STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225176	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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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 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. 42690 Based on observation, and interview, the facility failed to maintain a clean, comfortable, and homelike environment for one Resident (#79) out of a total sample of 20 residents. Specifically, for Resident #79, the facility failed to maintain the resident's wheelchair in a clean and sanitary manner. Findings include: Resident #79 was admitted to the facility in December 2023. On 11/20/24 at 8:27 A.M., the surveyor observed Resident #79's seated in a wheelchair in his/her room. The surveyor observed the wheelchair to have dirt/debris and/or food particles spackled on the chair cushion, frame, brakes, and wheels. On 11/21/24 at 1:18 P.M., the surveyor observed Resident #79 exiting the dining room after having lunch. The surveyor observed the Resident's wheelchair to have dirt/debris and/or food particles on the chair cushion, frame, brakes, and wheels. On 11/25/24 at 9:57 A.M., the surveyor observed Resident #79 sitting in his/her wheelchair in his/her room. The surveyor observed that the Resident's wheelchair remained with dirt/debris and/or food particles on the chair cushion, frame, brakes, and wheels. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 11/25/24 at 11:41 A.M., the Director of Housekeeping provided the surveyor with the wheelchair cleaning schedule. The Director of Housekeeping said that the housekeeping department is not always able to follow the wheelchair cleaning schedule, but they try. The surveyor and the Director of Housekeeping reviewed the wheelchair cleaning schedule, and the Director of Housekeeping said that the A-wing (unit on which the Resident resided) wheelchairs were scheduled to be cleaned on 11/3/24 and 11/24/24. The Director of Housekeeping said that each units' wheelchairs are cleaned twice a month but was unable to provide evidence of a tracking system of what wheelchairs had been cleaned. The Director of Housekeeping said that all wheelchairs on the unit scheduled to be cleaned, should be cleaned. The Director of Housekeeping said that each wheelchair is sprayed with disinfectant cleaner, showered off, then wiped dry. The surveyor and the Director of Housekeeping observed Resident #79 seated in his/her wheelchair. The Resident's wheelchair was observed to have dirt/debris and/or food particles on the chair cushion, frame, brakes, and wheels. The Director of Housekeeping said that the chair should not look like that and needed to be cleaned. The Director of Housekeeping said she could not speak to when the chair had last been cleaned.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on interview, and record review, the facility failed to notify the state mental health authority for a resident review (person-centered assessment taking into account all relevant information) after a significant change in mental condition occurred for one Resident (#12) out of a total sample of 20 residents. Specifically, the facility failed to request a Preadmission Screening and Resident Review Level II screen (PASRR-and evaluation done to determine if a resident has an intellectual or developmental disability [ID/DD] and/or serious mental illness [SMI] and is in need of additional specialized support services at the facility) after Resident #12 received a diagnosis of Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and experienced limitations in major life activities due to mental illness. Findings include: Review of the facility policy titled Coordination with PASRR Program, dated 2/2/24, indicated the following: -Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the State mental health or intellectual authority for a level II resident review. Resident #12 was admitted to the facility in March 2024, with diagnoses including Chronic Respiratory Failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue) and Obstructive Sleep Apnea (OSA: pauses in breathing due primarily to the collapse of the upper airway during sleep). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12: -was cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. -had not been evaluated by a Level II PASRR. -has active diagnoses of Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and Bipolar Disorder. Review of Resident #12's PASRR Level I (initial pre-screening completed prior to admission to a Nursing Facility) screen, dated 3/15/24, indicated: -No diagnosis of mental illness or disorder. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No treatment history for mental illness in the past two years. -No limitation in major life activities. -Negative SMI screen. Review of Resident #12's Behavioral Health Group Note dated 3/22/24, indicated: -diagnosis of Bipolar Disorder. -a long history of Depression and Anxiety. -will continue with therapy with his/her therapist in the community via telehealth. -will be seen be seen by Behavioral Health Group Provider the following week. During an interview on 11/21/24 at 3:32 P.M., the Social Worker (SW) said she had worked at the facility since September 2024 and the PASRR Level I for Resident #12 was completed before her time of employment. The SW said that she did not know what information was available when the PASRR Level I was completed prior to admission, but when it was evident that Resident #12 had a diagnosis of Bipolar Disorder, a Change of Condition should have been done through the portal. The SW checked the Massachusetts Executive Office of Health and Human Services (EOHHS) portal and said that a Change of Condition had not been submitted and should have been.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42741 Based on interview, and record review, the facility failed to ensure a baseline care plan was created within 48 hours of admission to the facility for two Residents (#47 and #36) out of a total sample of 20 residents. Specifically, the facility failed to: 1. for Resident #47, ensure a baseline care plan was created within 48 hours of admission relative to Resident #47 being actively treated for Methicillin-Resistant Staphylococcus Aureus (MRSA - an infection caused by a type of staph bacteria that has become resistant to many antibiotics, that is contagious and easy to spread by both direct and indirect contact requiring special precautions to be in place to prevent further spread) in a wound. 2. For Resident #36, ensure a baseline care plan was created within 48 hours of admission to ensure the Resident received the care and services necessary to care for him/her until a comprehensive care plan could be created. Findings include: Review of the facility policy titled Interim Care Plan, revised 11/6/24, indicated the following: -The purpose of the interim care plan is to guide care until the comprehensive care plan is completed. -To assure that the resident's immediate care needs are met and maintained, a preliminary care plan is developed upon admission. The interim plan of care should be implanted within forty-eight (48) hours of admission. {sic} Review of the facility policy titled Isolation Precautions, revised 10/28/24, indicated the following: -The establish transmission-based precautions for resident who are suspected or confirmed to have communicable diseases/infections that can be transmitted to other. {sic} -Appropriate communication/notices will identify the resident/room with isolation precautions implemented. -Contact Precautions (a set of safety measures used to prevent the spread of infectious agents that can be transmitted through direct or indirect contact)-Multi-Drug Resistant Organisms (which would include MRSA) . 1. Resident #47 was admitted to the facility in November 2024 with diagnoses including MRSA in left groin wound and sepsis (a life-threatening medical emergency that occurs when an infection triggers the body's immune system to damage its own organs and tissues). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Discharge/Transfer Note dated 11/5/24, indicated Resident #47 was actively being treated for MRSA infection in a wound on his/her groin with two antibiotics, Cephalexin and Doxycycline. Review of Resident #47's Baseline Care Plan, indicated the following: -the Baseline Care Plan was opened and completed on 11/14/24, eight days after the Resident was admitted to the facility -Resident #47 needed Contact Precautions due to a diagnosis of MRSA. Review of Resident #47's November 2024 Physician's orders indicated no order for Contact Precautions until 11/11/24, six days after the Resident was admitted to the facility. Review of Resident #47's Comprehensive Care Plan, titled I, indicated the Resident currently have an infection due to MRSA, Wound/Skin infection {sic}, and that a Comprehensive Care Plan was not created until 11/11/24. During an interview on 11/25/24 at 12:07 P.M., the Infection Preventionist (IP) said Resident #47 was admitted with a diagnosis of MRSA and needed to be on Contact Precautions when he/she was admitted to the facility. The IP said a Baseline Care Plan should have been created within 72 hours of Resident #47's admission to the facility, that indicated Resident #47 needed to be on Contact Precautions. The IP further said if a Baseline Care Plan had not been created the Resident should have had a Physician's order in place for Contact Precautions so the nursing staff knew how to provide care for the Resident and neither of these things were done at the time the Resident was admitted to the facility. 50563 2. Resident #36 was admitted to the facility in October 2024 with diagnoses including End Stage Renal Disease (ESRD: a medical condition where the kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [a procedure to remove waste products and fluid from the body when the kidneys stop working] or a kidney transplant to maintain life), and Type 2 Diabetes (DM II: condition in which the body does not produce enough insulin hormone and has trouble controlling blood sugar levels). Review of Resident #36's Baseline Care Plan indicated the following: -the Baseline Care Plan had been opened and completed on 11/2/24, four days after admission -a copy of the Baseline Care Plan had not been provided to the Resident. During an interview on 11/26/24 at 8:15 A.M., Unit Manager (UM) #2 said the Baseline Care Plan should be completed within 48 hours of admission. UM #2 further said she reviews the Baseline Care Plan with the residents after it is completed but does not provide the residents with a copy.

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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. 37400 Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice for one Resident (#346), for one applicable resident reviewed, out of a total sample of 20 residents. Specifically, for Resident #346, the facility failed to ensure the external catheter length and arm circumference were measured as ordered by the Physician when the Resident had a Peripherally Inserted Central Catheter (PICC: a thin, soft tube that is inserted into a vein in the arm, for long-term antibiotics, nutrition, medications, and blood draws. The PICC is a type of CVAD [Central Vascular Access Device] catheter) line) for intravenous administration of antibiotics increasing the potential risk of infiltration (when fluid or medication given by an intravenous [IV] device exits the vein and enters the soft tissues), migration (change in the length of catheter extruding from the insertion site, is a medical emergency and must be addressed immediately), and/or deep vein thrombosis (DVT: a blood clot in a deep vein). Findings include: Review of the facility policy titled PICC/Central Line/Port-a-Cath Maintenance, dated 10/15/23, indicated the purpose was to: -to identify standards of care for patients with PICC lines . -to act as a resource for staff so that errors leading to complications are reduced. -identify and comply with current best practices from infection control and infusion nursing standards. -Maintenance and Care: >dressing change every seven days and as needed (PRN). >measure the length of the lumen (cavity or channel within a tube) from the insertion to the end site. >measure the circumference of the upper arm and document. >this was to be done upon admission, with each dressing change and PRN. >record care provided in the electronic medical record (EMR). Resident #346 was admitted to the facility in November 2024 with diagnoses including open area of the lower leg, right lower extremity Cellulitis (potentially serious bacterial skin infection where the skin is swollen, inflamed, painful and warm to the touch) and Methicillin-Resistant Staphylococcus Aureus (MRSA: strain of gram-positive bacteria resistant to several antibiotics, making it difficult to treat, which spreads through contact with infected individuals). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #346's Vascular Access Insertion Note, dated 11/2/24, indicated: -right upper extremity PICC line was inserted. -catheter size measured 4 French (Fr: the French scale, commonly used to measure the size of a catheter or tubing). -catheter length 40 centimeters (cm). -middle arm circumference 10 cm above antecubital fossa (a triangular area inside of the elbow) = 28 cm. -the Vascular Access Insertion Note did not indicate the external catheter length. Review of the Minimum Data Set (MDS) Assessment, dated 11/15/24, indicated: -Resident #346 understands and was understood -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 -had a surgical wound and was receiving surgical wound care -received an antibiotic during the assessment period Review of the PICC Line Care Plan, initiated 11/15/24, indicated Resident #346 had Osteomyelitis (inflammation of bone or bone marrow due to infection) and MRSA present in a wound. The PICC Line Care Plan included the following interventions: -administer IV medications and IV fluids as ordered by the Physician ., initiated 11/15/24 -follow Physician orders and facility policy for care and maintenance of IV access and dressing care, initiated 11/15/24 Review of Resident #346's November 2024 Physician's orders indicated: -Daptomycin (antibiotic) 450 milligrams (mg) IV daily for septic (infected) knee until 12/9/24, initiated 11/9/24 -Normal Saline (NS: solution of sodium chloride in water) flush 0.9% use 10 milliliter (ml) IV every shift before/after IV medications and 10 ml IV PRN for prevention, initiated 11/8/24 -change PICC line dressing every seven days, initiated 11/8/24 -Measure the length of the lumen from the insertion to the end site, measure the circumference of the upper arm and document every shift on Saturday and PRN, initiated 11/8/24 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-monitor IV site to right arm daily, notify Physician of complications every shift, initiated 11/8/24 Review of the November 2024 Treatment Administration Record (TAR) indicated: -PICC line dressing change every seven days which included instructions to measure and document the length of the lumen from the insertion site to the end site (external catheter site). -measurement of the circumference of the upper arm was signed off as administered on 11/9/24, 11/16/24 and on 11/23/24. -no documented evidence of the obtained measurements for the external catheter length and arm circumference on those dates. Review of Resident #346's clinical record indicated no documented evidence of: -PICC line external catheter length measurement upon insertion or evidence of measurements obtained since admission. -measurements obtained of arm circumference since admission. On 11/20/24 at 9:36 A.M., the surveyor observed Resident #346 dressed and lying in bed. The surveyor observed an IV pole was in the room and a PICC line dressing dated 11/19/24 was in place on the Resident's right inner arm. On 11/26/24 at 11:11 A.M., the surveyor and Nurse #4 reviewed Resident #346's clinical record and Nurse #4 said the Resident's external catheter length and arm circumference should be measured with every PICC line dressing change weekly and as needed. Nurse #4 said the paperwork prior to the Resident's admission indicated the PICC line was 4 Fr and the total catheter length was 40 centimeters (cm), but it did not indicate the measurement of the length of external catheter. Nurse #4 said that she was unable to find evidence in the clinical record that measurements for the external catheter length and arm circumference had been recorded since the Resident's admission. Nurse #4 said it was important to monitor these measurements to ensure that the PICC line catheter had not migrated (moved out of place). Nurse #4 further said if the PICC line moved, then the IV medication may not be administered through the vein as indicated and an infection could occur. On 11/26/24 at 11:25 A.M., the surveyor observed the Resident's PICC line site with Nurse #4 and the following measurements were obtained: -external catheter length was 10 cm -arm circumference was 26 cm During an interview at the time, Resident #346 said that he/she could not recall staff obtaining these measurements since admission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 11:29 A.M., Unit Manager (UM) #2 said she was unable to find documented evidence of Resident #346's measurements for the external catheter length and arm circumference since his/her admission, that these measurements should have been obtained and documented.

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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** 42690 Based on observation, record review, and interview, the facility failed to ensure Activities of Daily Living (ADLs) were provided for one Resident (#45), out of a total sample of 20 residents. Specifically, the facility failed to provide assistance for Resident #45 to ensure daily oral hygiene was completed when the resident was unable to carry out ADLs independently. Findings include: Review of the facility policy titled Activities of Daily Living, initiated on January 23, 2024, indicated the following: -Residents will [sic] provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. -appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . a. Hygiene (bathing, dressing, grooming, and oral hygiene) Resident #45 was admitted to the facility in November 2019 with diagnoses including Epilepsy (seizure disorder), Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity) Apraxia (neurological syndrome characterized by difficulty in performing daily tasks even if the instructions are understood), Aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain centers), and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated the following: -Sometimes understands - responds adequately to direct, simple communication only. -Oral hygiene - dependent, (helper does all of the effort) Review of the ADL care plan, initiated on 11/22/19, indicated Resident #45: -Required assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to cognitive decline. -Arrange Resident/patient environment as much as possible to facilitate ADL performance, updated 11/23/19. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide Resident/patient with extensive assist to total assist of one for personal hygiene, updated 11/23/19. Review of Resident #45's Dental Group Encounter Note dated 9/9/24, indicated the following: -moderate buildup of soft plaque/food debris -moderate hard calculus deposits Review of the November 2024 task flow sheet for Oral Hygiene, completed daily by the Certified Nurses Aides (CNAs) indicated the following: *Key for Level of care/assistance: -01-Dependent-Helper does ALL of the effort. -06 -Independent -Resident completes the activity by themselves with no assistance from a helper. -05-Set up or Clean up assistance. *Resident #45: -Was dependent for oral hygiene care on the following dates and shifts: >11/1/24 -11/20/24 and 11/22/24 -11/24/24 during the day shift >11/3/24, 11/5/24, 11/7/24 -11/11/24, 11/14/24, 11/17/24, and 11/19/24 -11/24/24 during the evening shift -Was independent for oral hygiene care on the following dates and shift: >11/21/24 during the day shift -Was a set-up for oral hygiene care on the following dates and shift: >11/5/24 on the evening shift -Did not participate in oral hygiene care on the following dates and shift: >11/1/24, 11/2/24, 11/6/24, 11/12/24, 11/13/24, 11/15/24, 11/16/24, and 11/18/24 on the evening shift During an interview and observation on 11/20/24 at 8:48 A.M., the surveyor greeted Resident #45 in the dining room, where he/she was seated at a table with another resident waiting for breakfast to be served. The surveyor asked Resident #45 how he/she was doing today. The Resident responded with a smile and nonsensical words. When Resident #45 opened his/her mouth to speak, the surveyor observed the following: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a strong odor from his/her mouth -front teeth missing -plaque and debris built up on both upper and lower teeth During an interview and observation on 11/21/24 at 10:48 A.M., the surveyor and CNA #2 entered Resident #45's room to observe the Resident's teeth. CNA #2 said she does not always provide care for the Resident and she was not the CNA taking care of the Resident today, but she was familiar with the Resident's care. CNA #2 said that it did not appear that the Resident had brushed his/her teeth yet today. CNA #2 began to search the Resident's room for a toothbrush and toothpaste and was not able to locate either item. At this time, CNA #2 left the room and returned a few moments later with a new toothbrush, toothpaste, a small cup of water and a small kidney shaped container (used to spit into). CNA #2 placed the items on a tray table in front of Resident #45 and applied toothpaste on the toothbrush. Resident #45 smiled, said thank you and immediately picked up the toothbrush and began to brush his/her teeth independently. When the Resident was finished, he/she smiled, showing his/her brushed teeth while nodding his/her head up and down. CNA #2 said she could not speak to when the Resident's teeth had last been brushed or the last time the Resident was set up to independently to brush his/her teeth. During an interview on 11/21/24 at 11:35 A.M., CNA #3 said that she was the CNA assigned to Resident #45 and she did not provide morning mouth care for the Resident. CNA #3 said that she should have either assisted the Resident with brushing his/her teeth or set the Resident up with the items needed for him/her to do his/her own mouth care, as it is part of morning care routine. CNA #3 said that she does not always provide mouth care for Resident #45 because sometimes the Resident's gums bleeds and this makes her nervous. CNA #3 said that as an alternative she will give the Resident a toothette (a small sponge on a stick) to brush his/her teeth, but not an actual toothbrush. The surveyor and CNA #3 observed Resident # 45's brushed teeth that they were clean and did not have a foul odor. Resident #45 smiled and said thank you when his/her teeth were complimented. During an interview on 11/25/24 at 3:27 P.M., the Director of Nursing (DON) said mouth care should be provided every morning and every night. The DON said if a Resident is having a dental issue, we might use a swab (toothette), but other than that we should be using a toothbrush. The DON was not aware of any dental issues with Resident #45.

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Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435 Based on interview, observation, and record review, the facility failed to provide respiratory care and services consistent with professional standards of practice for one Resident (#12), out of one applicable resident, out of a total sample of 20 residents. Specifically, the facility failed to ensure: -a Physician's order was in place for the use of Continuous Positive Airway Pressure (CPAP- a type of non-invasive device that involves the administration of air usually through the nose and/or mouth by an external device at a predetermined level of pressure to keep the airways open) -respiratory equipment was stored in such a manner to prevent contamination and risk of infection. Findings include: Review of the facility policy titled CPAP and BiPAP (Bi-level Positive Airway Pressure - a noninvasive device capable of generating two adjustable pressure levels: inspiratory [IPAP - higher level] and expiratory [EPAP - lower level] that assists with ventilation) Usage/Maintenance, dated 1/10/24, indicated the following: -CPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. -Residents using CPAP/BIPAP will require a Physician's order to include approved order settings, duration of use and use of humidifier . -Verify Physician's order in the residents' chart. -Verify mode and settings on the machine, as prescribed. -Machine cleaning: Wipe machine with warm, soapy water (dish detergent is preferable) and rinse at least once a week and as needed (PRN). -Humidifier (if used): >Use clean, distilled water only in the humidifier chamber. Replace water daily. >Clean humidifier weekly and air dry. >To disinfect, place vinegar-water solution (1:3) in clean humidification chamber. Soak for 30 minutes and rinse thoroughly. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Filter cleaning: rinse washable filter under running water once a week to remove dust and debris. Replace the filter at least once a year. Replace disposable filter monthly. -Masks, nasal pillows, and tubing: clean weekly by placing in warm, soapy water (dish detergent is preferable) and soaking for five minutes. Rinse with warm water and allow air to dry between uses. -Headgear (strap): Wash weekly with warm water and mild detergent as needed. Allow to air dry. -Document the following in the resident's medical record: >Time therapy was initiated. >Mode and settings for the device. >Oxygen concentration and flow (if applicable) Oxygen saturation after application. >Adherence to treatment. Any complication observed. -Notify the Physician if the resident refuses the procedure. Resident #12 was admitted to the facility in March 2024, with diagnoses including Chronic Respiratory Failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly) and Obstructive Sleep Apnea (OSA: pauses in breathing due primarily to the collapse of the upper airway during sleep). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12: -was cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. -required substantial/maximal assistance (helper does more than half the effort) for personal hygiene and dressing. -required substantial/maximal assistance to roll left and right in bed. -was dependent (helper does all of the effort. Resident does none of the effort to complete activity) to go from sitting to lying and from lying to sitting. -was dependent for transfers. -used continuous Oxygen. -used CPAP. Review of the Respiratory Care Plan, dated 3/22/24, indicated the following: -Continuous Oxygen at 3 Liter Per Minute (LPM) via nasal cannula (a thin, flexible tube that is used to administer Oxygen through the nose). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CPAP setting: titrated pressure: [sic] cmH2O (centimeter of water-a unit of pressure) via nose mask or full-face mask) on at HS (hour of sleep) off in AM (morning), date initiated 3/22/24. Review of the medical record indicated Resident #12 had been transferred to the hospital on 7/28/24 and returned to the facility on [DATE]. Review of Resident #12's Physician's orders for August 2024, September 2024, October 2024, and 11/1/24 - 11/20/24, indicated no documented evidence that CPAP had been ordered. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for August 2024, September 2024, October 2024, and 11/1/24 - 11/20/24, indicated no documented evidence that CPAP therapy had been utilized. Review of the Nurses Progress Notes, dated 7/31/24 through 11/21/24, indicated no documented evidence that Resident #12 had utilized CPAP therapy. On 11/20/24 at 11:06 A.M., the surveyor observed Resident #12 lying in bed on his/her back with oxygen on via nasal cannula and a CPAP machine located on a table next to the bed. A partially filled bottle of distilled water and an undated, unbagged CPAP mask with tubing was observed next to the CPAP machine. Resident #12 said he/she used the CPAP machine when he/she remembered to ask staff for assistance with putting it on. Resident said he/she would like the Nurses to offer to apply the CPAP at night because he/she forgets and falls asleep and that he/she slept better with the CPAP on and felt more awake the next day. Resident #12 said the Nurses use the distilled water observed next to the CPAP machine when the CPAP device was used, but he/she did not remember when the last time he/she used it. On 11/21/24 at 7:31 A.M., the surveyor observed Resident #12 lying in bed on his/her back with Oxygen on via nasal cannula, the CPAP machine remained on the on the table next to the bed beside, an undated CPAP mask with tubing and a partially filled bottle of distilled water dated 11/15/24. On 11/21/24 at 9:39 A.M., the surveyor observed Resident #12 lying in bed on his/her back with oxygen administered via nasal cannula and the CPAP machine remained on the table next to the bed. The surveyor observed that a CPAP mask with tubing dated 11/21/24, was in a bag on the table with a partially filled bottle of distilled water dated 11/15/24. During an interview at the time, Resident #12 said he/she did not use the CPAP machine last night but that a Nurse had been paying a lot of attention to the machine today and told him/her that there was no Physician order for the use of the CPAP. During an interview on 11/21/24 at 10:31 A.M., Nurse #2 said that there should be Physician's orders for the use of CPAP and that the tubing and mask should be dated when first used and placed in a bag when not in use. Nurse #2 said that she had not worked on the unit for the past month and that she did not replace or label the tubing or distilled water that was in the Resident's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 11:02 A.M., Unit Manager (UM) #1 said that she became aware that there was a problem with Resident #12's CPAP orders that morning. UM #1 said she had obtained new CPAP tubing and mask today, labeled the tubing, and placed the mask in a bag for Resident #12. UM #1 said that she had labeled the distilled water 11/15/24 after she had called staff to determine the date the distilled water had been opened. UM #1 said when she looked into the situation, she saw that the CPAP orders had accidentally been omitted from the electronic medical record (EMAR) when the Resident had gone out to the hospital in July. UM #1 further said that when a Resident was transferred to the hospital, all of the Physician orders were discontinued, and when the Resident returns to the facility, all of the orders have to be re-entered into the EMAR. UM #1 said the Nurse that readmitted the Resident to the facility did not re-enter the CPAP orders as she should have, and Resident #12 should have had the CPAP applied every evening since his/her return from the hospital in July. During an interview on 11/21/24 at 11:26 A.M., the Director of Nursing (DON) said the Regional Nurse had done a record review and determined that the Physician orders for the CPAP machine were not obtained during the Resident's re-admission to the facility in July. The DON said the orders for the CPAP should have been in place and the Resident should have been offered the CPAP every evening and but this was not done.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37400 Based on interview and record review, the facility failed to ensure that Medication Regimen Review (MRR) was addressed timely by the Physician and facility for one Resident (#28), of five applicable residents reviewed for unnecessary medications, out of a total sample of 20 residents. Specifically, the facility failed to address the MRR recommendations made by the Consultant Pharmacist pertaining to Resident #28's use of a cholesterol medication and laboratory testing to monitor the Resident's cholesterol levels. Findings include: Resident #28 was admitted to the facility in December 2020, with diagnoses including Hypertension (HTN: high blood pressure. When the blood pressure measures consistently above 130/80 millimeters of mercury [mm Hg]) and hemiparesis/hemiplegia (paralysis on one side of the body) due to Cerebrovascular Accident (CVA: medical term for a stroke - when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel). Review of the Resident #28's clinical record indicated the Consultant Pharmacist conducted an MRR and made a recommendation on the following date: -4/18/24 Further review of the clinical record indicated no documented evidence of the MRR dated 4/18/24. During an interview on 11/22/24 at 1:26 P.M., Unit Manager (UM) #1 said the Director of Nursing (DON) oversees the pharmacy recommendations for the facility and was looking into the MRR requested by the surveyor. On 11/22/24 at 3:30 P.M., the DON provided the surveyor with the MRR dated 4/18/24 which indicated the following: -Resident was currently receiving Atorvastatin (medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, angina (chest pain), strokes, and heart attacks) . -please consider ordering a fasting lipid panel (blood test that measures cholesterol and fat levels in the blood) on the next lab day to monitor therapy and then once yearly thereafter if within normal limits. -the section for the response by the Physician/Prescriber had a handwritten x in the box for agree but was unsigned and undated. Review of the Resident's clinical record indicated no documented evidence that a lipid panel was drawn since the Consultant Pharmacist made the recommendation on 4/18/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 3:34 P.M., the DON said when the Consultant Pharmacist makes recommendations, they were sent to her email, printed, and given to the Provider to review. The DON said once the Provider addresses the recommendations, they are given back to the Unit Managers (UMs) to follow through with any new orders and are then filed in the clinical record. The DON said she was unsure who checked off the MRR dated 4/18/24, as it was unsigned and undated but thought it was probably the Nurse Practitioner (NP). The DON said she was unable to find evidence that the MRR dated 4/18/24, was followed through with because a lipid panel had not been drawn since the recommendation was made.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45435 Based on observation, interview and record review, the facility failed to maintain a medication pass error rate of less than five percent (%) for one Resident (#28), out of four applicable residents, out of 35 opportunities. Specifically, the medication error rate was observed to be 5.71% when Resident #28 was administered two scheduled medications later than the allowed timeframe. Findings include: Review of the facility policy titled Administering Medication, dated October 2024, indicated the following: -To ensure safe and effective administration of medication in accordance with Physician orders and state/federal regulations. -Medication should be administered within one hour of the prescribed times. Resident #28 was admitted to the facility in December 2020, with diagnoses including Cerebral Infarction (a condition that occurs when blood flow to the brain is blocked, causing brain tissue to die), Vascular Dementia (a general term describing problems with reasoning, planning, judgement, memory and other though processes caused by brain damage from impaired blood flow to the brain), and Gastrostomy (a surgical procedure that creates an opening in the abdomen that allows a feeding tube/ gastrostomy tube (G-tube) to be inserted into the stomach). Review of Resident #28's Physician orders dated 11/22/24, indicated the following: -Gabapentin oral solution (medication used to prevent seizures and relieve nerve pain) 250 milligrams (mg) per five milliliter (ml), give six ml via G-tube three times a day, for neuropathy (weakness, numbness and pain from nerve damage), order date 1/8/24. -Benztropine Mesylate tablet (medication used to treat certain neurological conditions and the side effects of other drugs) 0.5 mg give one tablet via G-tube two times a day, order date 2/8/24. Review of the Medication Administration Record (MAR), dated November 2024 indicated the following: -Gabapentin oral solution 250 mg per five ml, give six ml via G-tube three times a day, scheduled to be administered at 6:00 A.M., 11:00 A.M., and 4:00 P.M. -Benztropine Mesylate tablet 0.5 mg, give one tablet via G-tube two times a day for tremors and stiffness of the muscles, scheduled to be administered at 11:00 A.M., and 8:00 P.M. On 11/22/24 at 12:41 P.M., during a medication pass administration on the D-Wing unit, the surveyor observed Nurse #7 prepare and administer the following medications to Resident #28: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Gabapentin oral solution 250 mg/ 5 ml (one hour and 41 minutes after the scheduled administration time) -Benztropine Mesylate tablet 0.5 mg (one hour and 41 minutes after the scheduled administration time) During an interview on 11/22/24 at 1:39 P.M., Nurse #7 said that she was aware that she had administered the medication scheduled for 11:00 A.M. late, and that she was aware that medications should be given within one hour of the prescribed time. Nurse #7 said this was a system problem. Nurse #7 further said that she had been scheduled today to work on the A-Wing from 7:00 A.M. until 11:00 A.M, where she had 17 residents to administer medications and treatments and complete her documentation. Nurse #7 said that she got to the D-Wing as soon as she could, at about 11:10 A.M. and immediately started the medication pass process. Nurse #7 said there were several residents on the D-Wing that had medications scheduled for 11:00 A.M. and no matter what she did, some of the residents were going to get their medications late. During an interview on 11/22/24 at 2:12 P.M., the Director of Nursing (DON) said Resident #28 should not have received his/her 11:00 A.M. medications at 12:41 P.M.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 42690 Based on record review, and interview, the facility failed to ensure that one Resident (#10) out of a total sample of 22 residents, was free from significant medication errors. Specifically, the facility staff failed to adhere to the Physician's orders to hold (not administer) the dose of Midodrine (medication used to treat orthostatic [standing up] hypotension [low blood pressure]) when the blood pressure measured above 130 millimeters of mercury (mmHg) for a Systolic [the pressure in the arteries when the heart contracts] Blood Pressure (SBP). Findings include: Review of the facility policy titled Administering Medication, revised October 2024, indicated: -that medications shall be administered according to the physicians written/verbal orders upon verification of: >the right medication >the right dose >the right route >the right time >positive verification of the resident's identity when no contraindications are identified >the medication is labeled accordingly to accepted standards Resident #10 was admitted to the facility in December 2023, with the diagnoses including End Stage Renal Disease (ESRD -a medical condition where the kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [a procedure to remove waste products and fluid from the body when the kidneys stop working] or a kidney transplant to maintain life), Type II Diabetes Mellitus (DM II: non-insulin-dependent diabetes where the body does not produce enough insulin hormone and has trouble controlling blood sugar levels), Hypertension (high blood pressure), dependent on Renal Dialysis. Review of the Order Summary Report for active orders as of 11/26/24, indicated the following order: -Midodrine HCL Tablet 5 milligrams (mg). Give 1 tablet by mouth three times a day for hypotension. Hold for Systolic Blood Pressure above 130 mmHg, start date 9/17/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Administration Record (MAR) for the month of November 2024, indicated Resident #10 had a SBP over 130 mmHg, was initialed by the Nurse and a check mark was noted (to indicate that the Midodrine medication was administered) when it should have been held because the SBP was higher than the ordered parameters to hold the medication, on the following dates: -11/2/24: SBP 141 -11/3/24: SBP 138 -11/5/24: SBP 145 -11/14/24: SBP 134 -11/22/24: SBP 143 During an interview on 11/26/24 at 8:52 A.M., the surveyor and Nurse #5 reviewed the November 2024 MAR. Nurse #5 said before administering the Midodrine she would take Resident #10's blood pressure (BP). If the BP was outside the parameters (over 130 mmHg) she would note a number 4 on the MAR indicating the Systolic Blood Pressure was outside of the parameters and she would not administer the Midodrine. Nurse #5 said that if there is a check mark in the box on the MAR for the corresponding date and time, with initials, she would assume that the Nurse administered the medication. During an interview on 11/26/24 at 9:56 A.M., Unit Manager (UM) #1 said that the Midodrine should be administered per the Physician order and held when the Systolic Blood Pressure is over 130 mmHg. UM #1 reviewed the November 2024 MAR and said that on the five occasions: 11/2/24, 11/3/24, 11/5/24, 11/14/24, and 11/22/24, the Midodrine was not held when it should have been held.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 37400 Based on interview, and record review, the facility failed to obtain lab work as ordered by the Physician for two Residents (#28 and #52), of five applicable residents, out of a total sample of 20 residents. Specifically, the facility failed to: 1. For Resident #28, obtain lab work to monitor his/her valproic acid level (measures the amount of valproic acid [medication used for the treatment of seizures or to manage behaviors] in the blood). 2. For Resident #52, obtain routine lab work to monitor his/her blood glucose levels, thyroid hormone levels, and lipid [fat]/cholesterol levels. Findings include: Review of the facility policy titled Diagnostic Services, revised October 2024, indicated the following: -access to radiologist and clinical laboratory diagnostic services will be available seven days a week, to ensure that diagnostic tests relevant to the residents' health status was provided and reported as required by the physician. -all diagnostic service/test requires an order by the licensed prescriber assigned to the resident. 1. Resident #28 was admitted to the facility with diagnoses including Vascular Dementia with behavioral disturbance (deterioration of memory, language, and other thinking abilities with behavioral and psychological symptoms such as agitation, anxiety, and psychosis), Bipolar Disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]) and Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy). Review of the Minimum Data Set (MDS) Assessment, dated 10/31/24 indicated Resident #28: -had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 8 out of 15 -received an anticonvulsant medication Review of Resident #28's November 2024 Physician's orders indicated: -Valproic Acid 250 milligrams (mg)/ 5 milliliters (ml), give 2.5 ml .daily for Bipolar [sic], and give 5 ml .daily for Bipolar, initiated on 1/8/24 -Valproic Acid level every six months, initiated 6/26/23 (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's clinical record indicated no documented evidence that the valproic acid level was drawn. On 11/22/24 on 10:06 A.M., Unit Manager (UM) #1 said there was a Physician's order for the valproic acid level to be drawn routinely for Resident #28. UM #1 said she would review the Resident's record to verify that the lab work was drawn as ordered by the Physician. On 11/22/24 at 3:34 P.M., the Director of Nursing (DON) said there was a systems issue with the the facility obtaining routine lab work for residents. During a subsequent interview on 11/26/24 at 10:18 A.M., the DON provided the surveyor with the last obtained valproic acid for Resident #28, which was dated 12/26/23. The DON said the lab work had not been obtained since that date and should have been. 2. Resident #52 was admitted to the facility in May 2019, with diagnoses including Type 2 Diabetes (DM II: non-insulin dependent diabetes - disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in variable blood glucose [sugar] levels in the blood), Hyperlipidemia (abnormally high levels of fats (lipids) in the blood, including cholesterol and triglycerides), and Hypothyroidism (when the thyroid gland does not make enough thyroid hormone). Review of the MDS Assessment, dated 10/14/24, indicated Resident #52: -was cognitively intact was evidenced by a BIMS score of 15 out of 15 -received an anticoagulant (medication that decreases the body's ability to form clots), a diuretic (medication that promotes urine production to expel excess fluid from the body), and a hypoglycemic (medication that lowers blood sugar levels) during the reference period. During an interview on 11/22/24 at 9:14 A.M., Resident #52 said he/she had lab work every three months or so. Resident #52 said he/she was was unsure what the lab work was monitoring. Review of the November 2024 Physician's orders included the following: -Abixaban (anticoagulant) 2.5 milligrams (mg), one tablet twice daily, initiated 11/14/23 -Glipizide (hypoglycemic) extended release, 5 mg daily, initiated 12/3/23 -Lasix (diuretic) 20 mg twice daily, initiated 11/13/23 -Levothyroxine (thyroid) 50 micrograms (mcg) daily, initiated 11/12/23 -Simvastatin 40 mg daily, initiated 12/29/23 Review of the Physician Progress Note, dated 10/28/24, indicated the following plan: -HgbA1c (Glycosolated Hemoglobin A1c: measure of the average blood glucose levels over the past two to three months and is a crucial indicator for the management and monitoring of diabetes) was 6.0 % (goal less than 6.5%), repeat ordered and check HgbA1c every six months. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-TSH (Thyroid Stimulating Hormorne or thyrotropin, is a hormone that the pituitary gland releases to trigger the thyroid to produce and release its own hormones - thyroxine [T4] and triiodothyronine [T3]) , T3 and T4 levels every 6 months- repeat ordered. -Annual lipid panel (blood test that measures the level of different types of fat [lipid molecules]/cholesterol in your blood) Review of the Resident's clinical record indicated no documented evidence the HgbA1c, TSH, T3 and T4 lab work had been drawn since 2/28/24. Further review of the clinical record indicated no documented evidence that a lipid panel had been obtained for the Resident. During an interview on 11/22/24 at 10:06 A.M., UM #1 said that Resident #52 should have a standing order for routine lab work to be drawn. UM #1 said she would look into it and get back to the surveyor. During an interview on 11/22/24 at 3:34 P.M., the DON said she looked into the issue with the Resident's routine lab work which had been ordered by the Physician. The DON said the routine lab work was accidentally discontinued and should have been renewed and there was no evidence that a lipid panel was drawn or that the HgbA1c, TSH, T3 and T4 had been obtained since 2/28/24. The DON said education needed to be provided to the facility Nurses about the process for reviewing the monthly laboratory sheets that indicated resident lab work that needed to be reviewed/renewed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 45435 Based on observation, interview and record review, the facility failed to follow the dietary plan as recommended by the Registered Dietitian (RD) to meet the nutritional needs and preferences of one Resident (#50), out of a total sample of 20 residents. Specifically, for Resident #50, the facility failed to ensure that food as recommended by the RD and as indicated on the meal tickets were provided to the Resident at meal times. Findings include: Resident #50 was admitted to the facility in April 2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe) and Gastro-Esophageal Reflux Disease (GERD - a digestive disease in which stomach acid or bile irritates the food pipe lining). Review of the Minimum Data Set (MDS) Assessment, dated 8/20/24, indicated Resident #50: -was cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. -required set-up/clean-up for eating. -was dependent (helper does all of the effort. Resident does none of the effort to complete activity) for hygiene, dressing, toileting, bed positioning and transfer. -received Hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) care. Review of Resident #50's Dietary Evaluation, dated 8/30/24, indicated the following: -Resident on Hospice, provide foods/fluids for comfort pleasure. -Staff reports meal intake zero to 100 percent (%). -Fluid/nutrition was not adequate if the Resident eats less than 50% of meals. -Recommend liberalizing to regular diet to maximize intake. -Continue ice cream as ordered for comfort/pleasure. Honor preferences. Review of the Nutrition Care Plan, dated 8/30/24, indicated the following: -Provide foods of choice for comfort, date initiated 8/30/24 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Honor dietary preferences, date initiated 8/30/24. -Ice cream as ordered, date initiated 8/30/24. Review of Resident #50's Physician's orders, dated 11/22/24, indicated the following: -Regular diet, regular texture, thin liquid consistency, Ice Cream at 12N (12:00 P.M.) and 5p (5:00 P.M.), date initiated 8/30/24. On 11/21/24 at 8:34 A.M., the surveyor observed Resident #50 was sitting up in bed with his/her breakfast tray which had just been delivered. The breakfast meal ticket, dated 11/21/24, indicated the following items: -cold cereal -apple cinnamon muffin -margarine -eight-ounce whole milk -six-ounce hot coffee x2 -fried egg and cheese sandwich -send empty bowl/silverware The surveyor observed the apple cinnamon muffin and margarine to be missing from the tray. During an interview at the time, Resident #50 said that he/she never received the items on his/her tray that were on his/her meal ticket. Resident #50 further said that he/she would have liked to try the apple cinnamon muffin. On 11/21/24 at 12:40 P.M., the surveyor observed Resident #50 sitting up in bed with his/her lunch tray which had just been delivered. The lunch meal ticket, dated 11/21/24, indicated the following items: -Italian sausage -potato wedges -ketchup -sauteed spinach -dinner roll (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-sliced pears -ice cream -eight-ounce whole milk -six-ounce coffee x2 The surveyor observed the lunch tray contained buttered noodles (not listed on ticket), and the potato wedges and ice cream that were listed on the meal ticket were observed to be missing from the tray. Resident #50 said that he/she had wanted potato wedges, not noodles, and that he/she had already told the kitchen this. Resident #50 further said that he/she never received the ice cream on his/her tray. On 11/22/24 at 9:00 A.M., the surveyor observed Resident #50 sitting up in bed with his/her breakfast tray. The breakfast meal ticket, dated 11/22/24, indicated the following items: -cold cereal of choice -toast -jelly -margarine -eight-ounce whole milk -six-ounce hot coffee x2 -send empty bowl/silverware -fried egg and cheese sandwich. The surveyor observed the breakfast tray contained fat free milk instead of whole milk (which was listed on the tray ticket). Resident #50 said that he/she used to complain about the incorrect items on his/her tray but now he/she does not bother because nothing changes. During an interview on 11/22/24 at 12:21 P.M., Certified Nurses Aide (CNA) #2 said a Nurse checks the meal trays before the CNAs start distributing them to residents. During an interview on 11/22/24 at 12:22 P.M., Nurse #8 said she checks the trays to make sure the resident diets match the tickets, and the correct food items were on the meal tray. Nurse #8 said that if the resident meal was not correct, or items were missing, she would notify the kitchen. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 2:35 PM, the Food Service Director (FSD) said the residents should receive the items that are listed on the meal ticket. The surveyor and the FSD reviewed photos taken of Resident #50's meal trays with the meal tickets. The FSD said that Resident #50 should have received the apple cinnamon muffin at breakfast on 11/21/24, should have received potato wedges and ice cream at lunch on 11/21/24, and should have received whole milk at breakfast on 11/22/24. The FSD said the Dietary Aide that loads the meal trays onto the cart was responsible for checking that the proper items are on the trays.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections for three Residents (#346, #47 and #6) out of a total sample of 20 residents, and on three units (A Wing, C Wing, and D Wing) out of a total of three units. Specifically, the facility failed to: 1) ensure that wound care supplies used inside a Resident's room were not removed from the room and stored in the clean utility room on C Wing. 2) ensure infection control standards were maintained during wound care for Resident #346. 3) ensure that staff wore the necessary Personal Protective Equipment (PPE: items such as a gown, gloves, mask, eye protection, etc. to prevent transmission of communicable disease) to maintain contact isolation precautions (used to prevent transmission of a disease spread by touching a contaminated surface or person) for Resident #346 4) ensure that staff performed hand hygiene, wore the necessary PPE to maintain contact precautions for Resident #47 and that shared medical equipment used on Resident #47 was cleaned and disinfected between use on multiple residents. 5) ensure that staff wore PPE to maintain Enhanced Barrier Precautions (EBP: used to prevent a high risk residents from contracting potential infections) while a) administering medication through a feeding tube and b) providing care to Resident #6. Findings include: Review of the facility policy titled Isolation Precautions, revised 10/28/24, indicated the following: -Appropriate communication/notices will identify the resident/room with isolation precautions implemented. -Contact Precautions: prior to entering the isolation room, the following steps are required: >perform hand-hygiene and apply gloves and gown prior to entering the room. 1) During a wound care observation on 11/21/24 at 10:12 A.M. on C Wing, the surveyor observed Nurse #4 to: -bring a new sleeve of gauze into a resident's room -set the gauze sleeve on the resident's bedside table (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-at the completion of wound care, take the gauze sleeve from the bedside table and bring it out of the resident's room and place it in the C Wing clean utility room. During an interview immediately following the observation, Nurse #4 said she should not have removed the gauze sleeve from the resident's room as this would be a concern for potential spread of infection. 2) Resident #346 was admitted to the facility in November 2024, with diagnoses including Methicillin Resistant Staphylococcus Aureus (MRSA: a communicable infection caused by a bacterium that is resistant to multiple strains of antibiotics causing increased difficulty treating the infection) and resided on C Wing. During an observation of Resident #346's wound care on 11/21/24 at 10:57 A.M., the surveyor observed Nurse #4: -used scissors to cut off the old dressing from the right lower extremity and placed the scissors directly on the Resident's bed. -picked up the scissors from the Resident's bed and used them to cut Xeroform (a gauze type dressing material that is saturated with petroleum) without cleaning and disinfecting the dirty scissors, placed the Xeroform over the wound bed, and then placed the scissors directly on the Resident's bed again. -picked up the scissors from the bed and used them to cut Calcium Alginate (a super absorbent dressing material) without cleaning and disinfecting the dirty scissors, placed the Calcium Alginate over the xeroform and then covered the dressing as ordered. During an interview on 11/21/24 at 12:00 P.M., Nurse #4 said she should not have used the scissors that had been used to remove a contaminated dressing and placed on the Resident's bed to cut clean dressing materials due to the risk for cross contamination of the wound. 3a) During an observation on 11/20/24 at 9:36 A.M., the surveyor observed Rehabilitation (Rehab) Staff #1 brought Resident #346 back into his/her room where a Contact Precautions sign was present outside the doorway without first putting on (donning) a gown and gloves. The surveyor observed Rehab Staff #1 providing hands-on assistance to Resident #346 to stand and transfer from his/her wheelchair into bed without wearing a gown and gloves as required. During an interview on 11/21/24 at 2:51 P.M., the surveyor reviewed the Contact Precautions sign with Rehab Staff #1. Rehab Staff #1 said the sign indicated Resident #346 was on Contact Precautions and a gown and gloves should be worn in the room and for care including assisting with transfers. Rehab Staff #1 further said that he did not wear a gown and gloves during the observed transfer on 11/20/24, but should have. During an observation on 11/21/24 at 3:01 P.M., the surveyor observed Maintenance Staff #1 approach Resident #346's room, observe the Contact Precautions sign outside the Resident's room, and then enter the room without donning a gown and gloves. Maintenance Staff #1 was observed working on the Resident's wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/24 at 3:05 P.M., the surveyor reviewed the Contact Precautions sign with Maintenance Staff #1. Maintenance Staff #1 said the sign indicated he should have put on a gown and gloves before going into the room but he had not worn a gown or gloves in the room. 42741 3b) During an observation and interview on 11/21/24 at 10:33 A.M., the surveyor observed Nurse #4 enter Resident #346's room without donning any PPE. Nurse #4 was observed at Resident #346's bedside where her clothing came into contact with the Resident's bed sheets and the privacy curtain. During an interview following the observation the surveyor and Nurse #4 observed the sign outside the Resident's room which indicated the following: >Contact Precautions -Put on gloves before room entry. -Put on gown before room entry. Nurse #4 said she only needed to wear a gown and gloves for high contact care of Resident #346 and she had not donned any PPE to enter his/her room. Nurse #4 further said if she followed the directions on the Contact Precaution sign on the doorway then she should have put on gloves and a gown when she entered Resident #346's room. 37400 4) Resident #47 was admitted to the facility in November 2024 with diagnoses including sepsis (infection of the blood which is a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction), Methicillin-Resistant Staphylococcus Aureus (MRSA) and chronic ulcer (open area) of the skin. Review of the November 2024 Physician's Orders included the following: -MRSA Wound Infection Precautions- Contact Isolation . initiated 11/11/24 -Doxycycline Hyciate (antibiotic) 100 milligrams (mg) twice daily for MRSA . initiated 11/12/24 Review of the Infection Care Plan, initiated 11/11/24, indicated the following: -Resident had MRSA wound/skin infection -educate Resident/Responsible Person on isolation requirements and purpose -Type of precaution: Contact On 11/21/24 at 8:10 A.M., the surveyor observed signage posted outside of the Resident's room which indicated Contact Precautions were in place. The sign indicated the following: -conduct hand hygiene prior to and upon exiting the room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-put on a gloves and gown before room entry and discard the gown and gloves before room exit -clean and disinfect reusable equipment before use on another person The surveyor observed a bin with gowns and gloves outside of the Resident's room and Nurse #1 entered the Resident's room and delivered his/her breakfast tray. Nurse #1 did not don a gown and gloves prior to entering the Resident's room. Nurse #1 exited the room shortly after, did not perform hand hygiene, entered the nearby kitchenette, retrieved a poured cup of orange juice and re-entered the Resident's room without a gown or gloves in place. Upon exiting the Resident's room the second time, Nurse #1 performed hand hygiene. On 11/21/24 at 8:55 A.M., the surveyor observed Nurse #1 entering Resident #47's room with a cup of medications and the vitals machine (machine on wheels that measures blood pressure, pulse, body temperature). Nurse #1 did not perform hand hygiene or don a gown or gloves prior to entering the Resident's room. The surveyor observed Nurse #1 standing beside Resident #47's bed. At this time, a Certified Nurses Aide (CNA) entered the Resident's room and retrieved his/her breakfast tray which was located on his/her overbed table. The CNA did not perform hand hygiene and did not don a gown/gloves prior to entering the room. Nurse #1 exited the room shortly after with the vitals machine. Nurse #1 performed hand hygiene upon exiting the Resident's room and rolled the vitals machine to an area across from the nurses station, plugged in the machine and walked away, without disinfecting the machine. At 9:03 A.M., Nurse #1 unplugged the vitals machine and went into two other resident's rooms (42 and 48), obtained vitals using the same machine and did not clean/disinfected the machine after each resident use. During an interview on 11/21/24 at 2:35 P.M., Unit Manager (UM) #1 said Resident #47 was on Contact Precautions for MRSA infection in his/her wounds. UM #1 said the Contact Precautions will remain in place while the Resident is on the antibiotic therapy. During an interview on 11/21/24 at 2:46 P.M., Nurse #1 said Resident #47 was on Contact Precautions. Nurse #1 said a gown and gloves were to be worn when providing care or anytime you come in contact with the Resident including when vitals are obtained. The surveyor and Nurse #1 reviewed the Contact Precaution sign posted outside of the Resident's room. Nurse #1 said the Contact Precautions sign indicated to put on a gown and glove prior to entering the Resident's room. Nurse #1 said she did not have on a gown and gloves when she entered the Resident's room to deliver his/her breakfast tray, administer medications and while obtaining the Resident's vitals using the vitals machine. Nurse #1 said that the vitals machine should have been disinfected with bleach wipes after exiting Resident #47's room and should have been disinfected between each resident use. Nurse #1 said she realized that she forgot to to this. On 11/22/24 at 8:13 A.M., the surveyor observed CNA #6 enter Resident #47's room to deliver his/her breakfast tray. CNA #6 did not perform hand hygiene, and did not don a gown or gloves prior to entering the room. CNA #6 was observed to move the Resident's overbed table and assist with breakfast meal tray set up. Shortly after CNA #6 exited the Resident's room and did not perform hand hygiene. During an interview at the time, CNA #6 said she should have put on a gown and gloves prior to entering Resident #47's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 at 9:24 A.M., the surveyor observed Nurse #3 enter Resident #47's room with his/her medications without donning a gown or gloves. Nurse #3 was observed to move the Resident's bedside table, provided his/her medication and checked the setting on the Resident's mattress. During an interview at the time, UM #1 (who was with the surveyor outside the Resident's room), said Nurse #3 should have put on a gown and gloves prior to entering the Resident's room. During an interview on 11/22/24 at 9:26 A.M., Nurse #3 said gown and gloves were not required for Resident #47 because he was just administering medication and that they were not required unless direct care was being given. The surveyor and Nurse #3 reviewed the Contact Precaution sign outside of Resident #47's room. Nurse #3 said the Contact Precaution sign indicated that a gown and gloves were to be put on prior to entering the Resident's room. 42690 5) Review of the facility policy titled Enhanced Barrier Precautions, revised on October 28, 2024 indicated the following: -it is this facility's policy that enhanced barrier precautions EBP's are used to prevent transmission of infectious organisms spread by direct or indirect contact with the patient or patients environment EBP is used during high contact care activities for residents with chronic wounds or indwelling medical device . -high contact resident care activities include but are not limited to: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care; any skin opening requiring a dressing -Indwelling medical device examples include but are not limited to, central lines, urinary catheters, feeding tubes . Resident #6 was admitted to the facility in January 2003, with diagnoses including Traumatic Brain Injury (TBI- a violent blow or jolt to the head causing temporary or permanent brain injury). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -Ostomy in use - including urostomy, ileostomy, and colostomy -Feeding tube Review of the Order Summary Report for active orders as of 11/25/24 indicated: -G-Tube (Percutaneous Endoscopic Gastrostomy - a feeding tube inserted into the stomach through the abdomen, utilizing an endoscope for guidance) and ostomy: infection precautions enhanced barrier, staff wear gown/gloves when in direct patient contact every shift. Start date 11/12/24. On 11/21/24 at 8:53 A.M., from the hallway outside of Resident #6's room, the surveyor observed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBP signage hanging on the door frame at the entrance of the Resident's room that indicated for Providers to wear gloves and a gown for high-contact resident care activities. >High-Contact activities included: -dressing, transferring, providing hygiene, changing briefs, device care (urinary catheter), wound care (any skin opening that required a dressing). a) On 11/21/24 from 8:53 A.M. until 9:04 A.M., the surveyor observed the following: -Nurse #5 enter Resident #6's room to administer medications. -Don (put on) gloves. Nurse #5 was not observed to don a gown. -Remove the top bed sheet used to cover Resident #6 -Move Resident #6's hospital gown to access the G-tube -Administer medications through the G-tube without a gown -Doff (take off) gloves and discard them in the garbage can -Wipe the Residents face with an ungloved hand -Adjusted protective sleeve around the Resident's right ankle -Replace the top bed sheet to cover the Resident -Adjust the Resident's sheets -Wash her hands with soap and water in the bathroom prior to exiting the room. During an interview on 11/21/24 at 9:04 A.M., Nurse #5 said that when a Resident is on Contact Precautions you must wear PPE. Nurse #5 said that she does not usually wear a gown when administering medications through the G-tube, just gloves. The surveyor and Nurse #5 reviewed the EBP signage outside of the Resident's room and Nurse #5 said that she did not do any of the other activities that are identified as high contact care on the EBP sign located outside of the Resident's room. b) On 11/21/24 at 10:58 A.M., the surveyor observed CNA #2 and CNA #4 enter Resident #6 's room and close the door. The surveyor did not observe CNA #2 or #4 don gowns before entering the room. On 11/21/24 at 11:10 A.M., CNA #2 exited the room. The surveyor did not observe CNA #2 doff any PPE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225176	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agawam South Rehab and Nursing	65 Cooper Street Agawam, MA 01001

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 at 11:12 A.M., the surveyor entered Resident #6's room and observed CNA #4 was in the room, providing care for the Resident wearing only gloves. When the surveyor asked CNA #4 what PPE should be worn when providing care for Resident #6 as he/she had a colostomy and a feeding tube, CNA #4 said that she and CNA #2 were getting the Resident up for the day, provided morning care that included, cleaning the Resident up, getting him/her dressed and transferring him/her out of the bed into his/her wheelchair. CNA #4 said that she and CNA #2 should have had on a gown and gloves and did not, as required. CNA #4 said that the facility used reusable gowns and while there was no PPE readily available near the Resident's room, there was some down the hallway.