STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225223	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Rehabilitation and Healthcare Ctr (the)	56 Liberty Street Danvers, MA 01923

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 Note: The nursing home is disputing this citation.	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** 45984 Based on observations, record review and interviews, the facility failed to provide a dignified existence for one Resident (#68) out of a total sample of 30 residents. Findings include: Review of the facility policy titled Dignity, revised and dated February 2021, indicated the following: - Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. - Residents are treated with dignity and respect at all times. Resident #68 was admitted to the facility with diagnoses including Bipolar disorder and personality disorder. Review of Resident #68's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. The surveyor made the following observations: - On 3/11/25 at 7:59 A.M., Resident #68 was sleeping in his/her bed and was visible in the hallway with his/her bedroom door open. Resident #68 was only wearing briefs, his/her entire buttocks were visible from the hallway. Numerous staff members were observed walking past his/her room with the Resident exposed. There was no privacy curtain in his/her room. - On 3/12/25 at 7:12 A.M., Resident #68 was sleeping in his/her bed and was visible in the hallway with his/her bedroom door open. Resident #68 was completely naked, and his/her entire buttocks and genitals were visible from the hallway. Numerous staff members were observed walking past his/her room with the Resident exposed. There was no privacy curtain in his/her room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/12/25 at 8:16 A.M., the surveyor attempted to interview Resident #68 but he/she declined to be interviewed. Shortly after, Resident #68 was discharged out of the facility to the hospital, he/she was unavailable for the remainder of the survey. During an interview on 3/13/25 at 8:36 A.M., Nurse #10 all residents are entitled to privacy and dignity. Nurse #10 said if a resident is exposed and visible we would offer to cover them with a sheet or close their door so they cannot be seen from the hallway. Nurse #10 said staff should have attempted to cover up Resident #68. During an interview on 3/13/25 at 8:40 A.M., the Director of Nursing said all residents should be treated with dignity and privacy, she said staff should have intervened if Resident #68 was exposed and visible from the hallway.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44095 Based on record review and interview, the facility failed to file a grievance for one Resident (#111), out of a total sample of 30 residents. Specifically, the facility staff failed to ensure the Administrator filed a grievance on behalf of Resident #111's who expressed a complaint of staff sleeping on the night shift. Findings include: Review of the facility policy titled, Grievances/ Complaints, Filing, undated, indicated that Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/ or representative. 1. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning the care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. 2. Residents, family and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. 4. Upon admission, residents are provided with written information on how to file a grievance or complaint. A copy of our grievance/complaint procedure is posted on the resident bulletin board. 5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously. 6. The contact information for the individuals) with whom a grievance may be filed is provided to the resident and/or representative upon admission. 7. The administrator is the facility grievance officer. 8. Upon receipt of a grievance and/or complaint, the grievance officer or designee will review and investigate the allegations and submit a written report of such findings within five (5) working days of receiving the grievance and/or complaint. 9. The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. The grievance officer and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. 11. The grievance officer and associated department director will review the findings to determine what corrective actions, if any, need to be taken. 12. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. 13. If the grievance was filed anonymously, the grievance officer will inform the resident that a grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings. The grievance officer will reiterate to the resident that it is against facility policy and federal regulations to discriminate or sanction a resident who has filed or verbalized a complaint against the facility, and that his or her rights to be free of discrimination or reprisal will be protected. 14. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision. 15. This policy will be provided to the resident or the resident's representative upon request. Resident #111 was admitted to the facility in January 2025 with diagnoses including diabetes, anxiety, and post-traumatic stress disorder. Review of the Minimum Data Set (MDS) assessment, dated 1/21/25, indicated that Resident #111 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. Review of Resident #111's plan of care related to post-traumatic stress disorder, dated 1/15/25, indicated: - Patient reports his/her triggers are as follows: Being woken up in the middle of the night abruptly, flipping the lights on (I panic). Further review of Resident #111's active plan of care failed to include accusatory behaviors. During an interview on 3/11/25 at 8:08 A.M., Resident #111 said that staff during the evening and night shift are 'horrendous' and it takes upwards of 30 minutes for staff to answer call bells. Resident #111 said that there are several staff who sleep during the night shift and despite speaking with the facility staff there are still staff members who sleep during the night shift, and he/she has photos of staff members sleeping. Review of the facility grievance log dated January 2025 through March 13, 2025, failed to include documentation to support facility staff filed a grievance on behalf of Resident #111's complaints of staff sleeping on the night shift. During an initial interview on 3/12/25 at 8:02 A.M., the Administrator said she was aware of Resident #111's complaint of staff sleeping on the night shift, but she did not complete a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25 at 10:10 A.M., Nurse #8 said she was aware of Resident #111's complaints of staff sleeping during the night shift. During an interview on 3/13/25 at 10:23 A.M., Unit Manager #1 said that she was aware of Resident #111's complaint about staff sleeping during the night shift. During an interview on 3/12/25 at 5:58 P.M., the Social Worker said she was aware of Resident #111's complaint of staff sleeping during the night shift. The Social Worker said she told the Administrator and the Director of Nursing of these complaints and said a grievance should have been completed. During an interview on 3/13/25 at 11:15 A.M., the Director of Nursing (DON) said she was aware of Resident #111's complaint of staff sleeping during the night shift and the DON said the Social Worker or Administrator are responsible to file grievances. The DON said that there should be a grievance for Resident #111's concerns with staff sleeping. During a follow up interview on 3/13/25 at 12:22 P.M., the Administrator said she was unable to provide the surveyor with a grievance related to staff sleeping on the night shift.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43846 Based on observation, record review and interview, the facility failed to ensure physician orders were implemented for three Residents (#44, #80, and #102) out of a total sample of 30 residents. Specifically, 1. For Resident #44, the facility failed to complete a treatment to his/her left great toe per physician order. 2. For Resident #80, the facility failed to obtain a physician order for the use of his/her boot immobilizer. 3. For (a) Resident #80 and (b) Resident #102, the facility failed to obtain weekly weights per physician order. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #44 was admitted to the facility in June 2023 with diagnoses that included anxiety, anemia, depression, and osteoarthritis. Review of Resident #44's most recent Minimum Data Set (MDS) assessment, dated 12/31/24, indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has intact cognition. During an observation on 3/11/25 at 8:04 A.M., the surveyor observed Resident #44 in bed without a dressing on his/her left great toe. During an observation on 3/12/25 at 8:15 A.M., the surveyor observed Resident #44 in bed without a dressing on his/her left great toe. During an interview on 3/12/25 at 8:16 A.M., Resident #44 said nursing staff only change the dressing on his/her left great toe maybe once a week and it was not changed the last few days. Review of Resident #44's physician order, dated 2/14/25, indicated Left great toe: NSW (Normal Saline Wash), pat dry, apply bacitracin (antibiotic ointment) and cover with DPD (dry protective dressing) or band aid every evening shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's impaired skin integrity care plan, dated 9/19/24, indicated the following: Administer treatments as ordered and monitor effectiveness. On 3/12/25 at 12:04 P.M., Nurse #1 with the surveyor observed Resident #44 in bed without a dressing on his/her great left toe. Nurse #1 said the treatment is not done on his shift and said the evening shift should be following the doctor's order. During an interview on 3/12/25 at 12:20 P.M., the Director of Nurses (DON) said staff should be completing physician's orders. 2. Resident #80 was admitted to the facility in January 2025 with diagnoses that included non-displaced fracture of the right fibula, post-traumatic stress disorder, major depressive disorder, and lack of coordination. Review of Resident #80's most recent Minimum Data Set (MDS) assessment, dated 1/21/25, indicated he/she scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairments. Further review of the MDS indicated he/she needs partial/moderate assistance from staff members for lower body dressing and for putting on/taking off footwear. On 3/11/25 at 8:32 A.M., the surveyor observed Resident #80 in bed without a boot immobilizer on. On 3/11/25 at 12:09 P.M., the surveyor observed Resident #80 in his/her wheelchair with a boot immobilizer on his/her right foot. On 3/12/25 at 8:00 A.M., the surveyor observed Resident #80 in bed with a boot immobilizer on. Review of Resident #80's orthopedic consult appointment note, dated 2/21/25, indicated boot immobilizer on at all times expect with hygiene and exercises. Review of Resident #80's active physician orders failed to indicate an order for use of the boot immobilizer. During an interview on 3/12/25 at 11:56 A.M., Nurse #1 said the Resident was admitted with a hard cast on his/her leg, but it was removed at the last ortho appointment a few weeks ago. Nurse #1 said he is not sure when the boot immobilizer should be on the Resident because there is not a physician's order in place for the boot. During an interview on 3/12/25 at 12:00 P.M., the Assistant Director of Nurses said there should be an order in place for a resident wearing a boot immobilizer. During an interview on 3/12/25 at 12:11 P.M., Unit Manager #1 said there should be an order in place for the use of the Resident's boot immobilizer but there is not. 3. (a) Resident #80 was admitted to the facility in January 2025 with diagnoses that included non-displaced fracture of the right fibula, post-traumatic stress disorder, major depressive disorder, and lack of coordination. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #80's most recent Minimum Data Set (MDS) assessment, dated 1/21/25, indicated he/she scored a 13 out of a possible 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairments. Review of Resident #80's physician order, dated 1/15/25, indicated Weights Weekly one time a day every Wed (Wednesday). Review of Resident #80's weights indicated the last weight that was taken was on 2/19/25 and was 199.0 Lbs (pounds). Review of Resident #80's February and March 2025 Medication Administration Record (MAR), indicated on 2/12/25, 2/26/25, 3/6/25 and 3/12/25 the weight weekly on Wednesday order was left blank by nursing staff. Review of Resident #80's nutrition care plan, dated 1/17/25, indicated Obtain weights at ordered intervals. Review of Resident #80's nursing progress notes from 2/19/25 to 3/12/25 failed to indicate the resident refused weights. During an interview on 3/12/25 at 3:15 P.M., Nurse #2 said weekly weights are obtained weekly early in the day shift and the weights should be documented under the weights tab in the electronic medical record (EMR). During an interview on 3/12/25 at 3:51 P.M., the Director of Nurses said nursing staff should be following physician orders, obtaining the weekly weights weekly and documenting them in the weights tab in the EMR. (b) Resident #102 was admitted to the facility in January 2023 with diagnoses that included major depressive disorder, asthma, and muscle weakness. Review of Resident #102's most recent Minimum Data Set (MDS) assessment, dated 12/13/24, indicated he/she scored a 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating severe cognitive impairments. Review of Resident #102's physician order, dated 2/24/25, indicated Weights weekly one time a day every Wed (Wednesday). Review of Resident #102's weights indicated the last weight that was taken was on 2/19/25 and was 158.6 Lbs (pounds). Review of Resident #102's February and March 2025 Medication Administration Record (MAR), indicated nursing staff signed off the weekly weight order as administered on 2/26/25 and 3/5/25. Review of Resident #102's nutrition care plan, dated 6/17/24, indicated Obtain weights at ordered intervals. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's Nurse Practitioner (NP) progress note, dated 2/26/25, indicated Now he/she is losing weight-lost 13 pounds over the 6 weeks. Review of Resident #102's nursing progress notes from 2/19/25 to 3/12/25 failed to indicate the resident refused weights. During an interview on 3/12/25 at 3:15 P.M., Nurse #2 said weekly weights are obtained weekly early in the day shift and the weights should be documented under the weights tab in the electronic medical record (EMR). During an interview on 3/12/25 at 3:51 P.M., the Director of Nurses said nursing staff should be following physician orders, obtaining the weekly weights weekly and documenting them in the weights tab in the EMR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49880 Based on record review and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for one Resident (#381), out of a total sample of 30 residents. Specifically, the facility failed to follow physician orders to obtain daily weights and failed to notify a physician or nurse practitioner of a potential significant weight gain as indicated in the physician's orders for a resident with a diagnosis of liver cirrhosis (late stage liver disease, in which healthy liver tissue has been gradually replaced with scar tissue, causing symptoms such as swelling in the legs, feet, or ankles). Findings include: Review of facility policy titled Weight Assessment and Intervention, dated as revised March 2022, indicated the following: -Resident weights are monitored for undesirable or unintended weight loss or gain. -Residents are weighed upon admission and at intervals established by the interdisciplinary team. -Any weight change of 5% or more since the last weight assessment is retaken for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Resident #381 was admitted to the facility in March 2025 with diagnoses that include chronic kidney disease, cirrhosis and edema. Review of the Nursing Progress note, dated 3/12/25, indicated that the Resident is alert and oriented x 3, able to make needs known. Review of Resident #381's physician's orders indicated: -Weights Daily on day shift in the morning Contact MD/NP (medical doctor or nurse practitioner) if weight gain greater than 3 lbs. (pounds) in one day or 5 lbs. in 1 week, dated 3/8/25. Review of Resident #381's documented weights in the weight portal of the electronic medical record indicated the following: 3/7/25: 217.0 lbs. 3/11/25: 229.2 lbs. On 3/7/25, the Resident weighed 217 lbs and on 3/11/25, the Resident weighed 229.2 lbs., which is a 5.62% gain or 12.2 lb. difference in 4 days. Review of the Patient Care Referral form from the referring hospital indicated Resident #381 weighted 217 pounds on 3/7/25 at the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weight portal failed to indicate weights were obtained on 3/8, 3/9 or 3/10. Review of the March 2025 Treatment Administration Record (TAR) indicated that the Resident refused to be weighed on 3/8, 3/9 and 3/12. Review of the medical record failed to indicate that a practitioner had been made aware of the potential significant weight gain. During an interview on 3/12/25 at 1:47 P.M., Nurse Practitioner #1 said that he had seen and examined Resident #381 earlier today. He said that the Resident has an order from the referring hospital for daily weights due to anasarca and liver cirrhosis. He also said that changes had been made to the Resident's diuretic therapy (medication that pulls extra fluid out of the body) due to his/her kidney function so monitoring the weights were important. He said that he was not made aware of the potential significant weight gain or that the Resident had been refusing weights. He said that he would have expected staff to confirm the potential weight gain and report it to him. Review of the medical record at the time of the surveyor's interview with the Nurse Practitioner failed to indicate that the staff had attempted to re-weigh the resident and confirm the potential significant weight gain. Further review of the medical record failed to indicate any refusals by the Resident for a re-weight as well as Physician or Nurse Practitioner notification of the potential significant weight gain. Further review of the medical record indicated that on 3/12/25 at 3:07 P.M., the facility re-weighed the Resident and obtained a weight of 234 lbs., an additional 4.8 lb. weight gain in one day. Another weight was obtained on 3/13/24 at 5:28 A.M., indicating a weight of 234.6 lbs. Review of Resident #381's physician's orders following the confirmation of the weight gain indicated the following: -Fluid Restriction 1.5 Liters every day for edema, with a start date of 3/13/25. During an interview on 3/13/25 at 8:06 A.M., Nurse #9 said that nursing should have confirmed and then reported the significant weight gain to the Nurse Practitioner or Physician when the weight was obtained as indicated in the physician's orders. During an interview on 3/13/25 at 9:08 A.M., the Director of Nurses said that the weight should have been confirmed and if confirmed, reported to the practitioner as indicated in the physician's orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44095 Based on observations, record reviews, and interviews, the facility failed to ensure nursing implemented interventions for pressure ulcer care for one Resident (#119) out of a total sample of 30 Residents. Specifically for Resident #119 who had an actual pressure injury the facility failed to ensure that nursing implemented interventions including an air mattress and Prevalon boots (heel booties, a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure). Findings include: Review of the facility policy titled, Prevention of Pressure Injuries, dated as revised April 2020, indicated the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. -Preparation Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. - Support Surfaces and Pressure Redistribution 1. Select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice. Resident #119 was admitted to the facility in February 2025 with diagnoses including dementia, severe protein malnutrition, and failure to thrive. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/28/25, indicated that Resident #119 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This MDS indicated Resident #119 was totally dependent on staff for putting on and taking off footwear. The MDS indicated that Resident #119 was assessed by nursing as at risk for skin breakdown and he/she had two unstageable pressure ulcers. Review of Resident #119's physician's order, dated 2/28/25, indicated: - Left heel: Apply skin prep, one time a day. Review of Resident #119's physician's order, dated 3/7/25, indicated: - Wound Description for Site: Unstageable (due to necrosis) wound of the left heel, one time a day. Review of Resident #119's plan of care related to actual skin breakdown unstageable (due to necrosis) of the left heel, dated as revised on 3/6/25, indicated: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- air mattress to bed, initiated on 2/18/25. - heel booties while in bed as tolerated, initiated on 2/18/25. Review of Resident #119's specialty physician wound evaluation and management summary, dated 3/10/25, indicated: - unstageable full thickness pressure ulcer on left heel, float heels in bed; Prevalon boot when not floating heels. On 3/11/25 at 7:54 A.M., 10:15 A.M., 11:07 A.M. and on 3/11/25 at 4:14 P.M., the surveyor observed Resident #119 in his/her bed on a standard mattress and not an air mattress. Resident #119's feet were directly touching the mattress. There were no Prevalon boots in the room. On 3/12/25 at 8:30 A.M., 12:08 P.M., 4:34 P.M., and on 3/12/25 at 7:03 P.M., the surveyor observed Resident #119 in his/her bed on a standard mattress and not an air mattress. Resident #119's feet were directly touching the mattress. There were no Prevalon boots in the room. On 3/13/25 at 6:47 A.M., and on 3/13/25 at 11:00 A.M., the surveyor observed Resident #119 in his/her bed on a standard mattress and not an air mattress. Resident #119's feet were directly touching the mattress. There were no Prevalon boots in the room. During an interview on 3/13/25 at 7:44 A.M., Certified Nurse Assistant (CNA) #4 said that Resident #119 has an area on his/her heel and is dependent for care. CNA #4 said that Resident #119 accepts care, and he/she does not refuse care. CNA #4 said she was assigned to Resident #119 on 3/12/25 and 3/13/25 during the day shift, and CNA #4 said she was not aware the Resident #119 required an air mattress or Prevalon boots. CNA #4 and the surveyor searched Resident #119's room and were unable to locate Prevalon boots. During an interview on 3/13/25 at 7:50 A.M., Nurse #4 said that he is assigned to Resident #119 five days a week and is familiar with his/her care. Nurse #4 said that Resident #119 has pressure ulcers on his/her feet and Nurse #4 said that Resident #119 does not use an air mattress and does not have Prevalon boots. Nurse #4 said that Resident #119 would tolerate Prevalon booties if he/she was provided Prevalon boots. During an interview on 3/13/25 at 10:33 A.M., Unit Manager #1 said that Resident #119 has a left heel pressure ulcer. Unit Manager #1 reviewed Resident #119's care plan with the surveyor and she said that Resident #119's care plan indicates the use of an air mattress and the use of heel booties, and these interventions should have been provided. On 3/13/25 at 11:00 A.M., the surveyor along with Unit Manager #1 observed Resident #119 in his/her bed on a standard mattress and not on an air mattress. Resident #119's feet were directly touching the mattress. There were no Prevalon boots in the room. During an interview on 3/13/25 at 11:31 A.M., the Director of Nursing (DON) said that Resident #119 has a pressure ulcer and nursing should implement interventions that are in Resident #119's care plan for wound healing.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43846 Based on record review and interviews, the facility failed to adequately maintain the nutrition and hydration status of one Resident (#102) out of a total sample of 30 residents. Specifically, for Resident #102, who had a recent significant weight loss, the facility failed to have the Resident assessed by the dietitian for further interventions. Findings include: Review of facility policy titled Weight Assessment and Intervention, dated March 2022, indicated the following: -Resident weights are monitored for undesirable or unintended weight loss or gain. -Any weight change of 5% or more since the last weight assessment is retaken for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. -Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. Resident #102 was admitted to the facility in January 2023 with diagnoses that included major depressive disorder, asthma, and muscle weakness. Review of Resident #102's most recent Minimum Data Set (MDS) assessment, dated 12/13/24, indicated he/she scored a 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairments. Review of Resident #102's weight indicated on 1/2/25, the Resident weighed 171 lbs (pounds) and on 2/19/25, the Resident weighed 158.6 lbs which is a -7.25 % loss in one month. Review of Resident #102's Nurse Practitioner (NP) progress note, dated 2/17/25, indicated He/she has lost 13 pounds since the first of the year. Continues with significant weight loss. Review of Resident #102's Health Status Note, dated 2/18/25, indicated Note Text: Pt HCP (Health Care Proxy) notified of weight loss. Writer asked dietician to see pt.(patient) NP notified. Review of Resident #102's Nurse Practitioner (NP) progress note, dated 2/21/25, indicated Now he/she is losing weight-lost 13 pounds over the 6 weeks. He/she is under dietician supervision in the nursing home. Weight:158.6 Lbs - 2/19/25. Review of Resident #102's medical record indicated the last time the Resident had a Dietitian assessment was on 12/10/24 and the last progress note written by the Dietitian was on 4/11/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and medical record review on 3/12/25 at 3:09 P.M., the Dietitian said when a resident is identified as a significant weight loss she would be told by nursing staff. Then she would write a progress note that would include interventions and update the care plan. The Dietitian said she is not sure if nursing staff told her about Resident #102's significant weight loss from February because she was new to the facility then. The Dietitian said she does know there is a weight pending for Resident #102 to be obtained by nursing. During an interview on 3/12/25 at 3:15 P.M., Nurse #2 said Resident #102 has lost a lot of weight recently. During an interview on 3/13/25 at 3:51 P.M., the Director of Nursing said she was not aware of Resident #102 losing so much weight recently because she thought he/she was gaining weight. The Director of Nursing said a Resident who has lost a significant amount of weight should be assessed by the Dietitian for interventions and to document that in the medical record.

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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. 44095 Based on observation, interview, and record review, the facility failed to provide care and maintenance of a Peripherally Inserted Central Catheter (PICC: a flexible tube inserted through a vein in one's arm and passed through to the larger veins near the heart, used to deliver medications intravenously [IV]), consistent with professional standards of practice for two Residents (#232 and #381), out of a total sample of 30 residents. Specifically, 1. For Resident #232, the facility failed to ensure nursing changed the PICC line dressing with a transparent dressing as ordered. 2. For Resident #381, the facility failed to ensure that when a PICC line dressing was lifting (compromised), it was changed or reinforced and failed to change the PICC line dressing as indicated in the physician's orders on 3/8/25. Findings include: Review of the facility policy titled, Central Venous Catheter Care and Dressing Changes, dated as revised March 2022, indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled). 2. Maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing or sterile gauze) for all central vascular access devices. The type of dressing is based on the condition of the resident and his or her preference. 3. Change the dressing if it becomes damp, loosened or visibly soiled and: a. at least every 7 days for TSM dressing; b. at least every 2 days for sterile gauze dressing (including gauze under a TSM unless the site is not obscured); or c. immediately if the dressing or site appear compromised. 1. Resident #232 was admitted to the facility in February 2025 with diagnoses including enterocolitis due to clostridium difficile, pulmonary emboli, and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 2/13/25, indicated that Resident #232 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #232's plan of care related to intravenous therapy, dated as revised 2/19/25, indicated: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor dressing at IV insertion site daily and change as ordered and as needed (PRN). Review of Resident #232's physician's order, dated 3/6/25, indicated: - IV: (Midline, PICC, CVAD) Change Transparent Dressing on Admission and then every 7 days; Caps to be changed during dressing change, one time a day every Thursday and document. Review of Resident #232's Medication Administration Record, dated 3/7/25, indicated nursing changed Resident #232's PICC line dressing as ordered. On 3/11/25 at 12:09 P.M. and on 3/12/25 at 12:13 P.M., the surveyor observed a PICC line in Resident #232's right arm. The surveyor was unable to view the insertion site as it was obscured by gauze. The dressing was dated 3/7/25. During an interview on 3/12/25 at 12:14 P.M., Nurse #4 said he last changed Resident #232's PICC line dressing on 3/7/25, and said he did not obtain measurements when the PICC line dressing was changed. Nurse #4 said that he applied gauze under the transparent dressing to ensure that the line doesn't migrate when he does the dressing change. Nurse #4 said he is not able to visualize the insertion site with this type of dressing. During an interview on 3/13/25 at 10:45 A.M., Unit Manager #1 said that PICC line dressings should not have gauze under the dressing and if the insertion site is obscured by gauze the dressing needs to be changed more frequently. On 3/13/25 at 11:02 A.M., the surveyor and Unit Manager #1 observed Resident #232's PICC line dressing. Unit Manager #1 said that the insertion site was obscured by gauze and the insertion site could not be visualized. During an interview on 3/13/25 at 11:38 A.M., the Director of Nursing (DON) said nursing should use a transparent dressing without gauze so nursing can visualize the insertion site. 49880 2. Resident #381 was admitted to the facility in March 2025 with diagnoses that include chronic kidney disease and edema. Review of the Nursing Progress note, dated 3/12/25, indicated that the Resident is alert and oriented x 3, able to make needs known.[sic] Review of Resident #381's physician's orders indicated the following: -IV: (Midline, PICC, CVAD) Change Transparent Dressing on Admission and then every 7 days; Caps to be changed during dressing change, dated as 3/7/25. -IV: Assess that the IV catheter is secured well and does not slide around in the vein or become dislodged, the dressing is adhered with no moisture accumulation underneath it, dated 3/7/25. (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 Patient Care Referral Form from the acute care hospital indicated that a PICC line was placed on 3/7/25. On 3/11/25 at 8:43 A.M. and 2:37 P.M., the surveyor observed a right arm PICC line dressing dated 3/7/25, one side of the dressing was lifting at the edge. The insertion site was not visible due to a disk (medicated patch). On 3/12/25 at 7:36 A.M. and 2:16 P.M., the surveyor observed a right arm PICC line dressing dated 3/7/25. One side of the dressing was lifting at the edge. The insertion site was not visible due to a disk. On 3/13/25 at 7:55 A.M., the surveyor observed a right arm PICC line dressing dated 3/7/25, one side of the dressing was lifting at the edge. The insertion site was not visible due to a disk. Review of the March 2025 Medication Administration Record indicated the PICC line dressing was changed by Nurse #9 on 3/8/25. However, based on the surveyor's observation the dressing was dated 3/7/25. During an interview on 3/13/25 at 8:08 A.M., Nurse #9 said that if a resident has a PICC line dressing that is lifting, then it should be changed. He said he would let a Registered Nurse know because in this facility, as an LPN (Licensed Practical Nurse) he does not change the PICC line dressings. On 3/13/25 at 8:24 A.M., Nurse #9 and the surveyor observed the PICC line dressing on Resident #381. Nurse #9 said that the dressing was lifting on the side, and that he had not noticed it yesterday when he worked. When asked he said that he has not changed the PICC line dressing since the Resident has been here. During an interview on 3/13/25 at 9:13 A.M., the Director of Nurses said that if a PICC line dressing is lifting then it should be changed or reinforced. She said the policy is to change the PICC line dressing weekly. She further said that a nurse should not sign off in the medical record that a PICC line dressing was changed when it was not.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49880 Based on observations, record reviews, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when three out of four nurses observed made four errors out of 26 opportunities, resulting in a medication error rate of 15.38%. Those errors impacted three Residents (#66, #106, and #122), out of five residents observed. Specifically, 1. For Resident #66, Nurse #1 administered the wrong dose of Vitamin D3. 2. For Resident #106, Nurse #6 administered the incorrect medication (Banatrol Plus instead of Juven) and Nurse #6 administered the incorrect dose of a medication (Psyllium). 3. For Resident #122, Nurse #7 administered a medication (Sevelamer Carbonate) after a meal, not according to the manufacturer's recommendations. Findings Include: Review of facility policy titled Administering Medications, dated as revised April 2019, indicated the following: -Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. -4. Medications are administered in accordance with prescriber orders, including any required time frame. -7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before or after meals). -10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. Resident #66 was admitted to the facility in June 2019 with diagnoses that included Alzheimer's disease and bipolar disorder. Review of Resident #66's most recent Minimum Data Set (MDS) Assessment, dated 2/6/25, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the Resident is cognitively intact. Review of Resident #66's physician's orders included the following: -Vitamin D3 1000 units, give 1000 units one time daily for Vitamin D deficiency, dated, 11/7/19. On 3/12/25 at 9:30 A.M. Nurse #1 prepared and administered the following medication: -Vitamin D3 5000 units, two tablets. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/25 at 9:20 A.M., the Director of Nurses said she would expect that nurses would administer the correct dosage of medication to the residents. 44095 2. Resident #106 was admitted to the facility in February 2025 with diagnoses including anxiety and osteoporosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated that Resident #106 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #106 physician's order, dated 2/27/25, indicated: - Juven Oral Packet (Nutritional Supplements, used for wound healing containing arginine, glutamine, collagen protein, and micronutrients), give 27.5 gram by mouth two times a day for supplement. Mix with 8 to 10 ounces of water or fluid. - Psyllium Oral Packet (Psyllium), give 3.4 gram by mouth two times a day for constipation, mix with at least 8 ounces of juice, water or other beverage. Stir briskly for 3-5 seconds. Drink Promptly. On 3/12/25 at 5:22 P.M., the surveyor observed Nurse #6 prepare and administer the following medications to Resident #106: - one packet of Banatrol Plus (medication used for diarrhea and loose stools, containing banana flakes and a prebiotic), not Juven as ordered by the physician. - Psyllium Oral Powder, one heaping teaspoon, unmeasured and therefore unable to verify the correct dose. During an interview on 3/12/25 at 6:09 P.M., Nurse #6 said she was taught 3.4 grams is a heaping teaspoon. Nurse #6 then said she wasn't sure how else to measure 3.4 grams. During an interview on 3/12/25 at 6:12 P.M., Nurse #6 and the surveyor reviewed the medication cart, and she said she didn't realize she gave the Banatrol Plus packet instead of the Juven packet. Nurse #6 showed the surveyor that the Banatrol Plus packes and the Juven packets were both stored in a box labeled as Juven. During an interview on 3/13/25 at 10:54 A.M., Unit Manager #1 said that Nurse #6 should have measured the Psyllium Oral Powder to ensure the correct dose. Unit Manager #1 said that Banatrol Plus and Juven are not the same medication and Nurse #6 should have administered the correct medication. During an interview on 3/13/25 at 11:55 A.M., the Director of Nursing (DON) said that Nurse #6 should have measured the Psyllium Oral Powder to ensure the correct dose. Unit Manager #1 said that Banatrol Plus and Juven are not the same medication and Nurse #6 should have administered the correct medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #122 was admitted to the facility in January 2025 with diagnoses including end stage renal disease (ESRD), acute kidney failure, and edema. Review of the Minimum Data Set (MDS) assessment, dated 2/6/25, indicated that Resident #122 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of Resident #122's physician's order, dated 3/5/25, indicated: - Sevelamer Carbonate Oral Tablet 800 milligrams (Sevelamer Carbonate), give 2 tablets by mouth with meals for ESRD (1,600 mg total). Scheduled three times daily at 8:00 A.M., 12:00 P.M., and 5:00 P.M. On 3/12/25 at 6:20 P.M., the surveyor observed Nurse #7 prepare and administer medications to Resident #122 including: - Sevelamer Carbonate 800 mg, 2 tablets, 1 hour and 20 minutes after the scheduled time. Further review of the medication card indicated for the medication to be administered with meals. During an interview on 3/12/25 at 6:21 P.M., Resident #122 said he/she had already finished dinner and there was no dinner tray in front of him/her. Resident #122 said he/she returned from dialysis around 5:15 P. M. During an interview on 3/12/25 at 6:23 P.M., Nurse #7 said she should have given Resident #122's his/her medication during his/her dinner but did not. Nurse #7 said she was aware Resident #122 was back in the Unit around 5:15 P.M., but she did not give him/her his medications on time, but she should have. During an interview on 3/13/25 at 10:58 A.M., Unit Manager #1 said Resident #122 medications should be given with meals, Unit Manager #1 said she was aware that Nurse #7 did not administer the medications with the meal. During an interview on 3/13/25 at 11:58 A.M., the Director of Nursing (DON) said Nurse #7 should have administered Resident #122's medication with the meals as ordered by the physician.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44095 Based on record reviews and interviews, the facility failed to ensure one Resident (#232) was free from significant medication errors, out of a total sample of 30 residents. Specifically, for Resident #232 nursing failed to discontinue an order for Vancomycin HCl Oral Suspension (medication used to treat infections) when this brand was no longer covered by the insurance company, subsequently nursing obtained a different order under a different brand name of Vancomycin (Firvanq Oral Solution Reconstituted), which resulted in nursing administering both orders of Vancomycin (four times daily instead of twice daily). Findings included: Review of facility policy titled Administering Medications, dated as revised April 2019, indicated the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Resident #232 was admitted to the facility in February 2025 with diagnoses including enterocolitis due to clostridium difficile, pulmonary emboli, and diabetes. Review of the Minimum Data Set (MDS) assessment, dated 2/13/25, indicated that Resident #232 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. Review of Resident #232's nurse practitioner note, dated 3/7/25, indicated: - 3/7/25: Patient finished Vancomycin three times daily, has 1-2 soft bowel movements daily, abdomen is soft and mildly tender at left lower quadrant. Vancomycin decreased to 150 milligrams (mg) twice a day for 7 days and after 150 mg once a day for 7 days and discontinue. Review of Resident #232's physician's order, dated 3/7/25, indicated: - Vancomycin HCl Oral Suspension 50 milligrams/ milliliter (Vancomycin HCl), give 3 ml by mouth two times a day for C. Diff for 7 Days and then give 3 ml by mouth one time a day for C. Diff for 7 Days. Further review of the order indicated the medication was scheduled to be given at 8:00 A.M., and 8:00 P.M. Review of Resident #232's Medication Administration Record (MAR), dated March 2025, indicated nursing administered the Vancomycin on 3/10/25, 3/11/25, 3/12/25, and on 3/13/25, as ordered. Review of Resident #232's physician's order, dated 3/9/25, indicated: - Firvanq Oral Solution Reconstituted 50 mg/ml (Vancomycin HCl), give 3 ml by mouth two times a day related to enterocolitis due to clostridium difficile for 7 Days. Further review of the order indicated the medication was scheduled to be given at 9:00 A.M., and 5:00 P.M. (continued on next page)

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Brentwood Rehabilitation and Healthcare Ctr (the)	56 Liberty Street Danvers, MA 01923

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #232's Medication Administration Record (MAR), dated March 2025, indicated nursing administered the Firvanq mediation on 3/10/25, 3/11/25, 3/12/25, and on 3/13/25, as ordered. Review of Resident #232's health status note, dated 3/10/25 at 12:02 A.M., indicated: - pharmacy said the Vancomycin 50 mg/ml is not covered by insurance. The brand name Firvanq is covered by insurance. Medication was delivered later today. [sic] During an interview on 3/12/25 at 12:14 P.M., Nurse #4 said that he works Monday through Friday and on 3/10/25 and 3/11/25 he administered Resident #232 Vancomycin twice during his shift around 8:00 A.M., and 2:00 P.M. During an interview on 3/12/25 at 2:17 P.M., Nurse #3 said that on 3/11/25 she administered Resident #232 Vancomycin twice on the evening shift around 4:00 P.M., and again around 10:00 P.M. During an interview on 3/12/25 at 1:53 P.M., the Nurse Practitioner (NP) said that Resident #232 was prescribed Vancomycin for colitis. The NP said that on 3/7/25 he wanted the Resident to be administered Vancomycin twice a day for 7 days followed by daily for 7 days after that. During an interview on 3/13/25 at 10:44 A.M., Unit Manager #1 reviewed the duplicate orders in Resident #232's medical record with the surveyor. Unit Manager #1 said that the nurse should have discontinued the other dose of Vancomycin when she put in the new order for Firvanq. Unit Manager #1 said that if Resident #232 received Vancomycin four times daily it would be a medication error. During an interview on 3/13/25 at 11:41 A.M., the Director of Nursing (DON) said Resident #232 should receive Vancomycin twice a day. The DON said that if Resident #232 received Vancomycin four times a day it would be a medication error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45984 Based on observation and interview, the facility failed to properly adhere to food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety. Findings include: Review of the facility policy titled Handwashing/Hand Hygiene, dated from 2021, indicated the following: - Applying and Removing Gloves: Perform hand hygiene before applying non-sterile gloves The surveyor made the following observations during the lunch tray line service on 3/12/25: - At 11:41 A.M., the Foodservice Director (FSD) was wearing gloves and making a peanut butter and jelly sandwich on the tray line. The FSD removed her gloves and touched the lid of the garbage can that was on top of the garbage can with her bare hands contaminating them. The FSD then went back to the tray line and touched five resident meal trays, where food would be on, with contaminated hands. The FSD then left the tray line to sort meal tickets on the milk refrigerator. The FSD then came back to the tray line and touched four more resident meal trays where food will be on with contaminated hands. At 11:46 A.M., the FSD grabbed the handle to the walk-in refrigerator and then proceeded to grab a cup with contaminated hands and put it on a resident's tray. At 11:48 A.M., the FSD then went into her office and then grabbed oven mitts to get food from the oven. At 11:49 A.M., the FSD washed her hands. During an interview on 3/13/25 at 9:06 A.M., the FSD said staff need to wash their hands when they leave their stations in the kitchen and when changing gloves and when their hands become contaminated. The surveyor then shared his observations with the FSD and the FSD said she thought she washed her hands, and she should have after changing her gloves and touching the garbage lid.

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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. 43846 Based on observations, interviews, and record review, the facility failed to maintain accurate medical records for four Residents (#44 ,#80, #106 and #115), out of a total sample of 30 residents. Specifically, 1. For Resident #44, the facility failed to accurately document they completed a physician ordered treatment when they did not. 2. For Resident #80, the facility failed to accurately document his/her cast care when the cast was no longer there. 3. For Resident #106 the facility failed to ensure nursing maintained a complete record of blood pressures for midodrine administration. 4. For Resident #115, the facility failed to accurately document the location of blood pressure readings. Findings include: 1. Resident #44 was admitted to the facility in June 2023 with diagnoses that included anxiety, anemia, depression, and osteoarthritis. Review of Resident #44's most recent Minimum Data Set (MDS) assessment, dated 12/31/24, indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident has intact cognition. On 3/11/25 at 8:04 A.M., the surveyor observed Resident #44 in bed with out a dressing on his/her left great toe. On 3/12/25 at 8:15 A.M., the surveyor observed Resident #44 in bed with out a dressing on his/her left great toe. During an interview on 3/12/25 at 8:16 A.M., Resident #44 said staff only change the dressing on his/her left great toe maybe once a week and it was not changed the last few days. Review of Resident #44's physician order, dated 2/14/25, indicated Left great toe: NSW (Normal Saline Wash), pat dry, apply bacitracin (antibiotic ointment) and cover with DPD (dry protective dressing) or band aid every evening shift. Review of Resident #44's March 2025 Treatment Administration Record (TAR), indicated nursing staff administered the treatment to the left great toe on 3/10/25 and 3/11/25. Review of Resident #44's impaired skin integrity care plan, dated 9/19/24, Administer treatments as ordered and monitor effectiveness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/25 at 12:04 P.M., Nurse #1 with the surveyor observed Resident #44 in bed without a dressing on his/her left great toe. Nurse #1 said the treatment is not done on his shift and said the evening shift should be following the doctor's order. Nurse #1 said nurses should not sign off a treatment order that was not completed. During an interview on 3/12/25 at 3:50 P.M., the Director of Nursing said orders should only be signed off by nursing staff if they actually completed the physician order. 2. Resident #80 was admitted to the facility in January 2025 with diagnoses that included non-displaced fracture of the right fibula, post-traumatic stress disorder, major depressive disorder, and lack of coordination. Review of Resident #80's most recent Minimum Data Set (MDS) assessment, dated 1/21/25, indicated he/she scored a 13 out of a possible 15 on the Brief Interview for Mental Status indicating moderate cognitive impairments. Further review of the MDS indicated he/she needs partial/moderate assistance from staff members for lower body dressing and for putting on/taking off footwear. On 3/11/25 at 12:09 P.M., the surveyor observed Resident #80 in his/her wheelchair with a boot immobilizer on his/her right foot. On 3/12/25 at 8:00 A.M., the surveyor observed Resident #80 in bed with a boot immobilizer on. Review of Resident #80's active physician orders, dated 1/15/25, indicated Cast/ splint care: Keep cast/splint dry at all times. No dressing changes necessary. Review of Resident #80's March 2025 Treatment Administration Record (TAR), indicated nursing staff signed off the cast care every shift for the month of March from 3/5/25 to 3/11/25. During an interview on 3/12/25 at 11:56 A.M., Nurse #1 said the Resident was admitted with a hard cast on his/her leg but it was removed at the last ortho appointment a few weeks ago. Nurse #1 said nursing staff should not being signing off cast care was in place because the cast was removed weeks ago. During an interview on 3/12/25 at 12:11 P.M., Unit Manager #1 said the Resident had had a real cast and the order should have been changed but it wasn't. Unit Manager #1 said nurses shouldn't sign off something that wasn't done. 44095 3.) Resident #106 was admitted to the facility in February 2025 with diagnoses including anxiety and osteoporosis. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/27/25, indicated that Resident #106 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #106's physician's order, dated 3/2/25, indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Midodrine HCl Oral Tablet 5 milligrams (mg) (Midodrine HCl), give 3 tablets by mouth three times a day for hypotension (low blood pressure), hold for a systolic blood pressure for over 120. Review of Resident #106's Medication Administration Record (MAR), dated 3/4/25 through 3/12/25, indicated nursing documented the midodrine as administered three times daily at 8:00 A.M., 1:00 P.M., and 5:00 P.M. Review of Resident #106's weights and vitals tab titled, Blood Pressure Summary, in the electronic health record included the following values: 3/1/25 at 12:46 P.M., 132/68 3/1/25 at 10:02 P.M., 132/68 3/3/25 at 6:26 P.M., 126/79 3/4/25 at 9:48 A.M., 138/75 3/4/25 at 6:17 P.M., 127/79 3/5/25 at 9:16 A.M., 114/62 3/5/25 at 8:36 P.M., 121/69 3/6/25 at 3:35 P.M., 128/70 3/6/25 at 5:27 P.M., 123/69 3/7/25 at 10:26 A.M., 139/69 3/7/25 at 6:51 P.M., 128/64 3/8/25 at 9:59 A.M., 133/68 3/9/25 at 10:44 A.M., 129/66 3/10/25 at 2:38 P.M., 114/68 3/10/25 at 9:28 P.M., 119/67 3/11/25 at 1:55 P.M., 116/69 3/11/25 at 7:20 P.M., 120/78 3/12/25 at 3:18 A.M., 122/70 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Comparative review of Resident #106's MAR, weights and vitals tab, and nursing notes, failed to include documentation to support that nursing consistently obtained and documented blood pressure for each administration of Resident #106's midodrine in accordance with the physician's order at the scheduled times. During an interview on 3/11/25 at 8:52 A.M., Resident #106 said that staff do not always check his/her blood pressure prior to administering his/her midodrine. During an interview on 3/13/25 at 10:08 A.M., Nurse #8 said that Resident #106 receives midodrine for hypotension. Nurse #8 said that nursing should check Resident #106's blood pressure prior to the medication administration. Nurse #8 said that whoever put in the midodrine order did not put in the order correctly. Nurse #8 said that supplemental documentation should have been added to document the blood pressure. During an interview on 3/13/25 at 10:26 A.M., Unit Manager #1 said that Resident #106's midodrine is used for low blood pressure. Unit Manger #1 said that there should be associated blood pressure documented in the medical record for the administration of each midodrine dose. Unit Manager #1 and the surveyor reviewed the MAR and blood pressure summary tab, and Unit Manager #1 said that she was not sure what the documented blood pressures were for because many of them were above 120, and the midodrine should have been held however nursing documented midodrine as administered. During an interview on 3/13/25 at 11:28 A.M., the Director of Nursing (DON) said that the midodrine order should have supplemental documentation for nursing to document the blood pressures. The DON said at minimum there should be blood pressure added to the vital signs tab for each administration, if the blood pressure is not documented on the MAR. The DON reviewed the blood pressure documented in Resident #106's medical record and said the midodrine should be held for blood pressures greater than 120. 49880 4. Review of facility policy titled Hemodialysis Catheters- Access and Care of, dated as revised February 2023, indicated the following: -Care of AVFs (arteriovenous fistulas) -Do not use the access arm to take blood pressure (BP). Resident #115 was admitted to the facility in September 2024 with diagnoses that included end stage renal disease and dependence on renal dialysis (a process to remove extra fluid and waste products from the blood when the kidneys are not able to function properly). Review of Resident #115's Minimum Data Set (MDS) assessment, dated 12/26/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating that Resident #115 is cognitively intact. The MDS further indicated that Resident #115 receives dialysis. Review of Resident #115's physician's orders indicated the following: -NO Blood Draws, IVs, BPs on right arm, dated 9/18/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Check Right arm AV Fistula or AV Graft for bleeding, drainage, signs of infection, and the presence of bruit and thrill. Document abnormal findings in the nurses' notes and report to physician, dated 9/18/24. -Check AV fistula site thrill/bruit, dated 9/19/24. Review of the vital sign portal in the electronic medical record indicated that on 52 occasions since 9/18/24 nursing documented the blood pressure as being taken on the right arm. During an interview on 3/12/25 at 2:13 P.M. Nurse #6 said that she takes care of Resident #115 regularly. She said that the Resident has a fistula to their right arm and blood pressures are only checked on the left arm. She said that if it is documented on the right arm then it is an error. She said the Resident knows that he/she cannot have blood pressure done on the right arm and would not let staff obtain it there. During an interview on 3/13/25 at 9:06 A.M., the Director of Nurses said that medical records should contain accurate information including the correct side that a blood pressure was obtained.

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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. 44095 Based on observation and interview, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, 1. The facility failed to ensure Nurse #6 disinfected shared resident equipment between resident use. 2. The facility failed to ensure Nurse #9 disinfected shared resident equipment between resident use. Findings include: Review of the facility policy titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, dated as revised June 2011, indicated the purpose of this procedure is to provide guidelines for disinfection of non-critical resident-care items. d. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). Review of the CDC (Centers for Disease Control and Prevention) Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated June 2024, indicated the following: 4. Selection and Use of Low-Level Disinfectants for Noncritical Patient-Care Devices b. Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the label's safety precautions and use directions. 1. On 3/12/25 between 5:05 P.M. through 5:22 P.M., the surveyor made a continuous observation of Nurse #6 during the evening medication pass. For three different residents Nurse #6 placed the blood pressure cuff directly onto each resident's arm, directly touching his/her skin. Nurse #6 also placed each resident's fingertip into the fingertip pulse oximeter for all three residents. Nurse #6 did not disinfect the multiuse shared equipment between each resident. During an interview on 3/12/25 at 6:08 P.M., Nurse #6 said that she is supposed to clean the vital signs machine at the end of the shift. During an interview on 3/13/25 at 10:52 A.M., Unit Manager #1 said Nurse #6 should have cleaned the vital sign machine in between each resident. 2. During the medication pass, on 3/12/25 at 9:11 A.M., the surveyor observed Nurse #9 check the blood pressure of a resident with a portable blood pressure cuff. Nurse #9 did not sanitize the blood pressure cuff before or after obtaining the resident's blood pressure. (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 interview on 3/13/25 at 11:59 A.M., the Director of Nursing (DON) said nursing should clean the vital sign machine between each resident. 49880