STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225207	A. Building B. Wing	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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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 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** 49424 Based on record review and interview, the facility failed to have a consistent medical order honoring Advanced Directives for two Residents (#1 and #123), in a total sample of 28 residents. Specifically, the facility failed: 1. For Resident #1, to ensure the physician's order and medical record for Advance Directives matched the court ordered directives; and 2. For Resident #123, to ensure the physician's order and medical record reflected the resident's executed Advance Directives. Findings include: 1. Resident #1 was admitted to the facility in [DATE]. Resident #1 has a legal guardian who is responsible for making healthcare decisions. Review of the medical record indicated Resident #1 was admitted to hospice services on [DATE]. Review of Resident #1's Physician's Orders indicated: Code Status: Full Code revised [DATE]. Review of the Resident's record indicated a decree to authorize the guardian to consent to the following Advanced Directives: Do Not Resuscitate (DNR) and Do Not Intubate (DNI), dated [DATE]. During an interview on [DATE] at 8:35 A.M., Nurse #6 said Resident #1's Advance Directives are a full code at this time. Nurse #6 reviewed the Advanced Directives in the physical chart and the electronic health record (EHR) and said they did not match. During an interview on [DATE] at 8:41 A.M., Unit Manager #1 said the Resident is a DNR/DNI due to the court's order. She said the resident's code status is a DNR and DNI. She said the information in the computer indicated the Resident was a full code. She said this was not accurate and should have been updated. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:14 A.M., Hospice Staff #1 said the Resident is a full code at this time. During an interview on [DATE] at 1:26 P.M., Unit Manager #1 said she would expect that the advanced directives in the physical chart and the EHR match. She said it could get confusing during an emergency if they do not match. During an interview on [DATE] at 1:32 P.M., the Director of Nurses (DON) said her expectation is the physician's orders should match the court decree form. She expects the EHR and the physical chart to have the same advanced directives documented. 2. Resident #123 was admitted to the facility in [DATE]. Review of Resident #123's physical chart indicated a Massachusetts Order for Life Sustaining Treatment (MOLST) form was completed on [DATE], and the Resident's Advance Directives indicated DNR/DNI. Review of Resident #123's Physician's Orders indicated: Code Status: Full Code/CPR, dated [DATE]. During an interview on [DATE] at 1:51 P.M., Unit Manager #1 said the Advance Directives should be the same in the physical chart and the EHR. She said she needed to update the physician's orders in the computer to match the MOLST form. She said it could be confusing in an emergency if there is conflicting information regarding the Advance Directives. During an interview on [DATE] at 1:32 P.M., the DON said when a MOLST is completed the nurse who receives the MOLST should update the physician's orders to match the Advance Directives signed by the physician. She said Resident #123's orders needed to be updated as they incorrectly reflected his/her current code status.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36542 Based on interview and record review, the facility failed to notify the Resident's physician about changes in condition so as to re-evaluate the potential need to alter the treatment plan for one Resident (#90), from a total sample of 28 residents. Specifically, the facility failed to notify the primary physician of a new pressure ulcer in order to alter the treatment plan to prevent deterioration. Findings include: Resident #90 was admitted to the facility in February 2021. Review of the medical record indicated the Resident switched primary care physicians in October 2024. Review of the care plans for Resident #90 indicated the Resident was at risk for alterations in skin integrity related to weakness, poor safety awareness, and diabetes. Review of the current Physician's Orders indicated an order for triad paste (a zinc-oxide based sterile coating designed to manage low to moderate levels of exudate (drainage), while promoting a moist wound healing environment) to the coccyx (base of the spine, near the top of the buttocks) was implemented on 9/2/24. Review of the Pressure Injury Evaluation tool, dated 11/13/24 (locked 11/20/24), indicated Resident #90 had a new facility acquired, unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) pressure ulcer on the coccyx. The pressure ulcer measured 2.5 centimeter (cm) in length by 1.8 cm in width by an unmeasurable depth with 100 percent (%) eschar (dead or devitalized tissue that is hard or soft in texture). The evaluation indicated this was the start of treatment and the comment section for treatment was blank. Further review of the Pressure Injury Evaluation tool, dated 11/13/24, indicated the physician and responsible parties were notified. Review of the Pressure Injury Evaluation tool, dated 11/20/24, indicated the unstageable pressure ulcer to the coccyx had 50% healthy tissue and 50% unhealthy tissue, noted as yellow to white. The Pressure Injury Evaluation tool indicated the physician was notified. Review of the Physician's Orders indicated a new treatment began on 11/21/24 for the coccyx. The treatment was to wash with wound cleanser, pat dry, apply Calcium Alginate to wound base and cover with a foam dressing. The treatment was electronically signed by the primary physician on 11/26/24. Review of the medical record on 12/24/24 failed to include any documentation from the consultant wound physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/24/24 at 8:39 A.M., the Assistant Director of Nurses (ADON) said the consultant wound physician visit notes were not kept in the medical record and were kept in the office of the Wound Nurse. During an interview on 12/26/24 at 10:05 A.M., the Wound Nurse said on 11/13/24 she was notified of a new pressure ulcer on the coccyx of Resident #90 and went and evaluated it. She said she notified a physician who said to continue the triad paste that had been in place since September 2024. She said she could not remember who she contacted and who ordered the continued Triad paste. She said there was no documentation to indicate who she spoke with. She said the wound changed between 11/13/24 and 11/20/24 but she did not know when because there was no additional documentation from nurses between the weekly Pressure Injury Evaluations. Review of Physician Progress Notes from 11/13/24 through 12/10/24 from the Nurse Practitioner and Primary Physician failed to indicate Resident #90 had a pressure ulcer. During an interview on 12/26/24 at 12:00 P.M., the surveyor inquired about the pressure ulcer for Resident #90 and the Nurse Practitioner replied, The what? The Nurse Practitioner said she had been providing care to the Resident since October 2024 and did not know the Resident had a pressure ulcer. She said she was in the facility twice per week and was on call for all interim needs. She said she had recently discovered that staff were initiating treatment orders without obtaining physician verification of orders. She said she wanted to be actively involved in resident care and wanted to be called to verify recommendations and treatments. During an interview on 12/26/24 at 12:28 P.M., the Primary Physician said she did not recall being told about the pressure ulcer for Resident #90. She said she does not take calls from the facility and calls for orders or treatments were deferred to the Nurse Practitioner, and she addressed issues if she was in the facility. She said she was not in the facility on 11/13/24 or 11/20/24. She said if she had known about the pressure ulcer, she would have documented it in her visit on 12/10/24. During an interview on 12/26/24 at 12:35 P.M., the Wound Nurse said her process was to call the physician following wound rounds, including identification of a new wound. She said she cannot remember who she called on 11/13/24 and who she contacted was not documented anywhere. During an interview on 12/26/24 at 2:10 P.M., the Director of Nurses (DON) said the physicians for Resident #90 are saying they were unaware of the pressure ulcer. She said the consultant wound physician sends their consults to the primary physician. Review of the consultant wound physician visit summaries (11/25/24, 12/2/24, 12/9/24 and 12/16/24) indicated the previous primary physician was notified and not the current physician who started caring for the Resident in October 2024. The DON said she had not noticed that the incorrect primary physician was designated on the visit summaries. She said there was no additional information to verify the physicians were notified of the pressure ulcer.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49424 Based on observation and interview, the facility failed to provide a clean and homelike environment for six Residents (#82, #93, #96, #59, #104, #54) on the [NAME] Unit. Specifically, the facility failed to provide the Residents with assistive devices (wheelchairs and walkers) that were maintained in a clean and comfortable manner and promptly addressed any repair needs as required. Findings include: Review of the facility's policy titled Rehabilitation Services Policy and Procedure Manual, dated 1/17, indicated but was not limited to the following: -Adaptive devices will be checked with each use. Needed replacement parts will be kept in inventory to ensure timely replacement. Tightening of nuts/bolts will be done when needed as will wiping off of tips to prevent slipping. -All equipment malfunctions are to be reported immediately to the Rehab Program Manager. The equipment will be tagged Do Not Use and stored in a non-patient treatment area until repaired. On 12/19/24 at 9:05 A.M., the surveyor observed the following during the initial tour of the [NAME] unit: -Resident #82's rolling walker had a right arm pad with an approximate 5-inch crack in the foam that was taped together to prevent the foam from falling off. -Resident #93's wheelchair had a loose armrest on the left-hand side along with a ripped seat back and ripped arm rest. -Resident #96's wheelchair had multiple rips in the fabric of the seat back exposing inside foam cushion. -Resident #59's wheelchair was labeled with another Resident's name, had a ripped seat back that was separating the fabric on the back of the wheelchair to the handles, with an observed frayed fabric. -Resident #104's wheelchair was fraying and loose on the seat back where it attached to wheelchair handles. There was an approximate 4-inch rip in the fabric of the wheelchair exposing yellow foam inside cushion. -Resident #54's wheelchair was missing a padded armrest on the left side of the chair. There was a metal bar where there should have been a cushion. Review of the [NAME] Unit's Maintenance Log on 12/19/24 at 2:03 P.M., indicated the last entry in the log was dated 12/6/24, and was not for any of the above Residents' items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/23/24 at 5:11 P.M., Resident #82 said he/she has put tape along the arm cradle of the walker to prevent it from breaking off. Resident #82 said he/she requested glue from nursing staff to keep it in place more securely. During an interview on 12/24/24 at 8:32 A.M., Nurse #2 said the wheelchairs were not in good condition and she wasn't sure what the process was for routine repairs and upkeep. She said there is a wheelchair washing day, but someone should go around and review the condition of the chairs, some need to be replaced or repaired. She said Resident #59's wheelchair was labeled with another resident's name who was discharged over three months ago. During an interview with observation on 12/24/24 at 8:46 A.M., Rehab Staff #1 toured the unit with the surveyor and said she wasn't sure how the condition of this equipment was overlooked by facility staff. She said the wheelchairs with rips, loose parts, and holes should be replaced or repaired immediately. She said the wheelchairs and equipment should be clean, comfortable, and in good repair at all times.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50740 Based on record review and interview, the facility failed to ensure that a required Preadmission Screening and Resident Review (PASARR) was completed for one Resident (#91) with a diagnosed mental condition, out of a total sample of 28 residents. Findings include: Resident #91 was admitted to the facility in January 2024 with diagnoses including bipolar disorder and alcohol abuse. Review of the Hospital Medical Intensive Care Unit (MICU) Admission Note, dated 1/1/24, indicated the Resident's past medical history included bipolar disorder and alcohol use disorder. Review of the Psychiatric Evaluation and Consultation for Resident #91, dated 2/19/24, indicated the Resident's diagnoses included bipolar disorder and alcohol abuse. Review of the Minimum Data Set (MDS) assessment for Resident #91, dated 12/3/24, indicated under Section I (Active Diagnoses) the Resident had bipolar disorder coded as an active diagnosis. Review of the medical record failed to indicate a Level 1 PASARR was completed for Resident #91. During an interview on 12/23/24 at 4:31 P.M., Social Worker #1 said that the facility's three social workers are responsible for completing the PASARR prior to or at the time of admission to the facility. Social Worker #1 and the surveyor reviewed Resident #91's record and confirmed the only PASARR in the record was completed in 2020 by another facility when he/she was admitted there. Social Worker #1 said another PASARR should have been completed for the Resident when he/she was admitted to this facility. During an interview on 12/23/24 at 5:04 P.M., Social Worker #1 said she confirmed with the PASARR agency that the Resident did not have a Level 1 PASARR completed upon admission to the facility.

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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. 50740 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for one Resident (#91), out of 28 sampled residents. Specifically, the facility failed to ensure a comprehensive care plan was developed and implemented to address Resident #91's BiPAP (Bilevel Positive Airway Pressure, a non-invasive ventilation therapy that delivers air through a face mask to help with breathing) machine use. Findings include: Review of the facility's policy titled C-Pap (Continuous Positive Airway Pressure) and Bi-PAP Ventilatory System, undated, indicated but was not limited to the following: -Place the mask or pillows on the patient's face, and explain to the patient that he or she should breathe in and out normally. Resident #91 was admitted to the facility in January 2024 with diagnoses including chronic obstructive pulmonary disease (COPD), pneumonia, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (airway collapse with an associated decrease in oxygen levels or waking from sleep). Review of the Minimum Data Set (MDS) assessment, dated 12/3/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated the Resident utilized oxygen and a non-invasive mechanical ventilator (CPAP or BiPAP). Review of Resident #91's Physician's Orders indicated but was not limited to the following: -BiPAP - apply at HS (bedtime), remove in AM (morning). Settings: 6 cm (centimeters) H2O (water) (11/21/24) -BiPAP Headgear/Strap hand wash in mild soap and air dry as needed (11/21/24) -BiPAP Humidifier - Change distilled water daily right before bed every evening shift (11/21/24) -BiPAP Humidifier - Clean chamber weekly and let air dry every night shift every Monday (11/21/24) -BiPAP Replace disposable filter per manufacturer's guidelines per order as needed (11/21/24) Review of Resident #91's Medication Administration Record (MAR) for December 2024 indicated that the Resident's BiPAP was administered as ordered every evening shift 12/1/24 through 12/17/24 and 12/19/24-12/23/24. The MAR indicated that the Resident refused the BiPAP on the evening shift on 12/18/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #91's care plan failed to indicate a care plan for his/her BiPAP use had been developed. During an interview on 12/19/24 at 2:16 P.M., Resident #91 said that he/she got a BiPAP machine after his/her last hospitalization but he/she had not used it. During an interview on 12/23/24 at 4:02 P.M., Nurse #1 said that Resident #91 should be using a BiPAP machine at night but refused to use it. During an interview on 12/26/24 at 12:00 P.M., the Director of Nursing said that a care plan should have been developed and implemented for Resident #91's BiPAP use. The Director of Nursing said that if the Resident refuses to use the BiPAP, it should be documented in the Resident's record and care planned.

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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. 36542 Based on observations, interviews, and record reviews, the facility failed to ensure quality of care was provided, according to the plan of care, facility protocols, and professional standards of practice for one Resident (#79), out of 28 sampled residents. Specifically, the facility failed to ensure wound care treatments for Resident #79 were reflective of recommendations from the wound consultant physician and in line with the primary physician's treatment plan. Findings include: Review of the facility's policy titled Treatments, dated April 2015, indicated but was not limited to the following: -in order for residents to achieve an optimum in their physical state, various treatments may be necessary -these treatments may be ordered by the physician or, within the scope of nursing -it is the responsibility of all nursing staff to constantly evaluate the health state of residents as to the need for treatments -once treatments are ordered, they are to be carried out as prescribed -an order is written for each treatment indicating type, frequency and location -treatments are reviewed daily and the physician notified of all healed areas Resident #79 was admitted to the facility in October 2024 with a diagnosis of localized swelling, mass and lump to the right upper limb. Review of the Minimum Data Set (MDS) assessment, dated 11/21/24, indicated Resident #79 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. During an interview with observation on 12/19/24 at 9:10 A.M., Resident #79 said he/she had a large mass on their right elbow and showed the surveyor. The surveyor observed the right elbow swollen on all sides, there was no dressing and the area was open to air. The Resident said he/she had an upcoming appointment to have the cyst drained. Review of the care plans indicated the Resident had a right ulnar (elbow) and thigh cyst (initiated 10/23/24) with interventions including but not limited to administering treatments as ordered and wound consult as needed. Review of the Physician Progress Note from the Nurse Practitioner, dated 11/4/24, indicated Resident #79 had a large cyst to the right elbow and thigh with erythema (redness) and a wound from a cyst that opened with a plan to continue antibiotics until seen by the dermatologist, obtain dermatology evaluation, and continue to monitor clinically. (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 the Treatment Administration Record (TAR) indicated Resident #79 had the following treatment to the right elbow cyst from 11/4/24 through 11/18/24: mupirocin ointment (antibiotic ointment, also referred to as Bactroban), apply to right elbow cyst topically every day and evening shift: wash with wound cleanser, pat dry, apply Bactroban, followed by Alginate and dry dressing. Review of the nursing progress notes indicated the following: -11/4/24: Resident seen by consultant wound physician for the right elbow cyst with a new order for wound cleanser, pat dry, apply Bactroban followed by Alginate and dry dressing. -11/9/24: right elbow draining clear fluid -11/12/24: right elbow draining clear fluid -11/14/24: resident sent to hospital for change in mental status -11/20/24: resident returned from hospital -11/22/24: no dressing to right elbow cyst, not needed, no open area -12/2/24: right leg cyst with necrosis (dead tissue) Review of the consultant wound physician Visit Notes indicated the following: 11/11/24: right elbow draining large amount of serous exudate (a clear or pale yellow, watery fluid that drains from a wound as part of the healing process). Treatment: Adaptic (a primary wound contact layer made of knitted cellulose acetate with a woven mesh structure impregnated with petrolatum), Alginate (a highly absorbent dressing) followed by a dry, protective dressing, twice per day. 11/25/24: right elbow draining moderate amount of serous exudate. Treatment: Adaptic, Alginate and dry protective dressing, change daily. Review of the Physician Progress Note from the Nurse Practitioner, dated 12/2/24, indicated the right thigh cyst had opened and started draining and to continue to monitor. Review of the consultant wound physician Visit Notes indicated the following: 12/9/24: right elbow draining moderate amount of serous exudate. Treatment: Adaptic, Alginate and dry protective dressing. New right thigh cyst with moderate amount of purulent exudate (a thick, opaque, milky fluid that drains from a wound and indicates an infection). Treatment: Bactroban, Alginate, and dry protective dressing daily. 12/16/24: right elbow draining moderate amount of serous exudate. Treatment: Adaptic, Alginate and dry protective dressing. Right thigh cyst with moderate amount of purulent exudate (a thick, opaque, milky fluid that drains from a wound and indicates an infection). Treatment: Bactroban, Alginate, and dry protective dressing daily. (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 the medical record for the month of December 2024 failed to include monitoring or treatments to the right elbow cyst or the right thigh cyst. On 12/20/24 at 12:48 P.M., the surveyor observed Resident #79 sitting on the edge of the bed. The surveyor observed the cyst to the right elbow open to air and cyst to the right thigh open to air. During an interview on 12/24/24 at 10:43 A.M., the Nurse Practitioner said the plan for the Resident was to continue treatments as recommended by the consultant wound physician and the treatment could change as indicated by an external dermatologist, if needed. She said she defers treatments to the consultant wound physician and both the right elbow cyst and the right thigh cyst should have treatments. Review of the medical record on 12/19/24 failed to indicate any current treatments, dressings or monitoring of the cysts on the right upper or lower extremities. During an interview on 12/24/24 at 12:50 P.M., Nurse #2 said Resident #79 did not receive any dressing to the elbow or thigh. She said there used to be a treatment to the elbow, but there was not one any longer. During an interview on 12/24/24 at 1:35 P.M., the Assistant Director of Nurses (ADON) said the treatment for the elbow was discontinued in November 2024. She said the process was for the Wound Nurse to review the recommendations from the consultant wound physician, contact the primary physician and implement treatment orders. During an interview on 12/24/24 at 1:55 P.M., the ADON said she reviewed the consultant wound physician recommendations and the recommendations for changes to the treatment of the right elbow had not been implemented and the new treatment to the right thigh had also not been implemented. During an interview on 12/26/24 at 9:55 A.M., the Wound Nurse said the nurse should not have discontinued the treatment to the right elbow on 11/22/24. She said she was not sure why the wound treatment for the right elbow was not changed with the recommended change in treatment on 11/11/24. She said there was a miscommunication on who was entering the orders for the treatment to the right thigh and that was why it had not been implemented. She said the monitoring process included weekly assessments of wounds. She reviewed the medical record and said she was not sure why there were no weekly evaluations for the wounds for Resident #79, but there should have been.

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Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 50740 Based on observation, interview, and record review, the facility failed to ensure the proper care and treatment of a peripherally inserted central catheter (PICC) line device (inserted into a vein in the upper arm and is advanced until the internal tip of the catheter is in the superior vena cava, one of the central venous system veins that carries blood to the heart) was provided in accordance with professional standards of practice for one Resident (#92), out of a total sample of 28 residents. Specifically, the facility failed to ensure physician's orders were obtained and implemented for the care and maintenance of the Resident's PICC line. Findings include: Review of the facility's policy titled Central Venous Access Device Flushing, dated January 2022, indicated but was not limited to the following: 2. A prescriber order is required for vascular access device (VAD) flushing. The order will be specific with regards to flush solution, volume, and frequency. 3. The VAD will be flushed before and after intravenous medication administration, in between multiple medication administration, and routinely, at established intervals, when the VAD is not in use. Review of the facility's policy titled Central Venous Access Device Needleless Connector Change, dated January 2022, indicated but was not limited to the following: 2. Needleless connector will be changed according to the IV Therapy Order or Parenteral Nutritional Order: -Upon admission -At least every 7 days -After blood sampling from a CVAD (central venous access device) -Each time a bag of PN (parenteral nutrition) has infused -PRN for any complications 3. A needleless connector will be placed on the hub of all lumens of the VAD. Review of the facility's policy titled Central Venous Access Device (CVAD) Catheter Dressing Change, dated January 2022, indicated but was not limited to the following: 2. The IV therapy order for care and maintenance is required. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Dressing changes will occur according to the IV Order and when the dressing is compromised (drainage/moisture observed, loose, soiled). If at time of admission the transparent dressing is clean, dry, intact, dated and not due to be changed, it is NOT necessary to change the dressing at the time. If catheter is newly inserted and transparent dressing is clean, dry, intact and dated, it is NOT necessary to change the dressing 24 hours after insertion. If gauze is present, refer to the IV Order Form for frequency. 9. VAD assessment should occur: -At least every 2 hours during a continuous infusion -Before, during, and after medication administration -During dressing changes -At a minimum of once each shift, when not in use -At prescribed intervals if complications are observed 10. With each site assessment of the VAD, presence of the following, at a minimum, should be include [sic]: -Erythema -Drainage -Induration -Tenderness -Warmth -Swelling, of the extremity (if applicable) and at the site -Sutures, if present -External catheter length NOTE: External catheter site is measured from catheter exit site to the 0 mark or, if no 0 mark is present, to the suture flange. Each line is measured at 1cm. Review of the facility's policy titled Continuous Medication Administration, dated January 2022, included but was not limited to the following: 5. Continuous administration sets will be changed every 96 hours, when contamination is suspected, and as outlined in Policy IV3.3 Administration Set Change. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. The licensed nurse will evaluate the venous access site at least every 2 hours, for signs and symptoms of complications, during the infusion. Review of Lippincott Manual of Nursing Practice, Twelfth Edition, indicated: -Administration tubing set change - label with date, time opened, and initials. a. Continuous tubing administration sets used for medications and solutions should be changed no more frequently than every 96 hours but at least every 7 days. -Ensure proper vascular access site assessment and care. Change the IV dressing on a routine basis and immediately if it becomes damp, loosened, or soiled. a. Gauze dressing that prevents visualization of the site should be changed every 48 hours. b. Transparent semipermeable dressing should be changed every 7 days. Resident #92 was admitted to the facility in April 2021 with diagnoses including chronic osteomyelitis (an infection of the bone), resistance to Vancomycin (an antibiotic), ESBL resistance (Extended-Spectrum Beta-Lactamase, enzymes produced by some bacteria that cause resistance to many common antibiotics), and Crohn's disease (an inflammatory bowel disease) with fistulas (connections between two body parts that don't normally connect). Review of the Minimum Data Set (MDS) assessment, dated 12/9/24, indicated Resident #92 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #92's care plans indicated but was not limited to the following: Focus: Resident is receiving IV therapy for prevention of dehydration due to high out [sic] ostomy (5 liters/24 hr in hospital) Interventions: -Change IV tubing per policy and PRN -IV as ordered -Observe insertion site for s/s (signs/symptoms) of infection (i.e., pain, redness, swelling, warmth, infiltrate) and document. -Resident receives IV hydration via a picc (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's records from a long-term acute care hospital, dated 11/18/24, indicated Resident #92 was admitted there in October 2024 for continued care of high output ileostomy (a surgically made opening connecting the lower end of the small intestine to the abdominal wall), abdominal fistulas, therapy services, and TPN (total parenteral nutrition, feeding administered intravenously). The records indicated the Resident was treated for Staphylococcus capitis bacteremia (a bacterial infection in the bloodstream) and the Resident's existing IV access catheter was removed. The Resident had a new PICC line placed on 11/15/24. The Resident's record failed to include any additional PICC line insertion information. Review of the Nursing Visit Record from a consultant IV insertion nurse, dated 12/18/24, indicated the Resident's right arm PICC line was pulled back 4 centimeters (cm) per recommendations from the radiologist and the PICC line dressing was changed. No additional PICC line information, such as catheter length or arm circumference, were included in the record. Review of Resident #92's Physician's Orders indicated but was not limited to the following: -Sodium Chloride Intravenous Solution 0.45% Use 90 milliliters per hour (ml/hr) intravenously every shift for hydration (12/20/24) -Sodium Chloride Intravenous Solution 0.9% Use 60 ml/hr intravenously every shift for hydration continuously (12/26/24) The Resident record failed to include orders for the care and maintenance of the Resident's PICC line, such as IV flushing, site assessment, dressing changes, catheter measurement, and arm circumference measurement. Review of Resident #92's electronic Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated but was not limited to the following: -Potassium chloride in NaCl (sodium chloride) intravenous solution 20-0.9% milliequivalents per liter (meq/l) Use 90 ml/hr intravenously every shift for hydration continuous infusion at 90 ml/hr documented administered on 12/18/24 11:00 P.M.-7:00 A.M. and 12/19/24 7:00 A.M.-3:00 P.M.) -Sodium Chloride intravenous solution 0.45% Use 90 ml/hr intravenously every shift for hydration (documented as administered 12/20/24 7:00 A.M.-3:00 P.M. through all shifts on 12/25/24) Review of Resident #92's Infusion Therapy Flowsheet for December 2024 in the paper record indicated that the Resident had a right upper arm PICC line in place. The space for documentation of the date inserted, total catheter length, arm circumference, and external catheter length were blank. Further review of the Infusion Therapy Flowsheet indicated but was not limited to: -Dressing care and maintenance: The IV nurse changed the Resident's PICC line dressing on 12/18/24 and that the transparent dressing was to be changed weekly. The dressing change scheduled for 12/25/24 was not documented as completed. -Needleless connectors: No documentation indicating needleless connectors were ever changed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tubing change: The flowsheet indicated the Resident was on a continuous infusion and the tubing should be changed every 96 hours. The tubing was marked as changed on the 11:00 P.M.-7:00 A.M. shift on 12/18/24 and 12/24/24. No exact hour was indicated and the box indicating the tubing was to be changed on 12/22/24 was left unsigned. -PICC/Midline Measurements: The flowsheet indicated external catheter length was to be documented prior to medication administration, weekly, and as needed. The external catheter length was measured at 0 cm on 12/18/24. No other catheter length measurement was documented. -Site assessment: The flowsheet indicated site assessment was to be completed every 2 hours while on continuous therapy and at least once every shift. No site assessment was documented as completed on 12/19/24 after 2:00 P.M. until 12/20/24 at 4:00 P.M., 12/21/24 at 12:00 A.M. until 4:00 P.M., 12/22/24 at 12:00 A.M. until 8:00 A.M. and 12/22/24 at 4:00 P.M. until 12/23/24 at 8:00 A.M., and 12/23/24 at 4:00 P.M. until 12/24/24 at 12:00 A.M. Review of Resident #92's Infusion MAR for December 2024 in the paper record indicated that the Resident received Potassium Chloride 20 meq in Sodium Chloride 0.9% at 90 ml/hr continuously starting 12/19/24 and Sodium Chloride 0.45% at 90 ml/hr continuously starting on 12/20/24. During an observation with interview on 12/19/24 at 9:50 A.M., the surveyor observed Resident #92 with a dual lumen IV in his/her right upper extremity and Potassium in Sodium Chloride 20-0.9 meq/l-% was infusing via an IV pump at 90 ml/hr. The Resident said he/she had the IV line for a while and had been receiving fluids. On 12/23/24 at 8:22 A.M., the surveyor observed Resident #92 to have a dual lumen Bard Power PICC in his/her right upper extremity with a transparent dressing in place, undated. A bag of IV Sodium Chloride 0.45% dated 12/23/24 was infusing at 90 ml/hr via an IV pump with tubing dated 12/22/24. On 12/26/24 at 9:20 A.M., the surveyor observed Resident #92's PICC line dressing in place, undated, with the bottom medial corner of the dressing slightly lifted. A bag of NaCl 0.9% was infusing via an IV pump at 60 ml/hr. The IV bag and tubing were not labeled with a date and time. During an interview on 12/26/24 at 11:28 A.M., Nurse #4 said the facility utilizes two paper forms for IV documentation and there are no additional places IV information is documented aside from the electronic medical record and the paper forms. During an interview on 12/26/24 at 12:00 P.M., the Director of Nursing (DON) said Resident #92's PICC information (insertion date, length, etc.) should be included in the Resident's record and the nurses should be documenting dressing changes, external catheter length, arm circumference, and needleless connector changes on the flowsheet weekly. The DON said all IV fluids and tubing should be dated and that the facility has stickers that should be used for this. The DON said Resident #92's PICC line dressing should be changed per orders and the dressing dated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 50740 Based on observations, interviews, and record review, the facility failed to provide the necessary respiratory care and services for one Resident (#91), in a total sample of 28 residents. Specifically, the facility failed to administer oxygen at the correct liter flow per physician's orders, failed to ensure oxygen equipment was maintained in a sanitary manner to help decrease the risk of potential contamination and infection, and failed to ensure the Resident was referred to a pulmonologist. Findings include: Review of the facility's policy titled Oxygen Administration, undated, indicated a physician's order is necessary for the administration of oxygen. Review of the facility's policy titled Oxygen Concentrators, undated, indicated but was not limited to the following: -Verify the physicians order and review the patients' chart. -Adjust the liter flow in accordance with the physician's order by rotating the flow selector knob on the flow meter located on the front panel of the unit. Review of the facility's policy titled C-Pap (Continuous Positive Airway Pressure) and Bi-PAP Ventilatory System, undated, indicated but was not limited to the following: -Place the mask or pillows on the patient's face, and explain to the patient that he or she should breathe in and out normally. Resident #91 was admitted to the facility in January 2024 with diagnoses including chronic obstructive pulmonary disease (COPD), pneumonia, acute and chronic respiratory failure with hypoxia (low oxygen levels), and obstructive sleep apnea (airway collapse with an associated decrease in oxygen levels or waking from sleep). Review of the Hospital Discharge Summary, dated 11/20/24, indicated Resident #91's discharge diagnoses included respiratory failure with hypercapnia (too much carbon dioxide in the blood). The Discharge Summary indicated the Resident would need BiPAP at discharge given his/her underlying neurologic disorder and hypercapnia and that per review with the Case Manager, this was delivered to the facility. The Discharge Summary also indicated that the Resident should follow-up with pulmonology on a regular basis. The Resident's most recent vital signs at time of discharge included a pulse oximetry (measurement of oxygen levels in the blood) of 96% on 2 liters/minute (L/min) of oxygen. Review of the Minimum Data Set (MDS) assessment, dated 12/3/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Further review of the MDS assessment indicated the Resident utilized oxygen and a non-invasive mechanical ventilator (CPAP or BiPAP). Review of Resident #91's care plans indicated but was not limited to the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Resident has respiratory disease related to resp (respiratory) failure SOB with HOB (head of bed) flat Interventions: -Assist to reposition for maximum airflow -Auscultate lung sounds as indicated -Encourage resident to pace activities to prevent episodes of dyspnea and fatigue -If resident has shortness of breath, adventitious lung sounds, dyspnea or exertion [sic], fever or changes in mental status, this may indicate an infection. -O2 sats and O2 as ordered -Provide gentle touch, reassurance, emotional support as needed -Respiratory conversation technique training -SOB while lying flat elevate HOB to position of comfort for patient Review of Resident #91's Physician's Orders indicated but was not limited to the following: -Change O2 (oxygen) tubing every Sunday on 11:00 P.M.-7:00 A.M. (11/22/24) -Oxygen continuously via NC (nasal cannula) at 2 Liters/minute every shift Check pulse ox and liters per minute (LPM) (11/22/24) -BiPAP - apply at HS (bedtime), remove in AM (morning). Settings: 6 cm (centimeters) H2O (water) (11/21/24) -BiPAP Headgear/Strap hand wash in mild soap and air dry as needed (11/21/24) -BiPAP Humidifier - Change distilled water daily right before bed every evening shift (11/21/24) -BiPAP Humidifier - Clean chamber weekly and let air dry every night shift every Monday (11/21/24) -BiPAP Replace disposable filter per manufacturer's guidelines per order as needed (11/21/24) Review of Resident #91's Medication Administration Record (MAR) for December 2024 indicated that the Resident's BiPAP was administered as ordered every evening shift 12/1/24 through 12/17/24 and 12/19/24-12/23/24 and the Resident refused the BiPAP on the evening shift on 12/18/24. Further review of the MAR indicated the Resident's oxygen liter flow was set at 2-4 L/min, not 2 L/min as indicated in the physician's order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #91's Treatment Administration Record (TAR) for December 2024 indicated the Resident's oxygen tubing was changed on 12/1/24, 12/8/24, 12/15/24 and 12/22/24. On 12/19/24 at 9:39 A.M., the surveyor observed Resident #91 in bed, wearing a nasal cannula. The oxygen concentrator was observed to be set at 3.5 L/min and the oxygen tubing was dated 12/9/24. The Resident's BiPAP machine was on the nightstand. On 12/23/24 at 2:16 P.M., the surveyor observed Resident #91 in bed, wearing a nasal cannula. The oxygen concentrator was observed to be set at 3.5 L/min and the oxygen tubing was dated 12/23/24. The Resident's BiPAP machine was on the nightstand in the same position as it was on 12/19/24. On 12/26/24 at 9:25 A.M., the surveyor observed Resident #91 in bed, wearing a nasal cannula. The oxygen concentrator was observed to be set at 3L/min. The Resident's BiPAP machine was on the nightstand in the same position as it was on 12/19/24. During an interview on 12/19/24 at 2:16 P.M., Resident #91 said that he/she got a BiPAP machine after his/her last hospitalization but he/she had not used it. During an interview on 12/23/24 at 4:02 P.M., Nurse #1 said that Resident #91 should be using a BiPAP machine at night but refused to use it. Nurse #1 said that Resident #91's oxygen concentrator should be set at 2-3 L/min. Nurse #1 said that the Resident's order for oxygen was for 2 L/min, but when he/she returned from his/her last hospitalization she was told he/she was on 3 L/min. During an interview on 12/26/24 at 11:28 A.M., Nurse #4 said she did not work regularly on the unit but was aware that Resident #91 had a BiPAP machine. Nurse #4 said the BiPAP mask was not on the Resident when she arrived for her shift that morning. Nurse #4 said that the Resident's oxygen concentrator should be set at 2 L/min. During an interview on 12/26/24 at 11:49 A.M., Nurse #4 said she checked the Resident's oxygen concentrator and it was set at 3 L/min. During an interview on 12/26/24 at 12:00 P.M., the Director of Nursing (DON) said that physician's orders should be implemented as written. During an interview on 12/26/24 at 2:16 P.M., the DON said Resident #91 had not been scheduled for a pulmonology appointment and she could not find any documentation that the Resident had been seen by a pulmonologist while at the facility but should have been referred to one.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50740 Based on observations, interviews, and record reviews, for one Resident (#92) of 28 sampled residents, the facility failed to ensure the Resident's drug regimen was free from unnecessary drugs and was not used for an excessive duration. Specifically, the facility failed to ensure the Resident's Fosfomycin (an antibiotic) was administered for only one weekly dose instead of daily, resulting in an additional three administrations of the medication. Findings include: Resident #92 was admitted to the facility in April 2021 with diagnoses including chronic osteomyelitis (an infection of the bone), resistance to Vancomycin (an antibiotic), ESBL resistance (Extended-Spectrum Beta-Lactamase, enzymes produced by some bacteria that cause resistance to many common antibiotics), and Crohn's disease (an inflammatory bowel disease) with fistulas (connections between two body parts that don't normally connect). Review of the Minimum Data Set (MDS) assessment, dated 12/9/24, indicated Resident #92 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the After Visit Summary for Resident #92, dated 12/17/24, indicated the Resident had a urinalysis done which showed a urinary tract infection and the Resident was given antibiotics to treat the infection and will continue to get antibiotics to lower the risk of future urinary tract infections. The medication list indicated that the Resident should start taking Fosfomycin - Mix 1 packet (3 grams) with 3-4 ounces of cool water and take by mouth for 1 dose. The Resident had last received Fosfomycin on 12/17/24 at 2:56 P.M. while at the hospital. Review of Resident #92's nursing progress note, dated 12/18/24, indicated that the Resident returned from the hospital and had new orders for Fosfomycin 3 grams as prophylaxis. Review of Resident #92's Physician's Orders indicated the Resident was prescribed Fosfomycin 3 grams daily on 12/18/24 and the order was discontinued on 12/22/24. Review of the Medication Administration Record (MAR) for December 2024 indicated Resident #92 received Fosfomycin daily on 12/18/24, 12/19/24, 12/20/24, and 12/21/24. During an interview on 12/26/24 at 12:00 P.M., the Director of Nursing said the Resident's order for Fosfomycin was entered with a frequency of daily in error and should have been entered with a frequency of weekly. During an interview on 12/26/24 at 1:14 P.M., Physician #1 said that she had been on vacation the week prior and could not recall what frequency of Fosfomycin should have been ordered for Resident #92. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/26/24 at 2:37 P.M., Physician #1 said that she reviewed the Resident's record and a colleague had seen the Resident when he/she had returned from the hospital the week prior, but his note did not indicate the frequency Fosfomycin should have been prescribed. Physician #1 said Fosfomycin is typically dosed weekly, not daily.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49424 Based on record review and interview, the facility failed to ensure three Residents' (#1, #123, and #87) drug regimen was free from unnecessary psychotropic medications, out of a total sample of 28 residents. Specifically, the facility failed: 1. For Resident #1, to ensure a gradual dose reduction (GDR) of the antipsychotic medications risperidone and chlorpromazine were attempted, unless clinically contraindicated and documented in the medical record, in an effort to discontinue the drug; 2. For Resident #123, to ensure a GDR of the antipsychotic medication olanzapine was attempted, unless clinically contraindicated and documented in the medical record, in an effort to discontinue the drug; and 3. For Resident #87, to ensure a GDR of psychotropic medication was attempted, unless clinically contraindicated and documented in the medical record, in an effort to discontinue the drug. Findings include: Review of the facility's policy titled Psychotropic Medication Management, dated 4/15, included but was not limited to the following: -Each resident's drug regimen will be free from unnecessary drugs. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review. -Review should include verification that adequate indications for use of the psychotropic medication exist, the medications are not being used for extended duration, and the residents are free of duplicate therapy and being monitored for adverse consequences, per professional standards of practice. Review of the facility's pharmacy policy titled Psychotropic Medication Management, revised 12/19, included the following: -If a Resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually. -A GDR is considered clinically contraindicated if target symptoms return or worse after most recent attempt of a GDR and the physician documents the clinical rationale for why any attempted dose reductions would impair the resident's function, or the continued use is in accordance with relevant current standard of practice and the physician documents the clinical rationale for why any attempted GDR would impair the resident's function. 1. Resident #1 was admitted to the facility in May 2019 with diagnoses which included epilepsy (seizure disorder), dementia, traumatic brain injury, and bipolar disorder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Rehabilitation & Health Care Center	123 South Street Plymouth, MA 02360

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Physician's Orders included the following medications: Risperidone 2 milligrams (mg), dated 5/30/24 Chlorpromazine 25 mg, dated 5/29/24 Review of the medical record indicated Resident #87 was signed on to hospice services on 10/25/24. Further review of the medical record failed to indicate a GDR had been attempted in the previous 12 months. Review of the Minimum Data Set (MDS) assessment, dated 11/11/24, indicated the Resident did not have any symptoms of psychosis including delusions or hallucinations. On 12/20/24 at 12:45 P.M., the surveyor observed the Resident sitting in the hallway with his/her eyes open, quietly watching staff. On 12/23/24 from 10:28 A.M to 12:09 P.M., the surveyor observed the Resident sitting in the hallway in a reclining Broda chair (positioning chair) with no behavioral disturbances. Resident #1 was smiling and waving to staff as they passed by and occasionally closed his/her eyes. On 12/23/24 at 02:16 P.M., the surveyor observed the Resident being invited to attend an activity and nodded to attend in agreement. Resident #1 closed their eyes during the movie and slept in the dining room in a reclining Broda chair. During an interview on 12/24/24 at 8:23 A.M., Nurse #2 said the behavioral health service team will make psychotropic medication recommendations as well as the pharmacy. If it's not an emergency, we put the recommendations in a folder for the doctor to review. She said she was unsure if Resident #1 had a GDR attempted, she said he/she has had a physical decline and is on hospice services and has not had any symptoms of psychosis. During an interview on 12/24/24 at 11:36 A.M., the Director of Nurses (DON) said they have begun to review some residents beginning in October for GDRs as they were not previously being attempted for residents on antipsychotic medication. She said she could not provide evidence that a GDR was discussed or attempted for this Resident in the past year. 2. Resident #123 was admitted to the facility in January 2024 with diagnoses including but not limited to visual hallucinations and dementia. Review of the Physician's Orders indicated: Olanzapine 2.5 mg one time a day, dated 1/15/24 Olanzapine 7.5 mg one time a day, dated 1/15/24 Review of the MDS assessment indicated that the Resident scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact. Further review of the MDS indicated that the Resident had no signs or symptoms of delirium. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's behavioral health notes indicated the following: no changes in medications were recommended. The Resident had no hallucinations/ paranoia/delusions and no combative or aggressive behaviors. Review of the nursing progress notes from June 2024 through December 2024 failed to indicate Resident #123 exhibited any behaviors or changes in mood. Further review of the medical record failed to indicate a GDR had been attempted since the Resident was admitted to the facility. During an interview on 12/24/24 at 8:23 A.M., Nurse #2 said she wasn't sure how GDRs were reviewed or attempted. She said that Resident #123 is very pleasant with behaviors that are easily redirectable. She was unsure if the Resident's antipsychotic medication had been reviewed for a GDR. During an interview on 12/24/24 at 11:36 A.M., the DON said they have begun to review some residents beginning in October for GDRs as they were not previously being attempted for residents on antipsychotic medication. She said she could not provide evidence that a GDR was discussed or attempted for this Resident in the past year. 36542 3. Resident #87 was admitted to the facility in June 2021 with a diagnosis of dementia, major depressive disorder, post-traumatic stress disorder, developmental disorder of scholastic skills, and traumatic brain injury. Review of the medical record indicated Resident #87 was admitted to hospice services on 3/1/24. Review of the care plans indicated Resident #87 had a Focus for psychotropic medications with Interventions including but not limited to review with the IDT (interdisciplinary team) for GDR as indicated. Review of the Physician's Orders included the following medications: Lorazepam (antianxiety) tablet 0.5 mg- twice per day (4/30/24) Melatonin (supplement to aid in sleep) 3 mg at bedtime (10/6/23) Olanzapine 5 mg in the morning (1/4/23) Olanzapine 2.5 mg twice per day (10/6/23) Sertraline (antidepressant) 25 mg once per day (7/12/23) Trazodone (antidepressant) 50 mg three times per day (7/11/23) Review of the December 2024 Medication Administration Record indicated Resident #87 did not have any behaviors on any shift from 12/1/24 through 12/24/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/24 at 1:22 P.M., the family member of Resident #87 said the Resident had been putting his/her head on the table for about a year and she was not sure if this was related to his/her mood, the Resident was on a lot of medication to manage his/her mood and she was not sure if the medications were making the Resident tired. The surveyor observed Resident #87 during the following days of survey: 12/19/24 at 10:06 A.M. in the unit day room with his/her head on the table, eyes closed 12/19/24 at 1:00 P.M. in unit day room with head on a pillow on the table 12/20/24 at 8:41 A.M. in unit day room, having breakfast, sitting up right 12/20/24 at 8:53 A.M. in unit day room with a baby doll on the table in front of him/her 12/20/24 at 9:31 A.M. resident with chin tucked to chest and eyes closed 12/20/24 at 10:00 A.M. in unit day room with face hovering over table and staff placed a pillow between the Resident and the table 12/20/24 at 12:59 P.M. in unit day room with head down on a pillow on the table, rubbing nose around in circles 12/20/24 at 1:18 P.M. Resident did not respond when Certified Nursing Assistant (CNA) asked Resident if they would like to go to bed 12/24/24 at 10:15 A.M. in bed sleeping 12/24/24 at 12:51 P.M. in unit day room, head leaning back and forth During an interview on 12/24/24 at 12:55 P.M., CNA #1 said Resident #87 refused care at times, but was easily redirected. She said the Resident mostly sits in the unit day room with his/her head down on the table, rubbing his/her face. She said Resident #87 did not exhibit any other behaviors. Review of the nursing progress notes from June 2024 through December 2024 failed to indicate Resident #87 exhibited any behaviors or changes in mood. Review of the Psychiatric Evaluation and Consultation notes indicated the Resident was seen by the consultant psychiatric Nurse Practitioner for an initial evaluation on 2/14/24. All notes were reviewed and indicated the following: 2/14/24: no acute psychiatric needs or worsening mood/behavior reported 4/12/24: Resident refusing to leave dining room; continue to monitor behaviors and redirect verbally; no changes are indicated 5/18/24: presents overall less agitated and more pleasant; no behaviors observed or reported this visit (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/22/24: presents overall less agitated and more pleasant; no behaviors observed or reported this visit 7/20/24: presents overall less agitated and more pleasant; no behaviors observed or reported this visit 8/17/24: presents overall less agitated and more pleasant; no behaviors observed or reported this visit 9/14/24: presents overall less agitated and more pleasant; no behaviors observed or reported this visit 10/12/24: presents pleasant with minimal agitation, semi-confused and suspicious at times; no behaviors observed or reported this visit 11/9/24: presents pleasant with minimal agitation, semi-confused and suspicious at times; no behaviors observed or reported this visit 12/7/24: presents pleasant with minimal agitation, semi-confused and suspicious at times; no behaviors observed or reported this visit Review of the hospice Plan of Care, dated 10/17/24, indicated Resident #87 was leaning forward and resting their head on the table, and even when repositioned, would rub his/her nose on the table in circles, with increased lethargy and sleeping and would spend an entire day in bed sleeping and the next day be up in a chair but still slept on and off with their head on the table. Review of the medical record failed to indicate a GDR had been attempted in the previous 12 months. During an interview on 12/20/24 at 1:53 P.M., the Hospice nurse said the Resident had recently been recertified for Hospice services. She said the Resident at baseline will sit in the unit day room with his/her head on the table rubbing their nose on the table or sleeping, which was why the Resident was provided with a pillow or towel. She said she had not reviewed the psychotropic medications for GDRs and did not realize the last change in medications occurred in October 2023, prior to signing on to hospice services. During an interview on 12/20/24 at 2:50 P.M., the DON said she reviewed the medical record for Resident #87 and there had been no attempts for a GDR in at least the last 12 months. During an interview on 12/24/24 at 11:32 A.M., the DON said the facility had been attempting to work on GDRs for residents, but Resident #87 had not been discussed at their IDT meetings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50740 Based on observation, interview, and record review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, for Resident #53, the facility failed to ensure that a bottle of Fluticasone nasal spray (a medication used to treat allergy symptoms), a Trelegy inhaler (a medication used to treat symptoms of lung disease, such as shortness of breath and wheezing), a bottle of Calcium Carbonate chewable tablets (a medication used to treat indigestion), and a tube of Diclofenac cream (a topical medication used to treat pain) were not left unsecured in the Resident's room. Findings include: Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, indicated but was not limited to the following: -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. -Storage for other medications will be limited to a locked medication room. Resident #53 was admitted to the facility in January 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD, a lung condition causing airflow obstruction) and Diabetes. Review of the Minimum Data Set (MDS) assessment, dated 11/10/24, indicated that Resident #53 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. On 12/19/24 at 9:17 A.M. and 12/23/24 at 8:15 A.M, the surveyor observed the following in Resident #53's room: -A bottle of Fluticasone nasal spray on the Resident's overbed table, unsecured -A Trelegy inhaler on the Resident's overbed table, unsecured -A large bottle of Calcium Carbonate chews on the Resident's overbed table, unsecured -A tube of Diclofenac cream on the Resident's overbed table, unsecured. During an interview on 12/19/24 at 9:17 A.M., Resident #53 said he/she kept medications at his/her bedside and self-administered them. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/23/24 at 9:30 A.M., Nurse #1 said that she was aware Resident #53 kept medications at his/her bedside but was not responsible for administering those medications. Nurse #1 said that another nurse had given the Resident his/her nasal spray and inhaler and subsequently, the Resident refused to allow staff to remove the medication from his/her room. Nurse #1 said the Resident has not been assessed for self-administration and should not have medications in his/her room. During an interview on 12/23/24 at 4:08 P.M., the Director of Nursing (DON) said she was unaware that Resident #53 had medications in his/her room and that medications should not be left unsecured at the Resident's bedside.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46862 Based on observations, record review, and interviews, the facility failed to maintain accurate medical records in accordance with professional standards and practices for four Residents (#58, #92, #79, and #90), out of 28 sampled residents. Specifically, the facility failed for Residents #58, #92, #79, and #90 to ensure that documentation of wound physician visits was part of the medical record in a timely manner. Findings include: Review of the facility's policy titled Thinning of the Clinical Record, dated September 2015, indicated the following records were to be maintained in the active clinical record: Consultations: Most current year with exception of a one-time only consult. 1. Resident #58 was admitted to the facility in February 2019 with diagnoses including traumatic brain injury and protein calorie malnutrition. Review of Resident #58's current Physician's Orders indicated but was not limited to: -Monitor dressing site: left foot dressing every shift, dated 12/19/24 -Monitor dressing site: right foot dressing every shift, dated 11/21/24 -Treatment order: Wash with wound cleanser, pat dry apply Iodosorb followed by dry protective dressing. Location: right 3rd toe and right 4th toe every day shift, dated 12/19/24 -Treatment order: Wash with wound cleanser, pat dry apply skin prep to peri wound followed by Iodosorb, cover with dry protective dressing. Location: left plantar, left 5th toe every day shift, dated 12/19/24 -Treatment order: Wash with wound cleanser, pat dry, apply skin prep to peri wound, apply adaptic followed by calcium alginate to wound bed and cover with gauze, wrap with Kerlix. Location: right foot web space between 4th and 5th toe, and right lateral foot every day shift, dated 12/26/24 During an interview on 12/20/24 at 10:41 A.M., Nurse #5 said Resident #58 was being followed by the consultant wound physician. The surveyor and Nurse #5 reviewed the medical record and could not locate the wound physician's documentation. Nurse #5 said the Infection Control Preventionist (ICP) made rounds with the wound physician and oversaw the wound program. Nurse #5 said the ICP must keep the wound physician's notes in her office. Review of Resident #58's wound physician's visit notes, provided to the survey team by the Assistant Director of Nurses (ADON), on 12/24/24 at 8:47 A.M., indicated the Resident had been seen on the following days: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/16/24 -12/9/24 -12/2/24 -11/25/24 -11/18/24 -11/4/24 -10/21/24 -10/14/24 During an interview on 12/26/24 at 12:21 P.M., the ICP said Resident #58's medical record did not contain his/her wound physician's visit notes. The ICP said she had them in a folder in her office. The ICP said they should have been put in Resident #58's medical record. 50740 2. Resident #92 was admitted to the facility in April 2021. Review of the Minimum Data Set (MDS) assessment, dated 12/9/24, indicated Resident #92 had one Stage IV pressure injury and the Resident's care included the application of non-surgical dressings. Review of Resident #92's Physician's Orders indicated but was not limited to the following: -Treatment order: wash with wound wash, pat dry, apply skin prep to wound edge, apply calcium alginate, daily cover with foam dressing Location: sacrum as needed for drainage (9/5/24) - Treatment order: wash with wound wash, pat dry, apply skin prep to wound edge, apply calcium alginate, daily cover with foam dressing Location: sacrum every day and evening shift (9/5/24) Review of Resident #92's care plans indicated but was not limited to the following: Focus: Resident has a stg IV Pressure Ulcer Interventions: -Provide with a pressure relieving mattress -Signs of infection may include purulent drainage, swelling, increased pain, elevated temp, redness of wound, change in drainage. -Skin checks per facility protocol (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Treatment as ordered Review of the medical record failed to include visits from the consultant wound physician for the last year. During an interview on 12/24/24 at 8:47 A.M., the ADON said the Wound Nurse (also the ICP) has kept the consultant wound physician's visit paperwork for the last year in her office. The surveyor was provided with the Resident's consultant wound physician visit documentation for the last year, which had not been included in the electronic or paper medical record. 36542 3. Resident #79 was admitted to the facility in October 2024. Review of the medical record indicated Resident #79 had large cysts to the right upper extremity and the right lower extremity. Review of the medical record indicated the Resident was followed by the Nurse Practitioner (NP) and the Primary physician. Review of the Physician Progress Note dated 12/2/24 indicated the right lower cyst had opened and was draining. Review of the medical record on 12/19/24 failed to indicate any current treatments, dressings or monitoring of the cysts on the right upper or lower extremities. During an interview on 12/24/24 at 8:47 A.M., the ADON said the Wound Nurse (also the ICP) has kept the consultant wound physician visit paperwork for the last year in her office. The surveyor was provided with a large stack of papers. During an interview on 12/24/24 at 10:44 A.M., the NP said Resident #79 was being followed by the consultant wound physician for the right upper and lower extremity cysts. Review of all wound consultant physician visits for the last year included wound consultant visits for Resident #79 on the following dates: 10/28/24, 11/11/24, 11/25/24, 12/9/24 and 12/16/24, which had not been included in the electronic or paper medical record. 4. Resident #90 was admitted to the facility in February 2021. Review of the medical record indicated Resident #90 had developed a pressure ulcer on 11/13/24. During an interview on 12/24/24 at 8:40 A.M., the ADON said the Wound Nurse (ICP) does wound rounds with the consultant wound physician on Mondays and the visit summaries are kept in the office of the Wound Nurse. Review of all wound consultant physician visits from the office of the Wound Nurse included wound consultant visits for Resident #90 on the following dates: 11/25/24, 12/2/24, 12/9/24 and 12/16/24, which had not been included in the electronic or paper medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/26/24 at 10:05 A.M., the Wound Nurse (ICP) said the consultant wound physician comes to the facility on Mondays and then sends the visit summaries to her. She said she thought the consultant wound physician was uploading the visit summaries to the electronic medical record and had not realized that none of the visits had been uploaded this year.