STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225225	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Health Care Center	184 Lincoln Street North Easton, MA 02356

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. 31830 Based on observation, interview, and policy review, the facility failed to ensure residents in one of four dining rooms had a dignified dining experience. Specifically, residents seated at the same tables were not fed at the same time, resulting in residents having to sit and watch while others ate or were fed by staff. In addition, staff stood while assisting residents with eating. Findings include: Review of the facility's policy titled Meal Service/Tray Service, dated 4/2015, indicated but was not limited to: - To provide a pleasant meal/dining experience. During dining observations made on 4/30/24, 5/2/24, and 5/3/24, the surveyor observed the following in Dining Room A on the 400 Unit: On 4/30/24 at 12:28 P.M., the surveyor observed 17 residents seated in the dining room. The dining service started at 12:27 P.M., and the last tray was passed at 12:56 P.M. Additional observations on 4/30/24 included: -Table 1: Two residents were seated at the table. 12:28 P.M., one resident received a meal and a staff member assisted with set up, while the second resident watched. 12:43 P.M., 15 minutes later, the second resident was provided with a meal and assisted by a staff member to eat. -Table 2: Three residents were seated at the table. (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: 225225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Health Care Center	184 Lincoln Street North Easton, MA 02356

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:28 P.M., one resident had a meal and ate independently, while the other two residents watched. One resident was observed to reach out to the resident who was eating and grabbed an opened ice cream cup off the tray. The resident proceeded to lick the ice cream out of the cup while waiting for his/her meal to be served. 12:43 P.M., 15 minutes later, meals were served to the two other residents. -Table 3: Three residents were seated at the table. 12:28 P.M., one resident had a meal and ate independently, while the other two residents watched. 12:54 P.M., 26 minutes later, meals were served to the two other residents. The surveyor did not observe staff wash any resident's hands or wipe down the tables prior to meal delivery. On 5/2/24 at 12:15 P.M., the surveyor observed 16 residents seated in the dining room. The dining services started at 12:15 P.M., and the last tray was passed at 12:40 P.M. Additional observations on 5/2/24 included: -Table 1: Two residents were seated at the table 12:30 P.M., one resident was provided with a meal and waited for a staff member to assist with eating. 12:39 P.M., nine minutes later, the other resident was provided with a meal and assisted by a staff member. 12:40 P.M., Nurse #3 approached the resident who was provided with the meal at 12:30 P.M., and stood next to the resident as she fed him/her. Nurse #3 continued to stand, with one hand in her pocket as she continued to assist the resident with the meal. Nurse #3 said to the resident open up as she attempted to encourage the resident to take food from the utensil. -Table 2: Three residents were seated at the table. 12:20 P.M., two residents were provided with meals and ate independently, while the other resident watched. 12:38 P.M., 18 minutes later, the third resident was provided with a meal. -Table 3: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Southeast Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 184 Lincoln Street North Easton, MA 02356	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Three residents were seated at the table. 12:20 P.M., one resident was provided with a meal and ate independently while the other two residents watched. One resident was observed to reach out to the resident who was eating and was offered some food on a fork. This resident placed the food in his/her mouth. A staff member was observed to intervene and requested this resident spit the food out. The resident was moved from table #3 by a staff member to the side of the room and provided an overbed table. 12:30 P.M., 10 minutes later, both residents were provided with a meal. The surveyor did not observe staff wash any resident's hands or wipe down the tables prior to meal delivery. On 5/3/24 at 12:10 P.M., the surveyor observed 19 residents seated in the dining room. Several residents were observed seated in recliner chairs along the wall of the dining room. The dining services started at 12:34 P.M., and the last tray was passed at 12:51 P.M. Additional observations on 5/3/24 included: -Table 3: Three residents were seated at the table. 12:34 P.M., one resident was provided with a meal and ate independently as the two other residents watched. 12:40 P.M., six minutes later, the second resident was provided with a meal. 12:51 P.M., 11 minutes later, the third resident was provided with a meal. -Table 5: Three residents were seated at the table. 12:34 P.M., two residents were provided meals and ate with assistance of staff, while the other resident watched. 12:43 P.M., 10 minutes later, the third resident was provided with a meal. At 12:47 P.M., the surveyor observed a resident in the recliner chair watching the other residents eat lunch. At 12:51 P.M., a staff member brought a meal tray into the dining room and placed the tray on a shelf near the resident in the recliner chair. At 12:52 P.M., the staff member opened the tray which remained on the shelf, removed the plate and started to feed the resident in the recliner chair. The staff member stood to the side of the resident while holding the meal plate in one hand and fed the resident with the other hand. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor did not observe staff wash any resident's hands or wipe down the tables prior to meal delivery. During an interview on 5/7/24 at 12:20 P.M., Unit Manager #3 (UM) was made aware of the surveyor's observations. UM #3 said staff should never stand while assisting residents with meals and should always be seated. UM #3 said it was difficult to provide residents with meals at the same time but said it would be best for all residents seated at tables together to receive meals at the same time. During an interview on 5/7/24 at 12:39 P.M., the surveyor made Nurse #3 aware of observations made on 5/2/24. Nurse #3 said although she should be seated when assisting residents with meals, she did not feel like sitting due to stomach cramps and preferred to stand while assisting the resident with his/her meal. During an interview on 5/7/24 at 12:45 P.M., the Administrator was made aware of the surveyor's observations. The Administrator said staff should always be seated when assisting residents with their meals and all residents should have a dignified and homelike dining experience.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 31830 Based on interview, record review, and policy review, the facility failed to ensure one Resident (#134), out of a total sample of 29 residents, had information in advance to exercise their rights. Specifically, the facility failed to involve and inform the Resident, who was responsible for his/her own care, about care and treatment, including the risks and benefits of administration of psychotropic medication. Findings include: Review of the facility's policy titled, Consent to Treat, dated 7/2015, indicated but was not limited to: - Facility staff will obtain consent to treat upon admission of a resident to the facility. - If a resident is capable, the facility representative must obtain from the resident directly upon admission. Review of the facility's policy titled, Psychotropic Medication Informed Consent, dated 2/2016, indicated but was not limited to: - Prior to administering psychotropic medication, the facility shall obtain the informed written consent of the resident, the resident's health care proxy or the resident's guardian. Resident #134 was admitted to the facility in June 2023 with diagnoses which included chronic embolism, depression, and dementia. Review of the admission Minimum Data Set (MDS) assessment, dated 6/23/23, indicated Resident #134 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15, made self understood and was able to understand others. Review of Resident #134's medical record failed to indicate the Resident signed admission paperwork including Consent for Treatment and Informed Consent for Psychotropic Administration. Instead, the facility staff obtained informed consent from the Resident's family for Consent for Treatment and Informed Consent for Psychotropic Administration when the Resident was responsible for his/her own care. Subsequent review of the medical record failed to include an Invocation of the Health Care Proxy during his/her admission from June 2023 through May 2024. During an interview on 5/2/24 at 10:35 A.M., Resident #134 said he/she was unable to recall the admission process but did not believe he/she signed any paperwork including forms for medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 11:36 A.M., the Director of Social Services and surveyor reviewed the paper and electronic medical record. The Director of Social Services was unable to locate an Invocation of the Health Care Proxy or a Physician's order to invoke the health care proxy. The Director of Social Services said if there was no Invocation of the Health Care Proxy, the Resident should have signed all consents. The Director of Social Services said the paperwork was signed by Resident #134's family member. During an interview on 5/3/24 at 8:31 A.M., the Administrator was made aware of the findings. The Administrator said the expectation would be for the Resident to sign all paperwork unless a Health Care Proxy was activated.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 49428 Based on observation, record review, and interview, the facility failed to ensure medications were not self-administered without a physician's order and an assessment for self-administration was completed for one Resident (#34), out of a total sample of 28 residents. Findings include: Review of the facility's policy titled Self-Administration of Medications, dated July 2015, indicated but was not limited to the following: -Policy: Residents are afforded the right to self-administer their own medications, upon request, and after determination the practice is safe. If the resident elects to self-administer his/her own medications, an evaluation of their cognitive, physical, and visual ability to perform the task is conducted to ensure accurate and safe medication management. If the evaluation indicates the resident can safely perform required functions, self-administration of medications is allowed. If unable to safely perform this task, the licensed staff, or trained medication aides/technicians, as allowed by State law, will administer medication. -Procedure: -Evaluate the resident's cognitive, physical, and visual ability to self-administer medications, if they have requested to do so (Part II of Self-Administration of Medications Informed Consent and Evaluation). -Complete the Self Administration Evaluation and document whether the resident can safely self-medicate or is unable to safely self-medicate. -If approved, obtain a physician's order for self-administration of medications. -Perform resident education of all required self-medication protocols and document any education. -Mark the Medication Administration Record (MAR) for each medication being self-administered for daily compliance monitoring purposes. (Indicate that the resident has self-administered). Resident #34 was admitted to the facility in March 2021 with diagnoses including schizophrenia, metabolic encephalopathy, and undifferentiated somatoform disorder (is characterized by one or more persistent physical complaints that cannot be fully explained by a general medical condition or the direct effects of a substance). Review of the Minimum Data Set (MDS) assessment for Resident #34, dated 4/3/24, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the Resident was cognitively intact. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 3:37 P.M., Resident #34 said the nurses gave him/her the antibiotic ointment for a thumb wound today. Resident #34 took out of their pocket a clear plastic bag with a yellow label adhered to the bag and a tube of antibiotic ointment inside the bag. Resident #34 said they were given the ointment and told to hang on to it and to use it wisely. Resident #34 said they will probably apply the ointment tonight when they go to bed. During an interview on 5/1/24 at 10:05 A.M., the surveyor asked Resident #34 how often they were to apply the antibiotic ointment to their thumb; the Resident shrugged their shoulders and said, I'd say every 5 hours. Resident #34 said they applied a dab of the ointment to their thumb that morning with no nurse present during the application. The Resident said they preferred to apply the antibiotic ointment themselves and did not need a nurse to help or provide supervision. The Resident said they planned to apply the ointment to their thumb after lunch and then in the evening. During an interview on 5/2/24 at 2:17 P.M., Resident #34 said they applied ointment to their thumb twice today with no supervision. During an interview on 5/6/24 at 8:38 A.M., Resident #34 said they continue to apply the antibiotic ointment independently with no supervision. The Resident said they are capable of putting ointment on their thumb with no help or oversight from nursing. Review of Resident #34's active Physician's Orders included but was not limited to: -Mupirocin external ointment 2% for thumb, apply topically BID (the Latin abbreviation for twice a day) for skin for ten days, dated 4/29/24-5/9/24. Further Review of Resident #34's active physician's orders failed to include orders for self-administration of Mupirocin external ointment to the Resident's thumb. Review of Resident #34's April and May 2024 Medication Administration Record (MAR) indicated Mupirocin external ointment was being applied to Resident #34's thumb twice a day. Further review of the Resident's MAR did not indicate the Resident applied the Mupirocin external ointment themselves. Review of Resident #34's medical record indicated the Resident was last assessed for the desire to self-administer medication on 3/28/24 which indicated that the Resident did not desire to self-administer their medication. During an interview on 5/7/24 at 9:40 A.M., Nurse #2 said if a resident requested to self-administer medication: -nursing must complete a self-administration assessment for the resident -a Physician's order must be obtained -a paper self-administration consent must be completed -nursing must educate the resident on how to administer the medication -the resident must demonstrate they can administer the medication appropriately and independently (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 said none of the residents in her care, which included Resident #34, were currently self-administering medication. During an interview on 5/7/24 at 11:20 A.M., Resident #34 said Nurse #2 had given them the Mupirocin external ointment for their thumb and Nurse #2 had taken the antibiotic ointment away about an hour ago. During an interview on 5/7/24 at 11:35 A.M., Nurse #2 said she retrieved the tube of Mupirocin external ointment from Resident #34 and was not sure how the Resident had gotten it. Nurse #2 said Resident #34 was particular about and preferred to apply the ointment independently, and the Resident gets upset when receiving help. Nurse #2 said the Resident told her he/she had already applied ointment to their thumb this morning. Nurse #2 said she was unsure of how the Resident got a hold of the ointment and the Resident would not tell her who gave the ointment to the Resident. Nurse #2 said she put the clear bag containing the ointment in the treatment cart. Nurse #2 and the surveyor observed the treatment cart, from which Nurse #2 pulled a bag containing the used tube of Mupirocin external ointment with a yellow label adhered to the bag. The surveyor observed the label to be worn with no legible print and containing a tube of half used ointment. During an interview on 5/7/24 at 1:04 P.M., the Director of Nursing (DON) said if nursing is documenting an antibiotic ointment was administered, then the nurses should be administering or supervising the resident if the resident chooses to apply the ointment themselves. The DON said if a resident desires to self-administer independently, nurses must complete a Self-Administration of Medications Assessment and evaluate the resident for competence in self-administering medication. Review of Resident #34's medical record failed to indicate a Self-Administration of Medications Assessment was completed to reflect the Resident's desire to self-administer the Mupirocin external ointment. Further review of Resident #34's medical record failed to indicate the facility evaluated the Resident's cognitive, physical, and visual ability to self-administer the Mupirocin external ointment to their thumb. Resident #34's medical record failed to indicate the Resident was educated on all required self-medication protocols.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41106 Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Maintain the main kitchen, including the floors, shelves, and dry storage room floor in a sanitary condition; 2. Ensure food stored in the main kitchen reach-in refrigerator was labeled and dated; 3. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another). In addition, to ensure the use of gloves was limited to a single use task; and 4. Maintain sanitation and label and date food stored in resident kitchenettes in four of four units observed. Findings include: Review of the facility's policy titled Dietary Department Guidelines, undated, included but was not limited to the following: -The facility must store, prepare, and distribute food under sanitary conditions. -Dietary department supervisor will be a qualified food operator and have completed certification programs as required by state regulation. She or he will also supervise the cleaning and sanitizing of dishware and utensils, as well as the cleaning of the physical dietary plant. -The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness. -All dry storage (foods/paper supplies) will be stored 8 to 12 inches off the floor on pallets that permit cleaning underneath. -All food items should be labeled and dated to allow rotation of supplies. -All items stored in the refrigerator will be covered, labeled with the contents and the date. -All potentially hazardous foods must be discarded within three calendar days after the date prepared. -Handling of all food items during the preparation process will be minimized. This may be accomplished by using clean kitchen tools or by wearing clean gloves for each task. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Foods not prepared in the facility: -Foods brought into the facility by family members will be kept in appropriate storage, refrigerated if indicated, must be labeled, and dated and will be discarded as appropriate. -For example, prepared foods that require refrigeration should be discarded after three calendar days, whereas crackers stored in an airtight container may be kept longer. 1. On 4/30/24 at 7:40 A.M., four surveyors smelled a musty, pungent odor entering the main hallway by the kitchen enroute to the conference room. The surveyors continued to smell the same musty, pungent odor in the main hallway throughout the survey. The intensity of the pungent odor did vary, but it was present daily. On 4/30/24 at 8:00 A.M., the surveyor experienced a foul, sewage-type smell permeating throughout the main kitchen and into the hallway while observing the main kitchen. The surveyor made the following observations in the main kitchen: -On the right side of the kitchen there was water flowing out of the open drainpipe connected to the hand washing sink and where the ice machine overflow water drains into. -On the left side of the kitchen there was a mop head at the base of the door jamb, between the main kitchen area and the dish room. There was water leaking from the area of the mop head. The Food Service Manager (FSM) removed the mop head and the surveyor observed a trail of a black substance leaking out of the wall. -Water was leaking from the base of the wall under the prep sink, running onto the kitchen floor (the prep sink was not in use at the time). -Under the dishwasher there was a red plastic container catching water from the leaking pipe. The plastic container was overflowing onto the floor. -Under the prep table there was an open plastic bag of white lids, around the open bag of lids were remnants of some type of food. -Underneath the prep table was a gray plastic container with various condiments. On top of the condiments were pieces of trash, hair nets, and plastic bags. -Dry storage room located across the hallway from the main kitchen, underneath the metal racks the surveyor observed debris, which included trash, dirt, food remnants, and products that had fallen to the ground. During an interview on 4/30/24 at 8:22 A.M., the FSM said he has been here about a month and the smell has been present. The FSM said it smells like a septic smell. He said someone must have put the mop head there to catch the water. On 5/01/24 at 9:00 A.M., the surveyor made the following observations in the main kitchen: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. -On left side of the kitchen (by the two bay sink) there was standing water on the floor, and water leaking out from under the two bay sink. In addition, water continued to leak from the bottom of the door jamb onto the main kitchen floor. On 5/01/24 at 1:56 P.M., the surveyor made the following observations: -Waste water continued to leak out of the drainpipe by the hand washing sink and the ice machine overflow pipe. In addition, the hand washing sink remained in service. When the surveyor turned on the water to the hand washing sink, the water immediately began to drain from the open drainpipe onto the kitchen floor and flow towards the floor drain. -Standing water was again observed over on the left side of the kitchen by the two bay sink and the base of the door jamb between the main kitchen and the dish room. There continued to be a black substance around the door jamb. -The surveyor observed a dietary aide sweeping the water from in front of the prep sink towards the dish room. The water was observed to be black in color and had visible black particles floating in the water. -On the wall behind where the large mixer was stored on 4/30/24, there was a large amount of small dead flies stuck to the wall. On 5/03/24 at 7:45 A.M., the surveyor made the following observations in the kitchen: -The hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. -Water was again observed over on the left side of the kitchen by the two bay sink and the base of the door jamb between the main kitchen and the dish room. There continued to be a black substance around the door jamb. On 5/03/24 at 12:16 P.M., the surveyor made the following observations in the kitchen: -During lunch service, the hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. -Water was again observed over on the left side of the kitchen by the two bay sink and the base of the door jamb between the main kitchen and the dish room. There continued to be a black substance around the door jamb. During an interview on 4/30/24 at 8:22 A.M., the FSM said he has been here about a month and there has been a problem with the leaking water and the handwashing drain not working correctly. He said someone must have put the mop head there to catch the water (referring to the mop head placed at the bottom of the door jamb). He said that underneath the racks in the dry storage area needed to be cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/02/24 at 10:00 A.M., the Consultant Plumber said, If it is a yes or no question, he would have to say it is a sanitation issue with the grease from the pipes seeping onto the kitchen floor (water leaking on the left side of the kitchen with the black substance) and definitely a sanitation issue with the hand washing sink drain overflowing onto the kitchen floor. 2. On 4/30/24 at 8:00 A.M., the surveyor observed the main kitchen and made the following observations: -Gray tray of desserts with various dates including 4/23, 4/25, and 4/28. -Metal tin with unidentified food not labeled or dated and the plastic wrap partially detached on the left side. -Metal tin of chicken fingers uncovered, with an unidentified food plastic wrapped on top of the chicken fingers, undated. -Plastic wrapped bag of grated cheese, which was previously opened, undated. -White container labeled low fat cottage cheese, dated 4/12. -Six maroon containers with plastic lids containing a white food, not labeled, or dated. During an interview on 4/30/24 at 8:30 A.M., the FSM said all food in the refrigerator should be labeled and dated and thrown out after three days. 3. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: - 3-301.11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. - 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On 4/30/24 at 8:00 A.M., the surveyor observed the breakfast tray service and observed the Cook/Dietary Aide wearing blue gloves and observed plating pancakes and sausages with his gloved hands. The [NAME] was observed wearing the same pair of blue gloves, retrieving items from the stove and steamer behind the tray line (opening doors), gathering supplies, moving a muffin box, and advancing trays on the tray line. The Cook's gloves appeared to be moist, and he was not observed to change the blue gloves at any time during the breakfast meal service. During an interview on 4/30/24 at 8:15 A.M., the FSM said the Dietary Aide/Cook normally does not serve breakfast; the regular cook called out sick. The FSM said he should not be plating the food with gloved hands and when he leaves the station, he should change the gloves before returning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/24 at 8:20 A.M., the Cook/Dietary Aide said he does a lot of things in the kitchen and does serve breakfast occasionally. On 5/1/24 at 7:50 A.M., the surveyor observed breakfast tray service and observed the [NAME] wearing blue gloves and was observed plating sausages, toast, and muffins using her gloved hands. The [NAME] was observed touching multiple surfaces, retrieving items from the stove, removing items from the trays incorrectly placed on tray by another Dietary Aide, and advancing the trays on the tray line. The Cook's blue gloves appeared to be moist, and she was not observed to change the gloves at any time during the breakfast meal service. During an interview on 5/1/24 at 8:00 A.M., the FSM said they should not be plating any food with gloved hands and should be changing the gloves every time they leave the station. 4. On 5/2/24 at 1:27 P.M., the surveyor observed the following in the resident kitchenette located on the 300 Unit: -Plastic, clear container with light brown liquid (leftover food) in cabinet by right wall, not labeled or dated. -A half-eaten lemon meringue pie, with a spoon left in the pie, covered with a clear plastic dome, undated. On 5/2/24 at 1:52 P.M., the surveyor observed the resident kitchenette located on the 200 Unit and observed the following: -On top of the refrigerator there was a grilled cheese sandwich wrapped in plastic, not dated, and in a white paper bag was a cookie, undated. -The top shelf of the refrigerator had a yogurt with an expiration date of 4/9/24, not labeled. -The lower shelf in the refrigerator had a red reusable bag with food items, not labeled or dated. -On the refrigerator door was a bottle of green tea, not labeled or dated. On 5/2/24 at 2:05 P.M., the surveyor observed the resident kitchenette located on the 400 Unit and observed a bag of clean clothing protectors stored under the sink. On 5/2/24 at 2:15 P.M., the surveyor observed the resident kitchenette located on the 100 Unit and observed the following: -A local supermarket bag containing sweet potato wedges, labeled, and dated 4/22/24. -A sandwich wrapped in paper, labeled, and dated 4/23/24. During an interview on 5/2/24 at 2:25 P.M., the FSM said his staff check the kitchenettes twice a day, once at 6:30 A.M., and a second time at 3:00 P.M. He said they should be removing any food in the kitchenettes that are not labeled or dated. He checked the sign in sheet on the wall and said the dietary aide signed his initials today and didn't know why the food was not removed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observations, record review, and interviews, the facility failed to maintain medical records securely and accurately in accordance with accepted professional standards. Specifically, the facility failed to: 1. Maintain documentation of physician visits; and 2. Maintain the secure medical record shredding bins on the resident units and by staff offices. Findings include: Review of the facility's policy titled Thinning of the Clinical Record, dated September 2015, indicated the following records were to be maintained in the chart: Progress Notes: Admission MD Progress Note, Current Year Resident #12 was admitted to the facility in January 2021. Review of the medical record including Physician (MD (Doctor of Medicine) and NP (Nurse Practitioner)) Progress Notes from August 2023 indicated all physician visits had been conducted by Nurse Practitioners. On 5/1/24 at 2:40 P.M., the surveyor requested any Progress Notes conducted by the MD since August 2023. During an interview on 5/1/24 at 2:40 P.M., the Director of Nurses said she would have to check with medical records for the Physician Progress Notes. During an interview on 5/2/24 at 7:53 A.M., the Director of Nurses said the facility currently only had the NP Progress Notes. She said the assigned MD for Resident #12 switched from the prior medical director to the current medical director in January 2024. The Director of Nurses said she had a call out to the Resident's current physician to obtain the most recent visits. On 5/2/24 at 9:15 A.M., the surveyor received two physician Progress Notes from the MD, dated as 1/5/24 and 3/12/24, both dated as signed by the MD on 5/2/24. During an interview on 5/2/24 at 3:15 P.M., the Director of Nurses said she contacted the office of the previous MD who indicated Resident #12 was seen by the previous MD on 8/3/23 and 8/23/23. She said, as of this time, the Progress Notes for the visits had not been received at the facility. During an interview on 5/2/24 at 3:47 P.M., the Medical Record Staff said the process for receiving Physician Progress Notes was for the physician offices to fax over the Progress Notes. She said anything that is received was placed in a bin to be filed in the medical record. She said there was no way to know if the facility did not receive a Progress Note from a visit conducted by a physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41106 2. On 5/7/24 at 12:57 P.M., the surveyor requested a policy for securely discarding resident medical records on the Units. The Corporate Nurse said there was no policy for discarding resident medical records on the Units. On 4/30/24 at 9:42 A.M., the surveyor observed the secure medical record trash receptacle on the 200 Unit located in the nurses' station full-to-capacity with resident medical records able to be pulled out of the opening. The disposed medical records were easily accessible to any person entering into the nursing station area. On 5/02/24 at 1:54 P.M., the surveyor observed the secure medical record trash receptacle on the 200 Unit located in the nurses' station full-to-capacity with resident medical records able to be pulled out of the opening. The disposed medical records were easily accessible to any person entering into the nursing station area. On 5/2/23 at 2:33 P.M., the surveyor observed the secure medical record trash receptacle on the 300 Unit located in the hallway beside the nursing station with resident medical records sticking out of the opening. The disposed medical records were easily accessible to residents, visitors, and staff passing the secure medical records bin. On 5/07/24 at 11:32 A.M., the surveyor observed the secure medical record trash receptacle on the 200 Unit located in the nurses' station full-to-capacity with resident medical records able to be pulled out of the opening. The disposed medical records were easily accessible to any person entering into the nursing station area. The surveyor also observed a cardboard box located next to the secure medical record trash receptacle, which had no lid or top, was filled above the brim, and the resident medical records were exposed. During an interview on interview on 5/07/24 at 11:32 A.M., Nurse #1 said the cardboard box was being used for overflow since the secure medical record trash receptacle was full-to-capacity. On 5/7/24 at 11:51 A.M., the surveyor observed the secure medical record trash receptacle on the 100 Unit located in the nursing station with resident medical records sticking out of the opening. The disposed medical records were easily accessible to any person entering into the nursing station area. During an interview on 5/7/24 at 12:57 P.M., the Corporate Nurse said she noticed one of the secure medical record trash receptacles on the second floor was filled-to-capacity. The Corporate Nurse said the Units should call management in the event there is overflow of the secure medical record trash receptacles. The Corporate Nurse said a cardboard box is not an acceptable means of disposing resident medical records and management will take care of all the full receptacles within the facility. During a telephonic interview on 5/7/24 at 1:35 P.M., the Representative from the consultant shredding company said they last serviced the facility in February 2024 and have not returned due to billing issues. She said the facility is a high-volume facility and was scheduled to provide services every other week. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 3:15 P.M., the Administrator said she was not aware of billing issues with the consultant shredding company. She said she had asked the Front Desk Receptionist to follow up with the consultant shredding company. During an interview on 5/07/24 at 3:30 P.M., the Front Desk Receptionist said he was asked to call the consultant shredding company to empty the secure shredding receptacles in the facility. He said he was informed due to [NAME] issues the company would not service the building at this time.

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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.

49428

Based on observations, interviews, and policy review, 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 within the facility. Specifically, the facility failed to ensure staff adhered to infection control protocols for personal protective equipment (PPE) use when providing care and services to residents requiring precautions to prevent the possible spread of germs and illnesses.

Findings include:

Review of the facility's policy titled Enhanced Barrier Precautions Policy, undated, indicated but was not limited to:

-Enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multi-drug resistant organisms. High-contact care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care.

-Signage will be posted on the door or wall outside of the resident room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.

Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution sign indicated but was not limited to:

-everyone must: clean their hands, including before entering and when leaving the room

-providers and staff must: wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, wound care.

Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated 3/20/24, titled Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) indicated but was not limited to:

-For residents for whom Enhanced Barrier Precautions are indicated, Enhanced Barrier Precautions is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing.

Resident #31 was admitted to the facility in January 2024 with diagnoses including urinary retention, non-pressure chronic ulcer of left lower leg with fat layer exposed, and morbid obesity.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 4/30/24, indicated Resident #31 had an indwelling urinary catheter and two Stage III Pressure Ulcers (a wound that has broken through the top two layers of skin and into the fatty tissue). Review of Resident #31's Physician's orders included but were not limited to: EBP- Foley and wound, dated 5/1/24. To ACE (an abbreviation for all cotton elastic) wrap bilateral arm for edema in the morning, removed at bedtime, dated 5/2/24. On 5/2/24 at 9:35 A.M., the surveyor observed Nurse #2, wearing no gloves or gown, touching Resident #31's bed linen and holding Resident #31's hand. On 5/2/24 at 9:47 A.M., the surveyor observed Nurse #2, wearing gloves and no gown, wrapping Resident #31's arm with an ACE wrap. On 5/2/24 at 9:51 A.M., the surveyor observed Nurse #1, Nurse #2, and Certified Nursing Assistant (CNA) #1, wearing gloves and no gown, repositioning Resident #31, touching the Resident, the Resident's gown, bed linens, and the Resident's catheter bag. The surveyor observed Nurse #2 and CNA #1, wearing gloves and no gown, changing the Resident's gown. The surveyor observed Nurse #2, wearing gloves and no gown, place Resident #31's used gown into a plastic bag, touching the outside top of the bag with her gloved hands. The surveyor observed Nurse #2 doff (take off) her gloves, grab the outside top of the bag containing the Resident's used gown, and leave the Resident's room without performing hand hygiene. A CDC Enhanced Barrier Precaution sign was posted at the entrance of the room. During an interview on 5/6/24 at 5:10 P.M., Nurse #2 said she knows to wear gown and gloves when providing direct patient care to a resident on Enhanced Barrier Precautions and stated that staff always wear gown and gloves providing direct care for residents on Enhanced Barrier Precautions, including direct care for Resident #31. During an interview on 5/7/24 at 12:57 P.M., the Director of Nursing (DON) said staff must be gloved and gowned when providing direct care, such as touching bed linens, changing a resident's gown, or applying an ACE wrap, to a resident on Enhanced Barrier Precautions. The DON said staff should practice hand hygiene when entering and exiting rooms on Enhanced Barrier Precautions. During an interview on 5/7/24 at 1:15 P.M., the Infection Control Nurse said all staff are to wear a gown and gloves when providing high contact care to or when touching a resident on Enhanced Barrier Precautions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on policy review, document review, and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in line with the facility antibiotic stewardship program. Specifically, the facility failed to: 1. Ensure antibiotics prescribed were necessary for one Resident (#114), and 2. Ensure antibiotics were monitored/reassessed 48-72 hours after initiation to ensure the treatment remained appropriate for five Residents (#114, #1B, #1A, #37, and #66), out of a total sample of five residents. Findings include: Review of the facility's policy titled Antibiotic Stewardship, revised April 2023, indicated but was not limited to the following: -It is the policy of this facility to treat only symptomatic infections meeting criteria, and to promote antibiotic stewardship to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use. -The duration of the antibiotic therapy will be defined and/or regularly reviewed by the prescriber. -Antibiotics will be reassessed 48-72 hours after initiation to ensure treatment remains appropriate. -Audits will be done randomly to ensure antibiotic orders are complete and are reassessed as noted above. -Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infections with antibiotic resistance organisms. Review of the facility's policy titled Surveillance for Healthcare-Associated Infections (HAI), revised April 2023, indicated but was not limited to the following: -This facility will closely monitor all residents who exhibit signs/symptoms of infection When a resident exhibits signs/symptom of suspected infection: -The Infection Preventionist (IP) will gather additional data for infection tracking and reporting and provide consultation and education as needed. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The IP or designee will monitor the residents with infections and/or potential infections by completing the Monthly Infection Report by Unit. -The report is reviewed monthly by the IP and Director of Nurses (DON), Corporate IP, and quarterly by the medical staff. -The IP will review the Infection Report monthly for trends and new bacteria in the facility. 1. Resident #114 was admitted to the facility in March 2021. Review of the February 2024 [NAME] Square Unit Line Listing for Resident #114 indicated the following: Category- O (other) Date of Onset - 2/17/24 Symptoms - P, R, S (pain, redness, swelling) Culture Date - blank Site - O (other) Results - blank Treatment - Keflex (antibiotic) 500 milligrams (mg) 3 times a day x 5 days Infection Cleared - No Final Status - CAI (community acquired infection) Review of Resident #114's February 2024 Physician's Orders indicated the following: -Keflex (Cephalexin) oral capsule, 500 mg, give 500 mg by mouth one time only for right hand cellulitis until 2/17/24, start date 2/17/24 -Keflex oral capsule 500 mg, give 500 mg by mouth three times a day for right hand cellulitis until 2/22/24, start date 2/17/24 Review of a Nurse Progress Note, dated 2/17/24, indicated but was not limited to the following: -Right hand red and swollen, warm to touch, ROM (range of motion) WNL (within normal limits), denies pain. NP (Nurse Practitioner) made aware, new order to start Keflex 500 mg for 5 days for cellulitis. Review of the facility's Revised McGeer Criteria (nationally recognized criteria to define infections) for Infection Surveillance Checklist for skin and soft tissue infection (SSTI) surveillance definitions indicated the following: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cellulitis, soft tissue, or wound infection: Criteria: Must fulfill at least 1 criteria. -Pus at wound, skin, or soft tissue site; and/or -At least four of the following new or increasing sign or symptom (heat at affected site, redness at affected site, swelling at affected site, tenderness or pain at affected site, serous drainage at the affected site, at least one of the following (fever, leukocytosis, acute change in mental status, acute functional decline)) Further review of the line listing and McGeer Criteria checklist failed to indicate the antibiotic prescribed for Resident #114 met the criteria for appropriate antimicrobial use to help reduce any potential adverse drug events. Further review of the medical record failed to indicate a clinical rationale for initiating the antibiotic when the Resident's symptoms did not meet the criteria. During an interview on 5/6/24 at 12:32 P.M., the Director of Nurses (DON) said the line listings are completed monthly by her, the Assistant Director of Nurses (ADON), and now the Infection Preventionist (IP) going forward. She said she oversees the process. The DON said the date of onset, symptoms, culture (if done), site of symptoms, results of the culture (if applicable), treatment, and if community or facility acquired are all required to be documented on the line listings. She said the line listing for Resident #114 should have been documented as skin and not O for other. She said the Resident was followed by the wound doctor, but the antibiotic prescribed did not meet criteria for prescribing. The DON said it's been very difficult to have the providers not prescribe antibiotics if they did not meet the criteria. She said she would look for documentation of a rationale. The facility did not provide any further documentation to the survey team upon exit. 2a. Resident #114 was admitted to the facility in March 2021. Review of the February 2024 [NAME] Square Unit Line Listing for Resident #114 indicated the following: Category - O (other) Date of Onset - 2/17/24 Symptoms - P, R, S (pain, redness, swelling) Site - O (other) Treatment - Keflex 500 mg 3 times a day x 5 days Review of Resident #114's February 2024 physician's orders indicated the following: (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keflex (Cephalexin) oral capsule, 500 mg, give 500 mg by mouth one time only for right hand cellulitis until 2/17/24, start date 2/17/24 -Keflex oral capsule 500 mg, give 500 mg by mouth three times a day for right hand cellulitis until 2/22/24, start date 2/17/24 Further review of the medical record failed to indicate the antibiotic was re-assessed 48-72 hours after initiation by the prescriber to ensure the treatment remained appropriate. b. Resident #1B was admitted to the facility in March 2024. Review of the March 2024 Southeast Rehab Unit Line Listing for Resident #1B indicated the following: Category - UTI (urinary tract infection) Date of onset - 3/6/24 Symptoms - FO (foul odor) Site - U (urine) Treatment - Cephalexin 500 mg QID (four times a day) x 5 days Review of Resident #1B's March 2024 Physician's Orders indicated the following: -Cephalexin oral tablet 500 mg, give 500 mg by mouth four times a day for UTI x 5 days, start date 3/6/24 Further review of the medical record failed to indicate the antibiotic was re-assessed 48-72 hours after initiation by the prescriber to ensure the treatment remained appropriate. c. Resident #1A was admitted to the facility in March 2024. Review of the March 2024 Southeast Rehab Unit Line Listing for Resident #1A indicated the following: Category - O (other) Date of onset - 3/8/24 Symptoms - P, R (pain, redness) Site - O Treatment - Augmentin (antibiotic) 500 mg-125 mg two times a day x 7 days Review of Resident #1A's March 2024 Physician's Orders indicated the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Augmentin oral tablet 500-125 mg (Amoxicillin-Pot Clavulanate), give 500 mg by mouth two times a day for dental abscess x 14 days, start date 3/7/24 -Augmentin oral tablet 500-125 mg, give 500 mg by mouth two times a day for dental abscess until 3/16/24, start date 3/8/24 Further review of the medical record failed to indicate the antibiotic was re-assessed 48-72 hours after initiation by the prescriber to ensure the treatment remained appropriate. d. Resident #37 was admitted to the facility in November 2023. Review of the March 2024 Southeast Rehab Unit Line Listing for Resident #37 indicated the following: Category - O (other) Date of onset - 3/6/24 Symptoms - P, R, S (pain, redness, swelling) Site - W (wound) Treatment - Augmentin two times a day x 7 days Review of Resident #37's March 2024 Physician's Orders indicated the following: -Amoxicillin-Pot Clavulanate oral tablet 875-125 mg, give 1 tablet by mouth one time only for toe infection for 1 day, start date 3/6/24 -Amoxicillin-Pot Clavulanate oral tablet 875-125 mg, give 1 tablet by mouth two times a day for right great toe infection for 7 days, start date 3/6/24 Further review of the medical record failed to indicate the antibiotic was re-assessed 48-72 hours after initiation by the prescriber to ensure the treatment remained appropriate. e. Resident #66 was admitted to the facility in August of 2023. Review of the April 2024 Southeast Rehab Unit Line Listing for Resident #66 indicated the following: Category - UTI Date of onset - 4/2/24 Symptoms - FO (foul odor) Site - Urine (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment - Cipro (antibiotic) 500 mg twice a day x 5 days Review of Resident #66's April 2024 Physician's Orders indicated the following: -Cipro oral tablet (Ciprofloxacin HCL), give 500 mg by mouth two times a day for preventative maintenance for 5 days UTI, start date 4/2/24 Further review of the medical record failed to indicate the antibiotic was re-assessed 48-72 hours after initiation by the prescriber to ensure the treatment remained appropriate. During an interview on 5/6/24 at 12:44 P.M., the surveyor requested from the IP and DON documentation of 48-72 hour reassessment by the practitioners for the antibiotics prescribed for Residents #114, #1B, #1A, #37, and #66. The IP said follow up would be on the antibiotic tracking sheet or in physician progress notes. The DON said there were no audit sheets completed that monitored resident antibiotic usage. The IP said it should be completed for all residents prescribed an antibiotic per policy. The DON said this wasn't being done for any resident on the line listings. During an interview on 5/6/24 at 3:01 P.M., the IP said she and the DON were unable to locate any 48-72 hour practitioner/physician reassessment documentation of the antibiotics prescribed for any of the five sampled residents. During an interview on 5/6/24 at 3:06 P.M., the IP said it is the policy of the facility to treat only symptomatic infections that meet the criteria and to promote antibiotic stewardship. She said audits should be done to ensure orders are complete and the antibiotic has been reassessed, but this has not been done. The IP said the potential harm from antibiotic misuse includes adverse events or antibiotic resistance and that the elderly are more at risk.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures for flu and pneumonia vaccinations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42742

Based on record review, policy review, and interview, the facility failed to implement policies and procedures to ensure residents/residents' representatives were educated on the benefits and potential side effects of immunizations, ensure the medical record contained documented consent or refusal of the immunization, and offered and administered the influenza and pneumococcal immunizations in a timely manner for three out of five Residents sampled (#45, #106, and #8). Specifically, the facility failed:

1. For Resident #45, to educate the Resident and/or Resident's representative on the benefits and potential side effects of the influenza and pneumococcal vaccines, offer the immunizations, and document on the Informed Consent the Resident's consent to receive or refusal of the vaccines and place in the Resident's medical record;

2. For Resident #106, to educate the Resident and/or Resident's representative on the benefits and potential side effects of the pneumococcal vaccine, offer the immunization, and document on the Informed Consent the Resident's consent to receive or refusal of the vaccine and place in the Resident's medical record; and

3. For Resident #8, to educate the Resident and/or Resident's representative on the benefits and potential side effects of the influenza and pneumococcal vaccines, offer the immunizations, and document on the Informed Consent the Resident's consent to receive or refusal of the pneumococcal vaccine and place in the Resident's medical record.

Findings include:

Review of the Centers for Disease Control and Prevention (CDC) document titled Pneumococcal Vaccine Timing for Adults, dated March 2023, indicated the following:

Make sure your patients are up to date with pneumococcal vaccination.

Adults >= [AGE] years Old, Complete Pneumococcal Vaccine Schedules:

-PCV13 (pneumococcal conjugate vaccine) only at any age - PCV20 (pneumococcal 20-valent conjugate) or PCV23 (pneumococcal polysaccharide vaccine) >= 1 year later

-PPSV23 only at any age - PCV20 or PCV15 (pneumococcal 15-valent conjugate) >= 1 year later

Adults 19-[AGE] years Old with Chronic Health Conditions, Complete Pneumococcal Vaccine Schedules:

Chronic health conditions: Diabetes mellitus

-None - PCV20 or PCV15 then PPSV23 >= 1 year later

-PPSV23 only - PCV20 or PCV15 >= 1 year later

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Immunization of Residents, revised April 2023, indicated but was not limited to the following: -All eligible residents will be offered the influenza and pneumococcal vaccines unless medically contraindicated. The resident or the resident's legal representative will be provided education regarding the pros and cons of the vaccine prior to administration. The resident or resident's legal representative has the right to refuse the vaccine. -Identify residents who have not received the influenza vaccination for the current influenza season. -Screen all residents for contraindications and precautions to influenza vaccine. -Provide education about the benefits and risks of the influenza vaccination prior to administration. -Administer influenza vaccine and document vaccination in the Medication Administration Record (MAR) Review of the facility's policy titled Procedure for Pneumococcal Vaccination of Residents, revised April 2023, indicated but was not limited to the following: -Each resident or their responsible party will be asked on admission if they have previously had any pneumococcal vaccinations and their age at the time of vaccination. The records that accompany the resident will also be used to determine immunization status. -The pneumococcal conjugate vaccine will be offered to all eligible residents and the risks and benefits will be provided to the resident or the resident's legal representative prior to administration of the vaccine. -Adults >= [AGE] years who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, should receive a pneumococcal conjugate vaccine (either PCV20 or PCV15). If PCV15 is administered, this should be followed by a dose of PPSV23 >= 1 year later. -Adults aged 19-64 with certain underlying medical conditions or other risk factors who have not previously received pneumococcal conjugate vaccine or whose previous vaccination status is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PPCV15 is used, it should be followed by a dose of PPSV23 in >= 1 year. -Adults who have received PPSV23 only may receive a pneumococcal conjugate vaccine (either PCV20 or PCV15) >= 1 year after their last PPSV23 dose. 1. Resident #45 was readmitted to the facility in December 2022 and was [AGE] years old. Review of the medical record failed to indicate a Resident Admission Vaccination Education Form was completed upon admission to the facility in December 2022 to either receive or refuse the influenza or pneumococcal vaccines. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the Immunization Report indicated Resident #45 received the following vaccinations:

-Influenza, 10/20/22 (historical)

-Pneumovax Dose 1, 1/23/18 (historical)

Review of the facility's influenza immunization tracking log indicated Resident #45 reported he/she received the influenza vaccine, however, the log failed to indicate documentation of follow up by facility staff to confirm administration of the vaccine including a date when he/she may have potentially received it.

Review of the medical record failed to indicate documentation of follow up screening or assessment for eligibility to receive the annual Influenza vaccine, the provision of education related to the vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine per facility policy.

Further review of the medical record failed to indicate documentation of follow up screening or assessment for eligibility to receive the recommended pneumococcal vaccine dose (PCV20 or PCV15), the provision of education related to the pneumococcal vaccine, completed consent to either receive or refuse the PCV20 or PCV15 vaccine in the medical record, and re-offering or administration of the vaccine.

During an interview on 5/6/24 at 11:51 A.M., the Infection Preventionist (IP) said there was a note on the immunization tracker that the Resident may have received the 2023-2024 influenza vaccination. She said they should have followed up on it but didn't so the Resident had not received the vaccine that she knew of. The IP said there was no consent or declination form or documentation of education or offering of the influenza vaccine. The IP said Resident #45 had received the PPSV23 vaccine historically in 2018 and should have received either the PCV20 or PCV15 dose at least 1 year later. She said there was no documentation in the medical record that the Resident had been educated on or offered the vaccine. The IP said the Resident was not up to date with his/her Influenza or Pneumococcal vaccinations.

2. Resident #106 was admitted to the facility in April 2023 and was [AGE] years old with diagnoses including diabetes mellitus type 2.

Review of the Resident Admission Vaccination Education Form, dated 4/28/23, indicated Resident #106 had received the PPSV23 vaccination in the past. No date was indicated. The form failed to indicate consent or refusal to receive the recommended dose (PCV20 or PCV15 >= 1 year later) to ensure the Resident was up to date with his/her pneumococcal vaccination.

Review of the Immunization Report did not indicate Resident #106 had received any pneumococcal vaccinations.

Further review of the medical record failed to indicate documentation of follow up screening, an assessment for eligibility to receive the recommended pneumococcal vaccine dose, the provision of education related to the pneumococcal vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine in accordance with facility policy.

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F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 5/6/24 at 11:59 A.M., the IP and Director of Nursing (DON) said Resident #106 had a qualifying chronic medical condition and there was no evidence they could provide to the surveyor that the Resident had received the pneumococcal vaccine, but he/she should have received either the PCV15 or PCV20 dose. The IP said there was no evidence that the Resident was educated, offered, and either declined or consented to receive the pneumococcal vaccination. The IP and DON said Resident #106 was not up to date with the pneumococcal vaccination.

3. Resident #8 was admitted to the facility in October 2021 and was [AGE] years old.

Review of the Resident Admission Vaccination Education Form, dated 10/15/21, indicated Resident #8 consented to receive the annual influenza vaccine. The pneumococcal section of the form, however, was blank.

Review of the Immunization Report indicated Resident #8 received the following vaccines:

-Influenza, 10/18/22 (historical)

-PCV13, 12/14/15 (historical)

-PCV13, 9/9/20 (historical)

Review of the facility's influenza immunization tracking log indicated Resident #8 had a legal guardian and a message was left regarding the influenza vaccine. No further information was documented on the log.

Review of the medical record failed to indicate documentation of follow up screening or assessment for eligibility to receive the 2023-2024 annual influenza vaccine, the provision of education related to the vaccine, and offering or administration of the vaccine per facility policy.

Further review of the medical record failed to indicate documentation of follow up screening or assessment for eligibility to receive the recommended pneumococcal vaccine dose (PCV20 or PPSV23), the provision of education related to the pneumococcal vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine per facility policy.

During an interview on 5/6/24 at 12:01 P.M., the IP said when a resident is admitted the admitting nurse puts in their immunization status based on what they can find. She said the IP should be monitoring and ordering immunizations upon admission utilizing the Massachusetts Immunization Information System (MIIS) and in house trackers for vaccines. She said the immunization record and consents should be part of the residents' medical record. The IP said the vaccine education form should be completed upon admission with consent to receive the vaccines. She said she was unable to locate any information that Resident #8 had received the 2023-2024 influenza vaccination. She said the guardian was called but there was no follow up on it, just messages left. The IP further said the Resident's immunization record indicated he/she had received two doses of PCV13 and was eligible to receive the PCV20 or PPSV15 dose to complete the series. The IP and DON said there was no evidence they could provide to the surveyor that this was discussed with the Resident and/or legal guardian. The IP said there was no documentation, and that the Resident was not up to date with his/her seasonal influenza vaccine or the pneumococcal vaccination.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/24 at 12:12 P.M., the IP said all residents should be offered the influenza and pneumococcal vaccines unless medically contraindicated and should be screened each time a vaccine is given. The IP said pneumonia vaccines are ordered for each resident, but the facility had in house stock of the influenza vaccine. She said consents should be signed prior to administration and a copy maintained in the medical record but some were in folders in her office. The DON said she was responsible for oversight of the vaccination program. The IP and DON said they follow national standards of practice, and the purpose of the immunization program is to protect the residents to prevent disease, but that process was not followed for the sampled residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on record review, policy review, and interview, the facility failed to provide education, assess for eligibility, and offer the COVID-19 vaccination per the Centers for Disease Control and Prevention (CDC) recommendations and facility policy for two Residents (#8 and #107), out of a total sample size of five residents reviewed for immunizations. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled Stay Up to Date with Vaccines, revised April 2024, indicated but was not limited to the following: -CDC recommends the 2023-2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19. -Everyone 5 years and older should get 1 dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. None of the updated 2023-2024 COVID-19 vaccines is preferred over another. Review of the facility's policy titled COVID-19 Resident Vaccination Policy, revised April 2023, indicated but was not limited to the following: -It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 (SARS-CoV-2) by offering our residents immunization to COVID-19. -It is the policy of this facility, in collaboration with the medical director, to have an immunization program against COVID-19 disease in accordance with national standards of practice. -COVID-19 bivalent vaccines will be offered as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the resident has already been immunized during this time period, or resident/responsible party refuses to receive the vaccine. -If the facility has partnered with a preferred pharmacy provider, the pharmacy will coordinate with the facility and administer the COVID-19 bivalent vaccine according to the pharmacy partnership program guidelines. -COVID-19 bivalent vaccine may also be administered in the facility by the vaccine coordinator or designee. -Residents receiving the COVID-19 bivalent vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine (or provide verbal consent with two witnesses). The completed, signed, and dated record will be filed in the resident's medical record. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's medical record will include documentation that the resident and/or the resident's responsible party was provided education regarding the benefits and potential side effects of immunization. The documentation will also include if the resident received or did not receive the immunization due to medical contraindications or refusal, and if vaccine was administered, documentation will include follow-up monitoring post vaccine. 1. Resident #8 was admitted to the facility in October 2021 and was [AGE] years old. Review of the Resident Admission Vaccination Education Form, dated 10/15/21, indicated the COVID-19 vaccine section had not been completed by the Resident/Resident's representative or facility staff. Review of the Immunization Report indicated Resident #8 last received the COVID-19 bivalent vaccine on 11/28/22 outside of the facility. Review of the facility's COVID-19 immunization tracking log indicated Resident #8 had a legal guardian and a message was left regarding the vaccine. No further information was documented on the log. Further review of the medical record failed to indicate documentation of follow up screening, an assessment for eligibility to receive the recommended COVID-19 vaccine dose, the provision of education related to the COVID-19 vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine in accordance with facility policy. During an interview on 5/6/24 at 12:01 P.M., the Infection Preventionist (IP) and Director of Nursing (DON) said when a resident is admitted , the admitting nurse puts in their immunization status based on what they can find. The IP said there should be monitoring and ordering of the vaccine upon admission utilizing the Massachusetts Immunization Information System (MIIS) and in house trackers for vaccines. She said the vaccination admission form should be completed upon admission with consent for the vaccine. The IP said the Resident's last COVID-19 booster was on 11/28/22 and could not locate any evidence he/she received the most up to date booster. She said the Resident's legal guardian was called but there was no follow up on it, just messages left. The IP said the Resident was not up to date with his/her COVID-19 vaccination. 2. Resident #107 was admitted to the facility in July 2020 and was [AGE] years old. Review of the Resident Admission Vaccination Education Form, dated 7/28/20, did not indicate a section to be completed for the COVID-19 vaccine. Review of the Immunization Record indicated Resident #107 received the following vaccinations: -Pfizer Bivalent COVID-19 booster, 11/28/22 (historical) -Pfizer COVID-19 booster, 7/6/22 (historical) -Pfizer COVID-19 booster, 10/21/21 (historical) (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's COVID-19 immunization tracking log did not indicate that verbal or signed consent was received by the Resident/Resident's representative for the COVID-19 vaccine or that the Resident had received the most up to date vaccination. Further review of the medical record failed to indicate documentation of follow up screening or assessment for eligibility to receive the recommended COVID-19 vaccination, the provision of education related to the vaccine, completed consent to either receive or refuse the vaccine in the medical record, and offering or administration of the vaccine per facility policy and CDC guidance. During an interview on 5/6/24 at 12:11 P.M., the IP said Resident #107 had consented for the old booster on 9/23/22 but there was no recent consent for the most up to date COVID-19 booster. The IP said the Resident did not receive it that she knew of and there was no documentation of discussion with the Resident. The IP said Resident #107 was not up to date with the COVID-19 vaccination. During an interview on 5/6/24 at 12:12 P.M., the IP and DON said education should be provided prior to the administration of vaccines and that residents should be screened each time a vaccine is given. The IP further said residents should be offered and receive the most up to date COVID-19 vaccine per CDC and FDA guidelines unless medically contraindicated or the resident has already been immunized during this time period. The DON said their partnered pharmacy had conducted a COVID-19 booster clinic at the facility in February 2024 but not everyone got vaccinated that had a form completed, including Residents #8 and #107. She said she did not follow up with the pharmacy and had not asked for a supply of their own to administer to the residents. The IP said no COVID-19 vaccine order has been initiated. The DON said she oversees the vaccination program but she, the IP, or the nurses can give the vaccines if they're properly educated on it. The IP said vaccination consents should be signed prior to administration and be maintained in the chart. The IP and DON said the purpose of the immunization program is to protect the residents to prevent disease and to be in accordance with national standards of practice. He IP and DON said the immunization program process was not followed for Residents #8 and #107.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely.

41106

Based on observation and interview, the facility failed to maintain equipment in safe working order. Specifically, the facility failed to maintain:

1. Three of four microwaves located in the resident kitchenettes on the 200, 300 and 400 units,

2. The milk refrigerator unit located in the dry storage room across from the main kitchen, and

3. The grease trap by ensuring it was emptied as recommended by the consultant company.

Findings include:

Review of the facility's policy titled, dietary department guidelines, undated, included but was not limited to the following:

-The dietary department will be maintained in a clean and sanitary manner to prevent foodborne illness.

-All refrigerated foods and cold foods will be stored in how that refrigerated temperatures 41 F or below.

-Foods brought into the facility by family members will be kept in appropriate storage, refrigerated if indicated, must be labeled, and dated and will be discarded as appropriate.

-For example, prepared foods that require refrigeration should be discarded after three calendar days, whereas crackers stored in an airtight container may be kept longer.

1. On 5/2/24 at 1:27 P.M., the surveyor observed the resident kitchenette located on the 300 Unit and observed the microwave left lower rear wall to have a large, rusted area along the bottom and left side of the wall. In addition, the inside ceiling of the microwave had multiple small areas of rust that were flaking.

On 5/2/24 at 1:52 P.M., the surveyor observed the resident kitchenette located on the 200 Unit and observed the microwave ceiling to have multiple rust areas that were flaking.

On 5/2/24 at 2:05 P.M., the surveyor observed the resident kitchenette located on the 400 Unit and observed the microwave center rear wall to have a large, rusted area. In addition, the inside ceiling had three large, rusted holes in the ceiling that were flaking, along with multiple small areas of rust. The front door handle was broken off and one of the front legs.

During an interview on 5/2/24 at 2:25 P.M., the Food Service Manager (FSM) said when he started here about a month ago, he identified three of the resident unit kitchenettes needed to be replaced. He said the Maintenance Director was supposed to order them and they were never ordered.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225225	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Health Care Center	184 Lincoln Street North Easton, MA 02356

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 4/30/24 at 8:00 A.M., the surveyor observed the milk chest refrigeration unit in the dry storage room across the hall from the main kitchen, which contained multiple crates full of milk cartons. Two internal temperature thermometers indicated the temperature to be 48 degrees Fahrenheit (F). The FSM temped a carton of milk from the center crate and the temperature was 49 degrees F. During an interview on 4/30/24 at 8:00 A.M., the FSM said the milk chest refrigeration unit was not working properly. 3. On 4/30/24 at 7:40 A.M., four surveyors smelled a musty, pungent odor entering the main hallway by the kitchen enroute to the conference room. The surveyors continued to smell the same musty, pungent odor in the main hallway throughout the survey. The intensity of the pungent odor did vary, but it was present daily. During an interview on 5/01/24 at 9:00 A.M., the Maintenance Director said he did not think the pungent smell in the kitchen was coming from the grease trap because it had been cleaned out in June 2023. He said it is cleaned every six months. The surveyor requested the last invoice from when the grease trap was cleaned. Review of the most recent grease trap cleaning consultant invoice, dated 8/19/23, indicated but was not limited to the following: -Pumping-exterior grease (kitchen). -Upon opening the covers which were found to be in good condition, the grease in the tank was very heavy and thick. -Pumped one truckload of grease from tank. The tank appeared to be about 7000 gallons plus. -Only had time and scheduled to pump one load. Removed most of the greasy solids. -Recommend service and exterior grease trap again in a month or two to pump the tank to the bottom and be able to fully remove all grease content at that time. -After that the exterior grease trap should be serviced every three to six months going forward. During an interview on 5/07/24 at 10:24 A.M., the Maintenance Director said they never came back for the second pumping of the grease trap. He said there was a balance due on the account, which he was not aware of. During a telephonic interview on 5/07/24 at 1:32 P.M., the Supervisor from the consultant company said the second pumping of the grease trap was not performed for financial reasons. She said they have not been back to the building to pump the grease trap since August 2023.

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NAME OF PROVIDER OR SUPPLIER Southeast Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 184 Lincoln Street North Easton, MA 02356	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41106 Based on observation and interview, the facility failed to maintain the plumbing in the main kitchen in working order to prevent a buildup of pungent odors, puddling of water on kitchen floor in two areas, and the buildup of a black substance leaching form the wall between the wall between the dish machine and the prep the sink. Specifically, the facility failed to: 1. Maintain the drainpipes within the wall between the dish machine and the prep sink to prevent leakage of water/sewage into the main kitchen, build-up of a black substance oozing from the door jamb, and a foul, pungent odor emanating from the wall and left corner of the kitchen permeating out into the main hallway; 2. Maintain the drain which services the hand washing sink and the overflow valve to the ice machine from draining directly onto the kitchen floor into the floor drain. In addition, take the hand washing sink out of service when the drain was not properly functioning to avoid additional wastewater on the kitchen floor; and 3. Maintain the water pipes for the dish machine in working order, empty the bucket collecting the leaking water in a timely manner to avoid overflowing onto the kitchen floor. Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: -FDA Food Code 2022: 5-205 Operation and Maintenance: 5-205.15 System Maintained in Good Repair. A plumbing system shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair -Annex 3 Public Health Reasons/Administrative Guidelines; Chapter 5. Water, Plumbing, and Waste; 5-205.15: System Maintained in Good Repair. Improper repair or maintenance of any portion of the plumbing system may result in potential health hazards such as cross connections, backflow, or leakage. These conditions may result in the contamination of food, equipment, utensils, linens, or single service or single-use articles. Improper repair or maintenance may result in the creation of obnoxious odors or nuisances, and may also adversely affect the operation of warewashing equipment or other equipment which depends on sufficient volume and pressure to perform its intended functions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 4/30/24 at 7:40 A.M., four surveyors smelled a musty, pungent odor entering the main hallway by the kitchen enroute to the conference room. The surveyors continued to smell the same musty, pungent odor in the main hallway throughout the survey. The intensity of the pungent odor did vary, but it was present daily. During an interview with Dietary Staff #1 and #3 on 5/02/24 at 11:50 A.M., Dietary Staff #1 said she noticed the smell off and on starting almost a year ago, but it has gotten progressively worse in the last year. Dietary Staff #1 said she has told the Maintenance Director and the previous Food Service Manager (FSM) and they have done nothing about it. Dietary Staff #3 agreed and said the smell has gotten worse in the last six months. Both Dietary Staff #1 and #3 said the smell now is awful. During an interview on 5/02/24 at 12:09 P.M., Unit Manager (UM) #2 and Nurse #6 said the smell by the kitchen has been going on since the early part of this year. UM #2 said it is a very unpleasant smell. During an interview on 5/01/24 at 3:10 P.M., Dietary Staff #1 said the smell has been here for at least six months, and in the summer, the black colored substance (pointing to the floor) is worse and the odor is worse. On 4/30/24 at 8:21 A.M., the surveyor entered the back left corner by the prep sink of the main kitchen and smelled a very strong pungent odor. The sink was not in use, and the floor around the sink was observed to have puddles of water under sink, draining out onto the floor into the floor drain. The surveyor observed a mop head at the base of the door jamb (end of wall behind the prep sink), which was saturated with water. The FSM pulled the mop away from the door jamb and there was noted to be a buildup of black substance oozing out of the wall flowing along the lines in the floor. There was a loose white board against the back wall which the surveyor was able to slide away from the wall. The pungent smell intensified, and the surveyor had to pull back immediately. During an interview on 4/30/24 at 8:22 A.M., the FSM said he has been here about a month and the smell has been present. The FSM said it smells like a septic smell. He said someone must have put the mop head there to catch the water. During an interview on 5/01/24 at 9:00 A.M., the Maintenance Director said the building has had problems with all the rain and the high-water tables and the water in the basement. He thought the water was coming in from the outside. He said we recently tried looking in the walls for a leak and we couldn't find one. He said the grease trap was cleaned maybe in June 2023, and said it is cleaned every six months. The surveyor requested the last invoice for the grease trap cleaning. On 5/01/24 at 2:01 P.M., the surveyor smelled the rancid pungent odor to be very strong again in the corridor by the kitchen. The surveyor observed in the kitchen a large amount of water puddled on the floor by the prep sink area accompanied by a strong rancid smell. The surveyor observed an industrial fan blowing from the doorway entrance into the main kitchen area pointing toward the area of the prep sink. The FSM manager asked a dietary staff member to sweep up the water. The surveyor observed the dietary staff member sweeping the water from the main kitchen towards the dish room and observed the water to be light black in color with small black particles floating in the water. The water was seeping out of the wall between the prep sink and dishwasher machine. (continued on next page)

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Southeast Health Care Center	184 Lincoln Street North Easton, MA 02356

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/01/24 at 2:10 P.M., the surveyor and the FSM entered the outdoors courtyard and viewed the exterior wall to the kitchen at the location of the prep sink. The ground along the exterior wall had been dug down 8-10 inches and the soil was completely dry with no sign of water. During an interview on 5/01/24 at 2:20 P.M., Maintenance Staff #1 said he has only been working on the kitchen issue for about a month. He said they have been working on other water issues in the basement. He said they looked for a leak in the kitchen but couldn't find one. He said that's all they have done so far. On 5/01/24 at 3:00 P.M., two surveyors returned to the Main Kitchen and observed the back left wall where the baseboard was removed exposing the interior wall. The surveyors observed wet, rotting wood which had black colored substance. In addition, there were live black gnat-like flies on the wood; a few flew out of the opening. On the wall to the right there were multiple dead black bugs observed stuck to the wall. The surveyors observed the bottom of the doorway jamb between the kitchen and dishwashing room to have water leaking from the bottom onto the floor. There was a black colored substance at the bottom. The odor smelled stronger as the surveyor moved closer to the base of the wall. During an interview on 5/01/24 at 3:05 P.M., the FSM said they spray chlorine into the hole in the wall daily. During an interview on 5/01/24 at 3:10 P.M., the Maintenance Director said he was only made aware of the issue recently and said they looked for a leak but couldn't find one. The Maintenance Director said he called a plumber today, and he will come out and look at the problem either today or tomorrow. He said he had not called a plumber previously for this problem. During an interview on 5/02/24 at 10:00 A.M., the Consultant Plumber said it is definitely a grease problem. He suspects the drainpipes have rotted and the grease is leaking out, but he won't know the extent of the problem until you open up that wall. The consultant plumber said if it is a yes or no question, he would have to say it is a sanitation issue with the grease from the pipes seeping onto the kitchen floor. He said the pipes under the dishwasher and the prep sink are definitely rotted out and are leaking. During an interview on 5/02/24 at 11:45 A.M., the Administrator said she first noticed the smell two weeks ago. She said she was in the building last summer and nobody had reported a problem to her about the smell in the kitchen. She said the FSM has been here about a month and she knows the Maintenance Director has been in the kitchen. She said she is aware the plumber just came into the building, and she is awaiting a quote for the repairs. 2. On 4/30/24 at 8:00 A.M., the surveyor observed the main kitchen and made the following observations: -On the right side of the kitchen there was water flowing out of the open drainpipe connected to the hand washing sink and where the ice machine overflow water drains into. On 5/01/24 at 9:00 A.M., the surveyor made the following observations in the main kitchen: -Hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 1:56 P.M., the surveyor made the following observations: -Waste water continued to leak out of the drainpipe by the hand washing sink and the ice machine overflow pipe. In addition, the hand washing sink remained in service. When the surveyor turned on the water to the hand washing sink, the water immediately began to drain from the open drainpipe onto the kitchen floor and flow towards the floor drain. On 5/03/24 at 7:45 A.M., the surveyor made the following observations in the kitchen: - The hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. On 5/03/24 at 12:16 P.M., the surveyor made the following observations in the kitchen: - During lunch service the hand washing sink on the right side of the kitchen remained in service, water was observed flowing out of the drainpipe onto the kitchen floor. During an interview on 4/30/24 at 8:22 A.M., the FSM said he has been here about a month and there has been a problem with the leaking water and the handwashing drain not working correctly. During an interview on 5/02/24 at 10:00 A.M., the Consultant Plumber said the first time he was contacted for any plumbing issues in the kitchen was on 4/30/24. During an interview on 5/02/24 at 11:45 A.M., the Administrator said the FSM has been here about a month and she knows the Maintenance Director has been in the kitchen. She said she is aware the plumber just came into the building, and she is awaiting a quote for the repairs. 3. On 4/30/24 at 8:00 A.M., the surveyor observed the main kitchen and made the following observations: -Under the dishwasher there was a red plastic container catching water from the leaking pipe. The plastic container was overflowing onto the floor. On 5/01/24 at 9:00 A.M., the surveyor made the following observations in the main kitchen: -Under the dishwasher there was a red plastic container catching water from the leaking pipe. The red plastic container was half full. On 5/01/24 at 1:56 P.M., the surveyor made the following observations: -The pipe under the dishwasher continued leaking into red plastic container. During an interview on 5/02/24 at 10:00 A.M., the Consultant Plumber said the pipes under the dishwasher and the sink are definitely rotted out and are leaking. He said the first time he was contacted for any plumbing issues in the kitchen was on 4/30/24.