STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225229	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	6 Morrill Place Amesbury, MA 01913

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 36431 Based on record review and interview, the facility failed to ensure resident issues brought forth to staff during the Resident Council Meeting were responded to and a resolution provided. Findings include: Review of the facility's policy titled Grievances dated revised March 2021, included but was not limited to the following: The Facility will support each resident's right to voice grievances and to ensure after a grievance has been received, the Grievance Official (Administrator or designee) will collaboratively work with team members to resolve the issue and provide written grievance decisions to the resident and/or the residents family. Procedure: 9. The Resident Council is an additional forum within the facility for voicing complaints/grievances. Complaints/grievances received from the Council will be acted upon in accordance with this procedure. Review of the Resident Council Meeting Agenda dated 3/6/24 indicated the following as New Business; Resident comments/Concerns/Recommendations: Quality of Care issues: 1. No condiments on tray. 2. Pepper and ketchup with breakfast sandwich. 3. Milk not supplied one night. 4. Left alone 20 minutes in the shower 5. Call light not answered in the middle of the night. On 6/13/24 at 9:35 A.M., review of the logged grievances for March 2024 failed to indicate the above concerns were presented and acted upon. Review of the Resident Council Agenda dated 4/3/24, indicated old business issues from the last meeting and how they are being resolved: (Section was blank). New Business included: 1. Meals don't look good. Action taken: Told Kitchen staff and FSD (Food Service Director). [sic] 2. The aide shut off the call light and didn't help the resident. Action taken: Told nursing. There was no Resident Council Agenda dated for May 2024. (continued on next page)

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the resident group meeting on 6/10/24 at 2:07 P,M., with the surveyor, the residents in attendance said they do not get condiments with their meals, and call lights are not answered timely and there is not enough staff. One Resident said, I don't get showers if there are only 2 CNAs (Certified Nursing Assistants). The residents in attendance said these issues are brought up during meetings and they do not know how they get addressed. During an interview on 6/13/24 at 9:26 A.M., the Activity Director said she assists the residents in conducting their meetings. She said they did not have a meeting in May 2024 because the elevator was not working. The Activity Director said when the residents bring up concerns, she tells the specific department head, and they try to resolve the situation. The Activity Director said then the concerns will be discussed in the next meeting. The Activity Director reviewed the April Resident Council Meeting Agenda and said it was not reviewed. The Activities Director said she has not written out the concerns on a grievance form and just tells the department head or nursing staff directly.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews and record review, the facility failed to provide a safe environment free from abuse for one Resident (#41) out of a sample of 24 residents. Specifically, the facility failed to provide an environment free from physical, sexual and mental abuse. Findings include: Review of the facility policy titled 'Clinical Services, Subject: Abuse' with a revision date of March 2023 indicated the following: It is the policy of the facility that each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. It is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe environment. Definitions: -Abuse-means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Willful means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. -Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse included but is not limited to sexual harassment, sexual coercion or sexual assault. -Physical abuse includes hitting, slapping, pinching and kicking. It also included controlling behavior through corporal punishment. -Mental abuse- includes but is not limited to humiliation, harassment and threats of punishment or deprivation. Prohibited includes agitating a resident to solicit a response. Resident #41 was admitted to the facility in April 2024 with diagnoses including Hodgkin's lymphoma, anxiety, depression and pain in an unspecified shoulder. A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated the following: -Shower/bathe self-Partial/moderate assistance. -Sit to lying-Supervision/touch assistance: helper provided verbal cues or touching/steadying assistance as resident completes activity. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/10/24 at 9:45 A.M., Resident #41 said that on 6/7/24, Certified Nurse's Assistant (CNA#1) ripped him/her aggressively from a sitting position and threw him/her on the bed. Resident #41 said he/she was sleeping on his/her knees while sitting on the side of the bed. He/she said this is a comfortable position for him/her to sleep in. Resident #41 said his/her shoulder hurts as a result of being thrown on the bed in a forceful manner. The Resident said approximately three weeks ago, CNA #1 bathed him/her roughly during a shower, he/she said CNA #1 forcefully spread his/her legs, scrubbed him/her aggressively between his/her legs. Resident #41 said CNA #1 did not listen to him/her when he/she told him he/she wanted to wash himself/herself with supervision. Resident #41 said he/she told the Director of Nurses (DON) about these concerns. Resident #41 said he/she also told his/her family members who also reported the concerns to the DON. During an interview on 6/10/24 at 10:03 A.M., the Assistant Director of Nurses (ADON) said they were aware of both of the concerns the Resident told to the surveyor regarding CNA #1 washing the Resident roughly and CNA #1 throwing the Resident on the bed aggressively. The ADON said they have already reached out to the Resident's family members and managed these concerns as a customer service issue. The ADON then said the facility has also provided education to staff, including CNA #1. The ADON said the only new concern that she was not aware of was the pain the Resident was reporting on his/her shoulder. The ADON provided the surveyor with a list of handwritten concerns dated 5/29/24. The list indicated showers and waking up aggressive as concerns. [sic] The ADON provided an inservice she instructed, dated 5/29/24, signed off by staff. The list of staff did not include CNA #1. Review of the 5/29/24 staff schedule indicated CNA#1 called out. The inservice's subject was Resident #41. The detailed instruction of the inservice indicated the following: -When giving Resident showers, do not touch Resident, just give Resident face cloths and allow Resident to wash himself/herself. -When helping Resident at midnight, please do not yell, talk in low voice before assisting Resident. During an observation and interview on 6/12/24 at 8:00 A.M., Resident #41 was observed sitting on his/her bed, he/she did not give any eye contact to the surveyor, he/she looked down during the whole interview. Resident #41 said he/she was in so much pain this morning, he/she rated his/her pain at an 8 out of a possible 10. The Resident said his/her body is already in pain from his/her neuropathy and cancer diagnosis. He/she said since CNA #1 threw him/her on the bed, his/her pain level has increased on his/her shoulder, he/she said he/she is in pain when he/she breathes in and out. The Resident said when CNA #1 was in the shower with him/her, he/she felt violated by him, especially after he/she offered to clean himself/herself, the CNA refused and then proceeded to forcefully spread his/her legs and began scrubbing between his/her legs, turning him/her around to reach between his/her legs. The Resident said he/she felt as if he/she was getting a private parts wash. The Resident said he/she has never been touched by a staff member in that way, he/she felt his/her boundaries were violated, he/she said both incidents keep replaying in his/her head. Resident #41 said no one in the facility has sat down to talk to him/her about the incidents. Resident #41 said he/she would like to speak to a therapist to work through both incidents with a professional. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/11/24 at 12:17 P.M., the Resident's family members said Resident #41 told them about two concerns regarding CNA #1. The Resident's family members said the first concern happened approximately three weeks ago, they said Resident #41 told them that CNA #1 was helping him/her take a shower. Resident #41 told them that CNA #1 was washing him/her in a rough manner. Resident #41 told them that he/she told the CNA he/she could shower himself/herself. The CNA told Resident #41 that he/she was not doing a good job. The CNA then proceeded to kick the Resident's legs open and began scrubbing between his/her legs in a rough manner. Resident #41 told his/her family members that he/she felt like he/she was being sexually assaulted. Resident #41 told his/her family members that he/she had reported the concern to the DON. The Resident told the DON that he/she did not want the CNA caring for him/her again. The family members said they filed a formal complaint with the DON about this concern as well. The family members said the CNA was assigned to work with the Resident again because another incident involving CNA #1 and their father/mother occurred. They said they believed this was retaliation from the first incident. They said that on 6/7/24, Resident #41 told them that CNA #1 grabbed their father/mother, who was sleeping on his/her knees while sitting at his/her bedside, and threw him/her on the bed vigorously. The Resident's family members said their father's/mother's shoulders have been gone for years, they said staff should know not to move him/her with force. The family members said their father/mother injured his/her shoulder during this transfer. The Resident's family members said they told the facility's DON about this incident on 6/7/24. The Resident's family members said they have not heard from the facility with any follow up on how the two incidents were being addressed. A review of Resident #41's May 2024 Shower/Bathe self-tasks signed off by CNA #1 indicated the following: -Partial/Moderate Assistance, helper does less than half of the effort, helper lifts, holds or supports trunk or limbs but provides less than half of the effort. -Supervision/Touching Assistance, helper provided verbal cues and or touching, steadying or contact guard assistance. Assistance may be provided throughout or intermittently. -Evening Shift: -5/18-Supervision/Touching assistance, 5/20-Supervision/Touching assistance, 5/21-Partial/Moderate assistance, 5/24-Partial/Moderate assistance. -Night Shift: -5/4-Partial/Moderate assistance,5/6-Partial/Moderate assistance,5/7-Partial/Moderate assistance, 5/13-Partial/Moderate assistance, 5/21-Partial/Moderate assistance, 5/23-Partial/Moderate assistance, 5/28-Partial/Moderate assistance. A review of Resident #41's June 2024 Sit to Lying tasks signed off by CNA #1 indicated the following: Evening Shift: -6/1-Supervision/Touching assistance, 6/3-Supervision/Touching assistance, 6/4-Supervision/Touching assistance, 6/7-Supervision/Touching assistance. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Night Shift: 6/2-Supervision/Touching assistance, 6/5-Partial/Moderate assistance, 6/8-Supervision/Touching Assistance. During a telephone interview on 6/14/24 at 10:10 A.M., CNA #1 said he has never provided care to Resident #41 because he/she is able to provide his/her own Activities of Daily Living. CNA #1 said Resident #41 is able to shower/bathe and transfer himself/herself. During an interview on 6/11/24 at 1:11 P.M., the Administrator said he was not aware of any concerns reported by the Resident. He said he expects to be made aware of any abuse allegations made by residents. The ADON and DON said they managed the concerns as customer service with the family members so they did not report them to the Administrator. The DON and ADON said the facility expectation is, all allegations of abuse should be reported to the Administrator so an investigation can be initiated. The Administrator, ADON and DON said allegations of abuse should be thoroughly investigated. They said documentation of the investigations was not completed by initiating incident reports after Resident #41 made abuse allegations. They said they did not obtain statements from identified potential witnesses, they did not complete necessary evaluations and they did not maintain a timeline of the events. The Administrator, ADON and DON said allegations of abuse should be reported to the state agency and local law enforcement within two hours.

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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 0607 Level of Harm - Actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews and record review, the facility failed to implement their abuse policy for one Resident (#41) out of a sample of 24 residents. Specifically, 1. The Director of Nurses (DON) and Assistant Director of Nurses (ADON) failed to notify the Administrator about allegations of physical, sexual and mental abuse, 2. Keep Resident #41 safe by suspending the staff member involved in the abuse allegations, 3. Failed to report and investigate the abuse allegations as required, and 4. Failed to report the allegations to the state agency (SA) and law enforcement. Findings include: Review of the facility policy titled 'Clinical Services, Subject: Abuse' with a revision date of March 2023 indicated the following: It is the policy of the facility that each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. It is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe environment. Definitions: -Abuse-means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Willful means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. -Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse included but is not limited to sexual harassment, sexual coercion or sexual assault. -Physical abuse includes hitting, slapping, pinching and kicking. It also included controlling behavior through corporal punishment. -Mental abuse- includes but is not limited to humiliation, harassment and threats of punishment or deprivation. Prohibited includes agitating a resident to solicit a response. Procedure for Abuse Investigation: Identification: -Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported. Action: -Immediately protect Resident from alleged abuse. (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	-Immediately notify your administrative staff or nursing supervisor on duty of abuse allegation. -The Administrative staff/Nursing supervisor will immediately report all allegations to the Administrator and Director of Nurses. -Immediately suspend employee pending investigation. -The facility will notify the Department of Public Health and Local law enforcement no later than two hours after abuse allegation was received. Resident #41 was admitted to the facility in April 2024 with diagnoses including Hodgkin's lymphoma, anxiety, depression and pain in an unspecified shoulder. A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated the following: -Shower/bathe: self-Partial/moderate assistance. -Sit to lying-Supervision/touch assistance: helper provided verbal cues or touching/steadying assistance as resident completes activity. During an interview on 6/10/24 at 9:45 A.M., Resident #41 said that on 6/7/24, Certified Nurse's Assistant (CNA#1) ripped him/her aggressively from a sitting position and threw him/her on the bed. Resident #41 said he/she was sleeping on his/her knees while sitting on the side of the bed. He/she said this is a comfortable position for him/her to sleep in. Resident #41 said his/her shoulder hurt as a result of being thrown on the bed in a forceful manner. The Resident said approximately three weeks ago, CNA #1 bathed him/her roughly during a shower, he/she said CNA #1 forcefully spread his/her legs, scrubbed him/her aggressively between his/her legs. Resident #41 said CNA #1 did not listen to him/her when he/she told him he/she wanted to wash himself/herself with supervision. Resident #41 said he/she told the DON about these concerns. Resident #41 said he/she also told his/her family members who also reported the concerns to the DON. During an interview on 6/10/24 at 10:03 A.M., the ADON said they were aware of both of the concerns the Resident told to the surveyor regarding CNA #1 washing the Resident roughly and CNA #1 throwing the Resident on the bed aggressively. The ADON said they have already reached out to the Resident's family members and managed these concerns as a customer service issue. The ADON provided the surveyor with a list of handwritten concerns dated 5/29/24. The list indicated showers and waking up aggressive as concerns. [sic] (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 0607 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/11/24 at 12:17 P.M., the Resident's family members said their parent told them about two concerns regarding CNA #1. The Resident's family members said the first concern happened approximately three weeks ago. They said Resident #41 told them that CNA #1 was helping them take a shower. Resident #41 told them that CNA #1 was washing him/her in a rough manner. Resident #41 told them that he/she told the CNA he/she could shower himself/herself. The CNA told Resident #41 that he/she was not doing a good job. The CNA then proceeded to kick the Resident's legs open and began scrubbing between his/her legs in a rough manner. Resident #41 told his/her family members that he/she felt like he/she was being sexually assaulted. Resident #41 told his/her family members that he/she had reported the concern to the DON. The Resident told the DON that he/she did not want the CNA caring for him/her again. The family members said they filed a formal complaint with the DON about this concern as well. The family members said the CNA was assigned to work with the Resident again because another incident involving CNA #1 and their father/mother occurred. They said they believed this was retaliation from the first incident. They said that on 6/7/24, Resident #41 told them that CNA #1 grabbed their parent, who was sleeping on his/her knees while sitting at his/her bedside and threw him/her on the bed vigorously. The Resident's family members said their parent's shoulders have been gone for years, they said staff should know not to move him/her with force. The family members said their father/mother injured his/her shoulder during this transfer. The Resident's family members said they told the facility's DON about this incident on 6/7/24. The Resident's family members said they have not heard from the facility with any follow up on how the two incidents were being addressed. During a telephone interview on 6/14/24 at 10:10 A.M., CNA #1 said he has never provided care to Resident #41 because he/she is able to provide his/her own Activities of Daily Living. CNA #1 said Resident #41 is able to shower/bathe and transfer himself/herself. A review of Resident #41's May 2024 Shower/Bathe self-tasks signed off by CNA #1 indicated the following: -Partial/Moderate Assistance, helper does less than half of the effort, helper lifts, holds or supports trunk or limbs but provides less than half of the effort. -Supervision/Touching Assistance, helper provided verbal cues and or touching, steadying or contact guard assistance. Assistance may be provided throughout or intermittently. -Evening Shift: -5/18-Supervision/Touching assistance, 5/20-Supervision/Touching assistance, 5/21-Partial/Moderate assistance, 5/24-Partial/Moderate assistance. -Night Shift: -5/4-Partial/Moderate assistance,5/6-Partial/Moderate assistance,5/7-Partial/Moderate assistance, 5/13-Partial/Moderate assistance, 5/21-Partial/Moderate assistance, 5/23-Partial/Moderate assistance, 5/28-Partial/Moderate assistance. A review of Resident #41's June 2024 Sit to Lying tasks signed off by CNA #1 indicated the following: (continued on next page)

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F 0607 Level of Harm - Actual harm Residents Affected - Few	Evening Shift: -6/1-Supervision/Touching assistance, 6/3-Supervision/Touching assistance, 6/4-Supervision/Touching assistance, 6/7-Supervision/Touching assistance. -Night Shift: 6/2-Supervision/Touching assistance, 6/5-Partial/Moderate assistance, 6/8-Supervision/Touching Assistance. During an interview on 6/13/24 at 7:21 A.M., the Unit Manager said all abuse allegations made by residents should be reported to the ADON, DON and Administrator. During an interview on 6/11/24 at 1:11 P.M., the Administrator said he was not aware of any concerns reported by the Resident. He said he expects to be made aware of any abuse allegations made by residents. The ADON and DON said they managed the concerns as customer service with the family members, so they did not report them to the Administrator. The DON and ADON said the facility expectation is, all allegations of abuse should be reported to the Administrator so an investigation can be initiated. The Administrator, ADON and DON said allegations of abuse should be thoroughly investigated. They said documentation of the investigations was not completed by initiating incident reports after Resident #41 made abuse allegations. They said they did not obtain statements from identified potential witnesses, they did not complete necessary evaluations and they did not maintain a timeline of the events. The Administrator, ADON and DON said allegations of abuse should be reported to the state agency and local law enforcement within two hours.

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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 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews and record review, the facility failed to report an allegation of abuse for one Resident (#41) out of a sample of 24 residents. Specifically, the facility failed to report allegations of physical abuse, sexual abuse and mental abuse to the (SA) state agency. Findings include: A review of the facility policy titled 'Clinical Services, Subject: Abuse' with a revision date of March 2023 indicated the following: It is the policy of the facility that each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. It is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe environment. Definitions: -Abuse-means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Willful means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. -Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse included but is not limited to sexual harassment, sexual coercion or sexual assault. -Physical abuse includes hitting, slapping, pinching and kicking. It also included controlling behavior through corporal punishment. -Mental abuse- includes but is not limited to humiliation, harassment and threats of punishment or deprivation. Prohibited includes agitating a resident to solicit a response. Procedure for Abuse Investigation: Identification: -Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated and reported. Action: -Immediately protect Resident from alleged abuse. -Immediately notify your administrative staff or nursing supervisor on duty of abuse allegation. (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 0609 Level of Harm - Actual harm Residents Affected - Few	-The Administrative staff/Nursing supervisor will immediately report all allegations to the Administrator and Director of Nurses. -Immediately suspend employee pending investigation. -The facility will notify the Department of Public Health and Local law enforcement no later than two hours after abuse allegation was received. Resident #41 was admitted to the facility in April 2024 with diagnoses including Hodgkin's lymphoma, anxiety, depression and pain in an unspecified shoulder. A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated the following: -Shower/bathe: self-Partial/moderate assistance. -Sit to lying-Supervision/touch assistance: helper provided verbal cues or touching/steadying assistance as resident completes activity. During an interview on 6/10/24 at 9:45 A.M., Resident #41 said that on 6/7/24, Certified Nurse's Assistant (CNA#1) ripped him/her aggressively from a sitting position and threw him/her on the bed. Resident #41 said he/she was sleeping on his/her knees while sitting on the side of the bed. He/she said this is a comfortable position for him/her to sleep in. Resident #41 said his/her shoulder hurts as a result of being thrown on the bed in a forceful manner. The Resident said approximately three weeks ago, CNA #1 bathed him/her roughly during a shower, he/she said CNA #1 forcefully spread his/her legs, scrubbed him/her aggressively between his/her legs. Resident #41 said CNA #1 did not listen to him/her when he/she told him he/she wanted to wash himself/herself with supervision. Resident #41 said he/she told the Director of Nurses (DON) about these concerns. Resident #41 said he/she also told his/her family members who also reported the concerns to the DON. During an interview on 6/10/24 at 10:03 A.M., the Assistant Director of Nurses (ADON) said they were aware of both of the concerns the Resident told to the surveyor regarding CNA #1 washing the Resident roughly and CNA #1 throwing the Resident on the bed aggressively. The ADON said they have already reached out to the Resident's family members and managed these concerns as a customer service issue. The ADON provided the surveyor with a list of handwritten concerns dated 5/29/24. The list indicated showers and waking up aggressive as concerns. [sic] (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/11/24 at 12:17 P.M., the Resident's family members said Resident #41 told them about two concerns regarding CNA #1. The Resident's family members said the first concern happened approximately three weeks ago, they said Resident #41 told them that CNA #1 was helping them take a shower. Resident #41 told them that CNA #1 was washing him/her in a rough manner. Resident #41 told them that he/she told the CNA he/she could shower himself/herself. The CNA told Resident #41 that he/she was not doing a good job. The CNA then proceeded to kick the Resident's legs open and began scrubbing between his/her legs in a rough manner. Resident #41 told his/her family members that he/she felt like he/she was being sexually assaulted. Resident #41 told his/her family members that he/she had reported the concern to the DON. The Resident told the DON that he/she did not want the CNA caring for him/her again. The family members said they filed a formal complaint with the DON about this concern as well. The family members said the CNA was assigned to work with the Resident again because another incident involving CNA #1 and their father/mother occurred. They said they believed this was retaliation from the first incident. They said that on 6/7/24, Resident #41 told them that CNA #1 grabbed their father/mother, who was sleeping on his/her knees while sitting at his/her bedside and threw him/her on the bed vigorously. The Resident's family members said their father's/mother's shoulders have been gone for years, they said staff should know not to move him/her with force. The family members said their father/mother injured his/her shoulder during this transfer. The Resident's family members said they told the facility's DON about this incident on 6/7/24. The Resident's family members said they have not heard from the facility with any follow up on how the two incidents were being addressed. During an interview on 6/13/24 at 7:21 A.M., the Unit manager said all allegations of abuse reported by residents should be reported to the state agency and law enforcement within two hours. During an interview on 6/11/24 at 1:11 P.M., the Administrator, ADON and DON said allegations of abuse should be reported to the state agency and local law enforcement within two hours. A review of the Health Care Facility reporting system (HCFRS) did not indicate any abuse allegations were reported in May 2024 and prior to June 10, 2024.

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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 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on observations, interviews and record review, the facility failed to investigate allegations of abuse for one Resident (#41) out of a sample of 24 residents. Specifically, the facility failed to investigate allegations of physical, sexual and mental abuse. Findings include: Review of the facility policy titled 'Clinical Services, Subject: Abuse' with a revision date of March 2023 indicated the following: It is the policy of the facility that each resident has the right to be free from abuse, neglect and misappropriation of resident property and exploitation. It is the philosophy of the facility to encourage an environment that recognizes the special qualities of our residents and provides them with a safe environment. Definitions: -Abuse-means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Willful means that the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. -Sexual abuse means non-consensual sexual contact of any type with a resident. Sexual abuse included but is not limited to sexual harassment, sexual coercion or sexual assault. -Physical abuse includes hitting, slapping, pinching and kicking. It also included controlling behavior through corporal punishment. -Mental abuse- includes but is not limited to humiliation, harassment and threats of punishment or deprivation. Prohibited includes agitating a resident to solicit a response. Procedure for Abuse Investigation: -Any complaint of, or suspicion of resident abuse shall be thoroughly investigated. -Facility investigation will be completed within 72 hours of the incident, documentation of investigation to be completed by initiating an incident and accident report, obtaining statements from identified potential witnesses, completing necessary evaluations (i.e. skin/body checks, pain evaluation), and maintaining a timeline of events. Resident #41 was admitted to the facility in April 2024 with diagnoses including Hodgkin's lymphoma, anxiety, depression and pain in an unspecified shoulder. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition. Further review of the MDS indicated the following: -Shower/bathe: self-Partial/moderate assistance. -Sit to lying-Supervision/touch assistance: helper provided verbal cues or touching/steadying assistance as resident completes activity. During an interview on 6/10/24 at 9:45 A.M., Resident #41 said that on 6/7/24, Certified Nurse's Assistant (CNA #1) ripped him/her aggressively from a sitting position and threw him/her on the bed. Resident #41 said he/she was sleeping on his/her knees while sitting on the side of the bed. He/she said this is a comfortable position for him/her to sleep in. Resident #41 said his/her shoulder hurts as a result of being thrown on the bed in a forceful manner. The Resident said approximately three weeks ago, CNA #1 bathed him/her roughly during a shower, he/she said CNA #1 forcefully spread his/her legs, scrubbed him/her aggressively between his/her legs. Resident #41 said CNA #1 did not listen to him/her when he/she told him he/she wanted to wash himself/herself with supervision. Resident #41 said he/she told the Director of Nurses (DON) about these concerns. Resident #41 said he/she also told his/her family members who also reported the concerns to the DON. During an interview on 6/10/24 at 10:03 A.M., the Assistant Director of Nurses (ADON) said they were aware of both of the concerns the Resident told to the surveyor regarding CNA #1 washing the Resident roughly and CNA #1 throwing the Resident on the bed aggressively. The ADON said they have already reached out to the Resident's family members and managed these concerns as a customer service issue. During a telephone interview on 6/11/24 at 12:17 P.M., the Resident's family members said Resident #41 told them about two concerns regarding CNA #1. The Resident's family members said the first concern happened approximately three weeks ago, they said Resident #41 told them that CNA #1 was helping them take a shower. Resident #41 told them that CNA #1 was washing him/her in a rough manner. Resident #41 told them that he/she told the CNA he/she could shower himself/herself. The CNA told Resident #41 that he/she was not doing a good job. The CNA then proceeded to kick the Resident's legs open and began scrubbing between his/her legs in a rough manner. Resident #41 told his/her family members that he/she felt like he/she was being sexually assaulted. Resident #41 told his/her family members that he/she had reported the concern to the DON. The Resident told the DON that he/she did not want the CNA caring for him/her again. The family members said they filed a formal complaint with the DON about this concern as well. The family members said the CNA was assigned to work with the Resident again because another incident involving CNA #1 and their father/mother occurred. They said they believed this was retaliation from the first incident. They said that on 6/7/24, Resident #41 told them that CNA #1 grabbed their father/mother, who was sleeping on his/her knees while sitting at his/her bedside and threw him/her on the bed vigorously. The Resident's family members said their father's/mother's shoulders have been gone for years, they said staff should know not to move him/her with force. The family members said their father/mother injured his/her shoulder during this transfer. The Resident's family members said they told the facility's DON about this incident on 6/7/24. The Resident's family members said they have not heard from the facility with any follow up on how the two incidents were being addressed. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/13/24 at 7:21 A.M., the Unit manager said she manages all the units in the facility. She said she was a part of an abuse/neglect in-service on 5/29/24 presented by the ADON. She said she was not aware of the details but was aware abuse allegations had been made by a resident on the first floor. She said all allegations of abuse made by residents should be investigated. During an interview on 6/11/24 at 1:11 P.M., the Administrator, ADON and DON said allegations of abuse should be thoroughly investigated. They said documentation of the investigations was not completed by initiating incident reports after Resident #41 made abuse allegations. They said they did not obtain statements from identified potential witnesses, they did not complete necessary evaluations and they did not maintain a timeline of the events.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview the facility failed to accurately complete the Minimum Data Set Assessment for two Residents (#42 and #71) out of a total sample of 24 residents. Findings include: 1. Resident #42 was admitted to the facility in June 2023 with diagnoses including morbid obesity, heart disease and anemia. Review of the medical record indicated that Resident #42 sustained a significant weight loss of 10.63% between 12/2/23 and 1/1/24. Review of Minimum Data Set (MDS) assessment dated [DATE] (less than five months since the significant weight loss occurred) indicated that Resident #42 did not sustain a significant weight loss in the prior 6 months. During an interview on 6/11/24 at 10:49 A.M., the Assistant Director of Nursing said that she would expect the MDS to be accurate. During an interview on 6/12/24 at 10:50 A.M. the MDS Nurse said that she looks at the documented weights in the medical record to obtain the information she uses to document on the MDS. She then said that she made a mistake and should have documented that the Resident had an unplanned weight loss. 2. Resident #71 was admitted to the facility in January 2024 with diagnoses including multiple fractures, cerebrovascular disease and anxiety disorder. Review of the Minimum Data Set assessment dated [DATE], indicated that Resident #71 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. On 6/10/24 at 7:40 A.M., the surveyor observed Resident #71 to have teeth missing, broken and carious teeth. During an interview on 6/10/24 at 7:40 A.M., Resident #71 said that he/she had many issues with his/her teeth and needed them to be fixed. Review of the medical record failed to indicate that an oral assessment had been completed since admission. Review of the MDS dated [DATE], indicated that Resident #71 did not have any broken, missing or carious teeth. During an interview on 6/11/24, at 1:44 P.M. the Assistant director of Nursing said that she expects that the MDS would be accurate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 10:58 A.M. the MDS Nurse said that she made a mistake and should have documented that the Resident had broken, carious teeth on the MDS and not that the Resident had a full broken denture.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on interviews and records reviewed, the facility failed to develop care plans for one Resident (#27) out of a sample of 24 residents. Specifically, the facility failed to develop care plans related to a history of suicidal ideations and a history of alcohol abuse. Findings include: A review of the facility policy titled 'Care Plans-Comprehensive' with a revision date of July 2023 indicated the following: -All individualized comprehensive care plans that included measurable objectives and timetables to meet the resident's medical, nursing, emotional and psychological needs is developed for each resident. -Each resident's care plan is designed to: (a) Incorporate identified problem areas. (b) Incorporate risk factors associated with identified problems. (c) Reflect treatment goals timetables and objectives in measurable outcomes. Resident #27 was admitted to the facility in November 2023 with diagnoses including depression. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a BIMS (Brief Interview for Mental Status) score of 12 out of a possible 15 indicating moderately impaired cognition. A review of Resident #27's behavioral services therapy note dated 6/5/24 indicated the following: -Chief Complaint: Depression -Target Symptoms: Irritability History of Present Illness (HPI): -Problem: History of mood disorder and can have angry impulsive outbursts. -Severity: Severe. -Timing / Frequency: Episodic; Duration: Months. -Triggers: Coping with health complications.; Institutional Living. -Associated Symptoms: Behavioral disturbance. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Modifying Factors: Behavior management recommendations; May benefit from supportive counseling. -Inpatient Services Details: He/she reports being sent to (local) hospital and had a 2 week in-pt stay because he/she was saying he/she would kill himself/herself. He claims he/she told the psychiatrist he/she didn't mean it and didn't have a plan, so they returned him/her to the facility. -History of SI/SA/SIB: No. - Substance Use / Addiction History: past use of ETOH (alcohol abuse), sober for [AGE] years. A review of Resident #27's care plan did not indicate personalized care plans for a history of suicidal ideation and a history of alcohol abuse. During an interview on 6/11/24 at 8:31 A.M., the Licensed Mental Health Counselor said the Resident has a history of suicidal ideations based on her notes. She said the Resident does not have a history of suicide attempts or a history of self-injurious behavior. She said she expects the facility to develop a personalized history of suicidal ideation care plan. The Licensed Mental Health Counselor also said the Resident has a history of alcohol abuse based on her notes, she said even though Resident #27 has been sober for [AGE] years, the facility should develop a personalized history of alcohol abuse care plan for the Resident. During an interview on 06/12/24 at 10:57 A.M., the Director of Nurses and Assistant Director of Nurses said a history of suicidal ideations care plan and a history of alcohol abuse care plan should have been developed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43807 Based on record review and interviews, the facility failed to maintain professional standards of nursing practice for four Residents, (#63, #69, #27 and #54) out of a sample of 24 residents. Specifically: For Residents #63, Resident #69 and Resident #27, the records failed to indicate that medications were administered as ordered. For Resident #54, the facility failed to follow physician's orders to re-evaluate a temporarily invoked health care proxy. Findings include: 1. Resident #63 was admitted to the facility in October 2023 with diagnoses including atrial fibrillation, complications with kidney transplant, anemia, major depressive disorder, and delusional disorders. Review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] did not indicate a Brief Interview for Mental Status (BIMS) score. Further review of the medical record indicated a behavioral therapy note dated 6/5/24 indicating Resident #63 is alert and oriented to time, place and person. A review of the nurse's progress notes, admit/readmitted d 6/4/24 indicated Resident #63 was readmitted to the facility on [DATE]. Further review of the medical record indicated the Resident returned to the facility on [DATE] after medical leave. A review of the June 2024 Medication Administration Record (MAR) indicated the following: -Amiadorone HCl oral tablet 200 milligrams, give 200 milligrams by mouth one time a day related to unspecified Atrial Fibrillation. The medication was not administered on June 6 2024 at 6:00 AM. -Aspirin 81 Oral Tablet chewable, give 1 tablet by mouth 1 time a day related to hypertension. The medication was not administered on June 6 2024 at 6:00 AM. -Atorvastatin Calcium Tablet 20 milligrams, give 1 tablet by mouth at bedtime related to complications of kidney transplant. The medication not administered on June 5 2024 at 9:00 PM. -Famotidine oral tablet, give 20 milligrams by mouth at bedtime for GERD (gastroesophageal reflux disease). The medication was not administered on June 5 2024 at 8:00 PM. -Ferrous Sulfate tablet 325 milligrams, give 1 tablet by mouth one time a day for supplementation related to Anemia. The medication was not administered on June 6 2024 at 6:00 AM. -Flomax oral capsule, give 0.4 milligrams by mouth one time a day for BPH (benign prostate hyperplasia). The medication was not administered on June 5 2024 at 8:00 PM. -Seroquel oral tablet, give 50 milligrams by mouth at bedtime related to delusional disorders. The medication was not administered on June 5 2024 at 9:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sertraline oral tablet 50 milligrams, give 3 tablets by mouth one time a day related to major depressive disorder. The medication was not administered on June 6 2024 at 6:00 AM. -Tacromilus oral capsule, give 1 milligram by mouth one time a day related to kidney transplant status. The medication was not administered on June 6 2024 at 6:00 AM. -Tacrolimus Oral capsule, give 2 milligrams by mouth at bedtime related to kidney transplant status. The medication was not administered on June 5 2024 at 8:00 PM. -Magnesium gluconate oral tablet 1000 milligrams, give 1000 by mouth two times a day for hypomagnesemia. The medication was not administered on June 5 2024 at 8:00 PM and June 6 at 6:30 AM. -Mycophenolate sodium oral tablet delayed release, give 180 milligrams by mouth two times a day to prevent organ rejection due to kidney transplant. The medication was not administered on June 5 at 8:00 PM and June 6 2024 at 6:30 AM. -Gabapentin oral capsule 100 milligrams, give 2 capsules by mouth three times a day for neuro pain. The medication was not administered on June 5 2024 at 10:00 PM and June 6 at 6:00 AM. Review of the progress notes did not indicate any Nurses' progress notes indicating why the resident was not administered the above medications as ordered. During an interview and medical record review on 6/12/24 at 10:21 A.M., the Assistant Director of Nurses and Director of Nurses reviewed the Medical Administration Record (MAR) with the surveyor. They confirmed that Resident #63 was back in the facility from a medical leave on 6/4/24 at 10:14 P.M., they both said Resident #63's MAR had holes (blank spaces where Nurses should sign off after administering medications) in the above listed dates and time. They said Nurses should sign off in the MAR after they administer medications. 2. Resident #69 was admitted to the facility in November 2023 with diagnoses including hyperlipidemia. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMs) score of 14 out of a possible 15 indicating intact cognition. During an interview on 6/11/24 at 9:44 A.M., Resident #69 said he/she has not been getting his/her cholesterol medication as ordered especially at night. A review of the June 2024 Medication Administration Record (MAR) indicated the following: -Atorvastatin Calcium oral tablet, give 40 milligrams one time a day for hyperlipidemia. The medication was not administered on June 2 2024 at 8:00 PM. A review of the Nurse's progress notes did not indicate why the medication was not administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and medical record review on 6/12/24 at 10:21 A.M., the Assistant Director of Nurses and Director of Nurses reviewed Resident's #69's Medical Administration Record (MAR) with the surveyor. they both said Resident #69's MAR had a hole (blank spaces where Nurses should sign off after administering medications) on June 2nd at 8:00 PM. They said nurses should sign off in the MAR after they administer medications. 3. Resident #27 was admitted to the facility in November 2023 with diagnoses including type 2 diabetes mellitus and epilepsy. A review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 indicating moderate cognitive impairment. During an interview on 6/11/24 at 9:23 A.M., Resident #27 said he/she has not been getting his/her medications at night. A review of the June 2024 Medication Administration Record (MAR) indicated the following: -Dilantin oral capsule 100 milligrams, give 300 milligrams by mouth at bedtime related to epilepsy. The medication was not administered on June 2 2024 at 8:00 PM. -Insulin Glargine solution 100 Unit/Milliliters, inject 10 units subcutaneously at bedtime for diabetes. The medication was not administered on June 2 2024 at 8:00 PM. A review of the Nurses progress notes did not indicate why the medications were not administered. During an interview and medical record review on 6/12/24 at 10:21 A.M., the Assistant Director of Nurses and Director of Nurses reviewed Resident's #27's Medical Administration Record (MAR) with the surveyor. They both said Resident #27's MAR had holes (blank spaces where Nurses should sign off after administering medications) on June 2 at 8:00 PM. They said Nurses should sign off in the MAR after they administer medications. 4. Resident #54 was admitted to the facility in November 2023 with diagnoses including major depressive disorder. A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 indicating intact cognition. Review of the June 2024 physicians' orders indicated the following: -Patient healthcare is temporarily invoked pending re-evaluation in one week. [sic] start date 5/9/24. A review of the medical record did not indicate a re-evaluation to determine if the health care proxy should remain invoked was completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 9:35 AM., the Physician said he temporarily ordered Resident # 54's health care proxy to be invoked because he/she was confused. He said he wanted a MoCA (Montreal Cognitive Assessment) to be completed so he could determine if the health care proxy needed to be invoked. He said the facility did not follow through with the re-evaluation as he ordered. During an interview on 6/13/24 at 11:05 A.M., the Director of Rehab said she was an Occupational Therapist, but she was not certified to complete MoCA assessments, she said to get accurate answers about the Resident's cognition he/she would need to see a neurologist. The Director of Rehab said the Resident has not been seen by a neurologist.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to ensure hearing services were provided for one Resident (#4) out of a total of 24 sampled Residents. Findings include: By end of survey the facility had not produced a policy for audiology consults, per surveyor request. Resident #4 was admitted to the facility in June 2022 with diagnoses including hearing loss, dementia and adult failure to thrive. Review of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #4 has moderate difficulty hearing, and the speaker has to raise their voice and speak distinctly to be heard. Review of the doctor's progress note dated 1/29/24, indicated that Resident #4 was seen on 1/29/24 secondary to the family's concern of decreased hearing. Further review indicated that the ear canal was clear and without obstruction. Further review indicated that Resident #4 was unable to pass the whisper test with hearing aides in place and that a request for an audiologist evaluation of the patient and hearing aides will be made. Review of the doctor's progress note dated 3/12/24, indicated that Resident #4 was seen on 3/12/24 secondary to the family's concern of decreased hearing. Further review indicated that the ear canal was clear and without obstruction. Further review indicated that a request for an audiologist evaluation of the patient and hearing aids will be made. Review of the doctor's orders failed to indicate an order for an audiology appointment. Review of the medical record failed to indicate an audiology appointment was made. During an interview on 6/12/24, at 8:39 A.M., the Assistant director of Nursing said that no audiology consult has been made.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview for one Resident (#38), out of a total sample of 24 residents, the facility failed to ensure risk assessments and skin evaluations were implemented for the prevention for developing pressure ulcer/injuries. Findings include: Review of the facility's policy titled Pressure Injury Risk Assessment, not dated indicated; The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries. General Guidelines: The Risk Assessment should be conducted as soon as possible after admission, but no later than eight hours after the admission is completed. Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as required based on the resident's condition. Resident #38 was admitted to the facility in May 2024 with diagnoses that include chronic atrial fibrillation, hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side, and dementia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #38 scored an 11 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having moderately impaired cognition, is dependent on staff for bathing, toileting and transfers, and is at risk for developing pressure ulcers. On 6/10/24 at 10:00 A.M., Resident #38 was observed sitting in a wheelchair in the activity/dining room. Review of Resident #38's medical record indicated the following: -A Norton Scale for Predicting Risk of Pressure Ulcer, dated 5/2/24 with a score of 10.0 High risk. The medical record failed to have any further skin risk assessments. During an interview on 6/12/24 at 7:55 A.M., Nurse #2 said Resident #38 is at risk for developing pressure areas. Nurse #2 said all residents have weekly skin assessments. Nurse #2 said that skin checks are put in as a physician's order, so the skin check will pop up to be completed by the nurse on the TAR (treatment administration record). Nurse #2 reviewed Resident #38's medical record and said he did not see that any skin checks were done for the Resident. During an interview on 6/12/24 at 8:30 A.M., the Director of Nursing said all residents are to have orders for weekly skin checks and for Resident #38 the weekly skin checks should have been entered as a physician's order on admission. Review of Resident #38's medical record indicated five weeks of weekly skin checks were not implemented.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observation, interview, and record review, the facility failed to ensure staff provided appropriate care and services for one Resident (#40) with a Gastrostomy tube (G-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition, fluids, and medications), out of 24 sampled residents. Specifically, the facility failed to ensure staff labeled the enteral formula bag and water flush bag with the Resident's name, the formula used, the administration rate, duration, and initials of the staff member hanging them. Findings include: Review of the facility policy titled Enteral Tube Feeding via Continuous Pump and undated, indicated that, on the formula label document initials, date and time formula was hung/administered, and initial that the label was checked against the order. Resident #40 was admitted to the facility in February 2024 with diagnoses including dysphagia, encephalopathy and legal blindness. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #40 scored a 14 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review of the MDS indicated that Resident #40 requires feeding by tube and is not able to take anything by mouth. Review of the doctor's orders dated June 20224 indicated an order for nothing by mouth. Further review indicated an order for Glucerna 1.5 Cal liquid nutritional supplements give 50 ml (milliliters) via G-tube every shift for nutrition continuous feeding x 24 hours for a total volume of 1200 ml. and 150 ml every 4 hours of water for a total of 900 ml x 24 hours. On 6/10/24 at 9:44 A.M. the surveyor observed Resident #40 sitting next to his/her bed in a wheelchair with a G-tube feeding attached and running at 50 ml (milliliters) per hour. The surveyor observed the G-tube feeding bag and the water flush bag to be without a label containing the Resident's name, the contents of the bag, the date and time formula was hung/administered, or initialed that the label was checked against the order. On 6/11/24 at 7:35 A.M., the surveyor observed the tube feeding bag and the water flush bag dated 6/11/24 and time hung at 6 P.M. The surveyor also observed the G-tube feeding bag and the water flush bag to be without a label containing the Resident's name, the contents of the bag or initialed that the label was checked against the order. During an interview on 6/11/24 at 11:30 A.M., Nurse #6 said that the contents of the tube feeding bag should be indicated on the bag. Nurse #6 then said that the bag containing water should also be labeled with its contents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36431 Based on record review and interview, the facility failed to ensure sufficient staffing levels were maintained to provide resident care on two of two units. Findings include: Review of the Facility Assessment Tool, with the date(s) of assessment or update as 1/3/2024 and date assessment reviewed with the QAA/QAPI (Quality Assurance and Quality Assurance Performance Improvement) as 1/3/2024, indicated: Part 3 Facility Resources Needed to Provide Competent Support and Care for Our Resident Population Every Day and During Emergencies. 3.1 identify the type of staff members, other health care professionals, medical practitioners that are needed to provide support and care for residents. Further review of the facility assessment failed to indicate the staffing plan was filled out for Nurses' Aides and Licensed nurses providing direct care. Review of the facility's Payroll-Based Journal Staffing Data Report for Quarter 2 January 1, 2024, through March 31, 2024, indicated the facility triggered as having excessively low weekend staffing. During an interview on 6/10/24 at 11:17 A.M. a resident on the second-floor unit said there are not enough staff here to answer his/her call light. The resident said this happens frequently on the evening shift (3:00 P.M.-11:00 P.M.) The resident said he/she has told staff but maybe not the right staff. The resident said he/she uses his/her call bell for something to drink or to be changed. The resident said he/she has waited over an hour. During a Resident group meeting on 6/10/24 at 2:07 P.M., with the surveyor, ten residents actively participating said the following: *On the first floor the staff do not answer the call lights and we wait a long time. *There is not enough help when we need help. *Weekends are more difficult with having enough staff. *I do not get showers if they only have two aids (Certified Nursing Assistant (CNA) on my floor. During an interview on 6/11/24 at 4:33 P.M., Nurse #7 said many weekends they work with only two CNAs, when there should be at least three or four on the second floor. Nurse #7 said with two CNAs it is tough but that if they (CNA) are experienced and nurses pitch in, they get resident care completed. Nurse #7 it impacts getting medications out timely. Nurse #7 said the residents complain to her about not enough staff to help them. Nurse #7 said the resident's sense when they are down staff. During an interview on 6/12/24 at 8:01 A.M., Nurse #2 said weekends are hard when staff call out and they cannot get staff to fill in. Nurse #2 said for nursing the ADON (Assistant Director of Nursing) or DON (Director of Nursing) will come in to help. Nurse #2 said the second floor has many residents with memory loss. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/24 at 12:20 P.M., Certified Nursing Assistant (CNA) #1 said she typically works on the first-floor unit, and it is typically staffed to have three CNAs for the day shift. CNA #1 said there have been times with only two CNAs which makes it difficult to provide care, but that knowing the residents' routines they do the best they can to get the residents needs met. During an interview on 6/12/24 at 3:42 P.M., CNA #2 said she works full time. CNA #2 said if a CNA calls out then they work with only two CNAs. CNA #2 said they are not able to fill the hole especially on the weekends. CNA #2 said the last time she worked with only two CNAs was last week and because they worked together, they were able to take care of the residents. CNA #2 said it is hard and takes time, but we do not complain. During an interview on 6/13/24 at 10:57 A.M., the facility scheduler said she has worked at the facility since 10/2023. The scheduler said the facility is staffed is as follows: First Floor Unit: 7:00 A. M.- 3:00 P.M. 2 nurses, 3 CNAs, 3:00 P.M.-11:00 P.M. 2 nurses and 3 CNAs, 11:00 P.M.-7:00 A.M. 1 nurse and 2 CNAs. Second Floor Unit: 7:00 A. M.- 3:00 P.M. 2 nurses, 4 CNAs 3:00 P.M.-11:00 P.M. 2 nurses and 3 CNAs 11:00 P.M.-7:00 A.M. 1 nurse and 2 CNAs. Further the scheduler said the facility was short staff a few months ago and is better now. The scheduler said they did not have staff to cover shifts, or no one was available. The scheduler said they even reached out to a sister facility to cover shifts in April. The scheduler said the second floor is staffed with four CNAs and sometimes they only have three and if there are only 2 CNAs it is because of a call out that could not be filled. The scheduler said staff do get angry about working short or when staff call out last minute. Review of the working schedule for April 2024 indicated the following: First floor Unit: *2 CNAs worked 9 out of 30 days on the 7:00 A.M.-3:00 P.M. day shifts. *2 CNAs worked 7 out of 30 days on the 3:00 P.M.-11:00 P.M. shifts. Second Floor Unit: *2 CNAs worked 3 out of 30 7:00 A.M.-3:00 P.M. day shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*2 CNAs worked 2 out of 30 3:00 P.M.-11:00 P.M. shifts. Review of the working schedule for May 2024 indicated the following: First floor unit: *2 CNAs worked 3 out of 31 days on the 7:00 A.M.-3:00 P.M., shift. *2 CNAs worked 6 out of 31 days on the 3:00 P.M.-11:00 P.M. shifts. Review of the working schedule for June 2024 indicated the following: First floor Unit: *2 CNAs worked 5 out of 10 days on the 3:00 P.M.-11:00 P.M. shifts. Second Floor Unit: *2 CNAs worked 2 out of 10 days on the 7:00 A.M.-3:00 P.M. day shifts. *2 CNAs worked 1 out of 10 days on the 3:00 P.M.-11:00 P.M. shifts.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36431 Based on record review and interview, the facility failed to ensure staffing included the services of a Registered Nurse for a minimum of eight consecutive hours a day, seven days a week as required and failed to ensure the Director of Nursing did not act as a charge nurse. Findings include: 1. Review of the facility's 'Payroll-Based Journal Staffing Data Report 1705D', for Quarter 2 January 1, 2024, through March 31, 2024, indicated the facility triggered as a one-star staffing rating. Review of the document 'Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety and Oversight Group Ref: QSO-18-17-NH DATE: April 06, 2018' indicated the following: Requirement for registered nurse (RN) staffing - We are reminding nursing homes of the importance of RN staffing and the requirement to have an RN onsite 8 hours a day, 7 days a week. Nursing homes reporting 7 or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter. This action will be implemented in July 2018, after the May 15, 2018, submission deadline for data for 2018 Calendar Quarter 1, 2018 (January -March 2018) data. During an interview on 6/12/24 at 1:38 P.M., the Administrator said he started work at the facility in late April 2024 and was not aware the facility did not provide RN coverage as required. 2. During the entrance conference on 6/10/24 at 9:04 A.M., the Director of Nursing and Administrator said the facility did not have any nursing staffing waivers. Review of the actual working schedule provided by the facility administrator indicated the Director of Nursing Services worked the following shifts: *Thursday May 9, 2024, 11:00 P.M.-7:00 A.M. shift. Census: 78 *Sunday May 19, 2024, 7:00 A.M.-3:00 P.M., and 3:00 P.M.-11:00 P.M. Census: 74 *Monday May,20, 2024 7:00 A.M.-3:00 P.M., Census 74 *Tuesday June 4, 2024, 11:00 PM-7:00 A.M., Census 75 *Wednesday June 5, 2024, 7:00 A.M-3:00 P.M Census 75 *Thursday June 6, 2024,11:00 PM-7:00 A.M. Census 74 (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Saturday June 8, 2024, 11:00 PM-7:00 A.M. Census 74 *Sunday June 9, 2024, 11:00 PM-7:00 A.M. Census 74 On 6/10/24 at 7:00 A.M., the Director of Nursing was observed working on the floor and said she had also worked the 11 P.M. to 7 A.M. shift. During an interview on 6/13/24 at 11:32 A.M., the Director of Nursing said she has worked as a nurse on the floor for a couple of night shifts this month and has covered other shifts since she began working as the Director of Nursing. The Director of Nursing said she is responsible for the nursing services and has no choice but to cover the shifts to care for residents. The DON said it makes it hard because she has other duties as a Director of Nursing.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36431 Based on observation, record review and interview, the facility failed to ensure that nursing staff implemented standards of practice by failing to do the controlled substance count (a control measure to safeguard and maintain accurate dispensing and inventory of controlled substances), at the time of a change in shift, on one of two resident care units. Findings include: Review of the facility's policy, not titled or dated, indicated the following: The facility complies with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled medications. Policy interpretation 1. Only authorized licensed nursing and or pharmacy personnel have access to controlled drugs maintained on premises. 8. Controlled substances are reconciled upon receipt, administration, disposition, and the end of each shift. 12. At the end of each shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately. c. The director of nursing services investigates all discrepancies in controlled medication reconciliation to determine the cause, identify any responsible parties, and reports findings to the administrator. d. The director of nursing service consults with the provider pharmacy and the administrator to determine whether legal action is indicated. On 6/10/24 at 8:20 A.M., Nurse #2 said he worked the 3:00 P.M.-11:00 P.M., and 11:00 P.M. -7:00 A.M., and was waiting for the day shift nurses to come in. Nurse #2 said that one (nurse) called out and the other (nurse) was running late. On 6/10/24 at 8:32 A.M., twelve minutes after the interview with Nurse #2, Nurse #2 was observed wearing a backpack and leaving the floor through the staircase. The second floor was observed to have two medication carts. Observation of the controlled substance logbook on cart #1, on the page titled SHIFT COUNT, revealed the following: shift date: 6/10/24, time AM/PM: 7 A.M. was written in, Status of count Yes/No was blank, name of the coming on duty nurse was blank, and nurse going off duty was signed. Observation of the controlled substance logbook on cart #2, on the page titled SHIFT CHANGE, revealed all areas to be blank except for the signature for 'Nurse Going Off Duty' During an interview on 6/10/24 at 9:00 A.M., Nurse #1 said at shift change the nurses coming on shift receive report and do the narcotic (controlled substance) count and both nurses sign and document in the controlled substance logbook. Nurse #1 said report was given, said they counted, that the log was not filled out in its entirety, and that she began to do the medication pass. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/10/24 at 3:27 P.M., Nurse #2 said he left the floor after giving report and did not do the narcotic count with Nurse #1. Nurse #2 said the narcotic count is required for the control substance medications to keep an accurate count. During an interview on 6/13/24 at 11:32 A.M., the Director of Nursing said that the two nurses are to do the controlled substance count and document in the controlled substance log during shift change.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review and interview, the facility failed to ensure recommendations from the Monthly Medication Review conducted by the pharmacist were addressed and acknowledged by the physician in a timely manner for three Residents (#34, #59 and #46) out of a total sample of 24 Residents. Findings include: Review of the facility policy titled Documentation and Communication of Consultant Pharmacist Recommendations dated revised 7/2023 indicated that the consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding resident's medication therapies are communicated to those with authority and/or responsibility to implement the recommendations, and are responded to in an appropriate and timely fashion. 1. Resident #34 was admitted to the facility in January 2023 with diagnoses including diabetes, high blood pressure and dementia. Review of the Minimum Data Set (MDS) dated [DATE], indicated that Resident #34 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated that Resident #34 exhibited verbal behaviors directed towards others 4 to 6 days a week and refused care one to two days a week. Further review failed to indicate a diagnosis of psychosis to support the use of an antipsychotic. Review of the care plan dated 1/23/23, indicated a focus of; Resident #34 uses psychotropic medications related to behavior management. Further review indicated an intervention to discuss with doctor reason ongoing need for use of the medication. Review of the Pharmacist Consultant monthly drug regimen review dated 3/5/24 indicated a recommendation to clarify diagnosis on quetiapine (seroquel) order as current diagnosis does not support use. Further review indicated the doctor signed the recommendation without comment on 3/12/24. Review of the diagnoses list indicated that the diagnosis of unspecified psychosis not due to a substance or known physiological condition was not added until 5/7/24, 2 months later. Review of the doctor's order dated 5/3/24, indicated an order for the antipsychotic Seroquel oral tablet 25 MG (milligrams) by mouth as needed. Further review indicated no stop date for the medication. Review of the Pharmacist Consultant monthly drug regimen review dated 5/6/24, indicated the following: Currently has an active order for Quetiapine PRN (as needed) with a duration of 30 days. Please note the CMS (Centers for Medicaid and Medicare) guidelines do not allow maintaining orders for PRN antipsychotics for greater than 14 days on medication profiles. Please evaluate and consider discontinue Quetiapine PRN or correcting duration to be for 14 days or less if appropriate. Further review indicated that the doctor signed the recommendation on 5/6/24 to discontinue. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the doctor's orders dated May 2024 failed to indicate an order to discontinue the PRN antipsychotic Seroquel. Review of the Medication Administration Record (MAR) dated May 2024 indicated that Seroquel 25 MG was administered 5/24/24 and 5/31/24, after the 14 day limit without review by the doctor. Review of the MAR dated June 2024 indicated that Seroquel 25 MG was administered on 6/2/24, after the 14 day limit without review by the doctor. During an interview on 6/12/24, at 12:00 A.M. the Director of Nursing (DON) said that pharmacist consultant monthly review recommendations should be followed up with in a timely manner. The DON then said that a recommendation for a change to an antipsychotic medication should be followed through with within 24 hours. 2. Resident #59 was admitted to the facility in April 2023 with diagnoses including bipolar disorder and dementia. Review of the Review of the Pharmacist Consultant monthly drug regimen review dated 3/5/24, indicated the following: (Currently receiving Divalproex (Depakote). Unable to locate recent serum level in chart. Recommended 2 weeks after start then every 6 months thereafter. Please consider ordering.) Further review indicated labs done 4/17/24; over a month after the recommendation was documented. Review of the facility document titled Lab Results Report dated 4/17/24 indicated results for a serum blood level of Depakote. During an interview on 6/12/24, at 12:00 A.M. the Director of Nursing (DON) said that pharmacist consultant monthly review recommendations should be followed up with in a timely manner. The DON then said that she would expect that the lab would have been drawn within a week of the recommendation. 43807 3. Resident #46 was admitted to the facility in December 2023 with diagnoses including Dementia with agitation and delusional disorders. A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 00 out of possible 15 indicating severe cognitive impairment. A review of a document titled 'Medication Regimen Review, Psychoactive Medication Use Recommendations' dated 6/5/24 indicated the following: -Currently receiving Quentiapine (Seroquel) 100 milligrams in the morning, 100 milligrams in the afternoon and 50 milligrams at bedtime for agitation without recent attempt to taper. Please evaluate current dosing, consider trial taper to 100 milligrams in the morning, 50 milligrams in the afternoon and 50 milligrams at bedtime, or document inability to do so. The Physician/Prescriber agreed with the recommendation and wrote, will do. A review of the June 2024 physician's orders indicated the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Quentiapine Fumarte Oral tablet 50 milligrams, give 2 tablets (100 milligrams) by mouth in the morning for acute agitation. Start date 1/3/24. -Quentiapine Fumarte Oral tablet 50 milligrams, give 2 tablets (100 milligrams) by mouth in the afternoon for acute agitation. Start date 1/3/24. -Quentiapine Fumarte Oral tablet 50 milligrams, give 1 tablet by mouth at bedtime for acute agitation. Start date 1/2/24. A review of the June 2024 Medication Administration Record (MAR) indicated the following: - Quentiapine Fumarte Oral tablet 50 milligrams, give 2 tablets (100 milligrams) by mouth in the afternoon for acute agitation was administered on 6/6/24, 6/8/24, 6/9/24 ,6/10/24 and 6/11/24. During an interview on 6/13/24 at 9:38 A.M., the Physician said after he agrees with the Pharmacist's recommendations, the facility should put them in place as soon as possible, within twenty-four hours. He said any inability to do so should be documented. During an interview on 6/13/24 at 1:04 P.M., the Director of Nurses said recommendations made by the pharmacist and agreed upon by the physician should be put in place as soon as possible.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on record review, policy review and interviews, the facility failed to ensure psychotropic medications were re-evaluated after 14 days of use for two Residents (#34 and #46) out of a total sample of 24 Residents. Findings include: By end of survey the facility had not produced a policy for the use of as needed antipsychotic drug use, per surveyor request. 1. Resident #34 was admitted to the facility in January 2023 with diagnoses including diabetes, high blood pressure and dementia. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated that Resident #34 scored a 13 out of 15 on the Brief Interview for Mental Status exam indicating intact cognition. Further review indicated that Resident exhibited verbal behaviors directed towards others 4 to 6 days a week and refused care one to two days a week. Review of the care plan dated 1/23/23, indicated a focus of; Resident #34 uses psychotropic medications related to behavior management. Further review indicated an intervention to discuss with doctor reason ongoing need for use of the medication. Review of the doctor's order dated 5/3/24, indicated an order for the antipsychotic Seroquel oral tablet 25 MG (milligrams) by mouth as needed. Further review indicated no stop date for the medication. Review of the Pharmacist Consultant monthly drug regimen review dated 5/6/24, indicated the following: Currently has an active order for Quetiapine PRN (as needed) with a duration of 30 days. Please note the CMS (Centers for Medicaid and Medicare) guidelines do not allow maintaining orders for PRN antipsychotics for greater than 14 days on medication profiles. Please evaluate and consider discontinue Quetiapine PRN or correcting duration to be for 14 days or less if appropriate. Further review indicated that the doctor signed the recommendation on 5/6/24 to discontinue. Review of the doctor's orders dated May 2024 failed to indicate an order to discontinue the PRN antipsychotic Seroquel. Review of the Medication Administration Record (MAR) dated May 2024 indicated that Seroquel 25 MG was administered 5/24/24 and 5/31/24, after the 14 day limit without review by the doctor. Review of the MAR dated June 2024 indicated that Seroquel 25 MG was administered on 6/2/24, after the 14 day limit without review by the doctor. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24, at 12:00 A.M. the Director of Nursing (DON) said that PRN antipsychotic use must be evaluated by the doctor every 14 days, otherwise the medication must be stopped. 43807 2. Resident #46 was admitted to the facility in December 2023 with diagnoses including Dementia with agitation and delusional disorders. A review of the most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 00 out of possible 15 indicating severe cognitive impairment. A review of a document titled 'Medication Regimen Review, Psychoactive Medication Use Recommendations' dated 6/5/24 indicated the following: -Resident has an active order for Quetiapine PRN with a duration of 100 days. Please note that CMS (Center for Medicare & Medicaid Services) guidelines do not allow maintaining orders for PRN antipsychotics for greater than 14 days on medication profiles. Please evaluate and consider discontinue Quetiapine PRN or correcting duration to be for 14 days or less if appropriate. *THIRD REQUEST*. The Physician/ Prescriber agreed to the recommendation and stated will do. [sic] A review of the Resident's June 2024 physician's orders indicated the following: -Seroquel oral tablet (Quetiapine Fumarate) give 25 milligrams by mouth every 6 hours as needed for delusions/inability to redirect for 100 days. Start date 3/12/24 End Date 6/20/24. A review of the June 2024 Medication Administration Record (MAR) indicated the following: - Seroquel 25 milligrams was administered as needed on 6/9/24 and 6/11/24. During an interview on 6/13/24 at 9:38 A.M., the Physician said he agreed with the pharmacy recommendations because psychotropic medications should not be prescribed as needed beyond fourteen days. He said the facility should follow up on pharmacy recommendations he has agreed to within twenty four hours. During an interview on 6/13/24 at 1:04 P.M., the Director of Nurses said recommendations made by the pharmacist and agreed upon by the physician should be put in place as soon as possible.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 36797 Based on observation, record review and interview the facility failed to ensure it was free from a medication error rate of greater than 5% when two out of three nurses observed made 2 errors out of 30 opportunities resulting in a medication error rate of 6.67 %. Those errors impacted two Residents (#39 and #37), out of 5 residents observed. Findings include: Review of the facility policy titled Administering Medications, undated, indicated that medications are administered in accordance with prescriber orders. 1. For Resident #39, Nurse #3 gave the wrong dose of an ordered medication. Resident #39 was admitted to the facility in May 2023 with diagnoses including gastro-esophageal reflux disease, osteoarthritis and dementia. During medication pass on 6/11/24 at 7:49 A.M., the surveyor observed Nurse #3 give Resident #39 two tablets of Calcium Carbonate 750 mg (milligrams). Review of the doctors orders dated June 2024 indicated an order for Calcium Carbonate 500 mg give one tablet at 9:00 A.M. During an interview on On 6/11/24 at 9:45 A.M., Nurse #3 said that she gave the wrong dose of the Calcium Carbonate. 2. For Resident #37, Nurse #7 crushed an extended release medication and administered the medication. Resident #37 was admitted to the facility in October 2023 with diagnoses including high blood pressure and stroke. Review of the doctor's orders dated June 2024 indicated an order for Oxybutynin Chloride 24 hour extended release 24 hour tablet (used to treat over active bladder), give 5 mg (milligrams) by mouth one time a day. Further review failed to indicate an order to crush the medication. During medication pass on 6/11/24 at 8:27 A.M., the surveyor observed Nurse #7 pour and crush all scheduled medications for Resident #37. Nurse #7 placed the medications in pudding, including an Oxybutynin Chloride 24 hour extended release 5 mg tablet and handed the medication to the Resident. The surveyor then stopped the Resident from taking the medication and asked Nurse #7 to take the medications from the Resident and speak with the surveyor privately. Nurse #7 said that she had crushed the extended release medication and should not have.

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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. 36797 Based on observation, policy review and interview the facility failed to 1. ensure medications and biologicals were stored in a safe and secure manner in one of two medication carts, 2. failed to ensure medications were properly labeled in two of two medication carts observed, and 3. failed to ensure medication carts were locked when unattended. Findings include: Review of the facility policy titled Storage of Medications and not dated indicated that the facility stores all drugs and biologicals in a safe, secure and orderly manner. Further review indicated that medications are not to be stored on top of the medication cart and open medication carts are to be within view of the nurse at all times. 1. On 6/11/24 at 8:09 A.M., the surveyor observed Nurse #3 leave six cards of prescription medications on top of the medication cart, walk down the hall and enter a resident's room. The surveyor observed that Nurse #3 was not in eyesight of the medication cart for two minutes. During an interview on 6/11/24 at 8:09 A.M., Nurse #3 said that she should not have left the medication on top of the medication cart unsupervised. 2. On 6/11/24 at 9:48 A.M., the surveyor observed the following in the first-floor medication cart: Two bottles of artificial tears ophthalmic solution open, without a date One bottle of Atropine Sulfate ophthalmic solution open, without a date Two bottles of Brimonidine Tartrate ophthalmic solution open, without a date One bottle of Dorzolamide ophthalmic solution open, without a date One bottle of Timolol Maleate ophthalmic solution open, without a date One vial of Insulin Aspart open, without a date One Glargine Insulin pen open, without a date One Lantus Insulin pen open, without a date During an interview on 6/11/24 at 9:48 A.M., Nurse #3 said that the eye drops should have been dated as they expire 30 days after opening. Nurse #3 then said that all of the insulin should be dated when opened as well. On 6/11/24 at 10:00 A.M., the surveyor observed the following in the second-floor medication cart: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One bottle of liquid protein open and without a date. According to the manufacturer's directions the liquid protein is only good for 3 months after opening. 36431 3. On 6/10/24 at 7:04 A.M., two of two medications carts on the first-floor unit, were observed unattended, unlocked and able to be opened. The Director of Nursing entered the unit from the stairwell, went to the cart and said they should not be left unlocked. The DON said one of the carts is not easily locked and after a few tries was able to lock the medication cart.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, interviews and record reviews, the facility failed to provide dental services for one Resident (#71) out of a total of 24 residents. Findings include: By end of survey the facility had not produced a dental services policy per surveyor request. Resident #71 was admitted to the facility in January 2024 with diagnoses including multiple fractures, cerebrovascular disease and anxiety disorder. Review of the Minimum Data Set Assessment (MDS) dated [DATE], indicated that Resident #71 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating moderate cognitive impairment. On 6/10/24 at 7:40 A.M., the surveyor observed Resident #71 to have teeth missing, broken and carious teeth. During an interview on 6/10/24 at 7:40 A.M., Resident #71 said that he/she had many issues with his/her teeth and needed them to be fixed. Review of the medical record failed to indicate that an oral assessment had been completed since admission. Further review failed to indicate that Resident #71 had been seen by a dentist or that a dental services appointment had been made. During an interview on 6/13/24 at 11:10 A.M., the Director of Nursing (DON) said that Resident #71 should have been seen by a dentist.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 36797 Based on observation, menu review and interview the facility failed to ensure meals provided to residents on two of two resident care units for two of two meals tested , were palatable, attractive and at appetizing temperatures. Findings include: During the resident group meeting conducted with the surveyor on 6/10/24 at 2:07 P.M., the residents said the food is an on-going issue. Residents said: It is not good and I would not feed it to my dog. We don't know what we are eating many times. I think we had chili over cabbage. Hot food items are not hot. Coffee is never hot. There are no condiments for food. The residents said this has been brought up to staff and they are aware. Eight of ten residents actively participating in the meeting said hot food is not served hot. During the initial screening process on 6/10/24 starting at 7:30 A.M. 10 out of 27 residents said that the food was not good and the temperatures of the food were either to cold or to warm. Review of the menu posted on the second floor on 6/11/24 indicated the following: *Tuna Noodle Casserole *Lettuce and tomato salad *Choice of dressing *Baked apple slices *Condiments On 6/11/24 at 12:25 P.M., the second meal truck arrived at the first floor unit. The Nurse began checking the trays and the staff began passing the meal trays to residents. On 6/11/24 at 12:40 P.M. the surveyor received the last tray on the meal truck. The Surveyor recorded the following findings for the test tray: *The tuna noodle casserole recorded at 134 F (degrees Fahrenheit), did not look appetizing, with the noodles, tuna and peas all together. The tuna casserole was warm to taste, mushy and bland with no discernable flavor. *Sliced carrots recorded at 125 F, warm not hot to taste and were mushy and watery without flavor. *Sliced apples recorded at 50.2 F, had a cinnamon flavor, were cool to taste, were crisp and had a grainy texture. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Apple Juice was 55 F and cool not cold to taste. *Coffee recorded at 120.2 F, luke warm and bitter to taste. There was no cream or sugar on the tray. *There were no condiments served with the meal. On 6/11/24 at 1:00 P.M., the second meal truck arrived at the 2nd floor unit. The Nurse began checking the tray and the staff began passing the meal trays to residents. On 6/11/24 at 1:05 P.M. the surveyor received the last tray on the meal truck. The dial on the facility thermometer failed to move when inserted onto the food, therefore no temperatures were recorded. The Surveyor had the following findings for the test tray: *The tuna noodle casserole did not look appetizing, with the noodles, tuna and peas all mushed together. The tuna casserole was hot to taste, mushy and bland with no discernable flavor. *Sliced carrots were warm not hot to taste and were mushy and watery. *Sliced apples had a cinnamon flavor, were cool to taste, were crisp and had a grainy texture. *Coffee warm and bitter to taste. There was no cream or sugar on the tray. *There were no condiments served with the meal. On 6/12/24 review of the menu posted on the wall indicated the following: *Pork Loin *Apple gravy *Cauliflower with parsley *Sweet potato casserole *Frosted yellow cake On 6/12/24 at 12:16 P.M., the second meal truck was delivered to the 1st floor unit. Nursing began checking the trays and staff began passing the meal trays to the residents. On 6/12/24 the surveyor received the last meal tray on the truck at 12:30 P.M. and recorded the following: *Pork loin with gravy was 125 degrees Fahrenheit (F), was warm to taste and had flavor. No discernible apple flavor in the gravy. *Sweet potatoes mashed, recorded 122 F was warm to taste and were sweet with an after taste that was sour. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Green beans recorded at 110 F, were lukewarm and had no flavor. * Milk recorded at 62.2 F was warm not cold to taste. *Coffee black was 116.2 F and was luke warm and bitter to taste. *Apple Juice was 61.2 F and cool not cold to taste. No dessert on the tray *There were no condiments on the tray. On 6/12/24 at 12:51 P.M., the second meal truck was delivered to the 2nd floor unit. Nursing began checking the trays and staff began passing the meal trays to the residents. On 6/12/24 the surveyor received the last meal tray on the truck and recorded the following: *The thermometer provided by the facility did not work and the surveyor used her food thermometer. *Pork loin with gravy was 100 degrees Fahrenheit, was warm to taste and had flavor. No discernible apple flavor in the gravy. *Sweet potatoes mashed, recorded 100.9 degrees Fahrenheit, were warm to taste and were sweet with an after taste that was sour. *Green beans recorded at 80 degrees Fahrenheit, were lukewarm and bland to taste. * Milk recorded at 58 degrees Fahrenheit, was cool not cold to taste. *Coffee black was 100 degrees Fahrenheit and was warm and bitter to taste. *Apple Juice was 60 degrees Fahrenheit and cool not cold to taste. *Chocolate pudding was cool to taste and had flavor. *There were no condiments on the tray. During an interview on 6/12/24 at 1:32 P.M., The food service manager said the menu posted is typically what is served with the possibility of substitute items. The FSD said the food served to residents should be palatable and hot food hot and cold foods cold.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43807 Based on observations, interviews and record review, the facility failed to: 1. store food under sanitary conditions and 2. failed to prevent cross contamination evidenced by staff not performing hand hygiene before donning and doffing gloves. Findings include: A review of the facility policy titled 'Food Storage' with no revision date indicated the following: -Perishable food such as vegetables must be stored in the refrigerator immediately after receipt to assure nutritive value and quality. A review of the facility policy titled 'Hand hygiene' with no revision date indicated the following: -All staff shall use the hand hygiene techniques as set forth in the following procedure: (a) Before applying sterile gloves. (b)Always after removing gloves. 1. On 6/10/24 at 7:23 A.M., the surveyor observed two boxes of cabbages placed on top of the milk refrigerator. The cabbages appeared wilted, with yellow leaves, some of the cabbages appeared rotten, the leaves appeared decayed and slimy. The boxes had a receiving date of 5/29/24, there was no use by date on the boxes. On 6/11/24 at 11:23 A.M., the surveyor observed two boxes of cabbages placed on top of the milk refrigerator. The cabbages appeared wilted, with yellow leaves, some of the cabbages appeared rotten, the leaves appeared decayed and slimy. The boxes had a receiving date of 5/29/24, there was no use by date on the boxes. During an interview on 6/11/24 at 11:25 A.M., the Food Services Director said cabbages should not be stored out in the open, they should be stored in the refrigerator. She said a use by date on the cabbage boxes should be handwritten on the boxes after the deliveries are made. 2. On 6/11/24 at 11:53 A.M., the surveyor observed Dietary Staff #1 managing the tray line for lunch. The Dietary Staff #1 was observed wearing gloves, he stepped away from the tray line, removed the gloves and without performing hand hygiene, picked up a whisk and started to make gravy. Dietary staff #1 then went to the walk-in refrigerator, walked out with bread, picked up a wipe and started to clean the tray line surface. He then proceeded to put on a pair of gloves without performing hand hygiene. He then started serving lunch. (continued on next page)

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	225229	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Center	6 Morrill Place Amesbury, MA 01913

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/24 at 11:58 A.M., Dietary staff #1 said he should have performed hand hygiene after removing gloves and before putting on gloves. During an interview on 6/11/24 at 12:01 P.M., the Food Services Director said dietary staff are supposed to perform hand hygiene, after removing gloves and before wearing gloves.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 36431 Based on record review and interview, the facility failed to implement their Quality Assurance Performance Improvement plan during a transition of leadership to ensure practices to support quality of care were implemented. Specifically, the facility failed to identify, and develop a plan for services provided by Registered Nurses and failed to identify and develop a plan to ensure the Director of Nursing was not working as a charge nurse. Findings include: Review of the facility's policy titled, Quality Assurance Performance Improvement Plan (QAPI), not dated indicated the following: The QAPI plan had been developed to allow our facility to achieve its mission: to provide better care, compassion and solutions to the communities we serve. The facility will effectively identify, collect and use data and information from all departments and the facility assessment. Our facility will conduct Performance Improvement Projects (PIPs) that are designated to take systemic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPs that will lead to changes, guide corrective actions in our systems, and have impact on the quality of life and quality of care for residents living in our community. Review of the facility's 'Payroll-Based Journal Staffing Data Report 1705D', for Quarter 2 January 1, 2024, through March 31, 2024, indicated the facility triggered as a one-star staffing rating. Review of the document 'Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Quality, Safety and Oversight Group Ref: QSO-18-17-NH DATE: April 06, 2018' indicated the following: Requirement for registered nurse (RN) staffing - We are reminding nursing homes of the importance of RN staffing and the requirement to have an RN onsite 8 hours a day, 7 days a week. Nursing homes reporting 7 or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter. This action will be implemented in July 2018, after the May 15, 2018, submission deadline for data for 2018 Calendar Quarter 1, 2018 (January -March 2018) data. Review of the actual working schedule provided by the facility administrator indicated the Director of Nursing Services worked the following shifts: *Thursday May 9, 2024, 11:00 P.M.-7:00 A.M. shift. Census: 78 *Sunday May 19, 2024, 7:00 A.M.-3:00 P.M., and 3:00 P.M.-11:00 P.M. Census: 74 (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Monday May,20, 2024 7:00 A.M.-3:00 P.M., Census 74 *Tuesday June 4, 2024, 11:00 PM-7:00 A.M., Census 75 *Wednesday June 5, 2024, 7:00 A.M.-3:00 P.M. Census 75 *Thursday June 6, 2024,11:00 PM-7:00 A.M. Census 74 *Saturday June 8, 2024, 11:00 PM-7:00 A.M. Census 74 *Sunday June 9, 2024, 11:00 PM-7:00 A.M. Census 74 During an interview on 6/13/24 at 12:04 P.M., the Administrator said he started late April 2024 and reviewed the QAPI plan and meeting minutes for the April 2024 meeting. The Administrator said he conducted the May QAPI meeting. He said the QAPI plan involves reviewing trending areas by reviewing data and information provided from their compliance consultant report as well as other sources. The Administrator said the hiring and turnover of staff is reviewed as part of the QAPI meeting and that no other staffing concerns have been identified or PIP developed. The Administrator said the trigger for lack of services provided by an RN has not been identified, nor has a PIP been implemented. The Administrator said he reviews the staffing schedule on Wednesdays and gets a report daily, he also said he knew the Director of Nursing has worked as a nurse on the unit one or two times and did not know it was more and would need a PIP.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 36797 Based on interview and policy review, the facility failed to maintain an infection prevention and control program designed to help prevent the potential transmission of communicable diseases and infections within the facility. Specifically the facility failed to 1. track and trend infections in the facility and 2. failed to ensure a water management program was implemented to minimize the risk of Legionella and other opportunistic pathogens in building water systems by having a documented water management program. Findings include: 1. Review of the facility policy titled Infections - Clinical Protocol, not dated, failed to indicate a process for the monitoring and trending of infections in the building. During an interview on 6/12/24 at 2:25 P.M., the Director of Nursing (DON) said that she was responsible the implementation and monitoring of the infection control monitoring program. The DON then said that she did not complete the monitoring, tracking and trending of infections for the months of March 2024, April 2024 and May 2024. She then said that she could not find a policy for the tracking and trending of infections in the building. 2. Review of the facility policy titled, Water Management Program For Building Water Systems , dated May 1, 2018, indicated the following: - the purpose of a program is to reduce the risk from Legionella bacteria and other opportunistic pathogens that may contaminate building water systems, which can present an environmental and health related risk if not properly managed. Further review indicated that the facility must describe the potable and non-potable water systems with text at a minimum and, as necessary, with simple water system process flow diagrams and should include supply sources and services entrances, water treatment systems and control measures, water processing steps and water outlets. During an interview on 6/13/24 at 10:00 A.M., the Maintenance Director said the facility has not implemented it's water management program, implemented measures, or conducted any water assessments.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 36797 Based on record review, policy review and interview, the facility failed to implement their Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics. Findings include: Review of the policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, not dated, indicated the following: Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. Policy Interpretation and Implementation 1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection Preventionist, or designee. 2. The IP, (infection Preventionist) or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. During an interview on 6/12/24 at 2:25 P.M., the Director of Nursing (DON) said that she was responsible the implementation and monitoring of the facility antibiotic stewardship program. The DON then said that she did not complete the monitoring, tracking and trending of antibiotic use in the facility per their policy.