STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225219	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Worcester	59 Acton Street Worcester, MA 01604

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, and record review, the facility failed to preserve the dignity of one Resident (#55) out of a total sample size of 26 residents. Specifically, the facility failed to provide Resident #55 with a wheelchair that was properly maintained and repaired as required. Findings include: Review of facility policy titled Quality of Life-Dignity, undated indicated: -Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. -Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self esteem and self worth. Resident #55 was admitted to the facility in September 2020 with diagnoses including unsteadiness on feet. Review of Resident #55's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had moderate cognitive impairment as evidenced by a BIMS (Brief Interview for Mental Status) score of 10 out of a total possible score of 15. On 11/13/24 at 8:50 A.M., the surveyor observed Resident #55 sitting in a wheelchair with a broken left sided arm rest in his/her room. The surveyor further observed that the broken arm rest had a sharp uneven edge at the midway point and a screw post (area where the armrest is connected to the arm of the wheelchair) was exposed. During an interview at the time, Resident #55 said that the wheelchair he/she was sitting in belonged to him/her. Resident #55 said that he/she had told the staff about broken arm rest a few weeks ago but the staff have done nothing about it. On 11/14/24 at 1:38 P.M., the surveyor observed Resident #55 sitting in his/her wheelchair with the broken left sided arm rest in the unit hallway at the nurses station. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 8:57 A.M., the surveyor observed Resident #55 seated in day room eating breakfast with staff supervision of three Certified Nurses Aides (CNA). During an observation and interview on 11/15/24 at 9:17 A.M., the surveyor observed Resident #55 sitting in his/her wheelchair with the broken left arm rest in the unit hallway at the nurses station. Resident #55 said he/she had reported the broken wheelchair to the Nurse last week. Resident #55 said the wheelchair looks like it came from a junk yard, why wouldn't he/she tell someone about this, maybe if they gave he/she the screwdriver he/she could do it myself. During an interview on 11/15/24 at 9:26 A.M., CNA #1 said he had not noticed the broken arm rest on the wheelchair. CNA #1 said that Resident #55 required some help with care and staff were in contact with the Resident three to four times during any given shift. CNA #1 said the left sided arm rest that was broken, and the screw that was exposed, could cause some trouble. CNA #1 said he was surprised nobody had noticed the broken arm rest. During an interview on 11/15/24 at 11:10 A.M., Nurse #2 said she was a regular Nurse on the unit. Nurse #2 said that Resident #55 gets seen by a Nurse two to three times during a shift. Nurse #2 also said that Resident #55 was very social, and staff see him/her several times a day because he/she goes everywhere like activities, socializing in the hallway, eating in the dining room and was always in his/her wheelchair. Nurse #2 said Resident #55 requires assist for some care areas and it was ultimately the staff members' responsibility to identify broken equipment. Nurse #2 said the CNA providing care should have noticed the broken wheelchair and reported it to the Nurse. During an interview on 11/15/24 at 1:11 P.M., the Director of Nursing (DON) said that she would have expected a staff member would have identified the broken arm rest for Resident #55 because he/she is seen several times throughout the day. The DON said wheelchairs in disrepair could be a dignity issue. During an interview and record review on 11/19/24 at 12:19 P.M., the Director of Rehabilitation (DOR) said she did monthly audits on facility owned wheelchairs and personal wheelchairs for all residents. The surveyor reviewed the October 2024 audit log which indicated that Resident #55's wheelchair had been audited and not found to be in disrepair at the time of the October audit. The DOR said staff should report broken wheelchairs to herself or the maintenance department as broken wheelchairs could affect a Resident's safety and level of dignity.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, record review, and interview, the facility failed to provide care and services according to professional standards of practice for an indwelling urinary/Foley catheter (a flexible tube that passes through the urethra and into the bladder to drain urine outside the body) for two Residents (#86 and #286) out of a total sample of 26 residents. Specifically, the facility staff failed to ensure that the correct size indwelling urinary catheter, as ordered by the Physician, was in place for both Resident #86 and Resident #286, placing the Residents at risk for infection, discomfort, and potential damage to the urinary system. Findings include: Review of the facility policy titled Foley Catheter Care dated 5/1/22, indicated the following: -It is the policy of this facility to maintain MD (Medical Doctor) orders for care and maintenance of a Foley catheter. -The MD orders will include the size of the Foley lumen (diameter of the flexible tube passed through the urethra) and the size of the Foley balloon (a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body). 1. Resident #86 was admitted to the facility in November 2019, with diagnoses including neurogenic bladder (a condition where the nerves in the brain do not communicate with the bladder muscles resulting in difficulty urinating and retention of urine [inability to completely empty the bladder of urine]) and persistent vegetative state (a chronic condition that occurs when someone is awake but shows no awareness of their surroundings). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated no Brief Interview for Mental Status (BIMS) score entered for Resident #86. Review of the active Physician orders dated 11/18/24, for Resident #86 indicated the following: -Coude catheter (a specific type of indwelling urinary catheter with a curved tip) care every shift. Size #18 Fr (French)/ 10 ml (milliliter) balloon, initiated 10/29/24. -Coude #18 Fr/10 ml, change PRN (as needed) for blockage or if falls out, initiated 10/12/23. On 11/18/24 at 8:16 A.M., the surveyor and Nurse #6 observed that Resident #86 had a size 16 Fr/ 30 ml indwelling urinary catheter in place. During an interview at the time, Nurse #6 said that Resident #86 was ordered to have a size 18 Fr/ 10 ml indwelling urinary catheter in place. Nurse #6 said that the size 16 Fr/ 30 ml indwelling catheter the Resident had in place was incorrect and should be replaced with the correct size catheter as ordered. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #286 was admitted to the facility in November 2022, with diagnoses including paraplegia, unspecified (severe or complete loss of function in the lower extremities) and retention of urine. Review of the MDS assessment dated [DATE], indicated Resident #286 was cognitively intact as evidenced by a BIMS score of 14 out of a total possible score of 15. Review of the active Physician orders dated 11/18/24 indicated the following: -Foley catheter 22 Fr/ 10 ml. Change monthly on the 11th and PRN if becomes dislodged or blocked. On 11/19/24 at 11:32 A.M., the surveyor and Nurse #7 observed that Resident #286 had a size 22 Fr/ 30 ml indwelling urinary catheter in place. During an interview at the time, Nurse #7 said that the Physician orders indicate Resident #286 should have a size 22 Fr/ 10 ml indwelling urinary catheter in place and not the size 22 Fr/ 30 ml catheter that the Resident currently had in place. Nurse #7 said that Resident #286's indwelling urinary catheter should have been changed to reflect the correct size as ordered by the Physician.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, and record review, the facility failed to provide necessary care and services, relative to enteral feeding (nutrients provided directly into the stomach), for two Residents (#114 and #86) out of a total sample of 26 residents. Specifically, the facility failed to: 1. Ensure interventions were implemented in a timely manner to determine Resident #114's abilities for restoring oral eating skills, as recommended by the Ear Nose and Throat (ENT) Clinic Specialist and as requested by the Resident. 2. Adequately monitor Resident #86's gastric residual volume (amount of liquid drained from the stomach following enteral feeding), as ordered by the Physician, increasing the Resident's risk for aspiration (when food or liquid enters your airway or lungs by accident which may cause serious health problems such as Pneumonia [infection of the lungs]). Findings include: 1. Review of the facility's policy titled Enteral Feedings, undated, indicated the following: -The facility will remain current in and follow accepted best practices in enteral nutrition. -Check gastric residual volume every four hours for the first 48 hours after tube insertion and then every six to eight hours after target feeding volume and rate have been established or as ordered by the Physician. -Document all assessments, findings, and interventions in the medical record. Resident #114 was admitted to the facility in September 2023, with diagnoses including Hemiplegia (paralysis on one side of the body) and Hemiparesis (one-sided muscle weakness) following Cerebral Infarction (stroke) affecting the non-dominant left side, encounter for attention to Gastrostomy (G-tube: tube inserted through the abdominal wall into the stomach), encounter for attention to Tracheostomy (an opening surgically created through the neck into the trachea [windpipe] to allow placement of a breathing tube), and Oropharyngeal Phase Dysphagia (medical condition that causes a disruption or delay in swallowing). Review of Resident #114's Hospital Specialty Inpatient Provider Progress Note, dated 8/22/23, indicated the following: -The Resident had Oropharyngeal Phase Dysphagia -The Resident did not pass his/her FEES (flexible endoscopic evaluation of swallowing: procedure used to assess how well one swallows where a thin, flexible instrument is placed through the nose to view parts of the throat as one swallows) test completed 7/5/23. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident had notable swelling and left sided weakness with evidence of some aspiration. -A Modified Barium Swallow Study (MBSS: contrast-enhanced radiographic study commonly used to assess structural and functional characteristics of swallowing) was completed with the Resident on 8/16/23. -The MBSS revealed definite esophageal narrowing and little to no upper esophageal sphincter (UES: opens to allow food and liquids to pass into the esophagus) opening. -The Resident was to remain NPO (nothing by mouth) and continue on enteral feeding and free water flushes (water provided through enteral means that gets counted toward the Resident's fluid needs). -The Resident had been scheduled for an appointment with the ENT Clinic. Review of Resident #114's Hospital Specialty Inpatient Speech Therapy Treatment Record, dated 8/22/23, indicated the following long term goals: -Patient will improve swallow function . -Patient will maintain adequate hydration/nutrition via least restrictive means possible. Review of Resident #114's active Physician Order, initiated 9/5/23, with no stop date, indicated: -NPO diet texture. Review of Resident #114's active Nutrition Care Plan, initiated 9/6/23, indicated the Resident had alteration in nutrition related to Dysphagia . Review of Resident #114's active Advance Directive Care Plan, initiated 9/8/23, indicated the Resident had a healthcare proxy (HCP: individual appointed to make health care decisions for someone when they are unable to do for themself), but the Resident was currently his/her own responsible person. Further review of the Advance Directive Care Plan indicated the appointed HCP would make health care decisions for the Resident if the Resident became incapacitated (deprived of power). Review of Resident #114's Nurse Practitioner (NP) Progress Note, dated 9/29/23, indicated the Resident was awaiting an ENT visit. Review of Resident #114's clinical record indicated the following: -The Resident received Speech Therapy services, which included treatment of swallowing dysfunction, from 9/7/23 through 9/21/23. -Speech Therapy services were discontinued on 9/21/23 due to the Resident being discharged to the hospital. -The Resident returned to the facility on [DATE]. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A Speech Therapy Evaluation and Plan of Treatment was completed for the Resident on 10/2/23. Review of Resident #114's Speech Therapy Evaluation and Plan of Treatment, dated 10/2/23, indicated the following: -The Resident's level of function prior to medical decline and placement of a feeding tube included eating regular foods and managing thin liquids. -The Resident was currently NPO. -The Resident's Laryngeal (area in the top of the neck involved in breathing, producing sound and protecting the trachea against food aspiration)/Pharyngeal (the part of the throat behind the mouth and nasal cavity, and above the esophagus [tube that goes to the stomach] and trachea [tube that goes to the lungs] performance was impaired. -The Resident had a history of decreased opening of the UES to allow for passage of bolus (small rounded mass of a substance, especially of chewed food at the moment of swallowing). -The Resident's dry swallow was intact. -The Resident's Functional Oral Intake Scale score was one out of seven (seven is the highest functional level). -The Resident was at high risk for Pneumonia and was NPO. -The Resident had severe Oropharyngeal Phase Dysphagia. -The Resident was awaiting ENT assessment due to lack of UES opening for PO (by mouth) intake. -The Resident's goal was to eat again. Review of Resident #114's Speech Therapy Discharge Summary, dated 10/22/23, indicated the following: -The Resident remained NPO due to lack of UES opening. Review of Resident #114's Speech Therapy Evaluation and Plan of Treatment, dated 12/5/23, indicated the Resident was being assessed in response to the Resident's request for ice chips. Review of Resident #114's Speech Therapy Discharge Summary, dated 12/11/23, indicated the Resident was discharged from Speech Therapy services due to being transferred to the hospital. Review of Resident #114's ENT Clinic Consultation Report, dated 5/28/24, indicated: -The Resident had left vocal fold (muscular band inside one's voice box that produce the sound of one's voice and help one breathe and swallow food safely) immobility. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Resident exhibited minimal pooling (accumulation) of secretions in the pyriform sinuses (small recess on either side of the laryngeal inlet). -The Resident had possible severe stenosis (narrowing of a passage)/complete stenosis of the esophagus and left vocal fold paralysis. -The ENT Clinic Provider requested to see the MBSS performed in 2023 to see whether any contrast went through into the esophagus. -If not, an MBSS would need to be re-ordered. Further review of the ENT Clinic Consultation Report, dated 5/28/24, indicated the NP had reviewed the Consultation. Review of Resident #114's NP Progress Note, dated 5/29/24, indicated the following: -ENT visit completed one day ago. -Recommendations from Barium studies to be faxed to ENT. -Checking for dye (contrast) penetration into esophagus. Review of Resident #114's Interdisciplinary Quarterly Screen Form, dated 5/31/24, by the Speech Language Pathologist (SLP), indicated the following: -? need for MBSS. -The Resident told the SLP the MBSS would be performed through the ENT Clinic. Review of Resident #114's NP Progress Note, dated 6/5/24, indicated the following: -Discussion with SLP regarding obtaining MBSS results from another Provider. -Awaiting results . Review of Resident #114's NP Progress Note, dated 6/12/24, indicated the following: -Sourcing copies of MBSS completed outside of this facility with SLP support. -Results pending. Review of Resident #114's NP Progress Note, dated 6/28/24, indicated the following: -Request for previous MBSS studies discussion with SLP. -SLP will assist as able to get the Resident's records. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #114's Interdisciplinary Quarterly Screen Form, dated 8/30/24, indicated the Resident had experienced no change in swallowing. Review of Resident #114's Minimum Data Set (MDS) Assessment, dated 9/4/24, indicated the following: -The Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -The Resident demonstrated no refusal of care. -The Resident received 51% or more total calories through . tube feeding. -The Resident received 501 cc/day or more average fluid intake per day by . tube feeding. Review of Resident #114's Physician Progress Note, dated 8/20/24, indicated: -Consider ENT evaluation for the Resident's vocal cord . Review of Resident #114's Interdisciplinary Quarterly Screen Form, dated 11/14/24, indicated: -the SLP discussed scheduling an MBSS for the following week with the Nurse Practitioner (NP), Nursing, and the Resident, pending Respiratory Therapy (RT). -the Resident's BIMS score was 15 out of 15 total possible points. During an interview on 11/13/24 at 2:10 P.M., Resident #114 said he/she had not eaten any food in a year and a half. Resident #114 said his/her swallowing had been evaluated in the past and that he/she had been told his/her esophagus could be widened, but that widening of his/her esophagus had not been done. Review of Resident #114's Mobile Dysphagia Consultation Order Form, dated 11/14/24, completed by the SLP and signed by the NP, indicated the following: -The Resident consented to having an MBSS and Esophageal Assessment to Stomach. -The MBSS was being ordered per the ENT Clinic Provider's request. -The Resident was currently NPO. -The medical necessity for the consult included breathing difficulty with PO intake and vocal fold paralysis. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 10:00 A.M., the SLP said she was responsible to schedule MBSSs for Residents at the facility and that she would schedule the MBSSs once the order was obtained from the NP. The SLP said Resident #114 had an MBSS and a FEES prior to his/her admission to the facility in September 2023 and that the facility was never able to obtain the MBSS and FEES results. The SLP said she had been notified by Nursing Staff on 11/14/24 of a Physician request for an MBSS to be completed for Resident #114. The SLP said the MBSS was requested to determine whether any barium entered the Resident's esophagus during swallowing. The SLP further said she had not been made aware of the request for an MBSS to be completed for Resident #114 prior to 11/14/24. During an interview on 11/19/24 at 10:10 A.M., Unit Manager (UM) #1 said she referred Resident #114 to the SLP on 11/14/24 because the ENT Clinic staff had called the facility that same day to inquire of the status of the previously requested MBSS results. UM #1 said she thought the Resident had gone to see the ENT Provider in August 2024, then reviewed the Resident's record and said the Resident went to the ENT clinic in May 2024. UM #1 said she could not believe it had been almost six months since the Resident's appointment with the ENT clinic. UM #1 said she had been unavailable to work for about one month around the time Resident #114 went to the ENT clinic, so she did not see the results and recommendations from the Consultation. UM #1 said that if she had been working when the recommendations were made, she would have been responsible to follow-up on the recommendations from the ENT clinic consultation. UM #1 further said she returned to work in July 2024. UM #1 said could not speak to who would have been responsible to follow-up on the ENT clinic's recommendations when she was not at work. During a follow-up interview on 11/19/24 at 10:20 A.M., the SLP said that nursing staff should alert her to any new recommendations for residents relative to swallowing and requests for MBSSs when the recommendations are received by the facility. The SLP said she would complete a screen and address the recommendations within 24 hours of being notified by staff of the recommendations. The SLP said she spoke with Resident #114 when she completed the Quarterly Screen on 5/31/24, and that the Resident said he/she thought the MBSS was going to be scheduled through the ENT Clinic. The SLP further said she had not been alerted by staff whether the MBSS had been completed and had not been notified of any changes in the Resident's swallowing status, so she had no indication to follow-up with the Resident. The SLP said she should have been notified by nursing staff when the ENT clinic recommendations were made on 5/28/24, so she could have obtained the order from the NP for an MBSS to be completed for the Resident since the MBSS results from 2023 had never been obtained by the facility for review. The SLP said that the Resident experienced a delay in treatment because she was not aware of the ENT clinic recommendations and the MBSS was not ordered timely. During an interview on 11/19/24 at 10:25 A.M., the Nurse Practitioner (NP) said that she reviewed Resident #114's ENT Clinic Consultation Report on 5/29/24, and that her initials on the Consultation indicated agreement with the ENT Clinic's recommendations. The NP said that she expected that the facility would provide the results of the MBSS completed in 2023 for the ENT Clinic Provider to review and that if the MBSS results could not be obtained, staff would have discussed the need for an MBSS to be ordered and completed for the Resident. The NP said that the need for an MBSS to be completed for Resident #114 should have been addressed when the recommendations were made for the Resident by the ENT Clinic Provider. The NP said that the Resident's need for an MBSS not yet having been addressed resulted in a delay in care for the Resident. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/24 at 12:53 P.M., the Director of Nursing (DON) said that Resident #114's ENT Clinic recommendations from 5/28/24, should have been addressed when the recommendations were made and that the recommendations not yet being addressed was a concern for delay in treatment for the Resident. 44337 2. Review of the Facility Policy titled Checking Gastric Residual Volume (GRV) indicated the following: -The purpose of this policy is to assess tolerance of enteral feeding and minimize the potential for aspiration. -If the resident is on continuous tube feedings (enteral feedings), the stomach should contain no more than the total intake from the last hour. If so, withhold feeding and notify the Physician. -If the GRV is between 250-500 ml (milliliters), take measures to prevent aspiration. Resident #86 was admitted to the facility in November 2019, with diagnoses including Acute and 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 acute symptoms of trouble breathing and fatigue), Tracheostomy, G-Tube, and persistent vegetative state (a chronic condition that occurs when someone is awake but shows no awareness of their surroundings). Review of a Minimum Data Set (MDS) assessment dated [DATE], indicated no BIMS score entered for Resident #86. Review of the active Physician orders dated 11/18/24, indicated the following: -Enteral Feed Order every shift Glucerna 1.5 at 55 ml/hour via G-tube times 22 hours, initiated 2/21/24. -NPO Diet, initiated 9/16/21. -Check residual tube feeding (enteral feeding) every shift and record. If residual (GRV) is greater than 150 ml, hold feeding and notify MD, initiated 10/19/20. Review of Resident #86's Medication Administration Record (MAR) did not provide any evidence that gastric volume residuals had been completed and documented every shift as ordered. During an interview and record review on 11/19/24 at 9:06 A.M., the Director of Nursing (DON) said that the Physician orders for Resident #86 included to document the amount of gastric residual volume every shift. The DON said that the gastric residual volume for Resident #86 should have been documented on the MAR as ordered but was not documented. The DON said that it is important to document the gastric residual volume so that staff can assess Resident #86's tolerance to the tube feedings and be aware of any trends that can lead to complications for the Resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47646 Based on observation, and interview, the facility failed to ensure all medications used in the facility were stored and labeled in accordance with currently accepted professional principles of practice. Specifically, the facility failed to: 1. Ensure that staff properly labeled all medications stored in one of four medication carts reviewed. 2. Ensure that staff removed four expired medications from one medication room refrigerator of two refrigerators reviewed. Findings include: 1. Review of the facility's Labeling of Medication Containers Policy (dated 2017) indicated but was not limited to the following: 1. Any medication packaging containers that are inadequately or improperly labeled shall be returned to the issuing pharmacy. 2. Labels for individual drug containers shall include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use. 3. Only the dispensing pharmacy can label or alter the label on a medication container or package. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 1:42 P.M., the surveyor and Nurse #1 observed medication cart A on the third floor. Two Ventolin HFA (bronchodilator medication) inhalers in boxes were observed in the second drawer, with no pharmacy label affixed to the inhaler or the box. The labeling failed to indicate the resident's name, prescribing physician's name, the name, address and telephone number of the pharmacy, the prescription number, dispensing date or directions for use. The surveyor observed that a resident's name was handwritten in black marker on one of the Ventolin boxes, and the expiration date on the box was February, 2024. The other Ventolin box did not have a name written on it. During an interview at the time, Nurse #1 said he forgot to take the expired inhaler off the medication cart when the new inhaler came in. Nurse #1 said both medications should have pharmacy labels attached and that the resident was no longer receiving the Ventolin medication. During an interview on 11/15/34, at 11:00 A.M., the Director of Nursing (DON) said that all medications in medication carts and storage rooms needed to be labeled with the required information for use. 2. Review of the facility's Storage of Medications Policy (dated 2022) indicated but was not limited to the following: -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing facility or destroyed. Review of the facility's Insulin Storage Policy (dated 2022) indicated but was not limited to the following: -Insulin (medication used to manage blood sugars) has a 'use-by' date as well as an expiration date. Insulins removed from the refrigerator and/or opened shall be dated as such with the 'use-by' date not to exceed 28 days. On 11/14/24, at 3:52 P.M., the surveyor and Unit Manager (UM) #1 observed the medication room on the First Floor. In the refrigerator, medications were observed: -A bottle of Vancomycin Hydrochloride (liquid antibiotic) for Oral Solution, USP 50 mg/ml. Affixed to the bottle was a red sticker indicating Beyond Use Date including a date, 10/30/2024 (handwritten on sticker). -A bottle of Vancomycin Hydrochloride for Oral Solution, USP 25 mg/ml. Affixed to the bottle was a red sticker indicating Beyond Use Date including a date, 9/28/2024 (handwritten on sticker). -A bottle of Konvomep (A combination medication used to prevent upper gastrointestinal bleeding) [NAME] [sic] 2 mg/ml. Affixed to the bottle was a red sticker indicating Beyond Use Date including a date, 11/11/2024 (handwritten on sticker). -A vial of Humolog Insulin with the top seal removed and open. Affixed was a yellow label indicating: Date opened 9/11/24 and expiration date 10/1/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 3:52 P.M., UM #1 said she does not know what the Beyond Use Date means but she plans to dispose of the medication. UM #1 said that the opened bottle of Humalog Insulin should not have been in the refrigerator and it should have been disposed of when it expired on 10/1/24. During an interview on 11/14/24 at 4:25 P.M., Pharmacist #1 said that the Beyond Use Date is the date that the medication cannot be used passed. Pharmacist #1 said the Beyond Use Date is used for medications that are compounded and have short end expiration dates that is typically 14 days. Pharmacist #1 said the Pharmacist who compounds the medication places the sticker and writes the date on the sticker. Pharmacist #1 said that the three medications with the Beyond Use Date stickers were expired and they should not have been in the medication refrigerator because there is a risk that they could be used. Pharmacist #1 said the medications should have been disposed of. Pharmacist #1 also said the labeled opened Humalog Insulin that had an expiration date of 10/1/24, should have been disposed of and not in the refrigerator. Pharmacist #1 said there is no way of knowing how long the medication was out of the refrigerator and there is a risk that it could be used. During an interview on 11/15/34 at 11:00 A.M., the Director of Nursing (DON) said that all expired medications in medication carts and storage rooms should be removed or disposed of.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47646 Based on record review, and interview, the facility failed to electronically submit complete and accurate direct care staffing data based on payroll to Centers for Medicare and Medicaid Services (CMS) for the entire reporting period, Fiscal Year (FY) Quarter 3 2024 (April 1 - June 30) as required by CMS. Findings include: Review of Reporting Direct Care Staffing Information (Payroll-Based Journal) (PBJ) Policy (undated) indicated but was not limited to the following: 1. Complete and accurate direct care staffing information is reported electronically to CMS through the PBJ system in a uniform format specified by CMS. 2. Direct care staff are those individuals who, through interpersonal contact with residents or residents care management, provide care and services to allow residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Review of the PBJ Staffing Report, CASPER Report 1705D, FY Quarter 3 2024 (April 1 - June 30), indicated the facility triggered for: -One star staffing. -excessively low weekend staffing. -no RN (Registered Nurse) hours (four or more days within the quarter with no RN hours). -failed to have LN (Licensed Nurse) coverage 24 hours per day (four or more days within the quarter with less than 24 hour hours per day). Further review the PBJ Staffing Report indicated that the infraction dates for no RN hours and failed to have LN coverage 24 hours per day consisted of every day of the quarter (April 1 - June 30). Review of the facility's as worked schedules and payroll reports indicated that there was RN coverage for more than eight hours per day and LN coverage for 24 hours per day everyday through the quarter (FY Quarter 3 2024). During an interview on 11/14/24 at 11:00 A.M., the Director of Nursing (DON) said that everyday there is at least one or two RNs and LN 24 hours per day working on the units. The DON said she has been the DON since January 2024 and there has never been a day without an RN working or LN in the facility 24 hours/day. The DON said if that were to happen, she would ensure coverage was in place or come in herself. The DON said she monitors the schedule for staffing. (continued on next page)

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 11/14/24 at 11:55 A.M., the Administrator said that payroll data is reported to CMS by the ownership corporate office. The Administrator said he determined that the ownership corporate office did not submit the hours properly, that only the agency/contract hours were uploaded and accepted, so a majority of the hours were not submitted and accepted. The Administrator said that they were unaware of the issue until the surveyor brought it to his attention today. The Administrator said he would see if this could be corrected. The Administrator said he is unsure how or why it happened. The Administrator provided the surveyor with the CASPER Report 1702S, Staffing Summary Report from 4/1/2024 through 6/30/2024. Review of the CASPER Report 1702S indicated that total Staffing hours reported was 1,083.00. The Administrator said that the total hours reported should be around 70,000 hours because it is all of the Direct Care Hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50138 Based on observation, interview, and National Standards reviewed, the facility failed to provide a safe, and sanitary environment for all residents, staff, and visitors, on one Unit (Fourth Floor) out of four total units observed. Specifically, the facility failed to implement cleaning techniques to manage and eliminate rodent droppings according to National Standards in order to control the source of potential infection for all individuals on the Unit. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidelines, titled How to Clean up After Rodents, dated 1/3/23, indicated the following: -Diseases are mainly spread to people from rodents when they breathe in contaminated air. -CDC recommends you NOT vacuum (even vacuums with a HEPA filter) or sweep rodent urine, droppings, or nesting materials. -These actions can cause tiny droplets containing viruses to get into the air. -Always take precautions when cleaning to reduce your risk of getting sick. -Before you begin cleaning, prepare by gathering the proper equipment. -Use a preferred disinfectant: General-purpose household disinfectant cleaning product (confirm the word Disinfectant is included on the label), or Bleach solution made with 1.5 cups of household bleach in 1 gallon of water (or 1 part bleach to 9 parts water). -Make bleach solution fresh before use. -Wear rubber or plastic gloves. -Additional precautions should be used for cleaning homes or buildings with heavy rodent infestation. -Step 1: Put on rubber or plastic gloves. -Step 2: Spray urine and droppings with bleach solution or an EPA-registered disinfectant until very wet. Let it soak for 5 minutes or according to instructions on the disinfectant label. -Step 3: Use paper towels to wipe up the urine or droppings and cleaning product. -Step 4: Throw the paper towels in a covered garbage can that is regularly emptied. -Step 5: Mop or sponge the area with a disinfectant. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clean all hard surfaces including floors, countertops, cabinets, and drawers . -Step 6: Wash gloved hands with soap and water or a disinfectant before removing gloves. -Step 7: Wash hands with soap and warm water after removing gloves or use a waterless alcohol-based hand rub when soap is not available, and hands are not visibly soiled. On 11/13/24 at 9:00 A.M., the surveyor observed on the Fourth Floor: >Rooms 403, 405, 412, 414, and 415, with rodent droppings on the two corners of the floor closest to the window and along the floor behind the headboard of the beds within the rooms. >room [ROOM NUMBER] with rodent droppings on the windowsill and on the two corners of the floor closest to the window within the room. On 11/14/24 at 1:38 P.M., the surveyor observed on the Fourth Floor: >Rooms 403, 405, 412, 414, and 415, with rodent droppings on the two corners of the floor closest to the window and along the floor behind the headboard of the beds within the rooms. >room [ROOM NUMBER] with rodent droppings on the windowsill and on the two corners of the floor closest to the window within the room. During an interview on 11/14/24 at 4:41 P.M., the Maintenance Director said that the extermination company was visiting the facility every other day to bait and inspect the rodent traps inside and outside the facility on every floor. The Maintenance Director said that rodent activity had slowed down a lot, but he had never been provided with directions for care of the traps or rodent droppings. During an interview on 11/14/24 at 4:48 P.M., the Director of Housekeeping said that rodent activity had reduced significantly since the new extermination company had been in place, but the mouse droppings were still seen daily by his staff. The Director of Housekeeping said that the housekeepers were responsible to wipe down surfaces, sweep, and mop resident rooms once a day or more frequently as needed. The Director of Housekeeping said he had not been provided with any special instructions related to the care or cleaning of the rodent droppings and there were no special treatments or processes in place for the cleaning or disinfection of rodent droppings in the facility. On 11/15/24 at 8:48 A.M., the surveyor observed on the Fourth Floor: >Rooms 403, 405, 412, 414, and 415, remained with rodent droppings on the two corners of the floor closest to the window and along the floor behind the headboard of the beds within the rooms. >room [ROOM NUMBER] remained with rodent droppings on the windowsill and on the two corners of the floor closest to the window within the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/15/24 at 11:07 A.M., the surveyor observed Housekeeper #2 use a long handled broom and dustpan to sweep the rodent droppings off the floor in room [ROOM NUMBER] and then emptied the droppings into the trash bucket on the housekeeping cart. Housekeeper #2 said that she had always done it this way and she was not aware of special instructions to clean rodent droppings. Housekeeper #2 then identified rodent droppings to the surveyor and demonstrated the process of sweeping the droppings with her broom and dustpan and then placing the droppings into the trash bucket. Housekeeper #2 said she had not been instructed to clean rodent droppings differently than as demonstrated to the surveyor. Housekeeper #2 said that she had seen rodent droppings in almost every room on the Fourth Floor. During a follow-up interview on 11/15/24 at 1:56 P.M., the Director of Housekeeping said he had spoken with the Infection Preventionist (IP) and reviewed the CDC website related to cleaning for rodent droppings. The Director of Housekeeping said the facility had not been cleaning and disinfecting the rodent droppings in the correct way and that improper cleaning and disinfection could lead to a viral infection. During an interview on 11/15/24 at 2:51 P.M., the IP said the facility followed CDC guidelines for infection control practices, but she had been unaware that rodent droppings required special treatment and disposal when cleaning and disinfecting. The IP said that the Housekeepers should not have swept up rodent droppings because the droppings could contain Hantavirus (a family of viruses which can cause serious illnesses and death from contact with rodents like rats and mice, especially when exposed to their urine, droppings, and saliva). The IP said the facility had residents who were at high risk for infection if they were exposed to Hantavirus and the housekeeping staff should therefore update their procedures for cleaning and disinfecting rodent droppings.