STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225233	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of Dartmouth	567 Dartmouth Street South Dartmouth, MA 02748

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted within 14 days after a resident assessment was completed for seven Residents (#16, #38, #43, #48, #49, #52, and #84). Findings include: Review of the facility's policy titled MDS Policy and Procedure, dated as last revised ,d+[DATE], indicated but was not limited to the following: -It is the responsibility of the MDS Coordinator to ensure required assessments are completed and electronically submitted in accordance with submission requirements in the Resident Assessment Instrument (RAI) Manual. Review of Centers for Medicare and Medicaid Services (CMS) RAI Manual, Version 3.0, indicated assessments must be transmitted (submitted and accepted) in to CMS' Internet Quality Improvement and Evaluation System (iQIES) electronically no later than 14 calendar days after the MDS completion date. 1. Resident #16 was admitted to the facility in [DATE]. a. Review of the medical record indicated he/she was admitted to hospice services on [DATE]. Review of the significant change MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. b. Review of the medical record indicated he/she expired in the facility in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by MDS Nurse #1, a Licensed Practical Nurse (LPN) on [DATE] and failed to indicate the RN Assessment Coordinator had signed the MDS. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. (continued on next page)

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

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #38 was admitted to the facility in [DATE]. Review of the medical record indicated he/she was discharged to the community in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. 3. Resident #43 was admitted to the facility in [DATE]. Review of the medical record indicated he/she expired in the facility in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by MDS Nurse #1, an LPN on [DATE] and failed to indicate the RN Assessment Coordinator had signed the MDS. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. 4. Resident #48 was admitted to the facility in [DATE]. Review of the medical record indicated he/she was discharged to the community in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. 5. Resident #49 was admitted to the facility in [DATE]. Review of the medical record indicated he/she was discharged to the community in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. 6. Resident #52 was admitted to the facility in [DATE]. Review of the medical record indicated he/she was discharged to the community in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. 7. Resident #84 was admitted to the facility in [DATE]. Review of the medical record indicated he/she was discharged to the community in [DATE]. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by the RN Assessment Coordinator on [DATE]. Review of the iQIES submission data failed to indicate the MDS was transmitted and accepted. During an interview on [DATE] at 12:01P.M., MDS Nurse #1 said she was an LPN and completes the MDS assessments, then the RN MDS Coordinator signs off, and they are submitted to iQIES. She said an MDS needs to be done for a significant change, a death, and a discharge, and all would need to be submitted into iQIES within 14 days. She said the MDS assessments for Residents #16, #38, #43, #48, #49, #52, and #84, were not transmitted, were late, and would have to be submitted into iQIES. During an interview on [DATE] at 12:01 P.M., the RN MDS Coordinator/MDS Nurse #2 said she was not the RN MDS Coordinator at the time these MDS assessments should have been submitted. Additionally, she said they should have been submitted into iQIES within 14 days of completion and were all late.

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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 0642 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was signed off by the Registered Nurse (RN) MDS Coordinator as completed for two Residents (#16 and #43) per the Resident Assessment Instrument (RAI) guidelines. Findings include: Review of the facility's policy titled MDS Policy and Procedure, dated as last revised ,d+[DATE], indicated but was not limited to the following: -It is the responsibility of the MDS Coordinator to ensure required assessments are completed and electronically submitted in accordance with submission requirements in the RAI Manual. Review of Centers for Medicare and Medicaid Services (CMS) RAI Manual, Version 3.0, indicated an individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility and is responsible for coordinating and certifying completion of the resident assessment. 1. Resident #16 was admitted to the facility in [DATE]. Review of the medical record indicated he/she expired in the facility in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by MDS Nurse #1, a Licensed Practical Nurse (LPN) on [DATE], and failed to indicate the RN Coordinator had signed the MDS. 2. Resident #43 was admitted to the facility in [DATE]. Review of the medical record indicated he/she expired in the facility in [DATE]. Review of the Discharge MDS assessment, dated [DATE], indicated it was completed and signed by MDS Nurse #1, an LPN on [DATE], and failed to indicate the RN Coordinator had signed the MDS. During an interview on [DATE] at 12:01P.M., MDS Nurse #1 said she was an LPN and completes the MDS assessments, then the RN MDS Coordinator signs off, and they are submitted to iQIES. She said the MDS assessment for Residents #16 and #43, were not signed by the RN Coordinator and should have been. During an interview on [DATE] at 12:01 P.M., the RN MDS Coordinator/MDS Nurse #2 said she was not the RN MDS Coordinator at the time of these MDS assessments, but all MDS assessments must be signed as complete by an RN. During an interview on [DATE] at 4:15 P.M., MDS Nurse #1 said the previous RN MDS Coordinator used to sign off the RN Attestation for all MDS assessments and these death MDS assessments should have been signed and were not.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28450 Based on observation, record review, and interview, the facility failed to ensure professional standards of practice for food safety and sanitation to prevent the potential for foodborne illness to residents. Specifically, the facility failed to discard food that was past the manufacturer's expiration and use by dates in one of three kitchenettes reviewed. Findings include: Review of the facility's policy titled Foods Brought in From an Outside Source Policy and Procedure, reviewed [DATE], indicated: - Foods or beverages brought in from the outside will be labeled with the residents' name and dated by staff with the date the item(s) are brought into the facility for storage. - Food or beverage in the original container that is past the manufacturer's expiration date will be discarded by facility staff. On [DATE] at 10:10 A.M, the surveyor, with the Food Service Director (FSD) present, reviewed the first floor, North Unit kitchenette and observed the following food items in the refrigerator which the FSD identified as being brought in from an outside source: -One resealable plastic bag of crab classic meat with an expiration date of [DATE] -One resealable plastic bag of salami with an expiration date of [DATE] -A bag of Halos oranges labeled use by [DATE]. During an interview on [DATE] at 10:30 A.M., the FSD said there should not be expired food in the residents' refrigerator. She said any food beyond the expiration date and the use by date should have been discarded by the dietary aides. The FSD said the oranges and the meat products, which were way beyond expiration, should have been discarded. The FSD said there should be a guide for foods brought in by resident families and friends attached to the kitchenette's refrigerator door, but the sign was not there. During an interview on [DATE] at 11:15 A.M., Diet Aide #1 said expired food should have been discarded from the refrigerator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46862 Based on interviews and record review, the facility failed to ensure its staff maintained accurate documentation for one Resident (#25), out of a total of 20 residents. Specifically, the facility failed to ensure February 2025, Medication Administration Records (MAR) accurately reflected blood sugar values and dosage of insulin administered according to physician's orders. Findings include: Review of the facility's policy titled Diabetes-Clinical Protocol, revised 12/2020, indicated but was not limited to: -The Physician will follow up on any acute episodes associated with a significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. -As indicated, the Physician will order appropriate lab tests (for example, periodic finger sticks) and adjust treatments based on these results. -Examples of blood glucose monitoring for various situations might include the following: -For the resident receiving insulin, monitor 3 to 4 times a day if on a sliding-scale insulin. -The Physician will authorize pertinent parameters for monitoring and reporting information related to blood sugar management. -The staff will incorporate such parameters into the Medication Administration Record (MAR) and care plan. Resident #25 was admitted to the facility in January 2025 with diagnoses including diabetes mellitus. Review of Physician's Orders included but was not limited to: -Insulin Glargine 100 unit/1 millimeter (ML) solution (Insulin Glargine, Recombinant) give 20 units subcutaneous (SQ) every day at 9 AM -Lantus Solostar 100 units/1 ML solution (Insulin Glargine, Recombinant) give 10 units SQ every night at 8 PM -Insulin Lispro 100 units/1 ML solution (Insulin Lispro, Recombinant) Sliding Scale Injection Breakfast, Lunch, Supper for Capillary Blood Glucose (CBG) 100-150 Administer 2 Units, CBG 151-200 Administer 4 Units, CBG 201-250 Administer 6 Units, CBG 251-300 Administer 8 Units, CBG 301-350 Administer 10 Units, CBG 351-400 Administer 12 Units and notify MD. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Insulin Lispro 100 units/1 ML solution (Insulin Lispro, Recombinant) Sliding Scale Injection every night at 8 PM for CBG 100-150 Administer 2 Units, CBG 151-200 Administer 4 Units, CBG 201-250 Administer 6 Units, CBG 251-300 Administer 8 Units, CBG 301-350 Administer 10 Units, CBG 351-400 Administer 12 Units and notify MD. Review of the February 2025 MAR indicated the following blood sugars were not documented on 23 occasions as evidenced by several blank boxes corresponding to the dates and times blood sugars were to be obtained as follows: 2/1/25 17:30 2/2/25 07:30, 12:00, 17:30 2/3/25 07:30, 12:00, 17:30 2/4/25 07:30, 12:00, 17:30 2/5/25 20:00 2/6/25 20:00 2/7/25 20:00 2/8/25 20:00 2/9/25 20:00 2/10/25 20:00 2/11/25 20:00 2/12/25 20:00 2/13/25 20:00 2/14/25 20:00 2/15/25 20:00 2/16/25 20:00 2/17/25 20:00 Review of the February 2025 MAR indicated the following units of insulin were not documented on 24 occasions as evidenced by several blank boxes corresponding to the dates and times insulin were to be administered as follows: 2/1/25 17:30 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/2/25 07:30, 12:00, 17:30 2/3/25 07:30, 12:00, 17:30 2/4/25 07:30, 12:00, 17:30 2/5/25 20:00 2/6/25 20:00 2/7/25 20:00 2/8/25 20:00 2/9/25 20:00 2/10/25 20:00 2/11/25 20:00 2/12/25 20:00 2/13/25 20:00 2/14/25 20:00 2/15/25 20:00 2/16/25 20:00 2/17/25 20:00 2/18/25 20:00 During an interview on 2/18/25 at 12:32 P.M., the surveyor and Nurse #2 reviewed the physician's orders for insulin. Nurse #2 said the blood sugars and amount of insulin administered would be documented on the MAR. The surveyor and Nurse #2 reviewed the MAR and noted several missing entries. Nurse #2 reviewed the transcription of the insulin orders in the MAR. Nurse #2 said it appeared that the sliding scale order for breakfast, lunch and supper was clarified on 2/5/25 to include documenting the blood sugar and amount of insulin administered. Nurse #2 said the sliding scale for the 20:00 order was not completely entered. Nurse #2 said when the order was placed in the computer the supporting documents tab was not checked off to signify documenting blood sugar or amount of insulin administered. Nurse #2 said the Nurses would only be able to sign off their initials. During an interview on 2/19/25 at 1:03 P.M., the Director of Nurses (DON) noted there was no way to indicate what the blood sugar value was or how much insulin was administered. The DON said the expectation is nurses would document blood sugar values and amount of insulin administered on the MAR and follow up with the Physician if needed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to ensure staff implemented appropriate use of personal protective equipment (PPE) for residents placed on Isolation Precautions and ensure staff implemented appropriate use of source control PPE while on the units in the facility during a COVID-19, Influenza (FLU) and Respiratory Syncytial Virus (RSV) outbreak to help prevent the further spread of illness on three of three units observed. Findings include: Review of the facility's policy titled Infection Prevention Control, dated as reviewed 10/2024, indicated but was not limited to the following: -Standard and transmission-based precautions to be followed to prevent the spread of infections Review of the facility's policy titled Isolation - Categories of Transmission-Based Precautions, dated as revised September 2022, indicated but was not limited to the following: -Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infection and is at risk of transmitting the infection to other residents. -When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need for and the type of precaution. -The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE. -When transmission-based precautions are in effect, non-critical care equipment items will be dedicated to a single resident -If re-use of items is necessary, then the items will be clean and disinfected according to current guidelines before use with another resident Review of the facility's policy titled Coronavirus COVID-19, dated as revised 1/2014, indicated but was not limited to the following: -Use of Personal Protective Equipment (PPE) -Full PPE, including N-95 respirator, eye protection, gloves, and gown should be worn per DPH and CDC guidelines for the care of any resident with known or suspected COVID-19 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-If reusable goggles or face shields are used the facility must ensure appropriate cleaning and disinfection between uses according to manufacturer's instructions. -Clean and disinfect reusable equipment prior to removing from resident's room Upon entrance to the facility on [DATE] at 7:30 A.M., the Director of Nursing (DON) said the facility was currently undergoing an outbreak of COVID-19, FLU, and RSV. She said the facility is requiring all staff and visitors to utilize face masks and face shields or goggles while in the facility. Review of the most recent outbreak documentation provided by the DON on 2/12/25 at 8:44 A.M., indicated the facility had five residents currently positive for RSV and five residents currently positive for the FLU on North 1 unit. The facility had 10 residents currently positive for the FLU on North 2 unit. The South 2 unit currently had two residents positive for the FLU and three residents positive for COVID-19. On 2/12/25 at 9:34 A.M., the surveyor observed a table next to the elevator on the basement floor with goggles and face shields placed in an open plastic bin, and a box of face masks. Above the table a sign was posted which read - Face masks and goggles or face shields required on all units. On 2/12/25 at 9:36 A.M., the surveyor observed a staff member pushing a cart down the hallway on the North 1 unit with only a face mask in place, no goggles or face shield was worn. On 2/12/25 at 9:42 A.M., the surveyor observed a table next to the elevator on the second floor with goggles and face shields placed in an open plastic bin, and a box of face masks located next to it. Above the table a sign was posted which read - Face masks and goggles or face shields required on all units. On 2/12/25 at 9:45 A.M., the surveyor observed a hospice staff member at the nursing station on the North 2 unit wearing only a face mask, no goggles or face shield was worn. On 2/12/25 at 9:46 A.M., the surveyor observed a maintenance staff member repairing a medication cart, located on the North 2 unit, in the hallway, wearing only a face mask, no goggles or face shield was worn. During an interview on 2/12/25 at 9:49 A.M., Unit Manager (UM) #1 said everyone is required to wear a facemask and eye protection while in the facility because of the current outbreak. She said if a resident is positive for the FLU, COVID-19, or RSV, there is a sign outside of the door that says isolation precautions. UM#1 said all staff must wear a gown, gloves, eye protection and an N-95 mask (a filter mask that fits over the nose and mouth to protect against airborne particles) prior to entering the room. She said the staff does not need to change or clean eye protection when they exit an isolation room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/12/25 at 9:50 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 enter a resident's room on the North 2 unit, wearing gloves, surgical face mask and goggles. The room had a sign posted in the doorway that read general PPE precaution facility with COVID cases in the last 14 days, indicating staff were required to clean hands when entering and exiting, wear a gown, mask (N-95 for aerosol generating procedures), eye protection and gloves prior to entering the room. CNA #1 made the resident's bed, doffed (removed) her gloves and exited the room. The CNA did not perform hand hygiene after removing her gloves. The CNA did not don (put on) a gown prior to entering the room. A PPE holder was located on the front of the resident's door stocked with gowns, and an alcohol-based hand sanitizer pump (ABHS) was located on the wall outside of the room to complete hand hygiene. On 2/12/25 at 9:52 A.M., the surveyor observed CNA#1 approach the doorway to another resident's room on the North 2 unit, still did not perform hand hygiene, don an N-95 mask, gown, and gloves and entered the room. The N-95 face mask was applied with one strap placed around the back of her head, and the other was left dangling in front of her face, leaving the mask loose fitting. The room had an isolation contact/droplet precaution sign posted outside the door indicating staff were required to clean hands when entering and exiting, wear eye protection, a gown, an N-95 mask, and gloves prior to entering the room. The surveyor observed CNA #1 transfer the resident from the bed to the chair and then CNA #1 returned to the PPE bin located on the door of the room. CNA #1 reached into the bin and grabbed some N-95 masks. CNA #1 was still wearing the gloves she used to transfer the resident into the chair. She then dropped two clean N-95 masks on the ground, picked up the N-95 masks from the ground and placed them back in the clean PPE holder and then returned to assist the resident. On 2/12/25 at 10:01 A.M., the surveyor observed CNA #1 doff her gown and gloves and exit the resident's room. She walked down the hallway and doffed her N-95 mask at the nursing station, performed hand hygiene and put on a surgical face mask. CNA #1 did not change or clean her goggles after exiting the isolation precaution room. During an interview on 2/12/25 at 10:04 A.M., CNA #1 and the surveyor reviewed the general PPE precaution sign together that was posted outside of the first resident's room she had entered. She said the sign is placed on all the resident doors who are not on precautions. She said it is because the facility has COVID and FLU in the building. CNA #1 said she is aware the sign says to wear a gown, but she does not have to wear a gown when entering the room. CNA said she thought she cleaned her hands when she exited the room, and before she entered another resident's room, but must have forgotten. She said when she enters a room that has an isolation precaution sign, she must wear an N-95, gown, gloves and goggles. She said she does not have to change or clean her goggles upon entering or exiting the room. During an observation with an interview on 2/12/25 at 10:20 A.M., the surveyor observed CNA #3 enter a resident's room on the South 2 unit, wearing a surgical face mask, and goggles. The room had an isolation contact/droplet precaution sign posted outside the door indicating staff were required to clean hands when entering and exiting, wear eye protection, a gown, an N-95 facemask, and gloves prior to entering the room. CNA #3 spoke with the resident and then exited the room. CNA #3 said she is only required to wear an N-95, gown and gloves when she is providing care to the residents, and since she is only speaking with them it is not required. CNA #3 said when a resident is on isolation precautions she does not have to change or clean her eye protection when exiting the room. After speaking with the surveyor, CNA #3 performed hand hygiene, donned a gown and gloves and re-entered the room. CNA #3 did not don an N-95 mask prior to entering the room. A PPE holder was located on the front of the resident's door stocked with N-95 masks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Woods of Dartmouth	567 Dartmouth Street South Dartmouth, MA 02748

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/12/25 at 10:29 A.M., UM #2 said the PPE for precautions on the unit are for all staff and visitors to wear eye protection and a face mask while on the units. She said rooms with a sign posted saying isolation precautions require use of gowns, N-95 masks, gloves and eye protection to be worn upon entering. She said the general precaution sign that is placed outside of some resident rooms is confusing. She said PPE is not required to enter those rooms, and she is not sure why the sign states it is required. UM #2 said she will check with the DON for clarification. During an observation with an interview on 2/12/25 at 10:36 A.M., the surveyor observed CNA #5 approaching a resident's room on the North 1 unit wearing a surgical face mask and eye shield. CNA #5 donned a gown and gloves and entered the room. CNA #5 did not perform hand hygiene prior to donning the gloves. The room had an isolation contact/droplet precaution sign posted outside the door indicating staff were required to clean hands when entering and exiting, wear eye protection, a gown, an N-95 facemask, and gloves prior to entering the room. CNA #5 them removed her gown and gloves and exited the room. CNA #5 did not perform hand hygiene, remove her surgical face mask, or clean her face shield. A PPE holder was located on the front of the resident's door stocked with N-95 masks and face shields. A hand sanitizer dispenser was located on the wall outside of the room to complete hand hygiene. CNA #5 and the surveyor reviewed the precaution sign located outside of the room together. CNA #5 said she should have cleaned her hands prior to entering and exiting the room. She said she was never told to change her face mask or clean her face shield when leaving an isolation room. She said she should have worn an N-95 mask, On 2/12/25 at 10:37 A.M., the surveyor observed Housekeeper #1 in a resident's room on the North 1 unit, wearing gloves, surgical face mask and goggles. The room had an isolation contact/droplet precaution sign posted outside the door indicating staff were required to clean hands when entering and exiting, wear eye protection, a gown, an N-95 facemask, and gloves prior to entering the room. The housekeeper had her cleaning cart placed in front of the doorway. She was dusting the bureau, then approached her cart, placed the dirty dusting rag used in the isolation room on top of folded dusting cloths on the cart, uncovered. She took the mop off the cart, returned to the room and mopped the resident's floor. She returned the mop to the cart, removed her gloves, and proceeded down the hall with her cart. Housekeeper #1 did not perform hand hygiene, change her surgical mask or change or clean her goggles. Housekeeper #1 did not clean the mop used in the isolation precaution room. Housekeeper #1 did not don a gown, or a N-95 mask prior to entering the room. A PPE holder was located on the front of the resident's door stocked with gowns, and N-95 masks for use. During an observation with an interview on 2/12/25 at 10:42 A.M., the surveyor observed Staff member #1 exit a resident's room wearing a surgical face mask and goggles. The room had an isolation contact/droplet precaution sign posted outside the door indicating staff were required to clean hands when entering and exiting, wear eye protection, a gown, an N-95 facemask, and gloves prior to entering the room. A PPE holder was located on the front of the resident's door stocked with gowns, and N-95 masks for use. Staff member #1 said she only has to put on an N-95 mask, gown, and gloves if she is providing direct care. She said it is not required to be worn just to enter the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the DON, Administrator, and Infection Preventionist (IP), on 2/12/25 at 12:42 P.M., the DON said the IP is in charge of the precautions and PPE use on the units. The IP said she is new to this role, and when the outbreak started someone else was handling it and provided the education to the staff. The IP said she expects the nursing staff to monitor the PPE use on the units. The Administrator said he put into place the general PPE use signs for any residents who do not require isolation precautions, and for all staff and visitors to wear eye protection and a face mask on the units to mitigate the spread of the current outbreak of COVID-19, FLU and RSV. The Administrator said the staff are expected to follow the guidelines on the signs posted outside of the rooms. The surveyor reviewed PPE breeches observed on all units with DON, Administrator, and IP. The Administrator said the facility needs to provide further education to ensure the staff use proper PPE and include all departments. The DON said her expectations are for the staff to follow the PPE signs placed outside of the resident doors at all times. She said full PPE with N-95 facemask was required prior to entering isolation precaution resident rooms. She said eye protection must be cleaned or discarded prior to exiting the room. The DON said when an N-95 is worn, it must be applied properly to obtain a tight seal. She said once PPE is touched or dropped on the floor, it is considered dirty and must be thrown away. The DON said hand hygiene must be completed prior to entering and exiting any resident's room.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 49425 Based on record review and interview, the facility failed to implement an Antibiotic Stewardship Program to measure and improve how antibiotics are prescribed by clinicians and failed to complete antibiotic usage audit tools (line listings), which are used to track, report and evaluate antibiotic prescribing patterns in accordance with the Antibiotic Stewardship Program. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance. - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. - The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. - Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. Review of facility's policy titled Antibiotic Stewardship, last revised 12/2023, indicated but was not limited to 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. -All clinical infections treated with antibiotics will undergo review by the Infection Preventionist (IP), or designee -The IP will review all antibiotic starts within 48 hours to determine if continued therapy is justified, justified with needed interventions, or not justified. -At the conclusion of the review, the provider will be notified of the review findings and recommendations, and his/her response will be documented. -All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. The information gathered will include: Resident name, date symptoms appeared, name of antibiotic, start date, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome and adverse events. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/25 at 4:04 P.M., with the Director of Nursing (DON) , Infection Preventionist (IP) and the Administrator, the surveyor reviewed monthly antibiotic surveillance tracking records, dated November 2024, December 2024, and January 2025. The records were found to be incomplete as follows: The November 2024 tracking surveillance record, signed by the IP, dated 12/2/24, had missing documentation for 24 out of 27 residents. Nineteen residents had no documented culture date, site of infection, or results. Two residents had no documented culture date or site of infection. Three residents had no documented culture date, site of infection, results or infection status (i.e.: cleared/not cleared). All 27 residents were started on an antibiotic. The December 2024 tracking surveillance record, signed by the IP, dated 1/15/25, had missing documentation for 17 out of 26 residents. Sixteen residents had no documented culture date, site of infection, or results. One resident had no documented culture date, site of infection, results or infection status (i.e.: cleared/not cleared). All 26 residents were started on an antibiotic. The January 2025 tracking surveillance record, signed by the DON, undated, had missing documentation for 15 out of the 16 residents. Four residents had no documented culture date, site of infection or results. Six residents had no documented culture date, site of infection, results, infection status, or if the illness counted as an infection. Two residents had no documented symptoms, culture date, site of infection, results or if the illness counted as an infection. Two residents had no documented culture date, site of infection results, infection status or if the illness counted as an infection. One resident had no documented results or if the illness counted as an infection. All 16 residents were started on an antibiotic. After reviewing the surveillance tracking records, the Administrator said the facility uses McGeer criteria to determine if an illness is counted as an infection on the line listing. The IP said she just took this position a few weeks ago, is currently in training and has not completed any line listings yet. The DON said she has been tracking antibiotic use in the facility since the previous IP resigned back in January 2025. The DON said she reviews the resident progress notes daily and documents antibiotic use on the line listings. She then sends the completed line listings to the lab and they calculate the facility's antibiotic use. She said she has not reviewed any antibiotic use with McGeer criteria to determine if an illness meets the criteria for an infection, and the line listings are incomplete and incorrect. The DON said she does not review antibiotic justification for use or improvement of antibiotic prescribing practices with the providers per their antibiotic stewardship policy. The DON said she recently had an in-service with the nursing staff regarding the use of McGeer criteria and is in the process of training the new IP.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on interview and record review, the facility failed to provide the Pneumococcal immunization as requested/consented in a timely manner for one Resident (#56), out of a total sample size of five residents reviewed for immunizations. Findings include: Review of the Centers for Disease Control and Prevention (CDC) information sheet titled Pneumococcal Timing Vaccine Timing for Adults, dated 9/12/24, indicated the following recommendation: -If a patient has had the Pneumococcal Conjugate Vaccine-13 (PCV-13 at type of pneumococcal vaccination) at any age and Pneumococcal Polysaccharide Vaccine-23 (PPSV23 a type of pneumococcal vaccination) at or after the age of 65 after 5 years PCV-20 or PCV-21 should be offered. -Together, with the patient, vaccine providers may choose to administer PCV-20 or PCV-21 to adults = [AGE] years old who have already received PCV-13 (but not PCV-15, PCV-20, or PCV-21) at any age and PPSV-23 at or after the age of [AGE] years old. Review of the facility's policy titled Facility Vaccine Procedure, dated as revised in 12/2024, indicated but was not limited to the following: -To offer each resident/employee the recommended immunizations against Pneumonia -Obtain informed consent from each resident/responsible party to receive recommended vaccines -The licensed nurse will distribute to the resident/responsible party, information annually regarding risks/benefits of receiving any vaccine and document in the resident record, receipt of educational information and appropriate informed consent/declination of vaccine -The licensed nurse will administer the designated vaccine to all residents who have signed the informed consent requesting to be vaccinated with the vaccine Resident #56 was admitted to the facility in February 2025. Review of Resident #56's Immunization Consent form indicated the Resident consented to the Pneumococcal vaccine. Review of the medical record failed to indicate Resident #56 had been administered the Pneumococcal vaccine. Review of the Resident's Immunization record indicated the following: -Pneumococcal PCV-13 vaccine administered 11/2/18, outside of the facility (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pneumococcal PPSV-23 vaccine administered 11/4/19, outside of the facility; given after the age of 65 During an interview on 2/13/25 at 1:53 P.M., Nurse #2 said when a resident admits to the facility the admitting nurse will review the vaccine options and obtain either consent or declination for the vaccines. The consents are then given to the Infection Preventionist (IP), and the IP obtains the physician's orders and administers the vaccine. She said the facility also holds vaccine clinics for the residents. She said the IP left the position a couple of weeks ago and is not sure who will be giving the vaccines now. During an interview on 2/13/25 at 2:31 P.M., the Administrator said the facility holds vaccine clinics quarterly. He said if a resident is admitted into the facility and wants a vaccine, that is not timed with the clinic, the IP will order it from the pharmacy they use at the facility and administer it. The Administrator said whoever administers the vaccine inputs the information into the Massachusetts Immunization Information System (MIIS) for a history of immunizations and updates the medical chart accordingly. During an interview on 2/18/25 at 3:39 P.M., with the Director of Nursing (DON), IP, and Administrator, the IP said she is new to this position and will be responsible for monitoring resident and staff vaccines the facility offers going forward. The DON said the floor nurses review the vaccine risks and benefits with the residents and have the consents signed upon admission. She said they would provide the IP with a copy of the consents or declinations and the IP would obtain the physician's orders, administer the vaccine and document the information in the resident's chart. The DON said Resident #56 qualified to receive the Pneumococcal PCV-20 vaccine and the IP should have followed through and administered the vaccine.