STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225227	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Rehabilitation and Nursing Center	94 Summer Street Fitchburg, MA 01420

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 36431 Based on record review and interview, the facility failed to accurately execute an Advanced Directive for 1 Resident (#69), out of a total sample of 20 residents. Specifically, for Resident #69 the facility failed to ensure the Massachusetts Medical Order for Life Sustaining Treatment (MOLST) (An Advanced Directive that is reviewed and signed as an order by a Physician/Nurse Practitioner (NP), or Physician Assistant (PA) and confirms a Resident's decisions for life sustaining treatment), was valid and signed by the Resident. Findings include: Review of the Facility's policy titled Advanced Directives, revision date September 2022, indicated the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced Directives are honored in accordance with state law and facility policy. Resident #69 was admitted to the facility in December 2024 and has diagnoses that include muscle wasting and atrophy, sepsis, chronic obstructive pulmonary disease, atherosclerotic heart disease and peripheral vascular disease. Review of the Minimum Data Set assessment, dated 12/25/25 indicated Resident #69 scored an 11 out of 15 on the Brief Interview for Mental Status score, indicating he/she as having moderately intact cognition. Review of Resident #69's medical record indicated the following: - A MOLST form dated 12/23/24 indicating Do Not Resuscitate, and Do Not Intubate and Ventilate, signed by a nurse practitioner and signed by a person, not the resident. - Admission paperwork signed by Resident #69. Further review of the medical record failed to indicate a physician's order, or documentation to indicate Resident #69 had an invoked health care proxy agent, (an order/document that is signed by the physician, NP or PA that indicates the resident lacks the capacity to make their health care treatment decisions, allowing a designated health care agent to make informed decisions). (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:19 P.M., the Social Worker said that Resident #69's health care proxy was not invoked, and that the person who signed the MOLST did not have the authority to make health care decisions for Resident #69, resulting in the MOLST not being valid.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, record review and interview, the facility failed to notify the physician of a change in condition for one Resident, (#6), out of a total of 20 sampled residents. Specifically, the facility failed to notify the physician of a change in skin condition. Findings include: Review of the facility policy titled Change in a Resident's Condition or Status, dated revised December 2003 indicated that the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and or status. Resident #6 was admitted to the facility in February 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), chronic respiratory failure and schizophrenia. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #6 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. During an interview on 3/4/25, at 10:47 A.M., Resident #6 said he/she has a fungal infection in his/her right groin. Resident #6 said that he/she told the nurses, but no one has obtained a nystatin powder (antifungal) for it. Resident #6 said that he/she bought Gold Bond powder, but it doesn't work. Review of the physician's orders failed to indicate an order for antifungal powder. Review of the progress notes failed to indicate that the physician was notified of Resident #6 having a reddened groin and was requesting an antifungal powder to be applied. Review of the document titled weekly Skin Review dated 2/12/25, indicated groin is pink. antifungal powder applied, no new skin issues. Review of the document titled weekly Skin Review dated 2/19/25, indicated resident groin is pink, antifungal powder applied. Review of the document titled weekly Skin Review dated 2/25/25, indicated groin is pink, antifungal powder order is in place, no new skin issues noted. During an interview on 3/06/25, at 10:11 A.M., the Regional Nurse said that the physician should have been notified of Resident #6's reddened groin.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed to provide respiratory care in accordance with professional standards of practice, for three of 20 sampled residents. Specifically: 1. For Resident #18, the facility failed to develop a care plan for post-traumatic stress disorder. 2. For Resident #11, the facility failed to develop a care plan for post-traumatic stress disorder. 3. For Resident #12, the facility failed to develop a care plan for suicidal ideation. 4. For Resident #44, the facility failed to develop care plans for the presence of a cardiac pacemaker. 1. Resident #18 was admitted to the facility in April 2024, with diagnoses including post-traumatic stress disorder (PTSD), anxiety and depression. Review of the Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status exam of 7, signifying severe cognitive impairment, and an active diagnosis of PTSD. Review of the current care plan for PTSD/mood care dated 5/10/24, indicated: - Resident #18 was at risk for alteration in mood related to: diagnosis of Depression, PTSD. - The care plan goal: Resident will display positive affect through next review period. - Care plan intervention was limited to: Staff to report any changes in resident's mood to Social Worker, Director of Nurses and supportive services immediately for evaluation. During an interview with the Regional Nurse on 3/6/25 at 10:13 A.M., she said Resident #18's care plan for PTSD should be individualized to include specific triggers and interventions, and that the current care plan is not individualized. The Regional Nurse said the PTSD care plan should give direct care staff direction on how to manage the Resident's PTSD and associated behaviors. 36797 2. Resident #11 was admitted to the facility in July 2023 with diagnoses including post-traumatic stress disorder (PTSD), anxiety and borderline personality disorder. Review of the current care plan failed to indicate a plan of care for the diagnosis of PTSD. During an interview on 3/6/25, at 10:11 A.M., the Regional Nurse said that residents with a diagnosis of PTSD should have a care plan in place that addresses the Resident's PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36876 3. Resident #12 was admitted to the facility in August 2024 with diagnoses including dementia, chronic obstructive pulmonary disease and suicidal ideation. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12 is moderately cognitively impaired as evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. The MDS also indicated Resident #12 requires assistance with bathing and dressing and utilizes oxygen therapy. Review of Resident #12's discharge paperwork from the hospital indicated that he/she had a history of suicidal ideation and had been transferred to the psychiatric unit during his/her hospital stay after reporting suicidal ideation with a plan. Review of Resident #12's care plans failed to include a care plan identifying Resident #12's history of suicidal ideation or methods or means for staff to monitor for his/her mental well-being and physical safety. During an interview on 3/6/25 at 10:37 A.M., the Social Worker said residents with a history of suicidal ideation or attempt history should have care plans implemented to reflect triggers signs/symptoms and to notify the physician/administration of any changes of behaviors. The Social Worker said she was not aware Resident #12 did not have a care plan related to his/her suicidal ideation. 48671 4. Review of the facility policy titled Pacemaker, Care of a Resident with, dated as revised December 2015, indicated the purpose of this procedure is to provide information about and guidance for the care of a resident with a pacemaker. - Pacemakers are electronic devices that artificially stimulate the heart muscle with electrical impulses when the heart rhythm is too low (bradycardia). - Pacemakers are programmed to sense the heart and respiratory rate and to administer electrical pulses when the heart rate falls below a set threshold. Complications -If the pulse generator or battery fails or if the leads become displaced the pacemaker may not work properly leading to [NAME] arrhythmias. Resident #44 was admitted to the facility in August 2024 with diagnoses that included: presence of cardiac pacemaker, unspecified combined systolic (congestive) and diastolic (congestive) heart failure, unspecified atrial fibrillation (irregular heartbeat), essential (primary) hypertension, atherosclerotic heart disease of native coronary artery (buildup of plaque restricting blood flow), and acute respiratory failure with hypoxia (lack of oxygen). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent Minimum Data Set (MDS) assessment, dated 2/17/25, indicated that Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. Further review of the MDS indicated the presence of a cardiac pacemaker. On 3/4/25 at 9:43 A.M., the surveyor observed Resident #44 sitting in bed. A white box was located on the nightstand next to the Resident's bed. Resident #44 said he/she has a pacemaker and but did not know who manages it. Review of Resident #44's pacemaker care plan, dated 8/27/24, indicated the Resident has a pacemaker r/t (related to) A-fib (atrial fibrillation). - Will remain free from s/sx (signs /symptoms) of pacemaker malfunction or failure through the review date. - Obtain vital signs as ordered/per facility protocol and record. Notify MD of significant nursing abnormalities. Review of Resident #44's medical record failed to indicate information on the cardiac pacemaker. During an interview on 3/6/25 at 9:48 A.M., Certified Nursing Assistant #1 said Resident #44 does not have a pacemaker. During an interview on 3/6/25 at 11:36 A.M., Nurse #6 said Resident #44 does have a pacemaker and said the care plan should be completed with information related to the pacemaker and said she did not have any additional information regarding reports in the medical record. During an interview on 3/6/25 at 12:30 P.M., the Director of Nurses said the pacemaker care plan must be updated with information on how the pacemaker is monitored and specifics of the pacemaker and monitoring orders must be in place. During an interview on 3/10/25 at 10:08 A.M., Nurse Practitioner #1 said the medical record should indicate the presence of a pacemaker, so staff are aware.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671 Based on observation, record review and interview, the facility failed to meet professional standards of practice for three Residents (44, #29, and #1) out of a total of 20 sampled residents. Specifically, 1. For Resident #44, the facility failed to: a.) adequately assess, monitor, and implement a physician order for fluid restrictions (limiting the amount of fluid a person takes in) from August 2024 to March 2025. Subsequently, Resident #44 was hospitalized in February 2025, and admitted to ICU (intensive care unit) with diagnosis of acute hypoxic respiratory failure, acute renal failure and septic shock., b.) failed to follow up on physician recommendations for new prosthetic leg, and c.) failed to implement a physician order for bilateral shoulder X-ray. 2. For Resident #29, the facility failed to obtain labs as ordered by the physician. 3. For Resident #1, the facility failed to ensure the air mattress was set per the physician order. Findings include: 1. Resident #44 was admitted to the facility in August 2024 with diagnoses that include, chronic kidney disease stage 4 severe, retention of urine, type 2 diabetes mellitus, and congestive heart failure (CHF). Review of the most recent Minimum Data Set (MDS) assessment, dated 2/17/25, indicated that Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Further review of the MDS indicated Resident #44 requires substantial/maximal assistance for self-care and mobility, has functional limitation in range of motion to lower the extremity and has an impairment on one side requiring the use of an orthotic/ prosthetic. a. Review of Resident #44's active physicians orders indicated: No Concentrated Sweets diet- Regular texture, Thin consistency, 1500 ml/day fluid restriction 1500 ml (milliliters) Total in 24 hrs (hours): Nursing 660ml/24hr, (240 ml on 7-3, 240ml on 3-11, 180 ml on 11-7) Dietary 840ml/24 hrs) 360ml @ breakfast, 240ml lunch, 240 ml @ Dinner). Dated 8/27/24. Review of Resident #44's MAR and TAR failed to indicate monitoring of fluids and did not contain any information related to fluid restrictions. Review of Resident #44's nutrition care plan indicated: - Resident is nutritionally at risk r/t (related to) CHF, diabetes, anemia, COPD, poor dentition. Dated as revised 8/28/24. Interventions included: - Record and monitor intakes. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	- Continue diet as ordered. Review of Resident #44's current dietary slip failed to indicate fluid restrictions. Review of Resident #44's Kardex, (a form indicating level of care needs) failed to indicate the Resident was on fluid restrictions. Review of the nursing progress note dated 8/30/24, indicated: fluid restrictions maintained. Review of the Nutritional Risk Evaluation dated 1/13/25 indicated: Nutritional Plan: Identified at-risk for weight loss and dehydration - Yes. - Resident is on 1500ml F/R (fluid restriction). Resident had been admitted to Hospital for acute on chronic CHF and acute on chronic Renal failure. Resident had diuretics for excess water. Note that he/she is on diuretic and may experience wt.(weight) fluctuations via fluid shifts. He/she knows his nutritional expectations while on a diabetic diet with F/R. Will continue to monitor ongoing trends and adjust needs accordingly. Review of the nursing progress note dated 1/31/25 indicated: This RN was notified by this patients significant other that he/she would like this patient to be sent out to hospital. When RN asked why, he/she stated that he/she thinks he/she has pneumonia. I went to assess the patient.BP slightly low, 90/56, o2 90% on RA (room air), pulse 54. Afebrile. Patient agreeable to send out to hospital. EMS was called and patient was transferred out. Review of Resident #44's medical record indicated the following Nursing progress note dated 2/11/25, Per discharge paperwork the Resident was found to be covid positive, was admitted to ICU (intensive care unit) for management of acute hypoxic respiratory failure, acute renal failure and septic shock. Review of the hospital discharge paperwork dated 2/11/25, indicated that Resident #44 was admitted to the hospital and diagnosed with acute renal failure superimposed on stage 4 chronic kidney disease, acute hypoxic respiratory failure, hypokalemia (low potassium level), hyponatremia (low sodium level), community acquired PNA (pneumonia), and sepsis. - Disease course complicated by worsening kidney function. - AKI (acute kidney injury), hyponatremia, urinary retention. During an interview on 3/6/25 at 9:48 A.M., Certified Nursing Assistant (CNA)#6 said Resident #44 is not on fluid restrictions and said the Resident can have anything he/she wants to drink to stay hydrated. During an interview on 3/7/25 at 11:02 A.M., the assistant Director of Nurses (ADON) said Resident #44 has an order for fluid restrictions and said staff should be following the orders as written. The ADON said the care plan should indicate fluid restrictions and the order should be on the Medication Administration Record (MAR) or on the Treatment Administration Record (TAR) to track fluids. The ADON said the dietary slip should indicate the Resident is on fluid restrictions. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/10/25 at 10:17 A.M., Nurse Practitioner (NP) #1 said Resident #44 is very fragile and needs close monitoring due to his/her medical conditions and requires close monitoring of fluid restrictions. NP #1 said fluid restrictions should have been completed as ordered with ongoing monitoring of the fluid restrictions daily. NP #1 said staff should be following fluid restrictions as ordered especially after the recent hospitalization . b. During an observation on 3/4/25 at 9:45 A.M., Resident #44 was sitting in bed. There was a prosthetic leg on the floor next to the bedside table. During an observation on 3/7/25 at 8:40 A.M., Resident #44 was sitting in bed and said to the surveyor old leg not new one as he/she pointed to the prosthetic leg on the floor. When the surveyor asked if he/she was getting a new one, Resident #44 shook his/her head side to side and said I don't know. Review of the physician note dated 1/7/25, indicated: visit with patient today about new prosthetic. Patient stated old prosthetic is too heavy to ambulate, with increase fatigue and LE (left extremity) and low back pain. Would recommend new lighter fitting prosthetic to help increase ambulation distance and decrease pain with less caregiver asst. Review of the clinical record failed to indicate that Resident #44 had ever been evaluated for a new prosthetic leg. During an interview on 3/6/25 at 9:10 A.M., the Director of Rehab said Resident #44 may benefit from a new prosthetic leg because it is very old and he/she may have lost weight since admission and said he called the vendor last week, (approximately 2 months since the physician note recommending a newer prosthetic), but should call again to set up an evaluation. During an interview on 3/7/25 at 11:23 A.M. the Assistant Director of Nurses (ADON) said she would expect that an evaluation would be completed and said she was not aware of the recommendation. During an interview on 3/8/24 at 9:38 A.M., the Director of Nursing said that she would look into the consult for the prosthetic leg and said she would expect staff to follow up when the recommendation was made in January to start the process. During an interview on 3/10/25 at 10:28 A.M. Nurse Practitioner #1 said she would expect that recommendations would be implemented and documented in the medical chart to obtain a new prosthetic leg. c. Review of the Nurse Practitioner note dated 10/28/24, indicated, Chief complaint about shoulder pain. Assessment & Plan- bilateral shoulder pain: pt c/o (patient complained of) bilateral shoulder pain. Will order shoulder X-ray to assess for arthritis. Review of the nursing progress note dated, 11/1/24, indicated a physician order for Lidocaine patch for c/o pain to bilat (bilateral) shoulder. Review of the medical record indicated an imaging signature request form from an outside vendor dated 1/28/25, indicated, 4th request for ordering practitioner's signature. Exam date 10/29/24. Confirm this exam order by signing this document and faxing it back to imaging. The form was unsigned. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/7/25 11:23 A.M., the Assistant Director of Nurses (ADON) said Resident #44 should have had the X-ray completed as ordered and said she is not sure why it was not done. During an interview on 3/7/25 at 12:04 P.M., Nurse #7 said Resident #44 had an order for an X-ray but said she did not see that the X-ray was ever done. During an interview on 3/10/25 at 10:08 A.M., Nurse Practitioner #1 said Resident #44 was reporting shoulder pain and said she ordered an X-ray but was not aware that it was never done. NP #1 said the X-ray should have been obtained and followed up on and said Resident #44 has had pain in his/her shoulders and neck. 36876 2. Resident #29 was admitted to the facility in February 2023 with diagnoses including achondroplasia and hydronephrosis. Review of the Minimum Data Set (MDS) asssessment dated 12/4/24, indicated Resident #29 is cognitively intact as evidenced by a score of 14 out of a possible 15 on the Brief Interview for Mental Status exam. The MDS also indicated Resident #29 requires assistance for bathing, dressing and toileting. Review of Resident #29's physicians orders indicated: Sodium Chloride Oral Tablet 1 GM (Sodium Chloride) Give 1 tablet by mouth three times a day for Hyponatremia Repeat BMP every week until sodium level normalizes and adjust salt tablet, 10/18/24. Additional review of Resident #29's physicians orders indicated: November 2024: labs were not obtained the weeks of 11/10/24, 11/17/24 and 11/24/24. December 2024: no labs were obtained. January 2025: no labs were obtained. February 2025: labs were not obtained the weeks of 2/2/25, 2/9/25, and 2/16/25. During an interview on 3/7/25 at 11:25 A.M., the Assistant Director of Nursing (ADON) said staff should implement physicians orders. The ADON said that if the nursing staff had questions related to Resident #29's ordered weekly labs, they should have called the physician for clarification. 46339 3. Resident #1 was admitted to the facility in February 2023 with diagnoses including peripheral vascular disease and lymphedema. Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she was cognitively intact. The MDS further indicated the Resident had wounds. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 3/4/25 at 8:13 A.M., the surveyor observed Resident #1 lying in his/her bed. The air mattress was set at 10/380 lbs (pounds). On 3/6/25 at 7:59 A.M., the surveyor observed Resident #1 lying in his/her bed the air mattress was set at 10/380 lbs (pounds). On 3/6/25 at 11:00 A.M., the surveyor observed Resident #1 lying in his/her bed the air mattress was set at 10/380 lbs (pounds). Review of the medical record indicated the following physician order dated 4/18/24: - Low air loss mattress check settings and functions every shift - settings at 10/350 Lbs - every shift for preventative skin check proper function. Review of the current Treatment Administration Record (TAR) indicated the nurses had signed off that the air mattress was set at 10/350 Lbs. During an interview on 3/6/25 at 11:07 A.M., Nurse #6 said the physician order should match the air mattress setting and that nurses are responsible for ensuring the air mattress is checked for correct setting and proper functioning. During an interview on 3/7/25 at 11:10 A.M., the Assistant Director of Nursing (ADON) said the physician orders should match Resident #1's actual mattress pressure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview, the facility failed to ensure quality of care for two Residents (#69, and #6), out of a total sample of 20 residents. Specifically, 1. For Resident #69, the facility failed to ensure for Resident #69, who is treated with anticoagulant medication (a medication that hinders clotting of the blood), that areas of discoloration consistent with bruising were identified. 2. For Resident #6, the facility failed to obtain a treatment for a change in condition related to skin management. Findings include: 1. Review of the Facility's policy titled Anticoagulation - Clinical Protocol, revision date November 2018, included but was not limited to the following: Monitoring and Follow-up 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. A. If an individual on anticoagulation therapy, shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. Resident #69 was admitted to the facility in December 2024 and has diagnoses that include muscle wasting and atrophy, sepsis, chronic obstructive pulmonary disease, atherosclerotic heart disease and peripheral vascular disease. Review of the Minimum Data Set assessment, dated 12/25/25 indicated Resident #69 scored an 11 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having moderately intact cognition. During an observation and interview on 3/4/25 at 8:35 A.M., Resident #69 was in his/her bed. Resident #69's right arm had scattered red areas on the skin. Nurse #6 entered the room and said the Resident is on Lovanox (an anticoagulant) and administered the medication via an injection, and then she exited the room. Resident #69 said he/she transfers in out of bed with a slide board and can easily bump his/her arms. Review of Resident #69's physician's orders indicated the following: - Aspirin (a medication that can thin the blood) oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day for Arterial Insufficiency, start date 12/20/2024. - Lovenox (an anticoagulation medication that hinders the clotting of blood) Injection Solution Prefilled Syringe 40 MG/0.4ML (Enoxaparin Sodium). Inject 0.4 ml subcutaneously one time a day for supplement related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS (I25.10) start date 12/20/24. (continued on next page)

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Fitchburg Rehabilitation and Nursing Center	94 Summer Street Fitchburg, MA 01420

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Clopidogrel Bisulfate Oral Tablet (an antiplatelet medication) 75 mg, give 75 mg by mouth one time a day for prophylactic use for 3 months. Start date 1/9/2025. - Monitor for Bleeding/Bruising r/t (related to) Lovenox use every shift, start 12/19/24 - Weekly skin check every shift every Thu (Thursday), start date 12/25/2024. Review of Resident #69's care plans indicated a care plan 'the Resident will not experience complications secondary to anticoagulation therapy', date initiated: 12/22/24. Goal - Resident will not develop bruising or abnormal bleeding from anticoagulant use through next review, dated initiated 12/22/24, revision date 2/28/2025. During an observation and interview on 3/6/25 at 8:48 A.M., and on 3/6/25 at 9:16 A.M., Resident #69 was in bed. His/her right arm had an increase in the number of areas of reddish discoloration on his/her right arm. Resident #69 said his/her left arm now had marks and held his/her arm up revealing red circular areas. Resident #69 said his/her arms have the areas because he/she is on a blood thinner and when he/she moves around or bangs them on the bed rail they just pop. Resident #69 said his/her right arm is worse than his/her my left arm. Resident #69's right arm had large, darker reddened discolorations, and close to his/her elbow was a small dark raised area, consistent with a scab. Resident #69 said it was a small cut. Resident #69 said the nurses knows about his/her skin. During an interview on 3/6/25 at 10:35 A.M., Certified Nursing Assistant (CNA) #1 said any changes in a resident's skin is reported to the nursing staff. CNA #1 said she is taking care of Resident #69 today and was not aware of any skin issues other than the dressings to his/her feet. The surveyor and CNA #1 went to Resident #69's room and observed both his/her arms. Resident #69 said the area on the right elbow observed with a scab has been there a few days after he/she hit it on his/her wheelchair. CNA #1 said the areas on his/her arms should be reported to nursing staff. Review of the Weekly skin review-V3, dated 3/6/25 indicated it failed to document areas of red discoloration on Resident #69's right or left arms. Review of the progress notes entered in Resident #69's medical record from 3/1/25 through 3/6/25 failed to indicate any nursing progress note related to changes in Resident #69's skin, specifically the areas of discoloration to his/her right and left arms. Nor were there any progress notes to indicate the physician was made aware of the resident's areas of discoloration on his/her right and left arms. Review of the March 2025, Medication Administration Record (MAR) indicated: Monitor for Bleeding/Bruising r/t (related to) Lovenox use every shift, start 12/19/24, and from 3/1/25 through day shift on 3/6/25, the day, evening and night shifts were checked off by nursing staff, and failed to indicate if any bleeding or bruising was noted. During an interview on 3/6/25 at 10:51 A.M., Nurse #6 said she just been informed of the bruises on Resident #69's right and left arms. Nurse #6 said the Resident is on three blood thinners and requires close monitoring to make sure he/she does not have any bruises or bleeding. Nurse #6 said the weekly skin check should include documentation of any skin changes including bruises. Nurse #6 said the MAR should include if bleeding or bruising is present due to the use of blood thinners. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36797 2. Resident #6 was admitted to the facility in February 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), chronic respiratory failure and schizophrenia. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #6 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. During an interview on 3/4/25 at 10:47 A.M., Resident #6 said he/she has a fungal infection in his/her right groin. Resident #6 said that he/she told the nurses but no one has obtained a nystatin powder (an antifungal) for it. Resident #6 said that he/she bought Gold Bond powder but it doesn't work. Review of the physician's orders failed to indicate an order for antifungal powder. Review of the progress notes failed to indicate that the physician was notified of Resident #6 having a reddened groin and was requesting an anti fungal powder to be applied. Review of the document titled weekly Skin Review dated 2/12/25, indicated groin is pink. antifungal powder applied, no new skin issues. Review of the document titled weekly Skin Review dated 2/19/25, indicated resident groin is pink, antifungal powder applied. Review of the document titled weekly Skin Review dated 2/25/25, indicated groin is pink, antifungal powder order is in place, no new skin issues noted. During an interview on 3/6/25, at 9:00 A.M., Nurse #5 said that she did not know the residents very well and did not know Resident #6 had a reddened groin. Nurse #6 then said that the physician should have been notified when Resident #6's groin became reddened.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure for one Resident (#69) that a smoking assessment was completed and that a care plan was developed for smoking. Findings include: Review of the facility's policy titled Smoking Policy - Residents, revision date October 2023 indicted the following: The facility has established and maintains safe smoking practices. 1. Prior to and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 7. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes a. current level of tobacco consumption, b. method of tobacco consumption (traditional cigarettes electronic cigarettes, pipe, etc.) c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 9. A resident's ability to smoke safely is re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. 10. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to those issues. Resident #69 was admitted to the facility in December 2024 and has diagnoses that include muscle wasting and atrophy, sepsis, chronic obstructive pulmonary disease, atherosclerotic heart disease and peripheral vascular disease. Review of the Minimum Data Set assessment, dated 12/25/25 indicated Resident #69 scored an 11 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having moderately intact cognition. Further, the MDS indicated no tobacco use. Review of the list, not dated, provided by the facility to the surveyors on 3/4/25, indicated Resident #69 was listed as a person who smoked, requiring supervised/monitoring. Review of Resident #69's medical record indicated the following: - No person-centered care plan for smoking including individualized interventions. - No Safe Smoking Evaluation. - A smoking agreement signed by Resident #69, dated 12/23/24. -The admission nursing assessment dated [DATE] indicated Resident #69 did not smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at approximately 8:37 A.M., Resident #69 said he/she smokes when his/her friend visits a few times a week, but he/she does not go out to the smoking area. During an interview on 3/6/25 at 8:19 A.M., Nurse #6 said that she was not aware that Resident #69 smoked, and that Resident #69 had told her that he/she did not smoke. During an interview on 3/6/25 at 3:02 P.M., the Social Worker said Resident #69 signed a smoking agreement upon admission. The Social Worker said at admission Resident #69 was ill and did not smoke, and when he/she began to feel better he/she resumed smoking. The Social Worker said Resident #69 may have began smoking around the end of January. The Social Worker said there was no safe smoking evaluation in Resident #69's medical record. The Social Worker said a care plan for smoking was initiated and discontinued. During an interview on 3/6/25 at 3:58 P.M., the Administrator said he added Resident #69 to the supervised smoking list because he saw him/her smoking outside with his/her friend. The Administrator said a care plan for smoking should be in place and a safe smoking evaluation should have been conducted when staff became aware that Resident #69 began to smoke.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on record review, interview and observation, the facility failed to provide respiratory care for three of 20 sampled residents. Specifically: 1. For Resident #18, the facility failed to implement the physician's order for oxygen use. 2. For Resident #6, the facility failed to implement the physician's order for oxygen, and did not change expired oxygen tubing. 3. For Resident #12, the facility failed to obtain a physician's order for oxygen used by the Resident. Findings include: 1. Resident #18 was admitted to the facility in [DATE] and had diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Resident #18's Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status exam of 7, signifying severe cognitive impairment, and an active diagnosis of COPD. Review of Resident #18's respiratory care plan dated [DATE], indicated: - The Resident has oxygen therapy related to COPD. - Provide oxygen as ordered. Review of Resident #18's physician's order dated [DATE], indicated: - Oxygen via nasal cannula as needed at 2 liters per minute to maintain saturation at or above 90%. On [DATE] at 10:41 A.M., the surveyor observed Resident #18 lying awake in bed and wearing a nasal cannula. The cannula and tubing were attached to an oxygen concentrator, located on the floor by the side of the bed. The oxygen was running and set to 4 ,d+[DATE] liters per minute. On [DATE] at 7:58 A.M., the surveyor observed Resident #18 asleep in bed, and wearing a nasal cannula attached to the oxygen concentrator. The concentrator was running and set to 4 ,d+[DATE] liters per minute. During an interview with Nurse #2 on [DATE] at 8:05 A.M., the surveyor told her that Resident #18's oxygen was running at 4 ,d+[DATE] liters per minute. Nurse #2 reviewed the Resident's physician orders and said the oxygen delivery rate should be set to 2 liters per minute. Nurse #2 accompanied the surveyor to the Resident's room and observed the oxygen concentrator was running at 4 ,d+[DATE] liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #18 on [DATE] at 9:33 A.M., he/she said he/she does not adjust the oxygen level on the concentrator, and that only staff touch the concentrator. 36797 2. Resident #6 was admitted to the facility in February 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), chronic respiratory failure and schizophrenia. Review of the Minimum Data Set assessment date [DATE] indicated that Resident #6 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. On [DATE], at 8:09 A.M. the surveyor observed Resident #6 in bed receiving 4.5 liters/minute of oxygen via nasal cannula. The surveyor then observed the oxygen tubing to be dated [DATE]. Review of the physician orders dated [DATE] indicated an order for O2 via nasal cannula 1 to 3 liters/minute continuous. Review of the medication administration record dated [DATE] indicated that the oxygen tubing was changed on [DATE]. Review of the care plan indicated that Resident #6 is at risk for respiratory complications r/t COPD, respiratory failure and to provide O2 therapy as ordered. During an interview on [DATE], at 9:00 A.M., Nurse #5 said that the oxygen tubing was dated [DATE] and should have been changed on [DATE]. Nurse #5 then said that the oxygen was running at 4.5 liters/minute and was ordered to be running at no higher than 3 liters/minute. Nurse #5 then said that the medical record was inaccurate because a nurse had signed off that the O2 tubing was changed on [DATE]. 36876 3. Resident #12 was admitted to the facility in [DATE] with diagnoses including dementia, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 is moderately cognitively impaired as evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. The MDS also indicated Resident #12 requires assistance with bathing and dressing and utilizes oxygen therapy. On [DATE], the surveyor observed Resident #12 asleep in bed wearing oxygen via nasal cannula. The surveyor was unable to observe the oxygen concentrator due to its placement under the bed. Review of Resident #12's physicians orders failed to indicate a current order for the use of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:20 A.M., Resident #12 was observed seated in the hallway outside his/her door, not wearing 02. Resident #12 and said he/she wears oxygen at night and gave the surveyor permission to view the concentrator. The surveyor then observed the 02 concentrator running with the nasal cannula on the floor. The concentrator was set at 3 liters. Resident #12 said it should be set at 2 liters. During an interview on [DATE] at 10:16 A.M., Nurse #2 said that Resident #12 wears oxygen at night when he/she is sleeping. Nurse #2 and the surveyor reviewed the physician' orders and Nurse #2 said she could not see an order for the use of oxygen for Resident #12. Nurse #2 said residents on oxygen need a physician's order. During an interview on [DATE] at 11:25 A.M., the Assistant Director of Nursing (ADON) said that she knew Resident #12 wore oxygen at night and did not know there was no order in place.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on observation, record review and interview, the facility failed to ensure medications were stored as required for one Resident (#26), out of a total sample of 20 residents. Specifically, the facility failed to ensure that medication was not left at the Resident's bedside unattended. Findings include: Review of the facility policy titled 'Medication Labeling and Storage' dated February 2023, indicated the following but was not limited to: -The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Resident #26 was admitted to the facility in April 2019 with diagnoses including gastro esophageal reflux disease without esophagitis. Review of Resident #26's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she was cognitively intact. The MDS further indicated the Resident did not reject care. On 3/4/25 at 8:09 A.M., the surveyor observed three medicine cups by the Resident's bedside table with 15 round various colored tablets, and appeared to be calcium carbonate Tums. Review of the medical record indicated the following physician order. - Calcium carbonate tablet 1250 (500 ca) mg (milligram). Give 2 tablets by mouth with meals for supplement. Review of medical record failed to indicate a resident self-medication administration assessment had been completed. During an interview on 3/6/25 at 11:04 A.M., Nurse #6 said the nurses are supposed to stay with the Resident during medication administration to ensure all medications are taken. During an interview on 3/7/25 at 11:08 A.M., the Assistant Director of Nursing (ADON) said nurses are to stay with the resident until all the medication is consumed and should not leave any medications by the bedside.

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F 0773 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to notify the Physician of critical labs for two residents (#12, and #44) out of a total of 20 sampled residents. Specifically: 1. For Resident #12, the facility failed to alert the Physician of critically high BUN (measures how much blood urea nitrogen is in your body and can may indicated a problem with kidneys or liver) and critically low potassium (measures the electrolyte potassium in the blood that is essential for proper muscle and nerve function) results, which resulted in a delay of treatment and hospitalization for acute hypokalemia and acute kidney injury. 2. For Resident #44, the facility failed to obtain laboratory services as ordered by the Physician. Findings include: 1. Resident #12 was admitted to the facility in August 2024 with diagnoses including dementia, and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #12 is moderately cognitively impaired as evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. The MDS also indicated Resident #12 requires assistance with bathing and dressing and utilizes oxygen therapy. Review of Resident #12's clinical record indicated that a blood draw was obtained on 2/26/25 at 12:20 P.M. with results reported to the facility on [DATE] at 4:52 P.M. that were critical: - BUN:106 (Reference range 10 - 24). Critically high. - Potassium: 2.7 (Reference range 3.3 - 5.1) Critically low. Resident #12's lab draw on 11/6/24 indicated his/her previous levels were as follows: - BUN: 19 - Potassium: 4.2 Review of the nurse progress note dated 2/26/25 at 9:09 P.M., written by Nurse #4, indicated: Resident continues on antibiotic azithromycin for PNA (pneumonia), no ill effect noted, VSS (vital signs stable). Resident compliant with meds and care, no s/sx (signs or symptoms) of hypo/hyperglycemia noted, safety maintained at all times. The nurse progress note failed to indicate Resident #12's lab results were reported to the Physician. (continued on next page)

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F 0773 Level of Harm - Actual harm Residents Affected - Few	Review of the nurse progress notes dated 2/27/25 at 10:50 A.M. written by the Director of Nursing (DON) indicated: Resident alert and able to make needs known. Continues on abx (antibiotic treatment) for pneumonia with no adverse effect. Critical lab results with BUN of 106 . Reported to provider, new order obtained from [Nurse Practitioner] to send resident to ED for evaluation. Review of the hospital paperwork dated 2/27/25 indicated the following lab results: BUN: 106 Potassium: 2.3 (a decrease from his/her potassium level on 2/26/25) Additional review of the hospital paperwork indicated Resident #12 was admitted to the hospital and diagnosed with acute hypokalemia, and acute kidney injury. During an interview on 3/6/25 at 8:14 A.M., Nurse #2 said that labs are obtained for residents on Wednesdays and Friday mornings. Nurse #2 said that labs do not usually come back until the afternoon so nurses will give report to the 3:00 P.M. - 11:00 P.M. shift to be aware of pending lab results for residents. Nurse #2 said that if labs are critical, the lab will call the facility and alert the nursing staff who will then alert the physician immediately. During an interview on 3/6/25 at 10:58 A.M., Nurse #3 said she worked the 7:00 A.M. - 3:00 P.M., shift on 2/26/25 and remembered that the lab tech arrived late that day. Nurse #3 said she told the incoming nurse (Nurse #4) that Resident #12 had pending labs. Nurse #3 said that staff would immediately call the physician if there were critical lab results for a resident. During an interview on 3/6/25 at 1:56 P.M., Nurse #4 said that he worked the 3:00 P.M. - 11:00 P.M., shift on 2/26/25. Nurse #4 said that he completely forgot to check Resident #12's labs and the DON called him on 2/27/25 and said that Resident #12's labs were critical and Resident #12 was being sent to the hospital. Nurse #4 said he did not receive a call from the lab company and he did not think that the lab faxes over results to the facility. During an interview on 3/6/25 at 11:26 A.M., the Lab Coordinator said that the lab will place three calls to the facility to alert them of any critical labs in addition to faxing over a copy of the lab results. The Lab Coordinator said that if the facility misses the call, they can still view the lab results online. The surveyor was unable to locate a physical copy of Resident #12's labs in his/her paper chart or the unit lab book. Review of the lab report indicated that calls were placed to the facility on [DATE] at 5:04 P.M., 5:37 P.M., and 6:29 P.M., which were unanswered. The DON was unavailable for interview. During an interview on 3/7/25 at 11:18 A.M., the Assistant Director of Nursing (ADON) said that staff should be alerting providers with critical lab results immediately. The ADON said that the DON had found that Resident #12's critical labs were not reported on 2/26/25 and she alerted Nurse Practitioner #1 on 2/27/25. (continued on next page)

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F 0773 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/10/25 at 9:36 A.M., the Nurse Practitioner said that nursing staff should immediately notify the provider with any critical lab results. The Nurse Practitioner said that she was not made aware until 2/27/25 of Resident #12's labs and she ordered the Resident be sent to the hospital. The Nurse Practitioner said that Resident #12's potassium level was too low and required hospitalization and he/she should have been sent out right away on 2/26/25. 48671 2. Resident #44 was admitted to the facility in August 2024 with diagnoses that include, chronic kidney disease stage 4 severe, retention of urine, type 2 diabetes mellitus, and unspecified combined systolic (congestive) and diastolic (congestive) heart failure (CHF). Review of the most recent Minimum Data Set (MDS) assessment, dated 2/17/25, indicated that Resident #44 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15. Further review of the MDS indicated Resident #44 requires substantial/maximal assistance for self-care and mobility. Review of the physician lab orders for Resident #44 indicated: Add TSH (thyroid stimulating hormone), T4 (thyroxine), D3 (vitamin D), B12, FOLATE, Fe tibc (total iron binding capacity) ferritin, HgA1c (glucose blood levels in diabetic patients) and FLP (fasting lipid profile), dated 11/8/2024. Review of the electronic medical record for Resident #44 failed to indicate the ordered labs were obtained. The surveyor was unable to locate a physical copy of Resident #44's labs in his/her paper chart or the unit lab book. During an interview on 3/6/25 at 11:34 A.M., Nurse #6 said Resident #44 was in the hospital recently and should have orders for labs because he/she had elevated levels that needed to be checked and said the Resident has kidney issues. Nurse #6 reviewed Resident #44's medical record and said she did not see any of the labs ordered on 11/8/24. Review of Resident #44's medical record indicated a physician progress note dated 10/29/24, indicated the following: Patient was transferred off hospice care. Remains the same condition but we need to regulate meds (medication) and labs. Review of the physician progress note dated 11/15/24, did not include information related to the labs that were ordered on 11/8/24. During an interview on 3/6/25 at 12:30 P.M., the Director of Nursing said Resident #44 did not have labs drawn as ordered and said she would expect the orders to be followed and monitored. During an interview on 3/7/25 at 11:00 A.M., the Assistant Director of Nurses (ADON) said Resident #44 had an order for lab draws but did not see that they were done. The ADON said staff should have notified the doctor to obtain a new order for labs. The Physician was unavailable for interview. (continued on next page)

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	225227	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Rehabilitation and Nursing Center	94 Summer Street Fitchburg, MA 01420

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F 0773 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/10/25 at 10:14 A.M., Nurse Practitioner (NP) #1 said Resident #44 is very fragile and needs close monitoring due to his/her medical conditions and requires labs to be followed and monitored. NP #1 said labs should have been completed as ordered in November and said labs are checked to see if the resident needs to be transferred to the hospital for treatment. NP #1 said she was not aware that the labs in November were not completed and said Resident #44 should have had labs ordered when he/she returned from the hospital.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339 Based on record review and interview, the facility failed to ensure specialized rehab services were provided in a timely fashion for one Resident (#41) out of a total sample of 20 residents. Findings include: Resident #41 was admitted to the facility in November 2022 with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side. Review of Resident #41's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had a moderate impaired cognition and scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. Review of Resident #41's medical record indicated the following: - Nursing note dated 2/8/25: Patient continue to c/o (complain of) pain and stiffness of left-hand joints when he/she tries to use his/her hand and bend his/her fingers. No swelling, redness or signs of trauma noted. The doctor notified new order to start patient on Biofreeze gel every 8 hours, then refer patient to OT (Occupational Therapy) [sic]. During an interview on 3/7/25 at 11:41 A.M., the Assistant Director of Nursing (ADON) said the OT evaluation was done on Tuesday 3/4/25. She further said they have not had an OT on staff and the per diem (as needed) OT staff are here at the facility only once a month. The ADON said the expectation for a therapy screen to be completed should be no more than two weeks. During an interview on 3/7/25 at 12:03 P.M., the Rehab Director said they are made aware of residents requiring therapy evaluation either by nursing staff telling them verbally, filling out a slip or during morning meeting. He further said he has not had an occupational therapist on staff, and the expectation is a resident should be evaluated as soon as possible after the initial screen request.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 15016 Based on record review and interview, the facility failed to ensure the accuracy of its medical records for 3 of 20 sampled residents. Specifically: 1. For Resident #18, the facility failed to accurately document the oxygen delivery rate. 2. For Resident #6, the facility failed to accurately date oxygen tubing. 3. For Resident #1, the facility failed to accurately document wound dressing treatment. Findings include: 1. Resident #18 was admitted to the facility in April 2024 and had diagnoses which included chronic obstructive pulmonary disease (COPD). Review of Resident #18's Minimum Data Set assessment dated [DATE], indicated a Brief Interview for Mental Status exam of 7, signifying moderate cognitive impairment, and an active diagnosis of COPD. Review of Resident #18's respiratory care plan dated 10/20/24, indicated: - The Resident has oxygen therapy related to COPD. - Provide oxygen as ordered. Review of Resident #18's physician's order dated 5/14/24, indicated: - Oxygen via nasal cannula as needed at 2 liters per minute to maintain saturation at or above 90%. On 3/4/25 at 10:41 A.M., the surveyor observed Resident #18 lying awake in bed and wearing a nasal cannula. The cannula and tubing were attached to an oxygen concentrator, located on the floor by the side of the bed. The oxygen was running and set to 4 1/2 liters per minute. On 3/6/25 at 7:58 A.M., the surveyor observed Resident #18 asleep in bed, and wearing the nasal cannula, attached to the oxygen concentrator. The concentrator was running and set to 4 1/2 liters per minute. Review of Resident #18's Medication Administration Record (MAR) indicated that on 3/4/25, 3/5/25 and 3/6/25, staff documented he/she received oxygen via nasal cannula as needed at 2 liters per minute. The MAR did not indicate the Resident's oxygen was set to and running at 4 1/2 liters per minute. Review of Resident #18's nursing notes dated 3/4/25, 3/5/25 and 3/6/25, did not indicate the Resident's oxygen was set to and running at 4 1/2 liters per minute. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #2 on 3/6/25 at 8:05 A.M., the surveyor told her that Resident #18's oxygen was running at 4 1/2 liters per minute, but the MAR indicated it ran at 2 liters per minute. Nurse #2 reviewed the Resident's physician orders and said the oxygen delivery rate should be set to 2 liters per minute and that the MAR was inaccurate. Nurse #2 accompanied the surveyor to the Resident's room and observed the oxygen concentrator was running at 4 1/2 liters. During an interview with Resident #18 on 3/6/25 at 9:33 A.M., he/she said he/she does not adjust the oxygen level on the concentrator, and that only staff touch the concentrator. 36797 2. Resident #6 was admitted to the facility in February 2023 with diagnoses including COPD (chronic obstructive pulmonary disease), chronic respiratory failure and schizophrenia. Review of the Minimum Data Set assessment date 12/25/24 indicated that Resident #6 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. A. During an interview on 3/4/25, at 10:47 A.M., Resident #6 said he/she has a fungal infection in his/her right groin. Resident #6 said that he/she told the nurses but no one has obtained a nystatin powder (an anti fungal) for it. Resident #6 said that he/she bought Gold Bond powder but it doesn't work. Review of the physician's orders failed to indicate an order for fungal powder. Review of the progress notes failed to indicate that the physician was notified of Resident #6 having a reddened groin and was requesting an anti fungal powder to be applied. Review of the document titled weekly Skin Review dated 2/12/25, indicated groin is pink. antifungal powder applied, no new skin issues. Review of the document titled weekly Skin Review dated 2/19/25, indicated resident groin is pink, antifungal powder applied. Review of the document titled weekly Skin Review dated 2/25/25, indicated groin is pink, anti fungal powder order is in place, no new skin issues noted. During an interview on 3/6/25, at 10:11 A.M.,the Regional Nurse said that a doctor's order for an antifungal powder should be obtained before applying the powder. The Regional Nurse also said that the documentation should be accurate and not indicate a physician's order was in place when it was not. B. On 3/4/25 at 8:09 A.M., the surveyor observed Resident #6 in bed receiving 4.5 liters/minute of oxygen via nasal cannula. The surveyor then observed the oxygen tubing to be dated 2/24/25. Review of the physician orders dated March 2025 indicated an order for O2 via nasal cannula 1 to 3 liters/minute continuous. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record dated March 2025 indicated that the oxygen tubing was changed on 3/2/25. Review of the care plan indicated that Resident #6 is at risk for respiratory complications r/t COPD, respiratory failure and to provide O2 therapy as ordered. During an interview on 3/06/25, at 9:00 A.M., Nurse #5 said that the oxygen tubing was dated 2/24/25 and should have been changed on 3/3/25. Nurse #5 then said that the oxygen was running at 4.5 liters/minute and it was ordered to be running at no higher than 3 liters/minute. Nurse #5 then said that the medical record was inaccurate because a nurse had signed off that the O2 tubing was changed on 3/3/25. 46339 3. Resident #1 was admitted to the facility in February 2023 with diagnoses including peripheral vascular disease and lymphedema. Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she was cognitively intact. The MDS further indicated the Resident had wounds. On 3/4/25 at 8:13 A.M., the surveyor observed Resident #1 lying in his/her bed land the eft ankle had a border gauze dressing dated 3/2. Review of the medical record indicated the following physician order, dated 2/10/25: - Xeroform gauze, gauze island with border apply to left upper medial ankle once daily every day shift. Review of the current Treatment Administration Record (TAR) indicated the nurses had signed off that the wound dressing had been changed on 3/3/25. During an interview on 3/6/25 at 11:07 A.M., Nurse #6 said the treatment nurse does the wound treatments Monday through Friday and the floor nurses are responsible for the treatments when the wound treatment nurse is not available. She further said nurses should not document a treatment as complete if it was not completed. During an interview on 3/7/25 at 11:10 A.M., the Assistant Director of Nursing (ADON) said the floor nurses are responsible for ensuring the wound treatments are completed as ordered and document accurately.