician, and use of pressure relieving devices. Skin care treatments will be documented by the licensed nurse and the appropriate areas of the residence chart. All residents at risk for skin breakdown will be care planned quarterly and as needed skin barrier will be used on all residents. 1a. Resident #20 was admitted to the facility in June 2024 with diagnoses including Alzheimer's disease, anemia, vitamin D deficiency, overactive bladder and cognitive communication deficit. Review of Resident #20's Minimum Data Set (MDS) assessment, dated 6/23/24, indicated that Resident #20 had severely impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, and required assistance with activities of daily living. Further review of the MDS indicated Resident #20 was at risk for developing pressure injuries and indicated the use of a pressure reducing device for chair and pressure reducing device for bed. Review of Resident #20's Braden Scale for Predicting Pressure Injury Risk, dated 6/17/24, indicated a score of 15 indicating the Resident is at risk for developing pressure injuries. On 9/3/24 at 8:58 A.M., the surveyor observed Resident #20 laying in bed with one prevalon boot (Prevalon Heel Protectors help reduce the risk of bedsores by keeping the heel floated, relieving pressure), placed on his/her right heel. The left heel was observed to be directly on the mattress and was not elevated. There was no air mattress applied to the bed. On 9/4/24 at 8:05 A.M., the surveyor observed Resident #20 laying in bed with one prevalon boot placed on the right heel. The left heel was observed to be directly on the mattress and was not elevated. There was no air mattress applied to the bed. Review of the facility document titled Skin Only Evaluation (Assessment tool used to evaluate resident's skin for any abnormalities, including the presence of any open areas or lesions) dated 7/3/24, indicated Resident #20's skin was intact, no issues noted. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident #20's medical record indicated physician orders were put into place on 7/16/24 which included obtain pedal pulse every shift for wound ulcer and booties while in bed every shift for wound. The medical record failed to indicate any further documentation that a wound was identified on Resident #20, including the assessment, location, size of wound. During an interview on 9/5/24 at 8:06 A.M., Nurse #5 said treatment orders are entered if staff identify new skin areas until the resident can be seen by the wound doctor. Nurse #5 said the Nurse Practitioner (NP) or MD (medical doctor) will review the orders in the recommendations book and if the provider wants to change them they will let the nurses know. Nurse #5 said if a new skin area is observed there should be a skin check when it was first found. Review of the facility document titled Skin Only Evaluation dated 7/17/24, indicated that Resident #20 had open lesions of the foot with a right heel area measuring 2 cm (centimeters) x 2.5 cm, with documented granulation, exudate, purulent, thin, thick, opaque, tan/yellow drainage, erythema. Tissue documented as painful and warm. The skin note indicated Right heel area with open wound injury 2 cm x 2.5 cm. Stage 3. New order: Wash with NS (normal saline). Apply Xeroform every day then cover with dry dressing and wrap as ordered. Booties at Hs (hour of sleep). Further review of Resident #20's medical record indicated the above order was implemented to the Stage 3 on the right heel on 7/17/24, however the medical record failed to indicate the provider was notified of the newly identified pressure injury on the right heel. During an interview on 9/5/24 at 8:09 A.M., Nurse #4 said the right heel area was identified on Resident #20 on 7/16/24 and an order was entered, however the skin assessment was not completed until 7/17/24. Nurse #4 said nursing staff put in orders until the Resident is seen by the wound doctor. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician, dated 7/18/24, and indicated one right heel unstageable DTI (Deep Tissue Injury), closed, surface area 30 cm, length 5 cm, width 6 cm, no depth, intact with purple/maroon discoloration. Treatment plan: Alginate calcium cover with ABD pad and kerlix daily. Off-load wound, float heels in bed. Review of the medical record failed to indicate the facility notified the attending providers of the recommendations from the wound consultant and failed implement the above wound treatment recommendations of the newly identified pressure injury on the right heel until 7/24/24, 6 days after the wound consultant first saw the Resident. Review of Nurse Practitioner (NP) progress note dated 7/24/24, (9 days after the right heel pressure injury was first identified and 6 days after the Resident was first seen by the wound consultant MD) indicated the following: Suspected deep tissue injury to right heel. Acute on chronic Right heel due to elevated wbc (white blood cells) with wound odor swelling. I will order Keflex (antibiotic) 500 mg by mouth for wound infection X (times) 10 days, Probiotic 250 mg capsule twice daily X 15 days. continue in house wound team follow up. Further review of the medical record indicated on 7/24/24 the Resident started Keflex 500 mg every 12 hours for infected wound in the right heel until 8/2/24. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/5/24 at 8:12 A.M., the Consultant Wound Physician said Resident #20 had an unstageable DTI that required antibiotics for an infection and that wound treatments must be followed to promote healing. The Consultant Wound Physician said Alginate Calcium sterile primary dressing for wounds with moderate to heavy exudate /drainage, while maintaining a moist wound environment), is used to promote healing and he expects orders to be followed. Review of Resident #20's Skin Only Evaluation, dated 7/24/24, (the same date of the NP's assessment and progress note indicating right heel infection) indicated no signs and symptoms of infection. The assessment further indicated wound exudate: purulent thin, thick, opaque, tan/yellow drainage. Peri wound condition: Erythema Dressing saturation moderate 26-75%. Tissue: Painful, warm. Skin note indicated Right heel area with open wound injury 2 cm x 2.5 cm. Stage 3. New order: Wash with NS. Apply Xeroform every day then cover with dry dressing and wrap as ordered. Booties at Hs (hour of sleep). The skin only evaluation dated 7/24/24, indicated a new order for Xeroform dressing every day for the right heel pressure injury however this order had already been implemented on 7/17/24 and was inconsistent with the wound consultant recommendations on 7/18/24. During an interview on 9/4/24 at 9:42 A.M., NP #1 said staff must document skin checks accurately at the time of the assessment and when skin issues are identified, they must document findings and notify providers for any new treatment or medication orders before implementing them. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician, dated 7/25/24, and indicated undefined, exacerbated, wound is unstageable with necrosis, thick adherent devitalized necrotic tissues 100%. Expanded evaluation performed: The progress of this wound and the context surrounding the progress were considered in greater detail today. Patient not following repositioning or off-loading recommendations and counseling provided. Reviewed off-loading surfaces and discussed surfaces care plan. Treatment plan: Apply hydrogel with silver and xeroform gauze cover with ABD pad and kerlix daily. Off-load wound, float heels in bed. Review of the medical record failed to indicate nursing implemented the above wound treatment recommendations until 7/27/24, 2 days after the recommendation was made. During an interview on 9/5/24 at 8:10 A.M., the Consultant Wound Physician said Resident #20 requires and air-mattress and prevalon booties to both heels because he/she is at risk for pressure areas and requires turning and repositioning. The Consultant Wound Physician said an air mattress should have been in place when Resident #20 first developed the skin issue to the right heel and, he has recommended these preventative measures to the nursing staff as well as clinical management and expects them to be implemented and said Residents who are high risk for pressure ulcers require off-loading interventions. Review of Resident #20's physician order, dated 7/27/24 through 9/3/24, indicated right heel full thickness wash with NS, pat dry, apply xeroform gauze then hydrogel with silver change daily then ABD pad wrap with kerlix change daily. Off load wound, float heel in bed one time a day for wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of NP #1's note dated 7/29/24, indicated the following: Right heel cellulitis. Patient was recently evaluated for new right heel DTI infection and elevated WBC Keflex was added to medication list. Today follow up visit reviewed inhouse wound team visit summary agreed with plan. During an interview on 9/4/24 at 9:42 A.M., NP said she does not have access to wound recommendation or visit notes and she relies on the nursing staff to notify her of any new or worsening skin issues. The NP said she may have been told by staff that Resident #20 had cellulitis and that is why she documented it in her note. Review of the Resident #20's Skin Only Evaluation, dated 7/31/24, indicated, skin was warm/dry and indicated a Stage 4 wound to the right heel with copious drainage, no foul odor. The skin only evaluation failed to indicate any measurements or any further assessment of the wound. Further review of the medical record indicated a second wound treatment order was implemented on 7/31/24 to the right heel. Which indicated site unstageable due to necrosis of the right heel full thickness, wash with normal saline, apply Xeroform gauze, hydrogel once daily ABD pad wrap with Kling change daily. The medication administration record contained two active physician orders in place for the same right heel wound from 7/31/24 through 9/2/24 as follows: - right heel full thickness unstageable wash with normal saline padded dried apply xerofoam gauze then hydrogel with silver change daily then abd pad wrap with kerlix change daily offload wound float heel in bed one time a day for wound care. Dated (7/27/24-9/3/24). - site unstageable due to necrosis of the right heel full thickness wash with normal saline apply xerofam gauze hydrogel one daily Abd bad [SIC] wrap with kling [NAME] [SIC] daily one time a day for tage [SIC] 4 wound in right heel. Dated (7/31/24-9/3/24). Further review of Resident #20's MAR (Medication Administration Record) indicated the nursing staff documented both orders as administered to Resident #20's right heel for 34 days. (One order containing hydrogel with silver and one order containing hydrogel only- both being signed off on the same day). During an interview on 9/5/24 at 8:12 A.M., Nurse #4 said she did not realize that there were two treatments and that she does not recall documenting two different orders even though they are singed off and said most residents receive hydrogel for wounds. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/1/24, and 8/8/24, and indicated Stage 4 pressure wound of the right heel full thickness. Treatment recommendation is: Apply hydrogel with silver and xeroform gauze cover with ABD pad and kerlix daily. Review of the medical record indicated Resident #20 continued to have two active physician orders in place for the same right heel wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/5/24 at 8:12 A.M., the Consultant Wound Physician said he expects recommendations to be followed, and that Resident #20 should not have duplicate treatment orders for the same wound because hydrogel and hydrogel with silver are two different treatment orders. The Consultant Wound Physician said Hydrogel with silver helps to stop the growth of microorganisms and regular hydrogel does not contain the antimicrobial barrier. During an interview on 9/5/24 at 12:25 P.M., the Medical Director (MD) said he is not always made aware of orders that are entered under his name and that staff have been told not to enter orders unless they speak directly with providers. The MD said he was not aware that Resident #20 had a pressure area that developed an infection and deteriorated to a Stage 4 wound and he was not aware that Resident #20 was receiving two different treatment orders for the same wound and said he expects nursing staff to follow recommendations by the wound physician and discontinue orders that are no longer recommended by the wound physician. Review of NP's note dated 8/5/24, indicated the following: - Nursing report poor appetite with poor wound healing. Pt (patient) recently completed antibiotic for right heel cellulitis with good effect. Today follow up visit reviewed inhouse wound team visit summary agreed with plan. Notify provider with acute suspected deep tissue injury. Acute on chronic site unstageable due to necrosis of the right heel full thickness. This documentation was inconsistent as the Resident now has a Stage 4 right heel wound as documented by the Consultant Wound Physician on 8/1/24 and 8/8/24. During an interview on 9/4/24 at 9:46 A.M., the NP said she does not have access to wound recommendation or visit notes and she relies on the nursing staff to notify her of any new or worsening skin issues. NP said she was not aware that Resident #20 had a wound that deteriorated to a Stage 4 wound on 8/1/24 and is not aware of recommendations unless she is notified by nursing. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/14/24, 8/22/24, and 8/29/24, which indicated granulation, stage 4 pressure injury. Treatment recommendation indicated: Start Alginate calcium once daily cover with ABD pad and kerlix. Off load wound, float heels in bed. Review of the medical record failed to indicate nursing implemented the above wound treatment recommendations until 9/4/24 (a total of 22 days from the wound consultants first recommendation on 8/14/24) and continued to document the administration of the two previous orders for hydro gel with and without silver. During an interview on 9/5/24 at 12:25 P.M., the Medical Director said he expects the wound treatment recommendations and orders to be implemented and followed. The Medical Director said he expects a tracking system to be in place and reviewed by clinical management to update the plan of care and to track wound progression. The Medical Director said he expects senior management to be diligent and implement measures for clinical oversight for all residents. The Medical Director said clinical oversight is needed and must have access to the wound treatment recommendations and status of wounds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/4/24 at 9:01 A.M. Nurse #5 said Resident #20 has a right heel wound and that measurements are done weekly by the Wound Consultant. Nurse #5 said there is no unit manager or Director of Nurses (DON) currently and he does not have access to the wound recommendations and visit notes. Nurse #5 said the DON is the only one who had access the wound recommendations and treatments visit notes. During an interview on 9/4/24 at 9:28 A.M., Project Manager #1 said the DON is the only person with access to the Consultant Wound Physician visit and recommendation visit notes and that she has been out of the building since 8/22/24. Project Manager #1 said he would need to call the company to get access to the visit notes. During an interview on 9/5/24 at 11:56 A.M., the Administrator said he has no knowledge of wounds, infections, or any recommendations not being followed and that he was not aware that Resident #20 had an infected wound that progressed to a Stage 4. The Administrator said the DON should have known orders were not followed and treatment recommendations not implemented correctly and said he would not be notified of wounds unless its relevant and that wounds and infections are discussed only if there are concerns during the quarterly QAPI meeting. The Administrator said nursing staff should have access to the wound recommendations and that orders should be updated. 1b. Resident #20 developed a right hip wound as indicated on a skin check dated 9/11/24. The facility failed to implement the use of an air mattress and failed to follow up on a progress note indicating right hip redness dated 8/28/24. Review of the facility policy titled Bed Safety-Air Mattress-Side Rails undated, indicated but was not limited to the following: - It is the policy of the facility to provide air mattress, with a physician's order, to residents who are bedridden, have limited mobility, are at high risk for pressure sores on the buttocks/hips or who are recovering from a wound. Nursing will follow these procedures: - Obtain a physicians order for an air mattress. - Apply air mattress to residence bed. - Follow manufacturers instructions for use in care of the mattress. - The mattress should be pumped in accordance with their residence weight. - Document all skin assessments. - Maintenance will audit quarterly or as needed to determine proper usage of the air mattress. Review of medical record indicated Resident #20 was being followed weekly by the Wound Consultant Physician as of 7/18/24, for the development of a DTI to the right heel. Further review of the medical record indicated the Wound Consult Physician made recommendations to off load wound, float heels while in bed and the use of a pressure relieving boots and an air mattress. Review of the Care Plan's for Resident #20 included but was not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Venous/Stasis Ulcer (abnormal vein function) r/t (related to) CHF (Congestive Heart Failure- heart doesn't pump blood as well as it should), included the following interventions, dated 7/16/24: - I need heels kept off bed by and prevent direct contact between bony prominences keep heels off load. - Evaluate wound for: Size, Depth, Margins: peri-wound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. 7/25/24 prevalon boot at all times keep elevated at all times keep feet off load feet off load keep elevated and off load. (Dated: 7/26/24). - Booties while in bed (Dated 7/16/24). - ADL Self- Care Performance Deficit, included the following interventions dated 7/10/24, and revised on 8/31/24: - Bed Mobility: I required, 2 staff participation to reposition and turn in bed. I required an Air Mattress d/t (due to) stage 4 ulcer on my heel, and I am at risk for further skin breakdown. - Skin Inspection: I required, SKIN inspection daily. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. - Wound Management due to DTI care plan, initiated on 8/2/24 and last revised 8/31/24: - Provide wound care per treatment order. I require an air mattress (Dated 8/2/24). On 9/3/24 at 8:58 A.M., the surveyor observed Resident #20 laying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. On 9/4/24 at 8:05 A.M., the surveyor observed Resident #20 laying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. On 9/4/24 at 1:03 P.M., the surveyor observed Resident #20 laying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. On 9/6/24 at 8:05 A.M., the surveyor observed Resident #20 laying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. On 9/9/24 at 8:00 A.M., the surveyor observed Resident #20 laying in bed on his/her left side with one prevalon boot placed on the right heel. The left heel was directly on the mattress and was not elevated. There was no air mattress applied to the bed. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The observations made during survey failed to indicate Resident #20 had care planned interventions in place including the use of prevalon boots to bilateral feet, keeping bilateral heels elevated and the use of an air mattress. Review of the physician's orders for Resident #20 indicated the following: - May use prevalon boot every shift for use for skin protection (7/26/24). - May have booties all the time every shift (9/5/24). Further review of the medical record failed to indicate an order was in place for the use of an air mattress. Review of NP #1's note dated 8/28/24, indicated the following: Nursing requested right hip redness, and in house wound visit with rec (recommendation). Pt (patient) recently completed antibiotic for right heel cellulitis with good effect. Today follow up visit reviewed in house wound team visit summary agreed with plan. Cellulitis right heel suspected DTI. During an interview on 9/4/24 at 9:44 A.M., NP said she was notified by staff that Resident #20 had right hip redness and that she did not visualize the resident's skin. The NP said she was not aware that Resident #20 did not have an air mattress in place and said Residents at high risk for pressure ulcers should have an air mattress and heel booties in place and she expects staff to notify her of any new skin issues or if wounds are getting worse and that she expects preventative measures to be implemented and followed to prevent the wounds from deteriorating. The NP said she would expect the orders and care plan interventions be followed and said resident #20 requires and air mattress and prevalon booties to both feet. During an interview on 9/5/24 at 8:02 A.M., Nurse #4 said if a new skin area is observed there should be a skin check indicating the new area and the NP or MD will be notified. Nurse #4 said she notified NP that Resident #20 had redness to his/her right hip and that he/she was seen by the wound physician but was not aware of any new orders or follow up because the DON has been out. During an interview on 9/5/24, at 8:07 A.M., Certified Nurse Aide (CNA) #7 said that he was not aware that Resident #20 should have his/her legs elevated and that Resident #20 does not have an air-mattress. During an interview on 9/5/24 at 8:11 A.M., Nurse #5 said Residents with skin issues will have an air mattress and heel botties in place to prevent skin breakdown and the plan of care will be updated so staff know what the resident needs for care. Further review if the medical record failed to indicate Nurse #4 documented the right hip redness to Resident #20 hip, despite being reported to NP. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/5/24 at 8:09 A.M., the Consultant Wound Physician said Resident #20 requires an air mattress and prevalon boots to both heels because he/she is high risk for wounds and has wounds that need preventative measures. The Consultant Wound Physician said wound recommendations have not been implemented on admission and said he expects recommendations and preventative measures to be followed. The Consultant Wound Physician said Resident #20 is high risk for more pressure areas and prevalon booties, air-mattress and elevation of the legs at all times are needed and should have been implanted because he/she is dependent on staff and can't turn and reposition without staff assistance. Review of Resident #20's Skin Only Evaluation, dated 9/11/24, (15 days after right hip redness was first identified) indicated the following: - Pressure Ulcer/ Injury Right Hip, Stage 2 (Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible). - Pressure Ulcer / injury Right Heel, Stage 4 Full thickness tissue loss. - Area on right heel, moderate serosanguineous drainage on old dressing, no foul odor, wound measuring 3. 8 cm x 2.6 cm x no depth; wound bed remains red with healthy tissues surrounding the area; skin pink. Wound washed with NS, applied Calcium Alginate, cover with ABD and wrap with Kerlix as ordered. Further review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 9/12/24, and indicated the following: *Wound 1 -Stage 4 Pressure Right Heel (Existing Wound) Treatment Plan- Alginate Calcium apply once daily for 27 days. ABD pad apply once daily for 27 days. Gauze roll Kerlix 4.5cm apply once daily for 27 days. *Wound 2 Unstageable (due to necrosis) of Right Hip Full Thickness - New Wound Pressure, unstageable necrosis, 6x4 depth not measurable due to presence of nonviable tissue and necrosis. 100% thick adherent devitalized necrotic tissue. Treatment Plan- Xeroform gauze once daily for 30 days. Hydrogel with silver apply once daily for 30 days. Gauze island with bdr apply once daily for 30 days. Offload wound, reposition per facility protocol, low air loss mattress. *Wound 3 - Unstageable DTI of the Right, First Toe Undetermined Thickness New Wound. Pressure, unstageable DTI with intact skin 1x1.2 depth not measurable. Skin intact with purple/maroon discoloration. Treatment Plan: Skin prep apply twice daily for 30 days. Offload wound, reposition per facility protocol. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Wound 4 Unstageable DTI of the Right Ankle Undetermined Thickness New Wound Pressure, unstageable DTI with intact skin 1x1 depth not measurable. Skin intact with purple/maroon discoloration. Treatment Plan- Skin prep apply twice daily for 30 days. Off load wound reposition per facility protocol. The skin assessments completed on 9/11/24 and 9/12/24 indicated Resident #20 developed three additional areas on right 1st toe, right ankle and right hip. Resident #20 had a total of 4 wounds identified, 3 identified as new wounds within 2 days. During an interview and observation on 9/16/24 at 7:47 A.M., the surveyor along with Nurse #8, The MDS Nurse, and Nurse #6 observed Resident #20 during a wound dressing change. Nurse #8 said Resident #20 has wounds to his/her right hip, right heel, and right toe. Nurse #6 said the Resident does not have any other skin areas and that a skin check was completed, and these new areas were identified. The surveyor asked Nurse #8 and Nurse #6 to turn and reposition the Resident to look observe the Residents skin. The Resident was repositioned and the surveyor asked Nurse #8 to open the brief covering the left hip, observed was intact pink/maroon skin with a localized area of non-blanchable erythema. Nurse #6 said the area is a pressure area on his/her left hip bone in the same location as the pressure area to the right hip bone. Upon further skin inspection, Resident #20 was observed to have an open skin area to the left ankle, with pink and red drainage. Nurse #6 said the area to the left ankle is a Stage 2 wound that should have a dressing in place due to drainage. During an interview on 9/16/24 at 8:05 A.M., Nurse #6 said the open wound on Resident #20 is a Stage 2 and the area on the left hip bone is pressure that needs to be reported and documented. Nurse #6 said staff should have reported and documented any new areas observed when providing care and during any skin checks or dressing changes. 43846 2. Resident #23 was admitted to the facility in January 2013 with diagnoses that included traumatic brain injury, hemiplegia and hemiparesis and major depressive disorder. Review of Resident #23's most recent Minimum Data Set (MDS) assessment, dated 8/15/24, indicated a Brief Interview for Mental Status (BIMS) score of 5 out of a possible 15 indicating he/she has severe cognitive impairment. Further review of the MDS indicated that the Resident is at risk for developing

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984 Based on observations, interview and record review, the facility failed to maintain a safe environment for two Residents (#67, #2) out of a total sample of 26 residents. Specifically, 1. For Resident #67, the facility failed to implement physician's orders and the plan of care for the use of bed siderails and fall mats while in bed. 2. For Resident #2, the facility failed to conduct a complete, thorough and accurate investigation after the Resident sustained a fall resulting in hospitalization with a frontal scalp soft tissue hematoma and right nasal bone nondisplaced fracture. Findings include: 1. Resident #67 was admitted to the facility in May 2024 with diagnoses including dementia, incontinence without sensory awareness and anxiety disorder. Review of Resident #67's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 12 out of a possible 15 indicating moderate cognitive impairment. Further review indicated that the resident is frequently incontinent and needs assistance with all activities of daily living. The surveyor made the following observations: - On 9/3/24 at 8:07 A.M., Resident #67 was sleeping in his/her bed, the right side rail was not elevated in use and there were no fall mats next to the Resident's bed. - On 9/3/24 at 2:20 P.M., Resident #67 was observed sleeping in his/her bed laying sideways with his/her legs dangling over the edge of the bed, no side rails were elevated in use and no fall mats were in place. - On 9/4/24 at 7:19 A.M., Resident #67 was sleeping in his/her bed, no side rails were elevated in use and no fall mats were in place. - On 9/4/24 at 8:16 A.M., Resident #67 was lying in his/her bed, no side rails were elevated in use and not fall mats were in place. Resident #67 told the surveyor that the side rails normally go up higher. - On 9/5/24 at 6:59 A.M., Resident #67 was sleeping in his/her bed, only the right side rail was elevated in use, the left side rail was not upright, and no fall mats were in place. - On 9/6/24 at 7:01 A.M., Resident #67 was sleeping in his/her bed, no side rails were elevated in use and no fall mats were in place. - On 9/9/24 at Resident #67 was sleeping in his/her bed, no fall mats were in place. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's physician's order dated 5/25/24 indicated the following: 2 1/2 siderails elevated while in bed every shift. Review of Resident #67's Kardex (nursing care card) indicated the following: - I will have 2 top 1/2 siderails to define bed parameters and aide in repositioning - I will have floor mat(s) in place when I am in bed Review of Resident #67's falls care plan dated 5/29/24 indicated the following interventions: - I will have 2 top 1/2 siderails to define bed parameters and aide in repositioning - I will have floor mat(s) in place when I am in bed During an interview on 9/5/24 at 8:33 A.M., Nurse #5 said Resident #67's siderails are used for mobility and safety and should be upright when in bed and Resident #67 should have fall mats while he/she is lying in bed. Nurse #5 said he was not sure why the Resident's side rails or fall mats were in use. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said she would expect physician's orders and care plans to be followed and that Resident #67 should be using bed siderails and fall mats while in bed. 2. Review of the facility policy titled Fall Investigation, revised and dated 11/22/22 indicated the following: - An incident or the possibility of an incident should be reported immediately to the Director of Nursing. The Director of Nursing will determine if an investigation follow-up is needed. - A clinical evaluation should be performed to determine if a fall did indeed happen. - The investigation follow-up should be completed to review all factual information regarding the investigation. A description of the event, a summary of the investigation and recommendations should be noted on the follow-up, if needed. - The falls investigation form should be filled out by the charge nurse of the Director of Nursing. - If the resident sustains injuries from the fall, the charge nurse shall complete all appropriate reports. The Director of Nursing shall forward all information to the Department of Public Health as required. Resident #2 was admitted to the facility in February 2022 with diagnoses including asthma, muscle weakness, dementia, repeated falls and unspecified abnormalities of gait and mobility. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental score of 12 out of a possible 15 indicated that the Resident has moderate cognitive impairment. Further review of the MDS indicated that the Resident requires assistance with all activities of daily living and has had a fall in the facility since admission. Review of Resident #2's nursing progress notes indicated the following: - Dated 4/26/24 at 2:32 P.M. - sp (status post) fall resident noted to be in his/her left side while attempted grab a boxed of tissue in the floor slide from wc (wheelchair) and landing in the ground next to his/her wc. resident sustained an abrasion in bridge of his/her nose and hematoma in the right side of his/her temporal area. resident has bled profusely due to his/her medication eliquis. resident was sent out to be evaluated. Md (medical doctor) called gave order to send resident out for evaluation. - Dated 4/27/24 at 6:15 P.M. - Call hospital about 12:30 P.M., resident still in ER (emergency room) waiting to be admitted with right nasal bone fracture. - Dated 4/30/24 at 2:41 P.M. - Resident readmitted to facility, alert and oriented. VS (vital signs) stable BP (blood pressure):123/68 , PR:78 ,RR:19 T:97.8 . Was sent out to the hospital for post fall evaluation and was diagnosed nasal bone fracture and is on sinus precaution. Due to facial trauma has periorbital frontal and maxillofacial bruised areas. Review of Resident #2's fall investigation report conducted by the facility indicated the following: - 4/26/24 - Note: Resident was witnessed learning over to pick up her fork during meal time and slipped from his/her wheelchair. Staff witnessed the fall and he/she claimed he/she was dizzy. Resident did not appear to have any injury from the fall and said I am fine. Ambulance was called per procedure. Health Care Proxy was called. Per Resident had leaned over per his/her statement to pick something up on the floor. Will follow up with hospital. - Hospital Discharge Summary dated 4/29/24: The fall was apparently witnessed and he/she did not hit his/her head. CT scan brain shows right frontal scalp subgaleal/soft tissue hematoma, as well as a right nasal bone nondisplaced fracture. The facility's fall investigation failed to include any written statements from staff members despite being documented that the fall was witnessed. The investigation also noted that Resident #2 did not appear to have any injury from the fall despite a nursing progress note stating resident sustained an abrasion in bridge of his/her nose and hematoma in the right side of his/her temporal area. resident has bled profusely due to his/her medication eliquis. Review of Resident #2's assessment titled Fall Risk Evaluation dated 4/30/24, four days after the fall on 4/26/24, indicated that the Resident has had no falls in the past three months. The evaluation is noted to be in-progress and was never completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's assessment titled Fall Risk assessment dated [DATE], 10 days after the fall on 4/26/24, indicated that the Resident has no history of sustaining a fall within the last six months. During an interview on 9/4/24 at 1:31 P.M., the Administrator and the surveyor reviewed the fall investigation packet for Resident #2, he said the investigation was lacking information including a full and thorough investigation which included witness statement from staff. He continued to say the incident should have been reported into Health Care Facility Reporting System (HCFRS). Review of HCFRS indicated that the fall resulting in right frontal scalp subgaleal/soft tissue hematoma, as well as a right nasal bone nondisplaced fracture was not reported until 9/5/24 after the surveyor informed the Administrator. During a telephone interview on 9/5/24 at 9:50 A.M., the Consulting Nurse said an incident report should be completed and sent to the Administrator. The Consulting Nurse continued to say the incident report should be complete and thorough which includes having witness statements and a full breakdown of what happened as well as being reported to the state agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record reviews and interviews, the facility failed to follow professional standards of practice relating to catheter care and bladder incontinence for two Residents (#66, #67) out of a total sample of 26 residents. Specifically, 1. The facility failed to have an order for the catheter tube size and balloon volume amount for Resident #66, who was identified by the facility matrix as being the only resident in the facility with an indwelling catheter. 2. The facility failed to develop a comprehensive resident centered care plan for bladder incontinence with individualized, resident-focused interventions for Resident #67 Findings include: 1. Review of the facility's policy Foley Catheter, revised 7/15/22, indicated the following: Procedure: Catheter size and frequency of change will be determined by MD (medical doctor) order. Review of the facility Matrix (a document that is used to identify pertinent care categories) indicated the facility had one resident with an indwelling catheter (Resident #66). Resident #66 was admitted to the facility in February of 2024 with diagnoses that included but are not limited to benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, and retention of urine. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #66 scored a 15 out of 15 on the Brief Interview for Mental Status, indicating intact cognition. The MDS further indicated he/she is dependent on staff for toileting, and has an indwelling catheter. On 9/3/24 at 8:37 A.M., Resident #66 was observed resting in his/her bed. The urinary catheter drainage bag was visible and was resting on the floor. Resident #66 said the hook dislodged and he/she repositioned the bag off the floor. Review of Resident #66's medical record indicated the following physician's order: - Change foley catheter monthly every night shift every 1 month starting on the 23 rd for 1 day, dated 2/23/2024. Review of the care plan indicated: 'I have indwelling foley catheter: BPH, urinary retention.' Review of the interventions included Catheter: I have (size) (type of catheter), dated 2/29/24. Both size and type of catheter were blank. Review of Resident #66's physician orders and the care plan failed indicate the indwelling catheter tubing size and balloon volume amount. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 2024, August 2024 Medication Administration Record (MAR) indicated the foley catheter was documented as changed on the 23rd of both months. The MAR failed to indicate what size of the catheter tube or the balloon volume amount. During an interview on 9/4/24 at 8:51 A.M., Nurse #4 said a foley catheter change would require the specifics of the size catheter and balloon volume rate. Nurse #4 said she believed Resident #66's foley catheter is changed monthly on the 23rd. Nurse #4 reviewed Resident #66's physician's orders and said it did not include the specific catheter size or balloon volume amount. During an interview on 9/4/24 at 9:00 A.M., Nurse #7 said for a nurse to change a foley catheter they would need a doctor's order for the catheter tubing size and balloon volume rate. Nurse #7 said if there is no order for the size then a call should be made to the MD (medical doctor) or NP (nurse practitioner). 45984 2. Review of the facility policy titled Comprehensive Care Plan, dated 9/15/22 indicated the following: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident #67 was admitted to the facility in May 2024 with diagnoses including unspecified dementia, incontinence without sensory awareness and anxiety disorder. Review of the Resident's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 12 out of 15 indicating moderator cognitive impairment. Further review of the MDS indicated that Resident #67 needs assistance with all activities of daily living (ADLs) and is frequently incontinent of bladder. During an interview on 9/3/24 at 8:08 A.M., Resident #67 was observed lying in his/her bed, there was a smell of stale urine in the room. Next to the resident was a rolling walker with clothes draped over it. Resident #67 said he/she has an overactive bladder, and it can be hard making it to the bathroom. He/she continued to say that he/she wet his/her pants yesterday and he/she hung up his/her clothes to let them dry. Review of Section V - CAA of Resident #67's admission MDS dated [DATE] indicated the following under the Urinary Incontinence section: - Resident is incontinent of urine, he/she requires assist with toilet use d/t (due/to) weakness, at risk for soft tissue breakdown and infections. - Care Plan Considerations: Proceed to care plan to anticipate resident's toileting needs, maintain skin integrity. Review of Resident #67's active care plans failed to indicate that an individualized, person-centered care plan for bladder incontinence care was developed. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Nursing Assistant ADL Flow sheets for Resident #67 indicated that he/she has been incontinent of the bladder for all shifts for September 2024. During an interview on 9/4/24 at 1:16 P.M., Certified Nursing Assistant (CNA) #3 said it is her first day working in the facility. She said she would expect a census sheet listing all the resident's care needs but did not get one and is just winging it and asking all the residents what type of care they need. During an interview on 9/5/24 at 7:42 A.M., CNA #4 said he knows all the residents and does not need to look at care plans or the Kardex (a resident care card). CNA #4 says Resident #67 does okay with going to the bathroom and sometimes he/she will make it to the bathroom and sometimes he/she does not. During an interview on 9/5/24 at 8:33 A.M., Nurse #5 said Resident #67 should have a bladder incontinence care plan. During an interview on 9/6/24 at 11:11 A.M., the MDS Nurse said it is her second day in the facility. She said it is her expectation that if the MDS says to proceed with care planning then either the MDS Nurse or a floor nurse would develop a care plan. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said all residents should have an ADL care plan with resident-focused interventions.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review, and interview, the facility failed to address the nutritional status in a timely manner for one Resident (#6) out of a total sample of 26 residents. Specifically, the facility failed to address a significant weight loss in a timely manner for Resident #6, resulting in a 12% weight loss in one month. Findings include: Review of the facility policy titled Weight Management, revised and dated 10/21/19, indicated the following: - In the event where a resident shows a significant weight loss of 3 lbs (pounds) or more or the weight appears inaccurate, the resident shall be weighed again as soon as possible. If the weight loss is verified the following are completed: - Weights are recorded weekly and taken by a Certified Nursing Assistants. - Charge nurses are responsible to ensure that weights are documented appropriately. - Nursing will report weight loss to the Dietitian within 24 hours. - Report weight loss to the physician during physicians next visit. - If weight loss is verified, the Dietitian will seek the appropriate care plan adjustments to include snacks and supplements in order to curtail the weight loss. - Weight losses and gains are addressed quarterly at the QA (Quality Assurance) meeting. - Weights are performed weekly unless weights have been discharged . - If the weight loss is over the CMS guidelines, then a full assessment will be required and performed by the Dietitian. - When nutritional interventions such as supplements and recommended for weight loss, the orders for those interventions will be written within 7 days. Review of the facility policy titled Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, undated, indicated the following: Assessment and Recognition - The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, weight loss or gain, and significant risk for impaired nutrition. - The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of the weight loss and or impaired nutrition. - The staff will report to the physician significant weight gains or losses or food intake. - The physician will review for medical causes of weight gain, anorexia and weight loss before ordering interventions. - For individuals with recent or rapid weight gain or loss (for example a more than a pound a day), the staff and will review for possible fluid and electrolyte imbalance as a cause. - The physician and staff will monitor nutritional status, an individual's response to interventions and possible complications of such interventions. -The physician will help identify medical conditions (cancer, cardiac or renal disease, depression, dental problems, etc.) and medications that may be causing weight gain or loss or increasing risk for either gaining or losing weight. -The physician will review carefully, and rule out medical causes of, oral or swallowing problems before authorizing other consults or interventions to modify diet consistency. -Sometimes, an extensive workup may not be appropriate or knowing the cause may not change the interventions, Nevertheless, a systematic review for cause based on an individuals history, comorbidities, risk factors, etc. may be appropriate even if an extensive workups is not. -The physician and staff will collaborate to address any ethical issues related to weight and nutrition (for example, possible use of artificial nutrition and hydration) related to severe or prolonged impairment of nutritional status and weight loss. Resident #6 was admitted to the facility in March 2022 with diagnoses including dysphagia, vitamin B12 deficiency anemia, vitamin D deficiency, and dementia. Review of Resident #6 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 a possible 15 indicating no cognitive impairment. Further review of the MDS indicated that the Resident is at risk for malnutrition and requires a mechanically altered diet. On 9/3/24 at 8:55 A.M., Resident #6 was observed sitting in a wheelchair in the dining room. The breakfast tray was on the table and the Resident was not eating breakfast. Staff were present in the dining room. On 9/4/24 at 12:45 P.M., Resident #6 was observed sitting in a wheelchair in the dining room. The lunch tray was on the table and the Resident was not eating lunch. Staff were present in the dining room. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #6's medical record indicated the following documented weights: - 6/7/24: 91.2 lbs. - 6/14/24: 91.5 lbs. - 6/18/24: 91.6 lbs. - 6/26/24: 90.4 lbs. - 7/2/24: 91.2 lbs. - 7/16/24: 83.6 lbs. (Weight was struck-out - see Nutrition note dated 7/29/24) - 7/23/24: 92.8 lbs. - 8/11/24: 84.4 lbs. - 8/25/24 81.2 lbs. From 7/23/24 to 8/25/24, Resident #6 had a significant weight loss of 12.50%. Further review of the medical record failed to indicate that Resident #6 had any additional weights obtained after 8/25/24. Review of Resident #6's medical record failed to indicate a physician's order to obtain weights. Review of Resident #6's PCM (Protein Calorie Malnutrition) care plan, dated and revised 1/8/24 indicated the following: Resident meets criteria for PCM, has a potential for weight loss and further alteration in nutritional status as related to: -Chewing and swallowing difficulty, need for altered diet texture and thickened liquids. - Low body weight, potential for Inadequate oral intake, On planned weight gain program. Interventions Include: - Monitor weights as ordered. - Provide nutritional supplements as ordered - Provide diet as ordered- Puree diet, NTL (Nectar Thick Liquids) - Monitor intake of meal consumed Review of Resident #6's comprehensive Nutrition assessment dated [DATE] indicated the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- Diet Regular Pureed diet w/NTL (with nectar thick liquids) d/t hx (due to history) of dysphagia and high risk for aspiration. - PO (oral) intake is fair, which is his/her baseline. Resident is thin/underweight w/ BMI (with Body Mass Index) of 17.8, continues to meet criteria for Protein Calorie Malnutrition d/t (due to) severe subcutaneous fat depletion and severe muscle mass depletion. - Weight has remained stable +/- 3% over the past 6 months. On Remeron- which may aid appetite, diet is supplemented w/ 4 oz House Supplement BID (twice daily) and magic cup BID for added kcals (calories) and protein to assist w/ (with) prevention of weight loss. - Continue 4oz (ounces) house supplement and magic cup BID supervision and setup w/meals. Monitor weights, intake, diet tolerance. New Recommendations/Goals: Puree diet/w/NTL continue 4oz house supplement and magic cup BID. Supervision and setup w/meals. Monitor weights, intake, diet tolerance. Review of Resident #6's active physician's orders, indicted the following: - Magic Cup at lunch and dinner two times a day for unplanned weight loss. Dated 5/14/24. - House diet, Pureed texture, Nectar consistency. Dated 1/8/24 - House Supplement every day shift 4 oz at Breakfast and Lunch. Dated 11/14/23. Review of Resident #6's progress notes indicated the following: Nurse Practitioner (NP) progress note dated 7/15/24, indicated: Severe protein-calorie malnutrition. Chronic condition due to his/her progressive dementia his/her appetite has decrease, poor meal and fluid intake. Nutrition progress note dated 7/19/24, indicated: Weight: 83.6 (7/16), significant unplanned weight loss of 8. 7% x 1 month, 7.9% x 3 months, and 11.2% x 6 months. Will ask nursing to obtain a reweight to verify weight loss. (Resident) remains on a Pureed diet w/ NTL d/t hx (due to history) of dysphagia and high risk for aspiration. On Remeron - which may aid appetite, diet is supplemented w/ 4 oz House Supplement BID and magic cup BID. Continue to follow. Review of the medical record indicated a reweight was not done until 7/23/24, 4 days after the dietitian requested a re-weight. MD progress note dated 7/25/24: (Resident) has lost about 9 pounds in the last 6 months. (Resident) says he/she does not like the food here sometimes. Unintentional weight loss, Add supplements, Dietary consult. Review of the active orders failed to indicate an order was entered for a dietary consult. Further review of the medical record failed to indicate any new orders were implemented to address the unintentional weight loss since 7/23/24. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Dietician's Nutrition progress note dated 7/29/24, indicated: Wt (weight): 92.8(7/23/24), struck out wt of 83.6 (7/16/24), as it was an erroneous weight. No significant wt loss. Further review of Resident #6's documented weights indicated the Resident did not have another weight documented until 8/11/14, 19 days later. Review of the Nutrition Note dated 8/19/24, indicated: Wt: 84.4 (8/11/24), request a re-weight to verify wt loss. Review of the medical record indicated there was no re-weight until 8/25/24, 6 days after the dietitian requested a re-weight on 8/19/24. Review of the Nutrition Progress note dated 8/30/24, indicated: Wt: 81.2 (8/25), underweight w/ hx (history) of Protein Calorie Malnutrition and significant unplanned wt loss of 11.6# (12.5%) x 1 month. Lost 3.2# x 2 weeks. Recently came off SLP (Speech Language Pathology Therapy), remains on Pureed diet w/ NTL. On Remeron, house supplements BID, and magic cup BID. Will notify NP of wt loss as well. Review of the medical record failed to indicate the NP or MD was notified of the unintentional weight loss. Resident #6's documented significant weight loss was not addressed, and no additional weights were obtained after 8/25/24. The facility was unable to provide documentation of weights obtained after 8/25/24 throughout the survey. During an interview on 9/4/24 at 9:42 A.M., NP #1 said Resident #6 is receiving supplements for a history of weight loss but she was not aware of the significant weight loss of 12% and was not aware that Resident #6 did not have weekly weights completed. The NP said Resident #6 should have had an order for weekly weights and said daily weights should have been implemented to monitor for a decline in status. The NP said she expects reweights to be completed within 24 hours and to be reviewed by the nutritionist. The NP said Resident # 6 is on a weekly weight schedule and there is a binder located on the unit for staff to write weights in. Review of the weight binder indicated the following for Resident #6: -July 2024 weekly weights Week 1 dated 7/2/24 91.2lbs. Week 2 83.6lbs. Week 3 92.8lbs. Week 4 85.6lbs. -August 2024 weekly weights Week 1 dated 8/4/24 85.4lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Week 2 84.4lb.s Week 3 81.8lbs. Week 4 82.6lbs. The facility did not have any documented September 2024 weights in the binder durng the time of the survey. Review of Resident #6's Resident Care Kardex (a form indicating care needs), indicated the following: Weight frequency weekly, 7am -3pm, scale-chair. During an interview on 9/4/24 at 12:58 A.M., Resident #6 said his/her lunch was alright and said he/she doesn't care for the food but eats it anyway because he/she had weight loss. The surveyor asked the Resident about the weight loss, but he/she said, I don't know what they do. During an interview on 9/5/24 at 12:25 P.M., the Medical Director said he was not aware that Resident #6 had a significant weight loss and said he would expect the facility to obtain re-weights, check orders in place and to document assessments and re-assessments. The MD said Residents are weighed weekly to monitor for weight loss. The MD said the Resident should have been followed closely to monitor weight loss and daily weights should have been implemented and reviewed. The MD said he expects reweights to be completed within 24hours and reported to the Director of Nursing and Nutritionist. During an interview on 9/09/24 at 8:02 A.M., Nurse #6 said weights are obtained and entered into the electronic medical record system by the dietitian or MDS nurse weekly, and if a re-weight is needed the dietitian will notify staff by verbally telling staff or by leaving a note at the nurses desk. Nurse #6 said if the weight is off more than 2-5lbs the provider should be notified. Nurse #6 said Resident #6 has had some weight loss and is followed by the dietitian. Nurse #6 said the Director of Nursing would review the weight but she has not been in the facility for some time and she is not sure who is monitoring them. During an interview on 9/9/24 at 9:49 A.M., the Consulting Nurse said she expects staff to monitor and document weight loss and to notify appropriate staff if weight loss or gain is suspected. The Consulting Nurse said clinical management should be notified and reweights must be done to ensure accuracy and follow-up. She continued to say that the dietitian and providers must be notified, orders need to be followed and care plan interventions should be documented. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/09/24 at 9:51 A.M., the Registered Dietitian (RD) said she reviews weights weekly on Fridays and enters them into the electronic medical record system and if she identifies a discrepancy of more than a few pounds, she will request a re-weight to be completed within 48 hours. The RD said she reviews the re-weights the following week when she returns to the building, and said if there is a weight loss she is not notified because there is no Director of Nursing. The RD is not made aware of the weights because it is written down and not communicated verbally and said there is a delay because no one else monitors the weights if they were completed or of any weight loss. The RD said she struck out the weight on 7/16/24 because she didn't think that much weight loss was possible and it could not be right and said she wanted a reweight but it was not done. The RD said a reweight should have been done to ensure the weight loss was correct. The dietitian said Resident #6 had a significant weight loss in 4 weeks and that she was waiting to hear back from the family because they mentioned hospice services in July. The RD said she was going to obtain another weight this week and that she notified the provider about the weight loss on 8/30/24.

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F 0695 Level of Harm - 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** 48671 Based on observations, record review and interview, the facility failed to ensure Residents received respiratory care and treatment according to professional standards of practice and in accordance with physician's orders for one Resident (#6) out of a total sample of 26 residents. Specifically, The facility failed to provide consistent oxygen therapy for Resident #6 who required oxygen continuously resulting in the resident's oxygen saturation to drop to 77% resulting in respiratory distress. Findings include: Resident #6 was admitted to the facility in March 2022 with diagnoses including chronic obstructive pulmonary disease (COPD), acute respiratory failure, dysphagia, and anxiety. Review of Resident #6 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 a possible 15 indicating an intact cognitive status. Further review of the MDS indicated that the Resident requires assistance with activities of daily living and receives respiratory care. The surveyor made the following observations: On 9/3/24 at 8:49 A.M., Resident #6 was observed sitting in a wheelchair in the dining room receiving oxygen (O2) at 2.5 liters via nasal cannula. A portable oxygen concentrator was observed hanging off the back of the wheelchair. Staff could be seen walking around the dining room. On 9/3/24 at 8:59 A.M., Resident #6 was observed sitting in a wheelchair in the dining room eating breakfast. The Resident was not utilizing oxygen. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached, the nasal cannula was placed around the Residents head but was not placed in his/her nostrils and was off to the side of the nose. Staff could be seen walking around the dining room. On 9/3/24 at 9:16 A.M., Resident #6 was observed sitting in a wheelchair in the dining room. The Resident was not utilizing oxygen. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached, the nasal cannula was placed around the Residents head but was not placed in his/her nostrils. Staff could be seen walking around the dining room. Review of Resident #6's physician's orders dated 11/10/23 indicated the following: - O2 (Oxygen) at 2L (liters/minute) via nasal cannula continuously to maintain O2 saturation greater than 90% every shift for interstitial lung disease. Review of Resident #6's care plan for oxygen therapy dated 7/6/22 indicated the following intervention: - Monitor oxygen sat (saturation) every shift. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0695 Level of Harm - Actual harm Residents Affected - Few	- If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to nasal cannula). Return resident to usual oxygen delivery method after the meal. - Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (medical doctor) PRN (as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. - OXYGEN SETTINGS: I have, O2 via nasal prongs/mask @ 2L continuously as needed. For sob (shortness of breath) respiratory distress. Review of Resident #6's care plan for Emphysema (lung condition causing shortness of breath)/COPD (Chronic Obstructive Pulmonary Disease)/asthma (airway disease) dated 7/6/22 indicated the following intervention: - Give oxygen therapy as ordered by the physician - Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance. Review of the medical record indicated Resident #6's last recorded oxygenation saturation level was 86% via nasal cannula, dated 7/6/24, and failed to indicate the use of oxygen. Review of Resident #6's progress notes indicated the following: - 7/15/24 Nurse Practitioner (NP) Progress Note: O2 level 94%. - 7/25/24 Medical Director (MD) Progress Note: O2 level 90%. - 9/5/24 MD Progress Noted: O2 level 94%. Further review of the medial record indicated Resident #6 was hospitalized on [DATE], due to change in mental status and oxygen level 79%. On 9/3/24 at 10:01 A.M., Resident #6 was observed sitting in a wheelchair in the dining room. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached, the nasal cannula was placed around the Residents head but was not placed in his/her nostrils. Staff could be seen walking around the dining room and one staff member remained seated in the doorway. The Resident's back was to the staff member. During an observation and interview on 9/3/24 at 10:04 A.M., Nurse #1 said Resident #6 is on 2L of oxygen and wears a nasal cannula. Nurse #1 said he/she is using a portable concentrator in the dining room. The surveyor then asked Nurse #1 to observe Resident #6's oxygen status. The surveyor observed Resident #6 sitting in the wheelchair in the dining room, with his/her back facing another staff member sitting at the doorway to the dining room. A portable oxygen concentrator was observed hanging off the back of the wheelchair, the dial was turned to 2.5 L of oxygen, oxygen tubing was attached, the nasal cannula was placed around the Residents head, but was not placed in his/her nostrils. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	The surveyor continued to make the following observations in the dining room with Nurse #1 present: - At 10:06 A.M., Nurse #1 observed the Resident with the surveyor. The surveyor observed Resident #6 to be uncomfortable and could visualize the use of accessory muscles, as he/she was leaning forward with his/her mouth open. The surveyor observed the portable oxygen tank on empty as indicated by the arrow pointing to the red indicator section labeled 0 zero, the dial was set at 2.5 L. Nurse #1 said He/she is doing good and proceeded to walk out of the dining room. The surveyor stopped Nurse #1 from leaving the dining room and asked Nurse #1 to visualize Resident #6's nasal cannula. - At 10:08 A.M., Nurse #1 checked the nasal cannula by observing it on the Resident's face and then checked the concentrator level and said, Yes she is getting oxygen. Nurse #1 proceeded to walk away from the Resident and the surveyor had to stop Nurse #1 for a second time, from leaving the dining room. The surveyor asked Nurse #1 to again visualize the Resident, and Nurse #1 looked over the Resident and said he was going to get a pulse oximeter machine because he/she is having difficulty breathing. The surveyor asked Nurse #1 to visualize the nasal cannula placement and Nurse #1 said he was sorry and said Resident #6 is not wearing his/her nasal cannula correctly, and he adjusted the nasal cannula and placed the prongs into the Residents nose. Nurse #1 visualized the oxygen gauge at 0 zero. Nurse #1 told the surveyor that the machine is not empty and that he will check for air bubbles. Nurse #1 obtained a small plastic cup of water, removed the nasal cannula from Resident #6's nostrils and submerged the nasal cannula prongs into the water. Nurse #1 said there should be bubbles coming out of the nasal cannula prongs, to indicate the oxygen tank is not empty. Nurse #1 then observed the oxygen concentrator set at level at 2.5 L and said the Resident should be on 2 liters. Nurse #1 and the surveyor observed very few bubbles and Nurse #1 said the tank is empty and said he/she is not getting any oxygen. - At 10: 15 A.M., Nurse #1 then exited the dining room leaving Resident #6 without oxygen, to obtain a vital sign machine. Nurse #1 placed the pulse oximeter on to the Residents finger and was unable to obtain a reading. Nurse #1 said the machine was not working or turning on and exited the dining room again to obtain a portable pulse oximeter. - At 10:16 A.M., Resident #6 said I'm having a little bit of trouble but not too bad as Nurse #1 placed the pulse oximeter on the Residents finger. Resident #6's oxygen saturation level was 77%. Nurse #1 said he/she is having difficulty breathing and gasping for air. I need to get him/her on oxygen and left the dining room. Resident #6 continued to remain off oxygen. -At 10:17 A.M., the Project Manager observed Resident #6's portable concentrator and said oxygen tanks need to be held a certain way to check for levels to know if the machine is empty and said Nurse #1 will be right back with a new oxygen tank. -At 10:18 A.M., Nurse #1 said I will be back I'm going to check something to confirm orders are for 2 liters and get an oxygen tank. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0695 Level of Harm - Actual harm Residents Affected - Few	- At 10:20 A.M., another staff member wheeled Resident #6 to his/ her room and Nurse #1 carried a new oxygen tank and oxygen tubing into the Residents room. Nurse #1 attached a new nasal cannula to a concentrator that was already set up in Resident #6's room. Resident #6 continued to have difficulty breathing and his/her pulse oxygenation level was 76 %. Nurse #1 said I need to get shorter tubing and the surveyor had to tell Nurse #1 that the he must place the nasal cannula onto the Resident's nose as it was on the Residents bed. The Nurse placed the nasal cannula prongs appropriately into the Resident's nose. Nurse #1 said he/she is in respiratory distress and the oxygen is not working. Nurse # 1 rechecked the Residents oxygenation status, and its was 78%. Nurse #1 said his/her color does not look good and he/she is gasping. Nurse #1 proceeded to unhook the oxygen tubing from the concentrator in the bedroom and connected it to the new portable tank he brought into the room. Resident #6 continued to have labored breathing with the use of accessory muscles as Nurse #1 re-checked the oxygenation levels. Resident #6 continued to receive 2L oxygen via nasal cannula and his/her oxygen saturation level went to 80%, 86%, and 93% and remained at 93% during the remainder of the observation. Nurse #1 said the Resident is doing much better and his/her color has improved, and he/she is no longer in respiratory distress. Nurse #1 said the Resident needed oxygen and should not have been using an empty tank and said the nasal cannula needs to be applied to the nose correctly. During an interview on 9/3/24 at 10:26 A.M., Nurse #1 said he will check for respiratory treatment orders and call the doctor to report what happened. Nurse #1 said he did not realize he/she was not wearing the nasal cannula correctly and said the resident should not have been placed on an empty portable oxygen concentrator because he/she needs oxygen to breath. During an interview on 9/3/24 at 10:35 A.M., the surveyor notified the Administrator regarding Resident #6 and Nurse #1. The Administrator said the care was unacceptable and that he expects staff to provide appropriate care to all Residents. During an interview on 9/4/24 at 9:48 A.M., Nurse Practitioner (NP) said she was not aware that Resident #6 had respiratory distress yesterday and that she was not notified by the nurse or anyone in the building. The NP said Resident #6 requires oxygen and has an order for 2 liters, and she expects staff to recognize if a resident requires assistance. The NP said she expects staff to be checking oxygen saturation every shift and said orders for oxygenation parameters and level of oxygen requirements should be entered and followed. During an observation on 9/4/24 at 12:25 P.M., Resident #6 was observed sitting in a wheelchair in the dining room eating lunch. The Resident was receiving 2.5 L of oxygen via nasal cannula. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached. Staff were in the dining room and able to visualize the Resident. During an observation on 9/4/24 at 1:03 P.M., Resident #6 was observed sitting in a wheelchair in the dining room. The Resident was receiving 2.5 L of oxygen via nasal cannula. A portable oxygen concentrator was observed hanging off the back of the wheelchair, oxygen tubing attached. Staff were in the dining room and able to visualize the Resident. During an interview on 9/4/24 at 1:05 P.M., Nurse #4 said Resident #6 needs oxygen and is on 2 liters continuously and that overnight staff will fill the oxygen tanks. The surveyor and Nurse #4 observed the concentrator setting and Resident #6 was receiving 2.5 L of oxygen. Nurse #4 said he/she should be on 2L and not 2.5 L. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/5/24 at 10:30 A.M., Certified Nursing Assistant (CNA) #8 said Resident #6 requires oxygen all the time to help him/her breath and that staff will fill the oxygen containers during the overnight shift. CNA #8 said staff can check if a tank is full by looking at the gauge on the tank and it is red it is empty. During an interview on 9/5/24 at 12:25 P.M., the Medical Director said he expects staff to follow medication and treatment orders related to oxygen use and he expects staff to be trained and competent to use equipment and monitor for signs and symptoms of respiratory distress. The Medical Director said resident's requiring oxygen must have their oxygen checked at least each shift and as needed if compromised. The Medical Director said Resident #6 should not have been without oxygen due to her diagnosis and respiratory status. The Medical Director said staff should have notified the NP right away. During an interview on 9/9/24 at 9:54 A.M., the Consulting Nurse said Residents requiring oxygen must be placed on oxygen and staff must follow physician orders. The Consulting Nurse said care plan interventions should be followed and staff need to know if an oxygen tank is empty, how to check the oxygen setting and to recognize if a resident is having difficulty. The Consulting Nurse said staff should be aware if a resident is having difficulty breathing and is not wearing nasal cannula correctly. She also said staff must check settings on all types of oxygen systems.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36431 Based on observation, record review and interview the facility failed to ensure sufficient staffing to assure residents attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. Specifically, the facility failed to have sufficient staffing on the weekends as indicated on the payroll-based journal report submitted to The Centers of Medicare and Medicaid (CMS) for Fiscal Year Quarter 2, 2024. Findings include: Review of the PBJ Staffing Data Report CASPER Report 1705D FY Quarter 2 2024 (January 1 - March 31) indicated the following: - This Staffing Data Report identifies areas of concern that will be triggered (e.g., requires follow-up during the survey). - Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low Review of the facility's 'Facility Assessment Tool' dated April 5, 2024, indicated at the staffing plan the following: Total Number Needed or Average or Range of Staff: - Licensed nurses providing direct care 11.5. - Nurse Aides 26. The Facility Assessment Tool did not include Hours per resident days. Review of the Resident Council Meeting Minutes Binder indicated the following: On 8/6/24 Residents in attendance reported a shortage of nursing staff on the weekends, with longer wait time to get attended too. Staff: I did tell them that shortages are everywhere, and we are doing our best to hire new staff. During the Resident Group conducted on 9/4/24 at 10:00 A.M., several active participating residents out of the 17 residents in attendance said the following: - Every weekend is short staffed. When asked how they know the facility is short staffed the residents said the staff tell us, they hurry us and do not have time to spend with us, and some residents do not get the help to get out of bed. - They use temp agencies to help. - Staff will say we are short we are doing what we can. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/3/24 at 4:41 P.M., the Administrator said staffing is reviewed and talked about with the scheduler, during QAPI (Quality Assurance and Performance Improvement) meetings and that the beginning of 2024 was difficult for staffing. During a subsequent interview on 9/5/24 at 2:05 P.M., the Administrator said the facility shoots for a PPD (per patient day) of 3.56 hours to 3.60 hours with a typical census between 60-70 residents. Review of the report provided by the Administrator indicated the PPD including C.N.A. (Certified Nursing Assistant), L.P.N (Licensed Practical Nurse), Agency L.P.N., R.N. (Registered Nurse), Agency RN for the months of January 2024, February 2024 and March 2024 indicated the following: A daily census for January 2024, February 2024, and March 2024 that ranged from a low of 63 residents to a high of 67 residents. January 2024: 1/6/24 PPD 3.26 1/7/24 PPD 2.81 1/13/24 PPD 3.15. 1/14/24 PPD 3.30 1/20/24 PPD 3.12 1/21/24 PPD 3.12 1/27/24 PPD 3.20 1/28/24 PPD 3.05 Eight of Eight weekend PPDs in January 2024 were less than the facility's target of 3.56. February 2024: 2/3/24 PPD 3.37 2/4/24 PPD 2.80 2/10/24 PPD 3.30 2/11/24 PPD 2.76 2/17/24 PPD 2.96 2/18/24 PPD 3.69 (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2/24/24 PPD 2.72 2/25/24 PPD 3.02 Seven of Eight weekend PPD's for February 2024 were less than the facility target of 3.56. March 2024: 3/2/24 PPD 3.43 3/3/24 PPD 2.44 3/9/24 PPD 3.43 3/10/24 PPD 2.98 3/16/24 PPD 2.66 3/17/24 PPD 2.97 3/23/24 PPD 3.34 3/24/24 PPD 2.89 3/30/24 PPD 2.69 3/31/24 PPD 3.50 Ten out of Ten weekend PPDs for March 2024 were less than the facility target of 3.56.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48671 Based on observation, record review, and interviews the facility failed to ensure the nursing staff were trained and demonstrated the competencies and skill sets necessary to provide the level and types of care and services needed as outlined in the Facility Assessment. Specifically, the facility failed to: 1. Ensure licensed nursing staff were trained and demonstrated clinical competency related to pressure injury/wound care, including recognizing and reporting wound deterioration, evaluation and measurements for one resident (#20), out of a total sample of 26 residents. For Resident #20 the facility staff failed to implement treatments and physician orders recommended by the consulting wound physician resulting in the wound requiring antibiotic therapy, resulting in the deterioration of an unstageable pressure injury wound progressing to a Stage 4 pressure injury. 2. Ensure that 13 nursing staff employee files reviewed received the appropriate competencies, and skill sets necessary for the care and treatment of residents. 3. Ensure two scheduled and actively working nurses were clinically competent in providing pressure injury/wound care. 4. Ensure licensed nurses completed wound care competency by failing to be observed for the application of knowledge for delivering safe nursing care related to wound care and treatment. Findings include: Review of the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Review of the facility's document titled Facility Assessment Tool date of assessment or update April 5, 2024, indicated the following: Our Resident Profile indicated the average daily census: 1/1/24 - 3/31/24 as 65.25. Review of the common diagnoses include but are not limited to, Psychiatric/Mood Disorders, Congested Heart Failure, Coronary Artery Disease, Parkinson's Disease, Hemiparesis, Alzheimer's Disease, Visual Loss, Hearing Loss, Fractures, Osteoarthritis, Prostrate Cancer, Breast Cancer, Lung Cancer, Diabetes, Thyroid Disorders, Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Renal Insufficiency, Ulcerative Colitis, Gastroenteritis, Bowel Incontinence, Skin Injury, Injuries, Skin Infections, Respiratory Infections. Part 2: Services and Care We Offer Based on our Residents' Needs Pressure injury preventions and care, skin care, wound care (surgical, other skin wounds) (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Staff training/education and competencies. Staff members are provided inservices (sic) throughout the year and as needed on topics (see attached list of inservice (sic) types). Training and Inservice review at the Facility: included but not limited to - Specialized Care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. Throughout the Recertification Survey on 9/3/24 through 9/6/24 and 9/9/24, 9/12/24, 9/16/24 and 9/24/24, the surveyors identified multiple concerns regarding the repeated failure to implement wound care recommendations, notify the physician of wound care recommendations and failure to transcribe the physician's orders related to wound care. As well as failures in respiratory care practices and communicating changes to the medical provider of residents change in conditions. 1. Resident #20 was admitted to the facility in June 2024 with diagnoses including Alzheimer's disease, anemia, vitamin D deficiency, overactive bladder and cognitive communication deficit. Review of Resident #20's Minimum Data Set (MDS) assessment, dated 6/14/24, indicated that the Resident had severely impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, and required assistance with activities of daily living. Further review of the MDS indicated that Resident #20 was at risk for developing pressure injuries. Review of Resident #20's medical record indicated that Resident #20's new unstageable DTI (Deep Tissue Injury) wound to the right heel, identified on 7/16/24, required antibiotic therapy, resulting in the wound deteriorating and developed into a Stage 4 pressure injury on 8/1/24. Further review of the medical record failed to indicate that nursing staff implemented treatment and physician orders recommended by the Consultant Wound Physician to Resident #20's right heel, or that staff notified the physician that the right heel wound progressed from an unstageable DTI pressure injury to a Stage 4 pressure injury. Further review of Resident #20's medical record indicated the following: Nurse #7 completed a Skin Only Evaluation dated 7/17/24, indicated that Resident #20 had open lesions of the foot with a right heel area measuring 2 cm (centimeters) x 2.5 cm, with documented granulation, exudate, purulent, thin, thick, opaque, tan/yellow drainage, erythema. Tissue documented as painful and warm. Skin note indicated Right heel area with open wound injury 2 cm x 2.5 cm. Stage 3. Further review of the provider notification section of the Skin Only Evaluation form dated 7/17/24, failed to indicate the provider was contacted as the form was blank and contained no notification information. Review of the medical record failed to indicate that the (MD)/(NP) were notified of the right heel open wound. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician, dated 7/18/24, and indicated one right heel unstageable DTI (Deep Tissue Injury), closed, surface area 30 cm, length 5 cm, width 6 cm, no depth. Nurse #4 completed a Skin Only Evaluation, dated 7/31/24, which indicated, skin was warm/dry. Skin turgor normal. Does the resident have current skin issues? Documented answer is No. Skin Note indicated, Stage 4 wound right heel with copious drainage, no foul odor. The evaluation did not contain detailed information regarding the wound. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/1/24, and indicated an undefined, Stage 4 wound on the right heel, measurements: surface area 18.4 cm, 4 cm x 4.6 cm. Further review of Resident #20's medical record failed to indicate any wound assessments were documented on the Skin Only Evaluation form on the following dates: 8/7/24, 8/14/24, 8/21/24, and 8/28/24 and indicated: Does the resident have current skin issues? Documented answer is No. During an interview on 9/5/24 at 9:04 A.M. Nurse #5 said Resident #20 has a right heel wound and that measurements and skin checks are done weekly. Nurse #5 said the wound physician comes out weekly and he will send the wound report to the facility. Nurse #5 said he will round with the wound physician and look at wounds, but he does not document the information in a skin check. Nurse #5 said there is no unit manager or Director of Nurses (DON), so he reports issues to the (NP). Nurse #5 said he has not completed any clinical training or competencies here at this facility and said he signed a packet on orientation for new hire documents but has not been trained on wounds or any other clinical competencies. During an interview on 9/5/24 at 8:11 A.M., Nurse #4 said she will document information on the skin assessment but does not include measurements because the wound physician will do that. Nurse #4 said she has not completed any training aside from her new hire paperwork that was not related to wounds and has not completed any competencies. Review of Nurse #7 education files failed to include any demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Review of the education files failed to include recognizing and reporting wound deterioration, evaluation, measurements, and hands-on clinical competency evaluations. Nurse #7's education files indicated he/she did not have the necessary skills to properly evaluate Resident #20's unstageable DTI that deteriorated to a Stage 4 pressure injury. Review of Nurse #4's education files failed to include demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Review of the education files failed to include recognizing and reporting wound deterioration, evaluation, measurements, and hands-on clinical competency evaluations. Nurse #4's education files indicated he/she did not have the necessary skills to properly evaluate Resident #20's unstageable DTI that deteriorated to a Stage 4 pressure injury. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Nurse #5's education files failed to include demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Review of the education files failed to include recognizing and reporting wound deterioration, evaluation, measurements, and hands-on clinical competency evaluations. Nurse #5's education files indicated he/she did not have the necessary skills to properly evaluate Resident #20's unstageable DTI that deteriorated to a Stage 4 pressure injury. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said staff should report skin conditions and document findings as well as report new or worsening skin areas. The Consultant Nurse said all licensed clinical staff should have documented clinical competencies and know how to complete a skin assessment and document findings. The Consulting Nurse said nursing staff should know how to assess a pressure wound and apply treatment orders appropriately including how to do a sterile dressing change and follow appropriate infection control protocol. 2. Review of 10 personnel files of actively working clinical nursing staff including 4 Licensed Nurses and 6 Certified Nursing Assistants (CNA) on 9/3/24 and 9/4/24 indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Further review of the education files indicated licensed clinical staff did not have the necessary skills to evaluate, document, or recognize a change in condition related to skin integrity and proper wound management. Review of additional 3 personnel files of actively scheduled and working licensed nurses failed to indicate any competencies related to the specialized care areas outlined in the Facility Assessment including wound care/dressings. In all, 7 licensed nurses failed to have clinical competencies including care of pressure injuries, skin and wound assessments, and wound care dressing changes. During an interview on 9/6/24 at 9:40 A.M., the Administrator and Assistant Administrator (AA) said all newly hired employees come to the facility for about three hours and review policies and procedures, they do a skills fair annually, but they do not review any clinical topics. The AA said the Director of Nursing (DON) would determine when the staff are competent enough to work. The AA continued to say historically, the facility has used word of mouth and verbal confirmation to track newly hired employees' status of staff shadowing and training. The AA then said the facility has no training curriculum. The Administrator and AA said the facility provides clinical in-services for all staff. The surveyor requested to see the in-services for the last year. Upon review of the in-services, no clinical topics relating to wound/skin care, or oxygen care were provided. During an interview on 9/9/24 at 7:38 A.M., Nurse #6 said she did an orientation with the DON when she was hired a few months ago. Nurse #6 said they reviewed mostly administrative things, sensitivity training, abuse training, HIPPA over anything clinical. Nurse #6 said wound care/skin care was very limited and only verbal educations was done, nothing written. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said all licensed clinical staff should have documented clinical competencies. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Review of the facility's document titled Removal Plan indicated at: 7. As part of the training and re-education, the MDS (Minimum Data Set)/Educator Nurse has developed nursing competencies specific to wound care to be provided to all clinical team members to ensure that this practice does not recur. These competencies are for Registered Nurses and Licensed Practical Nurses. Wound Care competencies will be completed by September 13, 2024. The nursing competencies evaluate the nurse on identifying, assessing and treating wounds, wound care testing regarding sterile dressing changes, Decubitus care, knowledge of and review of each nurse's documentation, evaluations of careplan knowledge, lifting and positioning knowledge, transfer technique, incontinent skin relation to skin integrity, medication evaluations and many other skilled nursing techniques. On 9/16/24 at 8:18 A.M., Review of the working schedule of licensed nurses and the completed wound care competency check list for licensed nurses, failed to indicate two nurses currently working a shift that began at 7:00 A.M., had a completed wound care competency checklist. During an interview on 9/16/24 at 8:20 A.M. the Administrator said one nurse (Nurse #8) is being put through the competency now and the other nurse is an agency nurse and did not have the competency done and will have it done now. The Administrator said all nursing staff were to have the competencies completed by 9/13/24. During an interview and observation on 9/16/24 at 7:47 A.M., the surveyor along with Nurse #8, the MDS Nurse, and Nurse #6 observed Resident #20 during a wound dressing change. Nurse #8 was observed removing old treatment dressings from Resident #20's right hip, right heel, and right toe. Nurse #8 did not perform hand hygiene, remove her gloves or maintain infection control standards throughout the observation. The MDS nurse had to verbally remind Nurse #8 to follow proper infection control measures throughout the observation. Nurse #8 said she would follow proper infection control protocol, but she did not have time to perform all the dressing changes and would return later to complete the treatments. Nurse #8 said she should have worn the proper PPE (personal protection equipment) and removed her gloves and performed hand hygiene when removing the old dressings. Nurse #8 said she has not completed any wound training or clinical competencies in the building. During an interview with the MDS nurse on 9/16/24 at 8:18 A.M., she said she did not complete clinical wound competencies with Nurse #8 or with any nurses in the facility. The MDS nurse said she completed verbal education with nursing staff about following wound treatment recommendations, but no clinical competencies have been done. During an interview on 9/16/24 at 8:22 A.M., Nurse #6 said she has not completed any clinical competencies or had any clinical in-services since training she started working in the facility and continued to say that the DON (Director of Nursing) would verbalize how things should be documented but that was it. During a follow up interview on 9/16/24 at 9:38 A.M., with the MDS Nurse and Nurse #6, the MDS nurse said she just started working with the company last week and that she has not received any clinical training or in-services. The MDS nurse said she does not have a clinical competency on file and said the Administrator asked her to educate the nursing staff about wounds. The MDS nurse said she does not have any formal training on wound care. Nurse #6 said she does not have any clinical in-service or clinical competency on file and that she does not have any formal training on wound care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/16/24 at 9:41A.M., the Administrator said he did not have any outside clinical training or hands-on clinical competencies completed for the MDS nurse or Nurse #6 and said staff providing education need to be competent and have the necessary training and clinical competencies on file. 4. Review of the facility's policy entitled Wound Care, not dated, indicated the following: -All nurses will need to perform a wound care competency by the nurse trainer before starting a shift. All external agency staffing will need to check in with nursing leadership and perform a wound care competency before starting their shift. Review of the document titled Wound Care Competency for 15 out of 15 licensed nurses reviewed indicated the following: - Two licensed nurses had an incomplete page, indicating an incomplete wound care competency. - Fourteen out of fifteen licensed nurse competencies failed to be checked off as 'Cleaning a wound and applying a dry non-sterile dressing skill checklist requirement met/or Cleaning wound and applying a dry non-sterile dressing skill checklist requirement NOT met. During an interview on 9/24/24 at 8:07 A.M., Nurse #6 said she provided one-to-one education using the wound care competency document with each licensed nurse before they started a shift. Nurse #6 said the second part of the wound care competency would include observing the nurse completing wound care, then they would determine if the nurse met or not met wound care competency. During an interview on 9/24/24 at 10:10 A.M., the Director of Nursing (who recently started at the facility) said education was provided and that no clinical observation wound competency was conducted with the licensed nurses, except for two licensed nurses. Twelve of fifteen licensed nurses failed to have wound care competency to include the evaluated by a trained observer. 36431 45984

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	225049	A. Building B. Wing	09/26/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43846 Based on observations and interviews, the facility failed to ensure there was a Registered Nurse (RN) to serve as the Director of Nurses (DON) on a full-time basis. Findings include: During an interview on 9/4/24 at 4:31 P.M., the Administrator said there has not been a DON working at the facility since 8/22/24. The Administrator said he is looking to fill the DON spot. During an interview on 9/4/24 at 9:12 A.M., the Project Manager said he spoke with the Administrator as to who is providing nursing oversight in the building and the Project Manager said there is extra nursing staff working in the absence of the DON who are providing the oversight by working overtime. During an interview on 9/6/24 at 11:11 A.M., the MDS Coordinator said today was her second day working and before she was hired two weeks ago, she was told that the DON was out on medical leave. During an interview on 9/9/24 at 7:29 A.M., Nurse #3 said she is not sure who the DON is in the facility at this time. Nurse #3 said the DON has not worked since sometime in August. During an interview on 9/9/24 at 7:32 A.M., Nurse #6 said she is not sure who is in charge of the nursing department at the moment. Nurse #6 said the DON has been out of the facility for weeks. During an interview on 9/9/24 at 9:15 A.M., the Scheduler said the DON has been out of the building and has not worked since 8/22/24. The Scheduler said there is not currently a DON working at this facility.

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	225049	A. Building B. Wing	09/26/2024

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 45984 Based on personnel file review and interviews, the facility failed to ensure that one of seven Certified Nurse Assistants (CNA) reviewed were not employed as CNA's for more than four months after hire without passing the CNA exam and obtaining a CNA license. Findings include: Review of the Massachusetts Nurse Aide Registry information for employers indicated the following: - You can employ a Nurse Aide who has not yet taken and passed the CNA test for no more than 4 months. Review of CNA #6's personnel file indicated that CNA #6 was hired on 3/4/24 for the position of a CNA. Review of the Massachusetts Nurse Aide Registry indicated that CNA #6 is currently not registered as a CNA in the state of Massachusetts. Review of the facility's as-worked employee schedules indicated that CNA #6 has been working as a CNA providing direct resident care. CNA #6 was working as a CNA providing direct resident care during the survey period. During an interview on 9/6/24 at 9:59 A.M., the Administrator's Assistant said CNA #6 was hired on 3/4/24. The Administrator's Assistant said she was made aware that CNA #6 was not currently licensed on 7/4/24 and she brought it to the attention of the Director of Nursing. The Administrator's Assistant said that the DON did not remove CNA #6 off the schedule and the CNA continued to work. The Administrator's Assistant continued to say that CNA's need to have an active license to perform CNA duties to residents within the facility. The Administrator's Assistant removed CNA #6 from the schedule after the surveyor made her aware of CNA #6 not having an active license.

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	225049	A. Building B. Wing	09/26/2024

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 36431 Based on record review and interview the facility failed to ensure for three of three applicable Certified Nursing Assistant (CNA) employee files out of five CNA employees files reviewed had a performance review at least every twelve months. Findings include: Review of the review of the facility's policy titled Performance Evaluations' dated 4/18/20, indicated the following: Performance evaluations will be conducted, by the department manager or supervisor upon completion of the probationary period, approximately 90 days following hire. In the case of a job transfer or change in job classification, an evaluation will be conducted approximately 90 days after the change. Performance evaluations are then conducted on an annual and as needed basis. The purpose of the performance evaluation is to let each staff member know how well they are performing their assigned job duties, and whether they have any performance problems. Evaluations will be reviewed with the staff member in private with the opportunity for the staff member to comment. The staff member signs the form to acknowledge that an evaluation has been done On this date and receives a copy of the evaluation. Review of three Certified Nursing Assistant employee files indicated the following: - CNA employee file #1, with a date of hire of 6/26/06, failed to have a performance review. - CNA employee file #2 with a date of hire of 7/14/24 failed to have a performance review. - CNA employee file #3 with a date of hire of 12/5/22, failed to have a performance review. During an interview on 9/09/24 at 9:54 A.M., the Consultant Nurse said all facility employees including CNA's should have a performance evaluation yearly.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observations, record review and interviews, the facility failed to provide behavioral health services for one Resident (#34) out of a total sample of 26 residents. Findings include: Resident #34 was admitted to the facility in October 2022 with diagnoses that include major depressive disorder, mood disorder, dementia, and anxiety. Review of Resident #34's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Further review of the MDS indicated the Resident has behaviors occurring daily. Review of Resident #34's medical record indicated he/she was seen by the psychiatric physician for an initial evaluation on 7/18/24. Further review of the medical record failed to indicate the Resident has seen the psychiatric physician since 7/18/24. Review of Resident #34's Nurse Practitioner (NP) note, dated 8/7/24, indicated continue in house psych follow up. Review of Resident #34's nursing note, dated 8/12/24, indicated Resident #34 is aggressive with staff and residents at times. Review of Resident #34's nursing note, dated 8/18/24, indicated Resident very resistive with care. Non-compliant. Refusing to get washed and dressed. Disrobing. NP will be in the facility tomorrow morning. Will be notified regarding the resident behavior. (sic) Review of Resident #34's nursing note, dated 8/22/24, indicated the Resident is agitated, combative, aggressive with staff. Review of Resident #34's nursing note, dated 8/24/24, indicated the Resident remains confused with episode of anxiety and agitation. Non-compliant with care. Physically abusive. Attacking staff. Kicking. Punching. Assisted by nurse. Not easily redirected. (sic) Review of Resident #34's nursing note, dated 8/25/24, indicated the Resident remains very confused. Nonstop wandering. Resistive with care. Assisted by nurse. Very aggressive. (sic) Review of Resident #34's Nurse Practitioner (NP) note, dated 8/26/24, indicated Nursing report continue with restless behavior resident with cognitive impairment and mood disorder. As infection I have ruled out, I will order in house psych consults for medication reviewed. (sic) (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #34's nursing note, dated 8/27/24, indicated the Resident remains with no change in behavior. Confused and agitated. Resistive with care, very combative. Seen by NP new order in place for psych consult. (sic) Review of Resident #34's nursing note, dated 8/28/24, indicated No change in behavior. Very confused and resistive with care. Aggressive behavior. (sic) Review of Resident #34's Nurse Practitioner (NP) note, dated 8/28/24, indicated Nursing report continue with restless behavior Resident with cognitive impairment and mood disorder. Waiting for in house psych consults for medication review. (sic) Review of Resident #34's nursing note, dated 9/2/24, indicated Resident remains very confused. Resistive with care. Will be f/up [follow up] by psych as ordered by NP. (sic) Throughout survey the surveyor observed Resident #34 to have periods of being upset and wandering the unit. During an interview on 9/9/24 at 8:19 A.M., Nurse #3 said the psych team comes in weekly or as needed and she will call the psych doctor. Nurse #3 said Resident #34 should have been seen by psych by now and has not. Nurse #3 said Resident #34 is very behavioral.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed to ensure for one Resident (#7), out of a total sample of 26 residents, that psychotropic medication ordered as PRN (as needed) was limited to 14 days, and that the medical provider documented their rationale for continued PRN use in the resident's medical record. Specifically, the facility failed to limit the use of Lorazepam initially for 14 days, Findings include: Resident #7 was admitted to the facility in April 2021 and has diagnoses that include but not limited to basal cell carcinoma of skin of other parts of face, unspecified dementia, localized edema, moderate protein calorie malnutrition, venous insufficiency chronic peripheral, and paranoid schizophrenia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #7 had a score of 0 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment and requires substantial/maximal assistance with activities of daily living including bathing and dressing. Review of Resident #7's physician's orders indicated the following: - Lorazepam (benzodiazepine medication) tablet 0.5 mg (milligrams) give one tablet by mouth every four hours as needed for anxiety, insomnia, nausea, dated 8/9/24. Further review of the order indicated there was no end date or reevaluation date for the PRN Lorazepam. Review of the Medication Administration Record for 8/2024 and 9/2024 indicated Resident #7 was administered the PRN Lorazepam on 8/28/24, 8/31/24, 9/1/24 and 9/4/24. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said PRN psychotropic medication should not be ordered open ended and needs to be evaluated at 14 days.

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	225049	A. Building B. Wing	09/26/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43846 Based on observation and interview, the facility failed to ensure nursing staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, the facility failed to properly secure the medication cart on three of three units. Findings include: Review of the facility policy titled Medications Storage, dated 6/20/21, indicated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The surveyor made the following observations: - On 9/3/24 at 7:02 A.M., on the [NAME] unit, a medication cart was unattended next to the nursing station, the drawers were not locked. - On 9/3/24 at 7:56 A.M., on the Central unit, a medication cart was unattended and not locked. The surveyor was able to open the drawers. - On 9/3/24 at 9:06 A.M., on the Central unit, a medication cart was unattended and not locked. The surveyor was able to open the drawers. - On 9/3/24 at 10:35 A.M., on the North unit, two albuterol inhalers were left on top of the medication cart while the cart was unattended. - On 9/3/24 at 11:27 A.M., on the North unit, a medication cart was unattended and not locked. The surveyor was able to open the drawers. - On 9/3/24 at 2:16 P.M., on the North unit, a medication cart was unattended and not locked. The surveyor was able to open the drawers. During an interview on 9/3/24 at 9:06 A.M., Nurse #6 said the medication cart should be locked when unattended. During an interview on 9/3/24 at 11:27 A.M., Nurse #1 said the medication cart should be locked when unattended. 45984

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	225049	A. Building B. Wing	09/26/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observations, record review and interviews the facility failed to ensure that one Resident (#9), out of a total sample of 26 residents, was provided the correct therapeutic diet in accordance with the physician's orders. Findings include: Review of the facility document titled Diet & Dining Manual for Extended Care in a Culture Change Environment, undated, indicated: The consistency is the Ground Texture for the resident who had difficulty swallowing and cannot chew their food but can manipulate texture in their mouth and handle soft breads. For the resident who had a stroke and who is advancing in his or her dysphagia rehabilitation from a puree consistency. This is a quality of life consistency offering an option between the mechanical soft and pureed consistencies Resident #9 was admitted to the facility in July 2021 with diagnoses including dysphagia, anemia, hyperlipidemia, hyperkalemia, and muscle weakness. Review of Resident #9's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating he/she as cognitively intact. The MDS also indicated Resident #9 required a mechanically altered diet and required a change in texture of food or liquids. Review of Resident #9's physician's order indicated the following orders: - Diet Order: NAS (No Added Salt) diet, Mechanical Soft texture, Nectar (thickened liquid) consistency. Dated 8/19/24. During an observation on 9/3/24 at 12:21 P.M., Resident #9 was observed sitting in bed eating lunch with staff assisting him/her with the meal. The Resident had regular textured chicken pot pie with chunks of chicken, hard brown baked crusts, whole vegetables including peas, carrot chunks, whole small onions and a cup of chopped up fruit. Thin textured milk, thin water and thin tomato juice was observed to be on the lunch tray. During an observation on 9/4/24 at 12:40 P.M., Resident #9 was observed sitting in bed eating lunch with staff assisting him/her with the meal. The Resident had regular textured seafood pie containing chunks of meat and cut up chunks of zucchini. Thin textured milk, thin tomato juice and a bottle of water that was not thickened were observed on the lunch tray. During an observation on 9/5/24 at 8:35 A.M., Resident #9 was observed sitting up in bed eating breakfast with staff assisting him/her with the meal. The Resident had regular textured chunks of watermelon. Thin textured orange juice, thin milk and hot water that was not thickened were on the breakfast tray. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's Altered textured diet d/t (due to) dysphagia care plan indicated the following: - Provide diet as ordered. Dated as revised 8/26/24. Review of Resident #9's meal ticket for the days of the survey indicated the following: Diet Order: Ground, Regular Diet Standing Orders: 8 oz (ounces) Milk Whole- Nectar, 4 oz Water- Nectar Thick, 4 oz Tomato Juice. Review of the Speech Therapy Discharge summary dated 8/16/23, indicated the following: Aspiration/reflux precautions. Slow rate of eating/drinking. Small bites/sips. Ground consistency diet and nectar-thick liquids. Review of Resident #9's dietary progress note dated 8/19/24, indicated, diet was recently from Pureed to Ground, continues on NAS (no added salt) restriction with nectar think liquids. Review of the dietary communication form dated 8/26/24 indicated Thin Liquids, Texture Need is Ground. During an interview on 9/5/24 at 8:40 A.M., Certified Nursing Assistant (CNA) #5 said Resident #9 has a history of choking and requires a ground diet and said the diet is listed for each resident in the ADL (Activities of Daily Living) book on the unit. Review of Resident #9's current Resident Care Kardex (for indicating level and type of care needed) failed to indicate any diet information and was left blank. During an interview on 9/5/24 at 9:49 A.M., the Consulting Nurse said staff are expected to follow diet orders and check diet slips prior to passing out meals. The Consulting Nurse said Resident #9 should not be given foods that are not ground and said orders must be followed. During an interview on 9/9/24 at 8:02 A.M., the Nurse #6 said Resident #9 has a history of aspiration and was hospitalized for pneumonia, he/she requires assistance with meals and is on a ground diet, so he/she does not choke. The Nurse #6 said Resident #9 should not be eating hard foods or chunks of fruit and said the diet slip must be checked before delivering food items. During an interview on 9/6/24 at 1:36 P.M., The Dietitian said Resident #9 should not be eating chicken pot pie with hard crust or chunks of fruit and vegetables due to the risk of choking. The Dietitian said his/her diet was recently updated from puree to ground texture and that updated orders should be in the chart and communicated to all staff and the diet slip should be checked. The Dietitian said Resident #9 requested thin liquids and a recommendation was made but no orders have been updated and said the recommendation has not been implemented.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48671 Based on observations, interviews and record review the facility failed to ensure its administration used its resources effectively to provide appropriate wound care. Specifically, the facility administration failed to: 1. Provide nursing staff education and training to provide competent, safe, and effective wound care management. 2. Provide continuation of the pressure injury prevention and care services following the absence of the Director of Nursing (DON) and implement an effective system for pressure injury (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the hips, heels, or elbows) prevention and care per the Facility Assessment Tool. These failures resulted in the development of an infected Stage 4 pressure injury for one Resident (#20) out of a total sample of 26 residents. Findings Include: During the survey process it was identified that the Administration's failure to perform wound care competencies for nursing staff that were delegated to assume the responsibilities of wound care management in the absence of a wound nurse resulted in a failure to perform skin checks and wound evaluations, implement physician orders, updated the physician and plan of care when significant changes occurred, and the development of an infected stage 4 pressure injury. Review of the Facility Assessment Tool, dated as reviewed with the QAPI (Quality Assurance Performance Improvement) committee in April 2024, indicated the facility offers pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). Further review of the Facility Assessment Tool indicated, but was not limited to, the following: Licensed Nurses providing direct care - Plan 1 DON (Director of Nurses) RN full-time Days; if has other responsibilities, add X more RN as Asst. DON to equal one FTE (full time employee). RN or LPN Charge Nurse: 1 for each shift. 1-X residents DON may be Charge Nurse. Staff training/education and competencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Staff members are provided in-services throughout the year and as needed on topics (see attached list of in-service types). Infection control-handy hygiene, isolation standard universal precautions including use of personal protective equipment, MRSA/VRE/ CDI precautions, environmental cleaning. Resident assessment and examinations- admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. Caring for persons with Alzheimer's or other dementia. Specialized care catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. The facility provides an Infection Control Committee and an Infection Preventionist in the Director of Nursing. Areas Facility Assessment Informed: Training, Competencies - Up to date. 1. The facility failed to provide nursing staff education and training to provide competent, safe, and effective wound care management. According to the Board of Registration in Nursing, 244 CMR 9.00 &10.00: Standards of Conduct, Definitions and Severability; a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Resident #20 was admitted to the facility in June 2024 with diagnoses including Alzheimer's disease, anemia, vitamin D deficiency, overactive bladder and cognitive communication deficit. Review of the Minimum Data Set (MDS) assessment, dated 6/14/24, indicated that Resident #20 had severely impaired cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15, and required assistance with activities of daily living. Further review of the MDS indicated that Resident #20 was at risk for developing pressure injury. Review of the medical record indicated that Resident #20's new unstageable DTI (Deep Tissue Injury) wound to the right heel, identified on 7/16/24, required antibiotic therapy resulting in the deterioration and developed into a Stage 4 pressure injury on 8/1/24. The medical record failed to indicate that nursing staff implemented treatment and physician orders recommended by the Consultant Wound Physician to Resident #20's right heel, or that staff notified the physician that the right heel wound progressed from an infected unstageable DTI to a Stage 4 pressure injury. Review of the nursing notes, physician notes and wound evaluations failed to indicate nursing staff evaluated and monitored the wound, implemented preventative interventions and treatments, or notified the physician of a change in condition to prevent the worsening of Resident #20's wound. According to the Mayo Clinic, complications and outcomes of Stage 4 pressure injuries include: (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Osteomyelitis, which is characterized by a mixture of inflammatory cells, fibrosis, bone necrosis, and new bone formation. It is associated with nonhealing wounds, surgical flap complications, and an increased length of hospitalization . It may develop within the first 2 weeks of pressure injury formation and despite treatment may require amputation in lower extremity cases. - Joint infections (septic arthritis) can damage cartilage and tissue. - Bone infections (osteomyelitis) can reduce the function of joints and limbs. - Long-term, nonhealing wounds can develop into a type of squamous cell carcinoma. - Sepsis (blood infection). Further review of Resident #20's medical record indicated the following: Nurse #7 completed a Skin Only Evaluation dated 7/17/24, that indicated Resident #20 had open lesions of the foot with a right heel area measuring 2 cm (centimeters) x 2.5 cm, with documented granulation, exudate, purulent, thin, thick, opaque, tan/yellow drainage, erythema. Tissue documented as painful and warm. Skin note indicated Right heel area with open wound injury 2 cm x 2.5 cm. Stage 3. Further review of the provider notification section of the Skin Only Evaluation form failed to indicate the provider was contacted as the form was blank and contained no notification information. Review of the medical record failed to indicate that the (MD)/(NP) were notified of the findings on the 7/17/24 Skin Only Evaluation. Further review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician, dated 7/18/24, indicated one right heel unstageable DTI (Deep Tissue Injury), closed, surface area 30 cm, length 5 cm, width 6 cm, no depth. Nurse #4 completed a Skin Only Evaluation, dated 7/31/24, indicated, skin was warm/dry. Skin turgor normal. Does the resident have current skin issues? Documented answer is No. Skin Note indicated, Stage 4 wound right heel with copious drainage, no foul odor. The evaluation did not contain detailed information regarding the wound. Review of the medical record indicated Resident #20 was seen by the Consultant Wound Physician on 8/1/24, and indicated undefined right heel wound, Stage 4, measurements: surface area 18.4 cm, 4 cm x 4.6 cm. Further review of Resident #20's medical record failed to indicate any wound assessments were documented on the Skin Only Evaluation form on the following dates: 8/7, 8/14, 8/21, and 8/28 and indicated: Does the resident have current skin issues? Documented answer is No. During an interview on 9/5/24 at 8:11 A.M., Nurse #4 said she will document information on the skin assessment but does not include measurements because the wound physician will do that. Nurse #4 said she has not completed any training aside from her new hire paperwork that was not related to wounds and has not completed any competencies. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/5/24 at 8:11 A.M., the Consultant Wound Physician said he expects staff to have demonstrated competencies on file, know how to implement physician recommendations and treatment orders to care for residents in the facility. During an interview on 9/5/24 at 9:04 A.M., Nurse #5 said Resident #20 has a right heel wound and that measurements and skin checks are done weekly. Nurse #5 said the wound physician comes out weekly and he will send the wound report to the facility. Nurse #5 said he will round with the wound physician and look at wounds, but he does not document the information in a skin check. Nurse #5 said there is no unit manager or Director of Nurses (DON), so he reports issues to the (NP). Nurse #5 said he has not completed any clinical training or competencies here at this facility and said he signed a packet on orientation for new hire documents but has not been trained on wounds or any other clinical competencies. Review of Nurse #7, Nurse #4 and Nurse #5 education files failed to include any demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment. Review of the education files failed to include recognizing and reporting wound deterioration, evaluation, measurements, and hands on clinical competency evaluations. The education files indicated Nurse #7, Nurse #4 and Nurse #5 did not have the necessary skills to properly evaluate Resident #20's unstageable DTI that deteriorated to a Stage 4 pressure injury. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said staff should report skin conditions and document findings as well as report new or worsening skin areas. The Consultant Nurse said all licensed clinical staff should have documented clinical competencies and know how to complete a skin assessment and document findings. The Consulting Nurse said nursing staff should know how to assess a pressure wound and apply treatment orders appropriately including how to do a sterile dressing change and follow appropriate infection control protocol. 2. The facility failed to provide continuation of the pressure injury prevention and care services following the absence of the Director of Nursing and implement an effective system for pressure injury (wounds that occur when the skin and tissue are damaged by prolonged pressure, usually on bony areas like the hips, heels, or elbows) prevention and care per the Facility Assessment Tool. During an interview on 9/4/24 at 8:48 A.M., Project Manager #1 said the DON has been out of the building since last month, the facility has been without a unit manager since last September, and they have been without a supervisor. The Project Manager #1 said he helps around the building with various tasks and worked as the Director of Rehab prior to this role. During an interview on 9/4/24 at 8:51 A.M. Nurse #4 said when she got back from vacation around 8/19/24 the Director of Nursing was already out. Nurse #4 said resident care plans were only updated by the DON. Nurse #4 said if a resident experienced a change, she would notify the Nurse Practitioner. When asked who would be notified in the facility during the DON's absence, Nurse #4 said she would inform the Minimum Data Set (MDS) nurse. During an interview on 9/4/24 at 9:43 A.M., NP #1 said the DON would review wound and other treatment recommendations, and staff would call regarding updates to wounds in the facility but in the absence of the DON she does not have access to any wound recommendations and treatment plans unless staff call her with updates and new orders. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/4/24 at 4:16 P.M., the Administrator said in the absence of the DON the charge nurse is responsible for the clinical decision making in the building. The Administrator said the charge nurse on the [NAME] unit is Nurse #7 and the North Unit is Nurse #5. The Administrator said the charge nurse does rounding on the residents, provides medications, supervises the CNAs (Certified Nursing Assistants), updates care plans, reviews recommendations, puts in new orders, responds to pharmacy recommendations, and reviews admissions. During an interview on 9/5/24 at 9:06 A.M., Nurse #5 said staff contact the Nurse Practitioner (NP) since there is no unit manager or charge nurse available to help and said the former MDS Nurse was available on weekends only but has since left. Nurse #5 said he was never told that he was a charge nurse and that he does not have access to the wound recommendations. and does not have a login. Nurse #5 said he is not sure who is looking at the recommendations in the absence of the DON. During an interview on 9/5/24 at 9:50 A.M., the Consultant Nurse said the Administrator called her two days ago and asked if she could be a contact person for the facility and said she was not aware that the DON had been out of the building and that she is not familiar with this facility. During a follow up interview on 9/5/24 at 10:12 A.M., the Administrator said he is not clinical, had no knowledge of wounds, infections or treatment recommendations not being followed and said he would not be notified unless it's relevant and that information is discussed at QAPI meetings. The Administrator said the facility has been without a Director of Nurses since 8/23/24 and she was responsible for oversight of wounds in the building and has access to the wound treatment recommendations and visit summaries. The Administrator said the facility does not have an assistant director of nurses, infection preventionist, unit managers or supervisors at this time. The Administrator said no outside services were consulted or contracted to provide clinical oversite and that staff nurses were expected to follow up with wound recommendations and update the Nurse Practitioner and Medical Director with concerns. The Administrator said the facility hired a new Minimum Data Set (MDS) Nurse that will be a clinical support person and was scheduled to start this week but was unable to be in the building. The Administrator said there is a covering Director of Nurses at another facility that is available, and staff can call with questions. During an interview on 9/5/24 at 12:25 P.M., the Medical Director said he was notified on 9/4/24 that the DON was out on leave and said he went on vacation on 8/22/24. The Medical Director said he expects the facility to assign someone to cover for the DON because we do not have an assistant director, infection preventionist, or a staff development coordinator, and the new MDS Nurse is not here. The Medical Director said the building must have clinical oversite of areas such as infections, reporting wounds, implementing orders and clinical oversight. The Medical Director said every building must have a DON. The Medical Director said senior members are responsible for clinical oversite and he expects the Administrator to delegate and implement measures to ensure no lapse in clinical oversite. The Medical Director said he expects a tracking system in place, and wound recommendations to be reviewed and implemented. During an interview on 9/6/24 at 11:11 A.M., the MDS Nurse said it is her second day here and she was made aware today that she would be point person for clinical questions. The MDS Nurse said she was told the DON was out sick when she was hired two weeks ago but did not know she was the point of contact for clinical questions and said she is not familiar with the building because she is new.

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	225049	A. Building B. Wing	09/26/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 48671 Based on review of the Facility Assessment and interviews, the facility failed to conduct and document a facility wide assessment that accurately reflected the resources necessary to care for its residents. Specifically, the facility failed to ensure licensed nursing staff were competent in wound care. Findings include: Review of the facility's document titled Facility Assessment Tool date of assessment or update April 5, 2024, indicated the following: Our Resident Profile indicated the average daily census: 1/1/24 - 3/31/24 as 65.25. Review of the common diagnoses of residents in the facility include but are not limited to, Psychiatric/Mood Disorders, Congested Heart Failure, Coronary Artery Disease, Parkinson's Disease, Hemiparesis, Alzheimer's Disease, Visual Loss, Hearing Loss, Fractures, Osteoarthritis, Prostrate Cancer, Breast Cancer, Lung Cancer, Diabetes, Thyroid Disorders, Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Renal Insufficiency, Ulcerative Colitis, Gastroenteritis, Bowel Incontinence, Skin Ulcers, Injuries, Skin Injections, Respiratory Infections. Part 2: Services and Care We Offer Based on our Residents' Needs Pressure injury preventions and care, skin care, wound care (surgical, other skin wounds). Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Staff training/education and competencies. Staff members are provided inservices (sic) throughout the year and as needed on topics (see attached list of inservice (sic) types). Training and Inservice review at the Facility: included but not limited to -Specialized Care- catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. Review of seven licensed nurse personnel files that were active on the schedule during the survey dated 9/3/24 through 9/6/24, 9/9/24, 9/12/24 and 9/16/24 failed to demonstrate the licensed nurses were assessed for competency in providing wound care. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said all licensed clinical staff should have documented clinical competencies.

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	225049	A. Building B. Wing	09/26/2024

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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. 45984 Based on record review, observations and interview, the facility failed to maintain accurate medical records. Specifically, staff signed off on the Treatment Administration Record (TAR) that weekly skin checks were completed when they were not for two Residents (#67, #26) out of a total sample of 26 residents. Findings include: Review of the facility policy titled Medical Record Documentation - Nursing Care, revised and dated 4/19/23 indicated the following: - Resident treatments (MAR/TAR) shall be signed and documented once the ordered treatment is performed. If the resident refuses the treatment, it should be documented. 1. Resident #67 was admitted to the facility in May 2024 with diagnoses including unspecified dementia, incontinence without sensory awareness and anxiety disorder. Review of the Resident's most recent Minimum Data Set Assessment (MDS) assessment, dated 5/30/24, indicated that the Resident had a Brief Interview for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated that Resident #67 needs assistance with all activities of daily living (ADLs) and is at risk for developing pressure ulcers/injuries. Review of Resident #67's physician's order dated 5/31/24 indicated the following: Weekly skin assessment every evening shift every Friday. Review of Resident #67's Skin Evaluations indicated that the last documented skin evaluation was completed on 8/16/24. There are no documented skin evaluations for 8/23/24, 8/30/24 or 9/6/24. Review of Resident #67's medical record failed to indicate that the Resident had refused any skin evaluations. Review of Resident #67's Treatment Administration Record (TAR) for August and September 2024 indicated that staff signed off as completing the weekly skin check evaluations for 8/23/24, 8/30/24 or 9/6/24 despite not being completed and documented in the Resident's medical record. During an interview on 9/5/24 at 8:33 A.M., Nurse #5 said skin checks are done weekly and they should only be documented as completed after staff have completed the weekly skin check on the resident. Nurse #5 was not sure why the skin checks were marked as being completed when they were not done. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said skin checks should only be documented as complete after they have been completed by staff. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #26 was admitted to the facility in July 2024 with diagnoses including pressure ulcer of left buttock stage 2, pressure ulcer of right upper back, non-pressure chronic ulcer of skin of other sites and dementia. Review of Resident #26's most recent Minimum Data Set Assessment (MDS) assessment, dated 7/24/24, indicated that the Resident had a Brief Interview for Mental Status score of 4 out of a possible 15 indicating severe cognitive impairment. Further review of Resident #26's MDS under section M indicated that the Resident is at risk for developing pressure ulcers and has one or more unhealed pressure ulcers/injuries. Review of Resident #26's physician's order, dated 8/1/24, indicated the following: - weekly skin assessment on Thursday 7-3 shift one time a day every Thu (Thursday). Review of Resident #26's Skin Evaluations indicated that the last documented skin evaluation was completed on 8/26/24. There are no documented skin evaluations for 9/5/24. Review of Resident #26's medical record failed to indicate that the Resident had refused any skin evaluations. Review of Resident #26's Treatment Administration Record (TAR) for September 2024 indicated that staff signed off as completing the weekly skin check evaluations for 9/5/24 despite not being completed and documented in the Resident's medical record. During an interview on 9/5/24 at 8:33 A.M., Nurse #5 said skin checks are done weekly and they should only be documented as completed after staff have completed the weekly skin check on the resident. Nurse #5 was not sure why the skin checks were marked as being completed when they were not done. During an interview on 9/9/24 at 9:48 A.M., the Consulting Nurse said skin checks should only be documented as complete after they have been completed by staff.

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	225049	A. Building B. Wing	09/26/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview, the facility failed to ensure a current hospice care plan was present in the medical record and coordinated with facility staff for two Residents (#5 and #7) out of four applicable residents in a total sample of 26 residents. Findings include: Review of the facility's policy titled Hospice Program, not dated, indicated the following: - Hospice services are available to residents at end-of-life care. - 12. Our facility has designated (Name) (Title) (both left blank) to coordinate care provided to the resident by our facility staff and hospice staff. He or she is responsible for the following: - d. Obtaining the following information from the hospice: - (1) The most recent hospice plan of care specific to each resident. Review of the Hospice Provider Contract dated as entered into agreement on the 30th day of March 2023, indicated the following: Admission to the Hospice Program, there must be a written physician's order to admit a facility patient to Hospice. At the time of admission to the Hospice of eligible Facility residents in accordance with federal and state laws and regulations, Hospice shall (in conjunction with nursing facility personnel) develop a Hospice plan of care for the management of palliation for the resident's terminal illness. The facility shall be provided with a copy of the Hospice Plan of Care and if the Facility has any concerns in regard to the Hospice care plan, the Facility shall promptly advice Hospice of its concerns. [sic] 1. Resident #5 was admitted to the facility in November 2022 with diagnoses that include but are not limited to type 2 diabetes, schizophrenia, and peripheral vascular disease. Review of Resident #5's the most recent Minimum Data Set (MDS) assessment, dated 6/10/24, indicated he/she was unable to participate in the Brief Interview for Mental Status Exam and was assessed by staff as having severe cognitive impairment. The MDS further indicated the Resident is dependent on staff for all activities of daily living and is receiving hospice care services. Review of the current and discontinued physician's orders failed to indicate an order for hospice care services. Further review of Resident #5's medical record indicated the following: - A facility care plan: I am receiving hospice services, dated 6/6/23. - A hospice plan of care with the certification period of 5/31/24 through 7/29/24. No current hospice care plan was in the medical record. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Progress notes reviewed from 7/31/24 to 9/5/24 failed to indicate notes regarding the resident's current hospice plan of care. During an interview on 9/5/24 at 9:06 A.M., The Social Worker (SW) said the Director of Nursing is the go between for the facility and hospice providers. The SW said the hospice staff come in routinely, but she was not sure of the process for care planning. The SW reviewed the hospice binder for Resident #5 and said the plan of care was dated from 5/31/24 through 7/29/24 and that no current hospice care plan was in the record. The SW said the Director of Nursing would make sure the plan of care for hospice care services is up to date and followed. During an interview on 9/5/24 at 9:52 A.M. the Consultant Nurse said the hospice plan of care should be current and available for facility staff to review. 2. Resident #7 was admitted to the facility in April 2021 with diagnoses that include but are not limited to basal cell carcinoma of skin of other parts of face, unspecified dementia, localized edema, moderate protein calorie malnutrition, venous insufficiency (chronic) (peripheral), and paranoid schizophrenia. Review of the MDS dated [DATE] indicated Resident #7 had a score of 0 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment and requires substantial/maximal assistance with activities of daily living including bathing and dressing. Review of Resident #7's medical record indicated the following: - A physician's order dated 8/5/24, may be admit [sic] on hospice care and services. During an interview on 9/4/24 at 1:10 P.M., The hospice representative said Resident #7 signed on to hospice services on 8/9/24. Review of the hospice binder for Resident #7 failed to have an individualized comprehensive care plan for the provision of hospice services for the Resident. During an interview on 9/5/24 at 11:24 A.M., The SW said there was no plan of care for hospice services provided by the hospice provider for the facility staff to access. During an interview on 9/5/24 at 9:52 A.M. the Consultant Nurse said the hospice plan of care should be current and available for facility staff to review.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 43846 Based on observation, record review and interview the facility failed to implement an infection control program to prevent infection. Specifically, 1. The facility failed to develop and implement a plan for water borne illness, 2. The facility failed to develop and implement enhanced barrier precautions, 3. The facility failed to ensure infection control practices for the use of respiratory equipment was implemented for one Resident (#36) out of a total sample of 26 residents. Findings include: 1. Review of the facility policy titled Legionella Surveillance and Detection, not dated, indicated the facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Legionnaire's disease will be included as part of our infection surveillance activities. During an interview on 9/4/24 at 1:25 P.M., the Maintenance Worker said they currently do not have a water management program in place. The Maintenance Worker said he does not know what the risk assessment is for the building and has calls out to a water management company. 2. Review of the facility policy titled Infection Control, dated 10/11/23, indicated Enhanced barrier protection involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as those at risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). On 9/3/24 at 1:17 P.M., the surveyor observed Resident #26's wound care with Nurse #6. Nurse #6 pulled down the Resident's incontinence brief and removed the coccyx dressing only wearing gloves. Nurse #6 said she was unaware she needed to DON (apply) PPE (personal protective equipment) during wound care. During an interview on 9/9/24 at 7:29 A.M., Nurse #3 and Certified Nurse Aide (CNA) #2 said they are unaware of what enhanced barrier precautions are. Nurse #3 and CNA #2 said they have residents with wounds and do not utilize PPE (personal protective equipment) during care for those residents. Nurse #3 and CNA #2 they never received education from the facility on enhanced barrier precautions. During an interview on 9/9/24 at 7:32 A.M., Nurse #6 said she is unaware of what enhanced barrier precautions are. Nurse #6 said they have residents with wounds and do not use PPE during care. During an interview on 9/9/24 at 7:33 A.M., the Minimum Data Set (MDS) Nurse said she is aware of enhanced barrier precautions and noticed there are no signs or PPE in place on certain residents and there should be to alert the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Nursing Center	30 Watertown Street Lexington, MA 02420

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said residents with wounds, foley catheters and residents with feeding tubes should be on enhanced barrier precautions. The Consulting Nurse said there should be signs in place on the resident door indicating they need to be cared for with PPE. 36431 3. For Resident #36 the facility failed to ensure infection control standards of practice to prevent infection were implemented, when facility staff placed a nasal cannula that was on the floor of the dining/activity room on the Resident. Resident #36 was admitted to the facility in October 2021 with diagnoses that include chronic obstructive pulmonary disease and unspecified dementia. Review of the Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident #36 scored a 0 out 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicates Resident #36 is dependent on staff for daily care and uses oxygen therapy. Review of Resident #36's physician's orders indicated the following: -Oxygen Permeable Lens Products Solution (Oxygen Permeable Lens Products) 2 liter in nostril every shift for heart failure administer oxygen at 2 to 4 liter (sic) (flow rate) via NC (nasal cannula) may use nasal cannula as well to keep oxygen greater than 96%, dated active 3/26/2024. (sic) On 9/3/24 at 10:45 A.M., Resident #36 was sitting in his/her wheelchair with a portable oxygen tank on the back of the chair. Resident #36's nasal cannula was directly on the floor. On 9/3/24 at 10:49 A.M. the Activity Assistant picked up the nasal cannula up off the floor and placed the potentially contaminated nasal cannula in Resident #36's nose to administer oxygen. During an interview on 9/4/24 at 5:08 P.M., Nurse #8 said if a nasal cannula is on the floor it should be considered unclean and should be changed and not placed back on the resident.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 43846 Based on policy review and interview, the facility failed to implement an antibiotic stewardship program to promote and monitor the appropriate use of antibiotics. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled: The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance. - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. - The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. - Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of the facility policy Antibiotic Stewardship Program, dated 10/11/23, indicated it is the policy of the facility to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. Facility staff will provide education to nurses about the stewardship program. The facility will meet monthly as an Antibiotic Stewardship Committee. Facility staff will provide education to nurses about the stewardship program. The facility will have a tracking sheet that is designed to bring together all data about infection such as laboratory results, X-rays, organism name, prescribing clinician, and antibiotic therapy. The tracking sheet can also be used to communicate with health care providers about appropriate use of antibiotics. An antibiotic review process, also known as antibiotic time-out (ATO) for all antibiotics prescribed in the facility. ATOs prompt clinicians to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer, and more information is available. ATO can be considered a stop order of an antibiotic when diagnostic test results or symptoms of resident do not support the diagnosis of infection. Review of the facility's antibiotic stewardship line listing binder failed to indicate that antibiotics were tracked in the month of July 2024 and only one of three units were tracked in the Month of August 2024. Further review of the binder failed to indicate that antibiotics prescribed to the residents in the facility had an antibiotic time out to reassess the need for the antibiotic. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/9/24 at 7:29 A.M., Nurse #3 and Certified Nurse Aide (CNA) #2 said they are not sure what antibiotic stewardship is. Nurse #3 said all she does if a resident is on an antibiotic is she places them on the infection list. Nurse #3 said she does not notify the provider and ask about an antibiotic time-out. Nurse #3 and CNA #2 said they have never had education on the antibiotic stewardship program. During an interview on 9/9/24 at 7:32 A.M., Nurse #6 and the surveyor reviewed the antibiotic stewardship line listing binder, the binder had blank infection control criteria forms. Nurse #6 said she puts the resident names on the line listings and that's it. Nurse #6 said she has never received education on the antibiotic stewardship program. During an interview on 9/9/24 at 9:08 A.M., the Consulting Nurse said an antibiotic stewardship program is more than line listings and said nursing staff should be aware of what the program is and how to initiate the program when a resident starts an antibiotic.

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	225049	A. Building B. Wing	09/26/2024

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 43846 Based on interviews and review of the Facility Assessment, the facility failed to designate one or more individuals as the infection preventionist who are responsible for the facility's infection prevention and control plan. Specifically, the facility failed to have a qualified infection preventionist with completed specialized training in infection prevention and control. Findings include: Review of the facility policy titled Infection Preventionist, not dated, indicated the facility provides an Infection Preventionist to monitor the overall infections and infection control of the building. Infection Preventionists (IPs) are professionals who make sure healthcare workers and patients are doing all the things they should to prevent infections. Most IPs are nurses, epidemiologists, or public health professionals who work to prevent germs from spreading within healthcare facilities. During the entrance conference on 9/3/24 at 8:08 A.M., the Administrator said the Infection Control Preventionist was the Director of Nurses (DON) but she has been on leave since 8/22/24. Review of the DON's nursing home Infection Preventionist (ICP) training course modules failed to indicate the DON completed the post-test to receive the certificate of completion. During an interview on 9/9/24 at 7:29 A.M., Nurse #3 and Certified Nurse Aide #2 said they are not sure who is the ICP is currently in the building. During an interview on 9/9/24 at 7:32 A.M., Nurse #6 said she is not sure who is the ICP is currently in the building. Nurse #6 said the DON has been out for weeks. During an interview on 9/9/24 at 7:33 A.M., the Consulting Nurse said there should always be a back up to the ICP at the facility and said she is unaware of who that is. The Consulting Nurse said to be an ICP you need to complete the training modules as well as the posttest in order to successfully complete the nursing home Infection Preventionist (ICP) training.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48671 Based on review of the Facility Assessment, employee education record review, and interview, the facility failed to implement and maintain and effective training program per the facility assessment for all new and existing staff. Specifically, the facility failed to provide the required training necessary to meet the needs of each resident. Findings include: Review of the Facility Assessment, dated as reviewed in April 2024, included but was not limited to the following: Staff training/education and competencies. -Staff members are provided in-services throughout the year and as needed on topics including infection control-hand hygiene, isolation and standard universal precautions including use of personal protective equipment, MRSA/VRE/ CDI precautions, environmental cleaning. Resident assessment and examinations-admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. Caring for persons with Alzheimer's or other dementia. Specialized care catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. The facility provides an Infection Control Committee and an Infection Preventionist in the Director of Nursing. Areas Facility Assessment Informed: Training, Competencies - Up to date. Review of 10 personnel files of actively working clinical nursing staff including 4 Licensed Nurses and 6 Certified Nursing Assistants (CNA) on 9/3/24 and 9/4/24 indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the Facility Assessment. Further review of the employee records failed to indicate yearly competencies as determined by the needs of the residents based on the Facility Assessment. Review of additional 3 personnel files of actively scheduled and working licensed nurses failed to indicate any competencies related to the specialized care areas outlined in the Facility Assessment including infection control, clinical competencies, skin assessments, and wound care. In all, 7 licensed nurses failed to have any clinical competencies. Review of 10 direct care staff education files (6 Certified Nurse Assistants (CNAs) and 4 Licensed Nurses indicated the following training/competencies completed as applicable on hire. (continued on next page)

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	225049	A. Building B. Wing	09/26/2024

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 0 out of 10 had documentation they had completed any clinical training or competencies completed upon hire. During an interview on 9/6/24 at 9:40 A.M., the Administrator and Assistant Administrator (AA) said all newly hired employees come to the facility for about three hours and review policies and procedures, they do a skills fair annually, but they do not review any clinical topics. The AA said the Director of Nursing (DON) would determine when the staff are competent enough to work. The AA continued to say historically, the facility has used word of mouth and verbal confirmation to track newly hired employees' status of staff shadowing and training. The AA then said the facility has no training curriculum. The Administrator and AA said the facility provides clinical in-services (sic) for all staff. During an interview on 9/9/24 at 7:39 A.M., Nurse #6 said during orientation she reviewed mostly administrative things, sensitivity training, abuse training and said she did not completed any clinical competencies. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said all licensed clinical staff should have documented clinical competencies. No further educational documents were provided during the survey.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 48671 Based on review of the Facility Assessment, employee education record review, and interviews, the facility failed to implement mandatory infection control training for 10 out of 10 direct care staff. Findings include: Review of the Facility Assessment, dated as reviewed in April 2024, indicated: Staff training/education and competencies. -Staff members are provided in-services throughout the year and as needed on topics (see attached list of in-service types). Infection control-handy hygiene, isolation standard universal precautions including use of personal protective equipment, MRSA/VRE/ CDI precautions, environmental cleaning. Resident assessment and examinations- admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. Caring for persons with Alzheimer's or other dementia. Specialized care catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care. The facility provides an Infection Control Committee and an Infection Preventionist in the Director of Nursing. Areas Facility Assessment Informed: Training, Competencies - Up to date. Throughout the survey the surveyor requested staff education files with all training and competencies for direct care staff. Review of 10 personnel files of actively working clinical nursing staff including 4 Licensed Nurses and 6 Certified Nursing Assistants (CNA) on 9/3/24 and 9/4/24 indicated the facility failed to conduct training that included an evaluation of demonstrated competencies necessary to provide the level and types of care needed for the resident population as required per the facility assessment including infection control. Review of additional 3 personnel files of actively scheduled and working licensed nurses failed to indicate any competencies related to the specialized care areas outlined in the Facility Assessment including infection control. In all, 7 licensed nurses failed to have clinical competencies including infection control, hand hygiene, including the use of personal protective equipment. Review of 10 direct care staff education files (6 Certified Nurse Assistants (CNAs) and 4 Licensed Nurses indicated the following training/competencies completed as applicable on hire. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 0 out of 10 had documentation they had completed any infection control training or competencies completed upon hire. During an interview on 9/9/24 at 7:39 A.M., Nurse #6 said during orientation she reviewed mostly administrative things, sensitivity training, abuse training, HIPPA over anything clinical. Nurse #6 said infection control was talked about, but she did not completed any competencies. During an interview on 9/9/24 at 9:21 A.M., the Consulting Nurse said all licensed clinical staff should have documented clinical competencies.