STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225242	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westborough Healthcare	8 Colonial Drive Westborough, MA 01581

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, and interview, the facility failed to provide privacy and confidentiality for one Resident (#26), out of a total sample of 19 residents. Specifically, for Resident #26, the facility staff failed to ensure that personal privacy of the Resident's own body was maintained while providing personal care when he/she was observed to be naked. Findings include: Review of the facility policy titled Resident's Rights; last revised January 2024 indicated: -a dignified existence (a life where on is treated with respect, has the autonomy to make choices about their life, valued for their worth, regardless of their circumstances, allowing them to fulfil their potential and live with a sense of self-respect and self-worth). -privacy and confidentiality. Resident #26 was admitted to the facility in June 2024, with diagnoses including Schizoaffective Disorder (a combination of Schizophrenia and mood disorders), Bipolar Disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania or hypomania] and lows [depression]), Unspecified Psychosis (a group of symptoms that indicate a person has lost touch with reality: hallucinations, delusions, disordered thinking or speaking, unusual beliefs or thoughts), Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), and Cognitive Communication Deficit (difficulty with communication that is caused by an underlying impairment in cognition or how someone thinks). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #26: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) exam of score of 15 out of 15. -was dependent on staff for activities of daily living (ADLs) care (bathing, dressing, grooming). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 9:37 A.M., the surveyor was standing in Resident #26's doorway with an open room door and observed the Resident was lying in his/her bed naked and being washed by Certified Nurses Aide (CNA) #3. The surveyor observed that there were two other residents lying in their beds in the room. The surveyor further observed the two other residents were awake and could visualize Resident #26 being washed in his/her bed and naked because Resident #26's privacy curtain was not closed. On 11/12/24 at 9:42 A.M., the surveyor observed another resident walk in and out of Resident #26's room while the door remained opened. During an interview on 11/12/24 at 9:54 A.M., CNA #3 said he was not aware the door was open while he provided personal care to Resident #26. CNA #3 said he should have pulled the privacy curtain closed, but he did not. During an interview on 11/13/24 at 10:02 A.M., the Director of Nursing (DON) said staff were expected to provide privacy to the Resident during ADL care.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

45429

Based on observation, record review, and interview, the facility failed to ensure a clean, homelike environment on one unit (Spruce Unit) out of three resident care units.

Specifically, the facility failed to maintain the environment in a clean and homelike manner when the source of lingering odors of stale urine and unclean body odors in the Spruce Unit hallway were not adequately addressed and resolved.

Findings include:

The surveyors observed the following on the Spruce Unit:

-On 11/12/24 at 9:15 A.M., the hallway outside of the Day Room had a strong odor of stale urine and unclean body odor.

-On 11/13/24 at 7:58 A.M., the hallway outside of the resident rooms had a strong odor of stale urine and unclean body odor.

-On 11/14/24 at 9:22 A.M., the hallway outside of the Day room had a strong odor of stale urine and unclean body odor.

During an interview and observation with the Maintenance Director on 11/14/24 at 10:02 A.M., the Maintenance Director said that the Spruce Unit had a noticeable smell of body odor and urine while standing in the hallway outside of the Day room. The Maintenance Director also said that staff may have become accustomed to the smell and that it is more noticeable when you enter the unit from another floor.

During an interview on 11/14/24 at 10:14 A.M., the Housekeeping Department Manager (HDM) said that the smell of body odor and urine is noticeable on the Spruce Unit. The HDM also said that she believed the odor becomes amplified when the heat gets turned on during the colder months and that the Spruce Unit has more incontinent (having no or insufficient voluntary control over urination or defecation) residents which is also a contributing factor. The HDM said that she had three housekeepers a day assigned for a complete room of the day cleaning schedule for each unit and the HDM provided the surveyor with the cleaning schedule. The HDM said that the strong odors have not improved since this cleaning schedule had been implemented on the Spruce Unit however.

On 11/14/24 at 1:45 P.M., the surveyor observed the hallway outside of the residents rooms remained with a strong odor of stale urine and unclean body odor on the Spruce Unit.

On 11/18/24 at 8:56 A.M., the surveyor observed the hallway outside of the Day Room remained with a strong odor of unclean body odor and stale urine on the Spruce Unit.

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to ensure that the required transfer documentation was completed and the required transfer documentation communicated the appropriate information to the receiving health care institution for five Residents (#64, #18, #39, #11 and #29), out of a total sample of 19 residents. Specifically, the facility failed to ensure that Residents #64, #18, #39, #11, and #29, were transferred to the hospital with important information relative to the Residents' medical histories and the reasons for transfer, putting the Residents at risk for complications and adverse events upon transfer to the hospital. Findings include: 1. Resident #64 was admitted to the facility in October 2023, with diagnoses of Benign Prostatic Hypertrophy (prostate gland enlargement that can cause urination difficulty), Retention of urine (a condition that makes it difficult to empty the bladder), and mild cognitive impairment (slight decline in mental abilities). Review of the Resident's clinical record included the following: -a nursing progress note that indicated on 9/25/24 the Resident was transferred to the hospital for evaluation of difficulty swallowing. -MDS (Minimum Data Set) discharge tracking record dated 9/25/24, indicated that the Resident was discharged from the facility, return anticipated. -MDS entry tracking record dated 10/9/24, indicating that the Resident had returned to the facility. -a nursing progress note dated 11/6/24, indicated a Brief Interview for Mental Status (BIMS) Evaluation was completed with a of 15 out of 15, indicating that the Resident was cognitively intact. Further review of the Resident's clinical record did not include any evidence that any discharge paperwork that included the Resident's Advanced Directives (legal documents that provide instructions for medical care and only go into effect if you are unable to communicate your own wishes), any specific instructions or precautions for ongoing care, required clinical documentation, and/or Provider (Physician/Medical Doctor) information was completed and communicated to the hospital for the transfer on 9/25/24. During an interview on 11/14/24 at 2:00 P.M., Social Worker (SW) #2 said that she was unable to provide any evidence that the facility had provided the required necessary information to the hospital on 9/25/24 when the Resident was transferred to the hospital. 51571 (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #18 was admitted to the facility in September 2024, with diagnoses including Metabolic Encephalopathy (a change in how the brain works due to a chemical imbalance in the blood), Emphysema unspecified (a chronic lung condition where air is abnormally present in the lungs causing shortness of breath), Chronic Obstructive Pulmonary Disease with (acute) exacerbation (COPD: a chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing, with an acute worsening of symptoms that lasts for several days), and dependence on supplemental oxygen. Review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE] indicated that the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of a Nursing Progress Note dated 9/21/24, indicated: -the Resident fell when attempting to utilize the commode next to the bed and hit their head. Resident was noted with increased confusion and was sent out to the emergency room (ER). Review of a MDS (Minimum Data Set) discharge tracking record dated 9/21/24, indicated that the Resident was discharged from the facility, return anticipated. Review of a MDS entry tracking record dated 9/27/24, indicated that Resident#18 had returned to the facility. Review of the Resident's clinical record did not provide any evidence of necessary medical transfer information being provided to the hospital when the Resident was transferred to the hospital on 9/21/24. During an interview on 11/18/24 at 11:33 A.M., SW #2 said that she was unable to provide any evidence that the required medical information was sent on 9/21/24, when the Resident was transferred to the hospital. 47901 3. Resident #39 was admitted to the facility in October 2023, with diagnoses including Chronic Respiratory Failure with Hypoxia (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue and need for supplemental oxygen), Chronic Kidney Disease (when the kidneys are damaged and cannot filter blood the way that it should) and Psychotic Disorder with Delusions (a mental disorder characterized by a fixed, or false conviction in something that is not real or shared by other people). Review of Resident #39's clinical record indicated the following: -a nursing progress note that indicated on 9/6/24, the Resident was transferred to the hospital after the Resident had expressed not feeling comfortable in the facility. -MDS discharge tracking record dated 9/6/24, indicated that the Resident was discharged from the facility with anticipated return. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-a nursing progress noted that indicated on 9/7/24, that the Resident had been admitted with diagnoses of Shortness of Breath (uncomfortable feeling of not being able to breathe deeply or normally) and Congestive Heart Failure (CHF - caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs). -MDS entry tracking record dated 9/10/24, indicating that the Resident had returned to the facility. -a nursing progress note dated 9/10/24, indicating that the Resident had returned to the facility from the hospital. Further review of Resident #39's clinical record did not include any evidence that any discharge paperwork with specific instructions for the care of the Resident was sent to the hospital on 9/6/24 by the facility. During an interview on 11/14/24 at 11:08 A.M., Corporate Nurse #1 said she was unable to provide evidence that the facility had provided the required necessary information to the hospital on 9/6/24 when Resident #39 was transferred to the hospital. 45429 4. Resident #11 was admitted to the facility in May 2019, with diagnoses including personal history of traumatic brain injury (a head injury causing damage to the brain by external force or mechanism) and muscle weakness. Review of Resident #11's Nursing Progress Note dated 10/20/24, indicated that the Resident had been transferred to the hospital after shaking in his/her wheelchair and falling to the ground. Further review of Resident #11's clinical record did not include any evidence that the following information was provided to the receiving hospital when the Resident was transferred: -Contact information of the Practitioner responsible for the care of the Resident. -Resident Representative information including contact information. -Advanced Directive information. -All special instructions or precautions for ongoing care, as appropriate. -All other necessary information, . as applicable, to ensure a safe and effective transition of care. During an interview on 11/13/24 at 12:47 P.M., SW #1 said she could not find any evidence that the transfer paperwork had been completed for Resident #11's hospital transfer or that the required paperwork had been sent to the receiving facility. SW #1 also said that the required paperwork should have been completed but it had not been. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 3:01 P.M., SW #2 said that she was unable to locate a transfer summary for Resident #11's hospital transfer after searching through the Resident's clinical record. 5. Resident #29 was admitted to the facility in September 2024, with diagnoses including chronic heart failure (when the heart is unable to pump blood as it should resulting in fluid buildup in the feet, arms, lungs and other organs) and atrial fibrillation (A-fib: irregular, rapid heartbeat that can lead to blood clots and other heart related complications). Review of the Resident #29's Nursing Progress Note dated 11/7/24 indicated that the Resident was transferred to the hospital for chest pain and difficulty breathing. Further review of Resident #29's clinical record did not include any evidence that the following information was provided to the receiving hospital when the Resident was transferred: -Contact information of the practitioner responsible for the care of the Resident. -Resident Representative information including contact information. -Advanced Directive information. -All special instructions or precautions for ongoing care, as appropriate. -All other necessary information, . as applicable, to ensure a safe and effective transition of care. During an interview on 11/18/24 at 9:09 A.M., the Director of Clinical Operations #2 said that the transfer paperwork for Resident #29 had not been completed by the nursing staff for the hospital transfer, that it should have been completed but it was not.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to provide a Notice of Bed-Hold Policy at the time of transfer to a hospital or shortly thereafter for five Residents (#64, #18, #39, #11, and #29) and/or their Representatives, out of a total sample of 19 residents. Specifically, the facility staff failed to provide Resident's #64, #18, #39, #11, and #29) and/or their Representatives with written notification relative to Bed-Holds when the Residents were transferred from the facility to the hospital and were expected to return to the facility. Findings include: Review of the facility policy titled Bed Holds/Returns, dated 11/2017 and revised 11/2024, included that prior to transfers out of the facility, residents or resident representatives will be informed in writing of the bed-hold and return policy. 1. Resident #64 was admitted to the facility in October 2023. Review of the Resident's clinical record included the following: -MDS (Minimum Data Set) discharge tracking record dated 8/20/24, indicated that the Resident was discharged from the facility, return anticipated. -MDS entry tracking record dated 8/27/24, indicating that the Resident had returned to the facility. Further review of the Resident's clinical record did not include any evidence that the Resident or their Representative was provided with a written Bed-Hold notice, upon the Resident's transfer to the hospital on 8/20/24. During an interview on 11/14/24 at 2:00 P.M., Social Worker (SW) #2 said that she was unable to provide any evidence that the facility provided the required Bed-Hold information to the Resident and/or their Representative when the Resident was transferred and admitted to the hospital on 8/20/24. 51571 2. Resident #18 was admitted to the facility in September 2024. Review of the Resident's clinical record included the following: -review of the Resident's MDS Assessment, dated 9/21/24, indicated that the Resident was transferred to the hospital from the facility, return anticipated. -Resident #18 returned to the facility on [DATE]. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's clinical record indicated no documented evidence that Bed-Hold information was provided to the Resident and/or their Representative when he/she was transferred to the hospital on 9/21/24. During an interview on 11/18/24 at 11:33 A.M., SW #2 said she was unable to provide any evidence that the Resident and/or their Representative was provided with information relative to Bed-Hold notices when the Resident was transferred to the hospital on 9/21/24. 47901 3. Resident #39 was admitted to the facility in October 2023. Review of Resident #39's clinical record indicated the following: -MDS discharge tracking record dated 9/6/24, indicated that the Resident was discharged from the facility with anticipated return. -MDS entry tracking record dated 9/10/24, indicating that the Resident had returned to the facility. Further review of Resident #39 clinical record did not include any evidence that the Resident and/or their Representative was provided with a written Bed-Hold notice, upon the Resident's transfer to the hospital on 9/6/24. During an interview on 11/14/24 at 11:08 A.M., Corporate Nurse #1 said she was unable to provide evidence that the facility had provided the required Bed-Hold information to the Resident and/or their Representative when the Resident was transferred and admitted to the hospital on 9/6/24. 45429 4. Resident #11 was admitted to the facility in May 2019. Review of Resident #11's Nursing Progress Note dated 10/20/24, indicated that the Resident had been transferred to the hospital. Further review of the Medical Record indicated no evidence the Resident and/or Resident Representative received a Notice of Bed-Hold Policy when he/she was hospitalized on [DATE]. During an interview on 11/13/24 at 12:47 P.M., SW #1 said that she could not find any evidence that the Bed-Hold paperwork had been completed for Resident #11's hospital transfer. SW #1 also said that the Bed-Hold paperwork should have been completed but it had not been. During an interview on 11/14/24 at 3:01 P.M., SW #2 said that she was unable to locate the Bed- Hold policy for Resident #11's hospital transfer after searching through the Resident's clinical record. 5. Resident #29 was admitted to the facility in September 2024. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident #29's Nursing Progress Note dated 11/7/24, indicated that the Resident was transferred to the hospital. Further review of the medical record indicated no evidence the Resident and/or their Resident Representative received a Notice of Bed-Hold Policy when he/she was hospitalized on [DATE]. During an interview of 11/18/24 at 9:09 A.M., the Director of Clinical Operations #2 said that the Bed-Hold paperwork for Resident #29 had not been completed by the nursing staff for the hospital transfer, that it should have been completed but it was not.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on record review, and interview, the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) program for one Resident (#44) out of a total sample of 19 residents. Specifically, the facility failed to complete a new Level I PASARR Assessment when Resident #44 had a significat change in status with a new diagnosis of Delusional Disorders (a belief in something that is untrue) following a psychiatric hospitalization and was started on treatment with an antipsychotic medication (medication used to treat symptoms of mental illness, including delusions - false convictions about something that is not real or shared by other people). Findings include: Resident #44 was admitted to the facility in June 2021 with a diagnosis of Major Depressive Disorder (a mental disorder characterized by low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities) and dependence on renal dialysis (a treatment that removes excess water, toxins, and solutes from the blood when the kidneys are no longer able to function properly). Review of the Resident's clinical record included a Preadmission Screening and Resident Review Level I assessment completed the day before admission to the facility. The Level I screening was positive and identified a diagnosis of Mood which included Major Depression as the only documented diagnosis of serious mental illness. Review of the Minimum Data Set (MDS) assessment dated [DATE]: -did not indicate that the Resident had a serious mental illness -included Depression as the only mental health diagnosis Review of the Resident's clinical record progress notes included a nursing note dated 9/10/21 that indicated: -original leave [sic] reason being altered mental status. -returned from hospital stay with course of tx (treatment) of psyche with new medications .Zyprexa (an antipsychotic medication used to treat symptoms of mental illness) . Review of the Resident's Behavioral Health Group clinical report dated 9/22/21 indicated: -the Resident had been recently transferred and admitted to the hospital directly from the renal dialysis appointment for mental status changes. -while at the hospital the Resident was started on Zyprexa. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Resident was hospitalized for mental status changes, delusions, anxiety, and agitation. -the Resident returned to the facility with an order for Zyprexa 0.25 mg (mg - milligrams a unit of measure in the metric system equal to one-thousandth of a gram) by mouth daily. Review of the Resident's clinical record diagnosis list included a diagnosis of Delusional Disorders added on 9/22/21. Further review of the Resident's clinical record did not indicate that a new Level I Screening had been completed for the Resident, or referral for a Level II PASRR (an in depth evaluation to determine need, appropriate setting, and a set of recommendations for services to inform the individual's plan of care) evaluation as required. During an interview on 11/13/24 at 10:40 A.M., Social Worker (SW) #1 said that she was unable to provide evidence that a new Level I PASRR screen was submitted, or that a referral for a Level II evaluation was requested from the PASRR office, when the Resident returned from a psychiatric hospitalization on [DATE] with a new diagnosis of Delusional Disorder and an order for antipsychotic medication. SW #1 said that a new Level I evaluation and referral for a Level II evaluation should have been completed but it had not been.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 47901 Based on interview, and record review, the facility failed to ensure that a Preadmission and Resident Review Level (initial PASRR - initial pre-screening completed prior to admission to a Nursing Facility that assess for Serious Mental Illness [SMI] or Developmental Disabilities [DD]) screen was completed prior to admission to the facility for two Residents (#20 and #30) out of a total sample of 19 residents. Specifically, 1. For Resident #20, the facility failed to ensure the PASRR was completed accurately to reflect a psychiatric hospitalization . 2. For Resident #30, the facility failed to ensure that a Level I screen was completed prior to admission to the facility when the Resident had active diagnoses of mental disorders. Findings include: Review of the Preadmission Screening and Resident Review (PASRR) process retrieved from: https://www.mass.gov/preadmission-screening-and-resident-review-pasrr indicates the federal- and state-required process is designed to, among other things, identify evidence of serious mental illness (SMI) and/or intellectual or developmental disabilities (ID/DD) in all individuals (regardless of source of payment) seeking admission to Medicaid- or Medicare-certified nursing facilities. The PASRR process begins with a Level I Preadmission Screen, which is designed to identify all individuals seeking admission to a nursing facility that have, or may have, SMI and/or ID/DD. If the Level I screener suspects that the screened individual has SMI and/or ID/DD, he/she refers that individual to the appropriate PASRR authority for a Level II evaluation. The Level II evaluator confirms whether the individual has SMI and/or ID/DD and, if so, whether the individual requires a nursing facility level of care and specialized services. 1. Resident #20 was admitted to the facility in June 2019, with diagnoses including Alcohol Abuse, Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations), Psychotic disorder with delusions (a fixed, or false conviction in something that is not real or shared by other people), Manic episode (extreme change in mood, that can lead to extreme agitation or irritability), and Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of Resident #20's PASRR Level I screen dated 4/2/19, indicated the Resident did not have one or more inpatient psychiatric hospitalization s. During an interview on 11/13/24 at 2:15 P.M., Social Worker (SW) #1 said the Level I PASRR was filled out incorrectly as Resident #20 had an in-patient psychiatric stay and was admitted to the facility from an in-patient psychiatric hospital. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #30 was admitted to the facility in February 2016, with diagnoses including Delusional Disorder (a mental health disorder with one or more firmly held false beliefs that persist for at least one month), Unspecified Psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality) and Dementia. Review of Resident #30's medical record failed to indicate that a Level I PASRR had been completed prior to admission to the facility. During an interview on 11/18/24 at 10:02 A.M., SW #2 said Resident #30's Level I PASRR had not been completed, and should have been completed prior to the Resident's admission to the facility.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

50320

Based on record review, and interview, the facility failed to meet professional standards of practice pertaining to Polysomnography (sleep study) for one Resident (#10), out of a total sample of 19 Residents.

Specifically, for Resident #10, the facility failed to implement a Physician's order to obtain a sleep study to diagnose Obstructive Sleep Apnea (pauses in breathing during sleep, associated with partial or complete collapse of the throat and airway) resulting in delayed interventions and treatments for the Resident based on the sleep study results.

Findings include:

Review of the Board of Registration in Nursing Advisory, Ruling on Nursing Practice, titled: Accepting, Verifying, Transcribing and implementing Prescriber orders. Issued 9/22/93, revised 4/11/18, indicated:

-Nurse's Responsibility and Accountability:

>Licensed Nurses accept, verify, transcribe, and implement orders from duly authorized Prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations.

>Licensed Nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error.

>The paramount importance of patient safety must be reflected in practices that are specific to the setting and circumstance.

>Determination of individual client/resident/patient allergy must be included in each situation.

Resident #10 was admitted to the facility in December 2023, with diagnoses including Morbid Obesity (when the person's weight is found to be more than 80 - 100 pounds above the individual's ideal body weight), Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs), and Chronic Obstructive Pulmonary Disease (COPD: chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing).

Review of the Resident's MDS Assessment, completed 9/12/24, indicated Resident #10:

-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15.

-received Oxygen therapy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was dependent for bathing, dressing, and bed mobility, and required a Hoyer lift (a device that helps caregivers move a person from one place to another when the person cannot move themselves) for transfers. Review of the Resident's clinical record indicated the Resident's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself) was not invoked (put into effect). Review of Resident #10's care plan initiated 12/11/23 and revised 11/3/24 indicated the Resident: -had altered respiratory status/difficulty breathing related to obesity and diagnoses of COPD. -Care plan goals included to maintain the Resident's Pulse Oximetry above 90%. -will maintain a normal breathing pattern as evidenced by normal respirations, normal skin color and regular respiratory pattern. -interventions included Administer medications as ordered and monitor for signs and symptoms of respiratory distress. Review of Resident #10's clinical record indicated an active Physician's order was written on 3/12/24, for a sleep study for Obstructive Sleep Apnea. Further review of the clinical record showed no evidence that the Resident had a sleep study completed. During an interview on 11/14/24 at 1:51 P.M., the Director of Nursing (DON) said she was unable to find any evidence that anyone had scheduled an appointment for a sleep study for Resident #10 or that the Resident had participated in a sleep study. During an interview on 11/14/24 at 2:13 P.M., with the DON and the Director of Clinical Operations (DOC) #1, DOC #1 said there was no policy for implementing or following Physician's orders. The DON said if a Physician had written an order for a consult (Consultation), the Nurse transcribing the Physician's order was responsible for making sure the order was implemented. The DON said in the case of Resident #10, the Nurse who transcribed the order should have made an appointment for the sleep study prescribed by the Physician. The DON said the Physician's order for Resident #10 to have a sleep study should have been followed through with and an appointment for the sleep study should have been made for the Resident. During an interview on 11/18/24 at 7:48 A.M., Resident #13 said they did not remember anyone recommending a sleep study. Resident #13 said he/she knew what a sleep study was, and he/she have never had one since being in the facility. The Resident further said he/she would participate in a sleep study if the doctor ordered one.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to ensure two Residents (#69 and #82) out of a total sample of 19 residents were provided assistance with personal hygiene care and services. Specifically, the facility failed to ensure that: 1. Resident #69 was offered and/or provided with grooming assistance for nail care when the Resident required partial/moderate (staff does less than half the effort) assistance of staff. 2. Resident #82 was offered and/or provided grooming assistance timely for hair care, facial hair care, and personal care when the Resident required total dependence (full staff performance of an activity with no participation by resident) of staff for hygiene, bathing, and dressing. Findings include: Review of the facility policy for Activities of Daily Living (ADLs - important tasks you do on a regular basis to take care of your body and overall well-being), Supporting last revised 11/2024, indicated: -appropriate care and services will be provided for residents who are unable to carry out ADLS independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . hygiene (bathing, dressing, grooming and oral care) -Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice 1. Resident #69 was admitted to the facility in January 2023, with diagnoses including Age Related Cognitive Decline and Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment, weight loss, decreased appetite or poor nutrition and inactivity). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #69: -was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15 -had no behaviors. -required partial/moderate assistance with personal hygiene including grooming needs. Review of Resident #69's ADL care plan, last revised 11/2/24, indicated: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Resident will receive assistance needed in ADL activities -grooming: total dependence with staff assist of 1 -report changes in ADL self-performance to Nurse Review of Resident #69's November 2024 Physician's orders indicated: -a weekly shower, skin evaluation, nail care, vital signs, Nurse note - every evening shift, every Tuesday, start date 1/23/24. Review of Resident #69's Treatment Administration Record (TAR) for November 2024 indicated that the Resident received showers and nail care on 11/5/24 and 11/12/24. Review of Resident #69's Behavior Tracking Log for November 2024 did not indicate any documented behaviors from 11/1/24 through 11/14/24. Review of Resident #69's clinical record indicated no documented evidence that the Resident refused care relative to grooming or personal hygiene. On 11/12/24 at 8:36 A.M., the surveyor observed Resident #69 sleeping in his/her wheelchair in the Day room on the Spruce Unit. The surveyor observed that the Resident's fingernails were approximately 1/4 inch long and had a black substance underneath the fingernails on both of his/her hands. On 11/13/24 at 8:02 A.M., the surveyor and the Director of Nursing (DON) observed Resident #69 sleeping in his/her bed in a hospital gown. The surveyor and the DON observed that the Resident's fingernails had a black substance underneath the untrimmed nails on both of his/her hands. During an interview at the time, the DON said that Resident #69's fingernails should have been cleaned and trimmed and the fingernails had not been cleaned or trimmed. During an interview on 11/13/24 at 8:14 A.M., Nurse #7 said that the Resident should be receiving nail care on his/her shower days. On 11/13/24 at 1:59 P.M., the surveyor observed Resident #69 lying in bed, sleeping in a hospital gown. The surveyor observed that the Resident's fingernails remained untrimmed and with a black substance underneath the nails of both his/her hands. On 11/14/24 at 9:01 A.M., the surveyor observed Resident #69 sitting in bed in a hospital gown and eating breakfast with his/her bare hands. The surveyor observed that the fingernails on both of the Resident's hands remained untrimmed, and a black substance was still present underneath the fingernails nails on both of his/her hands. 50320 2. Resident #82 was admitted to the facility in November 2023 with diagnoses including Right Above the Knee Amputation (AKA: a surgical procedure to remove the leg above the knee joint) and Non-Traumatic Subdural Hemorrhage (a type of brain bleed that happens without any prior trauma or pathology). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) Assessment, dated 8/21/24, indicated Resident #82: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 points out of 15. -has no instances of rejections of care. Review of Resident #82's ADL care plan indicated the Resident required extensive to total dependent assist for hygiene, bathing, dressing. Review of the Resident's care Kardex (an overview of a resident's care needs) indicated the Resident was an extensive assist of one person to total dependence with hygiene, bathing and dressing. During an interview and observation on 11/12/24 at 9:38 A.M., the surveyor observed Resident #82 was dressed in a shirt and shorts, and the Resident's hair was sticking up on the right side of his/her head and he/she had facial hair growth on the cheeks, chin, and neck. During an interview at the time, the Resident said the Certified Nurses Aides (CNAs) only removed his/her facial hair when they felt like it and if he/she asked the CNAs to remove the facial hair, the CNAs would not always assist with his/her facial hair removal. On 11/13/24 at 8:28 A.M., the surveyor observed the Resident lying in bed and his/her hair was disheveled and sticking up in multiple directions, and facial hair growth remained on his/her cheeks, chin, and neck. The surveyor observed that the Resident was wearing a gray shirt from the previous day which had one large dark stain on the front of the shirt. During an interview at the time, the Resident said he/she was going to ask the Nurses to have his/her facial hair removed that morning. Resident #82 said his/her clothes had not been changed from the previous day and that he/she was still waiting to be washed up for the day. On 11/13/24 at 11:32 A.M., the surveyor observed Resident #82 was lying in bed, and was still wearing the gray shirt with a dark stain on the front. The surveyor observed the Resident's hair remained disheveled, was sticking out in all directions, and the facial hair growth on his/her cheeks, chin, and neck was still present. During an interview at the time, the Resident said he/she was still waiting to be washed up and have his/her clothes changed. On 11/13/24 at 4:12 P.M., the surveyor observed the Resident was still wearing the gray shirt with a dark stain on the front, his/her hair was disheveled and sticking up in all directions and he/she remained with facial hair on his/her cheeks, chin and neck. During an interview at the time, the Resident said he/she had not been washed up as yet today. Resident #82 said he/she asked to have the facial hair removed but no one came as yet to help him/her. During an interview on 11/14/24 at 9:06 A.M., CNA #4 said Resident #82 needed help with all of his/her Activities of Daily Living (ADLs). CNA #4 said she lets the Resident do as much as he/she can, and then CNA #4 will finish what care the Resident cannot complete. CNA #4 said that the Resident needed help with all parts of their ADL care except for feeding which the Resident completes independently. CNA #4 said the Resident never refused ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 9:10 A.M., Nurse #5 said Resident #82 needed help with all care including bathing, dressing and personal hygiene/grooming. Nurse #5 said the CNA's have a kardex to tell them how much assistance Resident #82 needed with ADLs. Nurse #5 said if anything changes with the Resident's care needs, the Nurses will tell the CNA's during morning report. Nurse #5 said the Resident did not refuse ADL care. Nurse #5 said the Resident should have assistance every day with ADLs. Nurse #5 said the Resident should have been provided assistance with facial hair removal when the Resident requested, and should have his/her clothes changed daily. Nurse #5 said he would speak to the CNA who was providing care for Resident #82 to make sure the Resident's facial hair was removed and he/she had clean clothes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51571 Based on observation, interview, and record review, the facility failed to maintain an environment that is free of accidents and hazards for one Resident (#18) out of a total sample of 19 residents. Specifically, for Resident #18, the facility failed to: -ensure that potentially hazardous smoking materials were stored in a secure area, and not inappropriately and insecurely stored in Resident #18's bedroom when both a stationary oxygen concentrator and portable oxygen concentrator were also stored and utilized in his/her bedroom putting the Resident and other residents at risk for accidental injury when there was easy access to the smoking materials. Findings include: Review of the facility's Policy titled Smoking Policy- Residents, established 11/2017 and last reviewed 3/2024 indicate the following: This facility shall establish and maintain safe resident smoking practices. -Oxygen use is prohibited in smoking areas. -Any smoking-related concerns will be noted in the resident care plan. -Residents are not allowed to keep lighters with them. Resident #18 was admitted to the facility in September 2024, with diagnoses including Metabolic Encephalopathy (a change in how the brain works caused by a chemical imbalance in the blood), Emphysema unspecified (a chronic lung condition where air is abnormally present in the lungs causing shortness of breath), Chronic Obstructive Pulmonary Disease with (acute) exacerbation (COPD: a chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing, with an acute worsening of symptoms that lasts for several days), and dependence on supplemental oxygen. Review of Resident #18's Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated that the Resident was moderately cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. Review of Resident #18's Smoking Evaluation, dated 10/12/24, indicated the following: -smokes. -can demonstrate smoking technique: holding cigarette, safe ability to get a cigarette, cigar, etc. lit safely by another (smoking supervisor), extinguishing and safe disposal of cigarette, etc. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was able to communicate that they understand smoking materials are for their own personal use. -was able to communicate that they understand smoking materials are for the use in designated smoking areas & must be stored in the facility's designated storage area (smoking box). -understands and agrees to use identified protective equipment while smoking, if indicated. -was currently evaluated to be a safe smoker under current facility policy. The Resident/Responsible party understands that they may not be permitted to smoke on the premises if future evaluations reveal that it is not safe. -was an independent smoker. -was independent with lighting cigarette. During an interview and observation on 11/13/24 at 3:15 P.M., Resident #18 said he/she had been independently going outside to smoke with no staff members and/or supervision. The Resident also said that he/she was never told that staff were supposed to supervise him/her when he/she go outside to smoke. The surveyor observed that the Resident had cigarettes and lighter in his/her room and the Resident said that he/she kept the lighter and cigarettes in their possession. Resident #18 further said that he/she store the lighter and cigarettes in a brown paper bag in the drawer of the nightstand in their room. Resident #18 said that nobody had told him/her to store the lighter and cigarette in any other place. During an interview and observation on 11/13/24 at 3:18 P.M., the Unit Manager (UM) said that the staff did a smoking evaluation on Resident #18 and assessed the Resident's ability to light his/her own cigarettes, hold the cigarette his/herself and that he/she did not require staff to light his/her cigarettes for him/her. The UM also said that the Resident does not need to be supervised by staff, but when he/she returned to the floor, his/her cigarettes and lighter were to be stored inside the medication cart and locked by nursing staff for safety. The surveyor observed the UM enter Resident #18's room at this time and ask the Resident about the storage of his/her cigarettes and lighter. The Resident said he/she kept the cigarettes and lighter in his/her possession in a brown bag inside their nightstand drawer. During an interview on 11/13/24 at 3:35 P.M., the UM said when the Resident was admitted to the facility, the Resident was not smoking. The UM said the Resident went to the hospital and when he/she returned from the hospital in October 2024, he/she was smoking. On 11/14/24 at 7:39 A.M., the surveyor observed the Resident lying in bed with eyes closed. The surveyor observed that a portable oxygen concentrator was located on the nightstand table next to a pack of cigarettes and a lighter. The surveyor observed the UM and a Nurse enter and then exit the Resident's room. The surveyor observed that the pack of cigarettes and lighter and portable oxygen concentrator remained on the Resident's nightstand table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/24 at 7:43 A.M., the surveyor observed the Administrator enter the Resident's room and discussed the facility policy on storage of smoking materials with Resident #18. The Administrator was observed informing the Resident that cigarettes and lighters were to be locked up in the medication cart for safety and storage. The Administrator also said to the Resident that the staff will label the smoking materials with Resident's name for safe keeping and will replace if the materials were missing. The Administrator educated the Resident that it is the facility policy that his/her cigarettes and lighter are to be kept in a secure and locked area for safe keeping. The surveyor observed the Administrator remove the cigarettes and lighter materials from Resident #18's room including the brown paper bag that contained the additional cigarette materials. During an interview at the time, the Administrator said that the Resident should not have the cigarettes and smoking materials on their possession or in his/her room especially since Resident #18 is using oxygen.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44222 Based on observation, record review, and interview, the facility failed to provide care and services according to professional standards of practice pertaining to an indwelling urinary catheter (a flexible tube inserted into the urethra to the bladder to drain urine outside of the body) for one Resident (#64) of two applicable residents, out of a total sample of 19 residents. Specifically, the facility failed to obtain Physician's orders, develop a plan of care, maintain and/or monitor Resident #64's indwelling urinary catheter. Findings include: Resident #64 was admitted to the facility in October 2023, with diagnoses including benign prostatic hypertrophy (prostate gland enlargement that can cause urination difficulty), retention of urine (condition that occurs when a person is unable to empty their bladder completely or partially of urine), and mild cognitive impairment (slight decline in mental abilities). Review of the Resident's clinical record included a Nursing Evaluation of the bladder completed on 10/10/24 which indicated that the Resident had a urinary catheter in place. Review of Resident #64's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident had an indwelling urinary catheter and was diagnosed with obstructive uropathy (a structural or functional hindrance of normal urine flow). Review of the Resident's clinical record included a Nursing Progress Note dated 11/6/24, which indicated a Brief Interview for Mental Status (BIMS) Evaluation was completed. The BIMS score was 15 out of 15 indicating that the Resident was cognitively intact. Review of the Resident's Care Plan last revised 11/10/24, did not include any goals or interventions for the care and maintenance of an indwelling urinary catheter. During an interview on 11/12/24 at 10:56 A.M., the Resident said that they had a urinary catheter in place, and there was a urine drainage bag strapped to their left leg to collect the urine. Resident #64 said that no one can see the drainage bag because it was beneath the leg of their pants. The Resident said he/she empty the urinary drainage bag his/herself into the toilet. Resident #64 said he/she did not remember the staff ever caring for his/her urinary catheter. Review of the Resident #64's Physician's orders as of 11/13/24, did not provide evidence of any orders for the care and maintenance of an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 10:30 A.M., the Director of Clinical Relations #2 said that she was unable to provide any evidence that the facility staff had put any care and services in place for the care of Resident #64's indwelling urinary catheter. The Director of Clinical Relations #2 further said that the indwelling urinary catheter was identified on the MDS assessment dated [DATE], and the Nursing Evaluation dated 10/10/24, but no Physician's orders were obtained and no plan of care was put in place, but should have been.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 51571 Based on observation, interview, and record review, the facility failed to provide respiratory care and services consistent with professional standards of practice for three Residents (#18, #10 and #13), out of a total sample of 19 Residents. Specifically, the facility failed to: 1. For Resident #18, obtain Physician's orders for oxygen administration or the maintenance of oxygen and respiratory equipment. 2. For Resident #10, and Resident #13, maintain the Resident's oxygen concentrators (medical device that uses air in the atmosphere, filters it, and delivers concentrated oxygen) and filters in a clean, safe, functioning manner. Findings include: Review of facility policy titled Oxygen Administration, dated 11/2012, and reviewed 1/2024, indicated the following: The purpose of this procedure is to provide guidelines for safe oxygen administration: -Verify that there is a physician's order in place. -Review the Physician's order or facility protocol for oxygen administration. -Assemble the equipment and supplies as needed. -Vital signs if applicable -Lung sounds if applicable -Oxygen saturation, if applicable -Store the tubing in a plastic bag as able, marked with date -After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record as warranted: >The date and time of administration. >The name and title of the individual who administered. >The rate of oxygen flow, route. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicated the following: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for oxygen therapy. -Initial and ongoing patient clinical assessment of oxygen patients should be performed by licensed and/or credentialed respiratory therapists. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in partial pressure of carbon dioxide (PaCO2). -Care plans should be developed at the initiation of oxygen therapy based on the needs of the individual patient and updated as necessary. Equipment maintenance and supervision indicated the following: -All oxygen delivery equipment should be checked at least once daily -Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. 1. Resident #18 was admitted to the facility in September 2024, with diagnoses including Emphysema unspecified (a chronic lung condition where air is abnormally present in the lungs causing shortness of breath), Chronic Obstructive Pulmonary Disease with (acute) exacerbation (COPD: a chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing, with an acute worsening of symptoms that lasts for several days), and dependence on supplemental oxygen. Review of Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated Resident #18: -was moderately cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. -had been receiving oxygen therapy during the reference period. Review of Resident #18's October 2024, and November 2024, Physician orders did not indicate any orders for oxygen administration or the care and services of oxygen and respiratory equipment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #18's hospital discharge summary dated 9/27/24, indicated the Resident had a diagnosis of COPD and was receiving on 3- 4 LPM (liters per minute: the flow rate) home O2 (oxygen). Review of Resident #18's Nursing Progress Notes indicated the following: -9/6/24: 4 LPM of O2 via NC (nasal cannula: thin flexible tube that provides supplemental oxygen through the nose via nasal prongs) in use. -9/12/24: SpO2 (oxygen saturation: measure of oxygen in the blood as a percentage of the maximum oxygen the blood could carry) - 96% on 2 LPM of O2 -9/18/24: SpO2 - 96% on 2 LPM of O2. -11/3/24 at 7:13 A.M.: O2 was utilized during the shift -11/5/24: the Resident was complaining of discomfort to his/her nose with the O2 -11/10/24: 2 LPM of O2 at bedtime (HS) The surveyor observed Resident #18 lying in bed with oxygen being administered by nasal cannula set at 2 LPM via a stationary oxygen concentrator on the following dates: -On 11/12/24 at 9:06 A.M. -On 11/13/24 at 7:46 A.M. The surveyor observed that the oxygen tubing in use by the Resident was not labeled with a date. The surveyor further observed a portable oxygen concentrator laying on the floor with the oxygen tubing and nasal cannula attached to the portable concentrator also laying on the floor and not labeled or dated. During an interview and observation on 11/13/24 at 3:09 P.M., Nurse #3 said she was assigned to provide care for Resident #18. The surveyor observed Nurse #3 pick up the oxygen tubing attached to the stationary concentrator and administering oxygen to the Resident, from the Resident's bed and the tubing was dated 11/12/24, on two different sections of the oxygen tubing. The surveyor and Nurse #3 observed the portable oxygen concentrator and the attached oxygen tubing and nasal cannula laying on the floor of the Resident's room and was not dated or labeled. Nurse #3 said that the oxygen tubing should not laying on the floor. During an interview on 11/13/24 at 3:15 P.M., the Resident said that he/she used his/her portable oxygen concentrator and tubing that morning to go to the Day Room. The Resident said that the tubing for the portable concentrator was his/hers from home and had not been changed since his/her admission to the facility. The Resident said that the oxygen tubing on the stationary concentrator was changed last night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 3:18 P.M., the Unit Manager (UM) #1 said that she believed that the Resident had their oxygen ordered on an as needed basis (PRN - pro re nata) and that the Resident usually used oxygen at night. UM #1 also said that there was usually an order set put in place upon admission for all residents who utilize oxygen. UM #1 also said she was not in the facility when Resident #18 was readmitted but remembered seeing Resident #18 being readmitted with oxygen and saw the Resident utilizing oxygen when he/she was readmitted . Further review of the medical record did not indicate an order set for oxygen ordered for Resident #18. During an interview on 11/14/24 at 11:18 A.M., the Director of Nursing (DON) said when the Resident was admitted to the facility the first time, the Resident was using oxygen and then left the facility. The DON said that the Resident has been in and out of the facility many times, and did not have oxygen orders when he/she was readmitted but should have orders for oxygen administration put in place. 50320 2a. Resident #10 was admitted to the facility in December 2023, with diagnoses including Morbid Obesity (when the person's weight is found to be more than 80 - 100 pounds above the individual's ideal body weight), Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs), and Chronic Obstructive Pulmonary Disease (COPD: chronic lung disease that causes obstructed airflow from the lungs and leads to respiratory problems including difficulty breathing, shortness of breath and wheezing). Review of the Minimum Data Set (MDS) Assessment, completed 9/12/24, indicated Resident #10: -was receiving Oxygen therapy -had no instances of rejection of care. -had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15 points. Review of Resident #10's care plan initiated 12/11/23 and last revised 11/3/24, indicated the Resident had altered respiratory status/difficulty breathing related to obesity and diagnoses of COPD. Care plan goals included: -maintain the Resident's Pulse Oximetry (SpO2) above 90% -the Resident will maintain a normal breathing pattern as evidenced by normal respirations, normal skin color and regular respiratory pattern. -Interventions included to administer medications as ordered and monitor for signs and symptoms of respiratory distress. Review of the Resident's November 2024 Physician's orders indicated: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Wipe down (oxygen) concentrator and clean filter weekly, every night shift every Sunday, initiated 2/15/24. -Oxygen at 0-3 liters per minute via nasal cannula, continuous, to maintain SpO2 88 - 92%, initiated 3/5/24. Review of Resident #10's November 2024 Treatment Administration Record (TAR) indicated the oxygen concentrator, and filter had been signed off as being cleaned on 11/3/24 and 11/10/24. On 11/12/24 8:51 A.M., the surveyor observed the filters on either side of the oxygen concentrator to be coated in dust. The surveyor also observed that the oxygen concentrator had a layer of dust at the base and the wheels. During an interview on 11/14/24 3:45 P.M., the Resident said he/she could not recall the staff ever cleaning his/her oxygen concentrator. During an interview on 11/14/24 3:46 P.M., Nurse #6 said she was responsible for cleaning Resident #10's oxygen concentrator the last two Sundays and that she signed the TAR that cleaning was completed on 11/3/24 and 11/10/24. Nurse #6 said she takes the filter out and cleans the filter and changes and dates the oxygen tubing during the cleaning process. When the surveyor asked Nurse #6 her process for cleaning the concentrator filter, Nurse #6 was initially unable to locate the filters on the oxygen concentrator. When the surveyor pointed out the filters that were observed, Nurse #6 demonstrated how she cleaned the filters by removing them from the concentrator and brushing and picking the dust off the filters and into the trash barrel. When the surveyor asked if Nurse #6 felt the filter was clean enough after completing the cleaning she demonstrated, she said no, the filters should be cleaned more thoroughly. 2b. Resident #13 was admitted to the facility in January 2019, with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue) and Dyspnea (difficult labored breathing or shortness of breath). Review of the Resident's MDS Assessment, completed 10/14/24, indicated: -Resident #13 was cognitively intact as evidenced by a BIMS score of 15 out of a possible 15. -Resident #13 was receiving oxygen therapy. -Resident #13 had no instances of rejection of care. Review of Resident #13's care plan initiated on 1/8/19 and revised 11/1/24, indicated: -the Resident had a focus area of respiratory alteration in gas exchange related to COPD, Dyspnea, and Respiratory Failure with hypoxia, and obstructive sleep apnea (a condition where sleep is interrupted by abnormal breathing). -interventions including administering oxygen per Physician's order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's November 2024 Physician's orders indicated: -Wipe down (oxygen) concentrator and clean filter weekly every night shift, every Sunday for infection control, initiated 2/14/24. -Oxygen from 1-3 liters to maintain oxygen saturations at 90% or above via nasal cannula. Titrate oxygen from 5-15 liters via non-rebreather or simple mask to maintain oxygen saturation at 90% if cannot maintain (oxygen saturation)send to emergency department for further evaluation, initiated 5/9/24. Review of Resident #13's November 2024 TAR indicated the oxygen concentrator, and filter had been cleaned on 11/3/24 and 11/10/24 by Nurse #6. On 11/12/24 at 9:01 A.M., the surveyor observed that Resident #13's oxygen concentrator had copious amounts of dust and dark gray smudges on the front and back panels of the device as well as the bottom and around the wheels. On 11/13/24 at 8:14 A.M., the surveyor observed the Resident's oxygen concentrator to have dust and a sticky film with stuck dirt and debris on the bottom and back, and dark gray stains, splatter, and smudges on the front and back of the device. On 11/13/24 at 12:32 P.M., the surveyor and Unit Manager (UM) #1 observed Resident #10 and Resident #13's oxygen concentrators. UM #1 said the oxygen concentrators and filters needed to be cleaned and it was embarrassing that they were not cleaned. UM #1 said the oxygen concentrators should be cleaned for infection control to keep bacteria from growing on the machine and the Resident breathing in the bacteria and causing an infection. UM #1 said the Nurse on duty was responsible for cleaning the machines per the schedule established by the Physician's order or as needed (PRN). UM #1 said if the Nurses were unable to clean the oxygen concentrators and filters, the Director of Nursing (DON) should be notified. During an interview on 11/14/24 at 3:57 P.M., the DON said the procedure for cleaning the oxygen concentrators and filters was to wipe the concentrators down with disinfecting wipes on the day the Physician's order specifies. The DON said the Nurses should be removing the filters and washing with water and allowing them to dry and then be put back on the concentrator. The DON said if the cleaning was not done, it should be passed on to the next Nurse to complete. The DON said there should be no dust or debris on the filters or on the Resident's concentrators.

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

47901

Based on observation, and interview, the facility failed to ensure that the appropriate competencies and skills related to medication administration and storage were maintained by one Nurse (#1).

Specifically, the facility failed to ensure that Nurse #1 did not pre-pour the residents medications and store the pre-poured medications in the bottom of the medication cart to administer at a later time.

Findings include:

On 11/13/24 at 4:30 P.M., during an observation of the Hickory Nursing Unit medication cart with the Nursing Supervisor, the surveyor observed the following in the bottom drawer of the medication cart:

-2 cups of crushed medications with no name, date or label.

-1 pre-poured liquid medication in a cup with no name, date or label.

During an interview on 11/13/24 at 4:34 P.M., Nurse #1 said she had pre-poured two residents' nighttime medications and was waiting to administer the medications to the residents with their meals at supper time. Nurse #1 said that she would pre-pour the residents' nighttime medications and mix the medications in the resident's meal at supper time.

Nurse #1 identified the unlabeled and undated cups with the two residents' medications, and listed the following medications:

>One cup of crushed medications contained:

-Gabapentin (medication used to treat seizures and pain)

-Topamax (medication used to treat seizures and migrains)

-Remeron (medication used to treat major depressive disorder)

-Trazodone (medication used to treat depression, anxiety or a combination of depression and anxiety)

Nurse #1 said she had pre-poured and crushed the resident's nighttime medications (Gabapentin, Topamax, Remeron, Trazadone) to put in his/her meals as that was the only way the resident would take his/her medication.

>The second cup of crushed medications contained:

-Lorazepam (medication used to relieve anxiety or treat insomnia)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tramadol (medication used to treat pain) >The cup of liquid medication contained: -Valproic Sodium (medication used to treat epilepsy) During an interview on 11/13/24 at 4:55 P.M., the Nursing Supervisor said the Nurses were not supposed to pre-pour the residents medications to be administered at a later time. During an interview on 11/14/24 at 10:02 A.M., the Director of Nursing (DON) said Nurses were expected not to pre-pour medications for multiple residents. The surveyor and the DON reviewed the annual competency evaluation completed in January 2024 for Nurse #1. The DON said Nurse #1 was hired on 2/17/23 as a Per Diem (as needed) Nurse but worked in the facility every Wednesday and Friday on the 7:00 A.M. to 3:00 P. M. (Day) and 3:00 P.M. to 11:00 P.M. (Evening) shifts every week. Please Refer to F755

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50320 Based on record review, and interview, the facility failed to post the required nurse staffing information daily. Specifically, the facility failed to: -post the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses (RN), Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (LVN), and Certified Nurses Aides (CNA). -maintain a copy of the staffing records for 18 months as required. Findings include: During the facility survey, the surveyor observed the nurse staffing information was posted in the front lobby at the elevator on the following days: -11/12/24 -11/13/24 -11/14/24 -11/15/24 -11/18/24 The surveyor observed that the nurse staffing postings did not include the total number of hours and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs, LVNs, and CNAs. During an interview on 11/18/24 at 8:03 A.M., the Director of Clinical Operations (DCO) #2 said there was no facility policy for posting staffing. During an interview on 11/18/24 at 8:10 A.M., the facility Scheduler said she posts the schedule for the day in the lobby and the schedule was not posted anywhere else in the facility. The Scheduler said she did not know she was supposed to post the actual and total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. During an interview on 11/18/24 at 8:48 A.M., the Administrator said he was unaware that the actual and total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift needed to be on the staff posting. The Administrator also said he was unaware the staff posting needed to be kept on file for 18 months. The Administrator said he only had postings for 11/15/24, 11/16/24, and 11/17/24, available for review. The Administrator said the staff postings were thrown away after a few days have gone by.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47901 Based on observation and interview, the facility failed to accurately and safely provide pharmaceutical services pertaining to administering and storing medications on one of three medication carts observed. Specifically, the facility failed to ensure that medications were not pre-poured in medication cups and the pre-poured medication and medication cups stored in the medication cart prior to being administered to residents. Findings include: Review of the facility policy titled, Administration Procedures for All Medications, revised August 2020 indicated: -Once removed from the package or container, unused or partial doses should be disposed of in accordance with the medication policy. -If the medication is a controlled substance, the procedure for destruction of controlled substances should be followed. Review of the facility policy titled, Storage of Medications, revised August 2020, indicated: -The provider pharmacy dispenses medications in containers that meet regulatory requirements, medications are kept in these containers. -All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label. On 11/13/24 at 4:30 P.M., during an observation of the Hickory Nursing Unit medication cart with the Nursing Supervisor, the surveyor observed the following: -2 cups of crushed medications with no name, date, or label. -1 pre-poured liquid medication with no name, date, or label. During an interview on 11/13/24 at 4:34 P.M., Nurse #1 said she had pre-poured two residents' nighttime medications and was waiting to administer the medications to the residents with their meals at supper time. Nurse #1 said that she would pre-pour the residents' nighttime medications and mix them in the resident's meal at supper time. During an interview on 11/13/24 at 4:55 P.M., the Nursing Supervisor said the Nurses were not supposed to pre-pour residents medications and administer the medications at a later time. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 10:02 A.M., the Director of Nursing (DON) said the Nurses were not expected to pre-pour medications for multiple residents.

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NAME OF PROVIDER OR SUPPLIER: Westborough Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 8 Colonial Drive Westborough, MA 01581	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47901 Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater when one Nurse (#2) of one Nurse observed during the medication pass procedure, made five errors in 35 opportunities, for a total medication error rate of 15.15%, impacting one Resident (#2) out of five residents observed, out of a total sample of 19 residents. Specifically, for Resident #2, Nurse #2 failed to: 1. Administer the correct dose of Ferrous Sulfate Elixir (Iron) as ordered. 2. Administer the correct form of Ferrous Sulfate Elixir as ordered. 3. Administer the following medications as ordered: Glycolax Powder (stool softener)/ Levetiracetam Solution (antiseizure medication)/Artificial Tears Solution (eye drops)/Ocean Spray Nasal Solution. 4. Administer the correct form of Omeprazole suspension as ordered. 5. Individually crush and administer all the medications separately. Findings include: Review of the facility policy titled Administration Procedures for All Medications, revised August 2020, indicated: -Medications will be administered in a safe and effective manner. -Prior to removing the medication from the container, check the label against the order on the Medication Administration Record (MAR), -note any supplemental labeling that applies such as volume of liquid, shake well. Review of the facility policy titled Enteral Tube Medication Administration, revised August 2020, indicated: -Check the MAR to confirm the order. -Note the medication dose. -Crush each immediate-release tablet, one at a time into a fine power and dissolve in at least 15 milliliters (ml) of warm purified or sterile water. -Administer each medication separately and flush the tubing between each medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the facility in February 2024, with diagnoses including Cardiovascular Disease (heart disease), Hemiplegia (paralysis of one side of the body) and Hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting Right Dominant Side, Intracranial Injury (pressure in the skull caused by brain swelling as a result of injury), Traumatic Brain Injury (TBI - a form of acquired brain injury that occurs when a sudden trauma causes damage to the brain) and Gastrostomy Tube (G-tube: a tube that is placed directly into the stomach through an abdominal wall incision for the enteral [passing through the gastrointestinal tract] administration of food, fluids, and medication). Review of Resident #2's November 2024 Physician orders indicated: -Flush g-tube with 5 milliliter (ml) of water between each medication, start 2/20/24. -Tylenol 325 mg (milligrams) tablet, give 2 tablets via g-tube, two times a day, start 6/3/20 -Artificial Tears Solution 0.4%, two drops in both eyes, two times a day for dry eye syndrome, start 3/31/20 -Aspirin 81 mg tablet, one tablet on Monday, Wednesday and Friday, start 5/19/24 -Ferrous Sulfate Elixir 220 mg/ 5 ml, give 7 ml via g-tube one time a day, start 5/11/23 -Levetiracetam Solution 100 mg/ml, give 15 ml via g-tube, every 12 hours, start 7/10/20 -Metoprolol Tartrate 12.5 mg via g-tube, two times a day, start 7/3/24 -Multivitamin with Minerals tablet, 1 tablet daily, start 6/4/20 -Omeprazole Suspension 2 mg/ml, 10 ml daily, start 7/12/22 -Glycolax powder 17 grams (gm), daily, start 11/9/23. -Ocean Spray Nasal Solution, 1 spray into each nostril, two times a day, start 10/14/22 On 11/13/24 at 10:35 A.M., the surveyor observed Nurse #2 prepare and administer the following medications to Resident #2. -Ferrous Sulfate 325 milligrams (mg) tablet, 1 tablet -Omeprazole Capsule 20 mg, 1 capsule -Tylenol 325 mg, 2 tablets -Aspirin 81 mg tablet, 1 tablet -Multivitamin with mineral tablet, 1 tablet -Metoprolol 25 mg tablet, 1/2 tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 prepared the medications by removing the Omeprazole capsule from the rest of the medications in the medication cup with her ungloved finger. Nurse #2 crushed all the tablets together, then opened the Omeprazole capsule and poured into the rest of the crushed medications. Nurse #2 mixed the medications together and administered the medications to Resident #2 via the G-tube (a small flexible tube that is surgically inserted into the stomach through the abdomen to provide nutrition, fluids and medication). Review of Resident #2's November 2024 MAR indicated that on 11/13/24 at 10:35 A.M., the following medications were signed off as being administered: -Aspirin 81 mg -Ferrous Sulfate Elixir 220 mg -Glycolax powder 17 gm -Multivitamin with minerals -Omeprazole Suspension -Tylenol 325 mg (2) tablets -Artificial Tears Solution -Levetiracetam Solution -Metoprolol tablet -Ocean Spray Nasal Solution During an interview on 11/13/24 at 11:45 A.M., Nurse #2 said she had not given the Omeprazole suspension, and the Ferrous Sulfate Elixir as ordered by the Physician. Nurse #2 said she omitted the Levetiracetam solution and had not followed the Physician orders for the medications. Nurse #2 said she had crushed all the medications and administered the medications together in Resident #2's G-tube. During an interview at the time, the Director of Nursing (DON) said Nurse #2 did not follow the Physician's orders for Resident #2, and should have followed the orders. The DON also said Nurse #2 made medication errors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45429 Based on observation, and interview, the facility failed to adhere to safe food practices to prevent contamination of food and beverage items intended for resident consumption in the facility's main kitchen. Specifically, the facility failed to implement safe food practices in the main kitchen relative to: -discarding food that was spoiled. -labeling/dating, storage guidelines. -maintaining the facility kitchen in a clean, sanitary, and free of dust and debris manner. Findings include: Review of the facility policy titled Food and Supply Storage Department: Dietary and Hospitality, last revised 6/2018, included the following: -Refrigerated TCS Foods (Time/Temperature Control for Safety- are perishable items that require specific time and temperature controls to limit bacterial growth and reduce risk of foodborne illness, i.e. meat, eggs, dairy products, cut fruits and vegetables) -ready to eat foods prepared on site that is held longer than 24 hours should be properly labeled and dated with the common name, the preparation date (day 1) and use by date (maximum of 7 days .) -food products that are opened and not completely used: transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates. -Discard food that exceeds their use-by date or expiration date, is damaged, is spoiled, has the time and the temperature danger zone requirements, or incorrectly stored such that it is unsafe, or its safety is uncertain. Review of the Food and Drug Administration (FDA) Food Code, dated January 2023, included the following: -Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During an initial walk-through of the facility kitchen on 11/12/24 at 7:18 A.M., the surveyor and Dietary Staff #1 observed the following: >the walk-in Refrigerator: -a large box of cucumbers and lemons that were covered in mold -an unlabeled and undated metal container of a brown sauce covered in mold -an unlabeled and undated metal container with white cooked meat -an unlabeled tray of individual containers of a white creamy substance >the reach-in Refrigerators: -six trays of unlabeled and undated individual containers of pudding in refrigerator #1 -two unlabeled and undated large containers of juice -four trays of unlabeled and undated individual containers of pudding in refrigerator #2 -two trays of unlabeled and undated individual containers of fruit >dry storage area: -an opened and resealed devil's food cake mix, undated -an opened and resealed brownie mix, undated -an opened and resealed 10-pound bag of macaroni, undated -an opened and resealed 10-pound bag of penne, undated -an opened and resealed bag of breadcrumbs, undated -a delivery truck/cart with cleans cups covered in food debris and a splattered white substance that had brown flecks in it. -a container of six black bananas During an interview on 11/12/24 at 7:36 A.M., Dietary Staff #1 said that the spoiled food, and unlabeled and undated items should have been thrown away in the trash. Dietary Staff #1 also said that the items should have been labeled or dated and they had not been. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/12/24 at 11:40 A.M., the Food Service Director (FSD) said that the spoiled items should have been thrown away and they had not been. The FSD also said that all the unlabeled items and undated items should have been labeled and dated and they were not and should have been discarded. The FSD said that the delivery truck/cart should have been cleaned and it was not cleaned.