STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Northbridge	85 Beaumont Drive Northbridge, MA 01534

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1) who had a court appointed a legal Guardian, the Facility failed to ensure they notified Resident #1's Guardian that Resident #1 refused his/her daily antipsychotic medication and meals for several days, and that Resident #1 was transferred to the Hospital. Findings include: The Facility Resident Rights Policy, dated as last revised 10/2022, indicated that Federal and State laws guaranteed certain basic rights to residents which included, appointing a legal representative, to be notified of his/her medical condition and to be informed of and participate in his/her care planning and treatment. The Facility Notifications Policy, dated as revised 1/2023, indicated that except in a medical emergency, the Facility must notify the resident's designated representative when there is a significant improvement or decline in the resident's physical, mental or psychosocial status, a need to alter treatment significantly or a decision to transfer or discharge the resident from the Facility. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated that the court appointed a Legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. The Nursing Clinical Admission Note, dated 3/06/24, indicated Resident #1 was alert and oriented to person, place and time, communicated verbally and took nutrition and hydration orally. (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: 225248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/28/24 at 2:37 P.M., Resident #1's Guardian said that on 3/12/24 the Facility Admission Director told her the Facility might need to send Resident #1 to the hospital, not that he/she had already been transferred. The Guardian said that the Admission Director told her that for several days, Resident #1 hadn't been eating or accepting antipsychotic medications. The Guardian said that the Admission Director told her that in an attempt to get Resident #1 to eat, staff members had purchased food from outside of the Facility for Resident #1 which Resident #1 had not consistently accepted. The Guardian said that although Resident #1 had already resided at the Facility for six days, the call from the Admission Director on 3/12/24 was her first notification of Resident #1's refusal to eat meals and take his/her medication. The Guardian said that during the telephone conversation, she told the Admission Director that if Resident #1 had to be transferred to the hospital, he/she should be transferred to the closest hospital (around 10 miles away.) The Guardian said that the Admission Director told her that it would be a disservice to Resident #1 and unfair to the closer hospital to send Resident #1 there, and that ifResident #1 needed to be transferred to the hospital, the Facility thought he/she should go back to the Hospital that referred him/her to the Facility (which was around 60 miles away). Review of nursing, social work and physician Progress Notes for Resident #1 from 3/06/24 through 3/11/24 indicated there was no documentation to support the Facility having notified Resident #1's Guardian that Resident #1 was not eating and refused his/her antipsychotic medications. During an interview on 3/25/24 at 12:45 P.M., the Licensed Social Work Associate (LSWA) said that she tried to call the Guardian on 3/11/24 to discuss Resident #1's diet and left a message with the Guardian's office. The LSWA said that although she emailed the Guardian on 3/11/24, she subsequently found out that she used an incorrect email address. The Guardian provided the Surveyor copies of email correspondence with the Facility, dated 3/07/24, 3/08/24 and 3/11/24, concerning matters unrelated to Resident #1, which supported the Facility had known how to reach her. The Guardian said that later in the afternoon on 3/12/24, the Hospital notified her that Resident #1 was in their Emergency Department (ED). The Guardian said that the Facility had not notified her when they transferred Resident #1 to the ED. During an interview on 3/25/24 at 12:00 P.M., the Admission Director said that when she informed the Guardian on 3/12/24 that Resident #1 was being transferred to the Hospital, Resident #1 had already left the Facility and was on his/her way.

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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 - Few

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.

15203

Based on interviews and records reviewed, for one of three sampled residents (Resident #1), the Facility failed to permit Resident #1 to remain in the Facility or to ensure that, prior to discharge, Resident #1's Physician documented the danger posed by the Facility's failure to discharge Resident #1 and the Resident's needs which could not be met in the Facility, as required.

Findings include:

The Facility Discharge/Transfer Policy, dated as revised 10/2022, indicated that each resident will be permitted to remain in the Facility and not be transferred or discharged unless:

- a) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility;

- b) the transfer or discharge is appropriate because the Resident's health had improved;

- c) the safety of individuals in the Facility is endangered due to the clinical or behavioral status of the resident;

- d) the health of individuals in the Facility would otherwise be endangered;

- e) the resident has failed after reasonable and appropriate notice to pay for the stay at the Facility;

- f) the Facility ceased to operate, or,

- g) the transfer/discharge is resident/family initiated.

Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis.

The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023.

The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder.

The Nursing Clinical Admission Note, dated 3/06/24, indicated Resident #1 was alert and oriented to person, place and time, communicated verbally, was in a pleasant mood and exhibited no unwanted behaviors.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/26/24 at 3:50 P.M., the Hospital Case Manager said that on 3/12/24, the Facility discharged Resident #1 to their Emergency Department (ED). The Case Manager said that on 3/12/24, when case management staff in the ED contacted the Facility, Facility staff refused to permit Resident #1 to return. During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that on 3/12/24 a Hospital ED staff person called her and notified her that Resident #1 was in the ED and the Facility refused to permit Resident #1 to return. During an interview on 3/25/24 at 11:00 A.M., the Administrator said that the Facility discharged Resident #1 to the Hospital ED. During an interview on 3/08/24 at 12:45 P.M., the Licensed Social Work Associate (LSWA) said that, on 3/12/24, she faxed a Notice of Transfer or Discharge for Resident #1 to the Long Term Care Ombudsman office, but said she had not provided a copy of the Notice to Resident #1 or to the Guardian. During a telephone interview on 3/26/24 at 3:27 P.M., the Physician said that on 3/12/24 he received a call from the Unit Manager about Resident #1. The Physician said that the Unit Manager told him that Resident #1 was out of control, wasn't caring for him/herself, wasn't eating, was agitated, uncooperative, was not accepting his/her medications and defecated in his/her room. The Physician said that he gave an order to transfer Resident #1 to the emergency department for an evaluation. The Surveyor asked the Physician about Resident #1's discharge from the Facility to the Hospital ED. The Physician that he did not give the Facility an order to discharge Resident #1. The Surveyor asked the Physician whether of not the Facility was unable to meet Resident #1's care needs. The Physician said that it would be difficult for the Facility to claim an inability to meet Resident #1's needs when they had admitted him/her with those needs a week prior and had cared for him/her for a week. Review of Resident #1's Record indicated there was no documentation to support that the Facility identified specific care needs the Facility could not meet and/or the attempts to meet the needs. Furthermore, the Facility was unable to provide any documentation by he Physician that supported that they could not meet Resident #1's needs.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 15203 Based on interviews and records reviewed, for one of three sampled resident (Resident #1) the Facility failed to provide a properly completed written Notice of Transfer or Discharge to the resident/resident's representative at the time the Facility initiated discharge for Resident #1, in accordance with the Federal regulations and per Facility Policy. Findings include: The Facility Discharge/Transfer Policy, dated as revised 10/2022, indicated that each resident will be permitted to remain in the Facility and not be transferred or discharged unless: - a) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility; - b) the transfer or discharge is appropriate because the Resident's health had improved; - c) the safety of individuals in the Facility is endangered due to the clinical or behavioral status of the resident; - d) the health of individuals in the Facility would otherwise be endangered; - e) the resident has failed after reasonable and appropriate notice to pay for the stay at the Facility; - f) the Facility ceased to operate, or, - g) the transfer/discharge is resident/family initiated. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. During telephone interviews on: - 3/25/24 at 1:13 P.M. with the Hospital Director of Regulatory Affairs, and, (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/26/24 at 3:50 P.M. with the Hospital Case Manager and Hospital Social Worker, they said the following: the Facility discharged Resident #1 to the Hospital Emergency Department (ED) on 3/12/24, that Resident #1 arrived at the ED without a written Notice of Transfer or Discharge from the Facility, with all of his/her personal belongings and when ED case management staff contacted the Facility, the Facility said they would not permit Resident #1 to return. During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that on 3/12/24 the Hospital ED called and notified her that Resident #1 was in the ED and the Facility would not permit Resident #1 to return. The Guardian said that the Facility had not provided her with a written Notice of Transfer or Discharge for Resident #1 at the time of his/her transfer to the ED and discharge from the Facility. The Guardian said she was not aware that Resident #1 was entitled to 30-day's notice of the Facility's intention to discharge him/her or that he/she had the right to appeal the Facility's discharge. During an interview on 3/25/24 at 11:00 A.M., the Administrator said that the Facility had not issued a Notice of Transfer or Discharge to Resident #1 or to his/her Guardian. During an interview on 3/25/24 at 12:45 P.M., the Licensed Social Work Associate (LSWA) said that she faxed a Notice of Transfer or Discharge for Resident #1 to the Long Term Care Ombudsman office, however said she had not provided a copy to Resident #1 or to his/her Guardian.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who had a court appointed legal Guardian who specified to Facility staff that if needed that Resident #1 be transferred to the closest hospital (which was only 10 miles away,) the Facility failed to ensure Resident #1's transfer was safe and orderly when, on 3/12/24 a physician order was obtained by nursing for Resident #1 to be transferred to the Hospital Emergency Department (ED) for evaluation however, the Facility instead discharged Resident #1 to an ED approximately 60 miles away, alone via a wheelchair van with all of his/her personal belongings. Findings include: The Facility Resident Rights Policy, dated as revised 10/2022, indicated staff members would treat residents with respect. The Policy indicated that Federal and State laws guaranteed certain basic rights to all residents, which included the right to participate in decision-making regarding their care. The Facility Care Plans Policy, dated as revised 1/2023, indicated each resident of the Facility would be involved in the development of his/her care plan, along with his/her family member. The Policy indicated the interdisciplinary team would collaborate with the resident and family in revising care plans Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. Review of the Progress Note, dated 3/12/24 at 12:41 P.M. (written by the Unit Manager), indicated Resident #1 refused care, refused to eat any Facility food and a physician order was obtained by nursing staff to transfer Resident #1 to the Hospital for further evaluation. During a telephone interview on 3/26/24 at 3:27 P.M., the Physician said that on 3/12/24, he received a call from the Unit Manager about Resident #1. The Physician said that the Unit Manager told him that Resident #1 was out of control, wasn't caring for him/herself, wasn't eating, was agitated, uncooperative, was not accepting his/her medications and defecated in his/her room. The Physician said that he gave an order to transfer Resident #1 to the emergency department for an evaluation. During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that on 3/12/24 the Facility Admission Director called her and said that the Facility might need to send Resident #1 to the hospital because he/she had, for several days, not been eating or accepting his/her antipsychotic medications. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Guardian said that during the telephone conversation, she told the Admission Director that if Resident #1 had to be transferred to the hospital, he/she should be transferred to the closest hospital (around 10 miles away.) The Guardian said that the Admission Director told her that it would be a disservice to Resident #1 and unfair to the closer hospital to send Resident #1 there, and, if Resident #1 needed to be transferred to the hospital, the Facility thought he/she should go back to the Hospital that referred him/her to the Facility (around 60 miles away). The Guardian provided the Surveyor with an email, dated 3/12/24, to the Facility Unit Secretary, which indicated the Guardian's request that, in the event of a transfer to the hospital, Resident #1 be transferred to the closest hospital and not the Hospital which had referred him/her to the Facility. During telephone interviews on: - on 3/25/24 at 1:13 P.M. with the Hospital Director of Regulatory Affairs, and, - on 3/26/24 at 3:50 P.M. with the Hospital Case Manager and Social Worker, they said the following: on 3/12/24, Resident #1 presented to the Hospital ED alone, with several bags of personal belongings, Resident #1 was brought to the hospital in a wheelchair van, not an ambulance, and the ED had not been prepared for or expecting Resident #1's arrival. The Guardian said that a short while later, the Hospital ED notified her that Resident #1 was in the ED. The Guardian said that despite her request, the Facility had transferred Resident #1 to the Hospital that was 60 miles away and not to the closest hospital. The Guardian said that the Facility had not notified her when they transferred Resident #1 to the ED or told her that they were in fact discharging Resident #1. The Hospital Case Manager, Social Worker and Director of Regulatory Affairs said that on 3/12/24, when case management staff in the ED contacted the Facility, Facility staff told them they would not permit Resident #1 to return to the Facility. The Guardian said that on 3/12/24 the Hospital ED notified her that the Facility refused to permit Resident #1 to return. During an interview on 3/25/24 at 11:00 A.M., the Administrator and the Director of Nurses said that when the Facility arranged transportation to the ED for Resident #1, a wheelchair van was available sooner than an ambulance. They said that because Resident #1 was not having a medical emergency and had no need for life support, the Facility scheduled a wheelchair van for Resident #1 instead of an ambulance. The Surveyor asked the Administrator and the Director of Nurses how Resident #1 and the Guardian were prepared for Resident #1's transfer/discharge to the Hospital. They said that because prior to admission, an arrangement had been made with the referring Hospital that if Resident #1's admission to the Facility did not go well, he/she could return to their Hospital, the Facility staff prepared Resident #1 and the Guardian for the transfer/discharge by telling them that the Facility was sending Resident #1 back to the Hospital. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Surveyor asked the Physician about Resident #1's discharge from the Facility to the Hospital ED. The Physician said he had not given the Facility an order to discharge Resident #1.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 15203 Based on interviews and records reviewed for one of three sampled residents (Resident #1), who had a court appointed legal Guardian, the Facility failed to ensure the Guardian was provided with a written notice which specified the duration of the Facility Bed-hold Policy at the time of Resident #1's transfer to the hospital on 3/12/24, as required. Findings include: The Facility Bed Hold Policy, dated as revised 10/2022, indicated that it was the policy of the Facility to provide the resident, responsible party or legal representative with notice of the Facility's Bed Hold Policy at the time of transfer from the Facility to ensure continuity of care and residence post therapeutic leave or hospitalization . The Policy indicated it applied to all residents regardless of payor source and indicated that a written notice including the duration of the State bed hold policy and the reserve bed payment policy would be provided to the resident and/or representative. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. Review of the Progress Note, dated 3/12/24 at 12:41 P.M. and written by the Unit Manager, indicated Resident #1 refused care, refused to eat any Facility food and a physician order was obtained by nursing staff to transfer Resident #1 to the Hospital for further evaluation. During an interview on 3/25/24 at 11:00 A.M., the Surveyor asked the Administrator whether a copy of their Bed Hold Policy was provided to Resident #1 and his/her Guardian at the time of Resident #1's transfer to the hospital on 3/12/24 and she said one was not. The Administrator said that the Facility did not provide a copy of the Bed Hold Policy to Resident #1 or the Guardian because the Facility discharged Resident #1 to the Hospital and a bed-hold was not in effect.

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), the Facility failed to permit Resident #1 to return following an evaluation in the emergency department (ED) when on 03/12/24, the Facility considered Resident #1 discharged at the time of the transfer. Findings include: The Facility Discharge/Transfer Policy, dated as revised 10/2022, indicated that each resident will be permitted to remain in the Facility and not be transferred or discharged unless: - a) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the Facility; - b) the transfer or discharge is appropriate because the Resident's health had improved; - c) the safety of individuals in the Facility is endangered due to the clinical or behavioral status of the resident; - d) the health of individuals in the Facility would otherwise be endangered; - e) the resident has failed after reasonable and appropriate notice to pay for the stay at the Facility; - f) the Facility ceased to operate, or, - g) the transfer/discharge is resident/family initiated. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. Review of the Progress Note, dated 3/12/24 at 12:41 P.M. and written by the Unit Manager, indicated Resident #1 refused care, refused to eat any Facility food and a physician order was obtained by nursing staff to transfer Resident #1 to the Hospital for further evaluation. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interviews on: - 3/25/24 at 1:13 P.M. with the Hospital Director of Regulatory Affairs, and, - 3/26/24 at 3:50 P.M. by telephone with the Hospital Case Manager and Hospital Social Worker, they said the following: the Facility discharged Resident #1 to the Hospital ED on 3/12/24 and when the ED case management staff contacted the Facility, the Facility would not permit Resident #1 to return. During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that on 3/12/24 the Facility Admission Director called her and said the Facility might need to transfer Resident #1 to the hospital due to refusing to eat or take medications. The Guardian said that a short while later, the Hospital ED called her and notified her that Resident #1 was in the ED and the Facility refused to permit Resident #1 to return. The Hospital Director of Regulatory Affairs, Hospital Case Manager and Social Worker said that on 3/13/24, they attended a virtual meeting about Resident #1 with Facility leadership and the Guardian. The Director of Regulatory Affairs, the Case Manager, Social Worker and Guardian said that the Facility refused to permit Resident #1 to return to the Facility during that virtual meeting on 3/13/24. During an interview on 3/25/24 at 11:00 A.M., with the Administrator and Director of Nursing they said they had attended the virtual meeting with Hospital leadership and the Guardian on 3/13/24 concerning Resident #1. The Surveyor asked whether Hospital staff told them during the virtual meeting that Resident #1 was ready to return and they said not specifically, however, they said the Hospital staff repeatedly stated that Resident #1 did not need to be in the Hospital and did not belong in the Hospital. The Administrator and Director of Nursing said that the Facility did not permit Resident #1 to return to the Facility. The Administrator and Director of Nursing said that when Resident #1 was at the Facility, he/she would not allow staff members to enter his/her room to clean, would not allow staff to assist him/her with personal care and would not accept food or medications. The Administrator and Director of Nursing said they determined the Facility could not meet Resident #1's needs. During an interview on 3/26/24 at 3:27 P.M., the Physician said that it would be difficult for the Facility to claim an inability to meet Resident #1's care needs when they had admitted him/her with those same needs a week prior and had cared for him/her for a week. The Physician said that he did not give an order to nursing staff for Resident #1's discharge.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who had a court appointed legal Guardian and complex mental health needs, the Facility failed to ensure they developed an effective discharge plan that addressed his/her needs and availability of services, prior to discharge, as required. Findings include: The Facility Discharge/Transfer Process Policy, dated as revised 10/2022, indicated that that Facility interdisciplinary team and the physician would regularly review a resident's potential for discharge and/or need to transfer to an alternate setting. The Policy indicated that a physician order was required in cases on non-emergent discharge. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed the Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder. The MDS indicated that there was no active plan for Resident #1 to return to the community. Review of Resident #1's Care Plan concerns, which were initiated 3/06/24, 3/07/24 and 3/09/24 and revised 3/09/24, indicated the Facility developed Care Plans with a focus on Resident #1's Activities, Mobility, Use of Antipsychotic Medication, Fall Risk, Self-care, Advanced Directives, Potential for Malnutrition, history of Suicidal Ideation and Skin Breakdown. Review of the Care Plan indicated there was no documentation to support the Facility having developed a Care Plan with a focus on any discharge plans for Resident #1. During an interview on 3/25/24 at 2:45 P.M., the Unit Manager said that Resident #1's adjustment to the Facility had not gone well and on 3/12/24, she spoke with the Physician about sending Resident #1 to the Hospital. Review of the Progress Note, dated 3/12/24 at 12:41 P.M. and written by the Unit Manager, indicated Resident #1 refused care, refused to eat any Facility food and a physician order was obtained by nursing staff to transfer Resident #1 to the Hospital for further evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/26/24 at 3:27 P.M., the Physician said that, on 3/12/24, he received a call from the Unit Manager about Resident #1. The Physician said that the Unit Manager told him that Resident #1 was out of control, wasn't caring for his/herself, wasn't eating, was agitated and uncooperative, was not accepting his/her medication and defecated in his/her room. The Physician said that he gave an order to transfer Resident #1 to the emergency department (ED) for an evaluation. During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that on 3/12/24 the Facility Admission Director called her and told her the Facility might need to send Resident #1 to the hospital. The Guardian said that during the phone call, the Admission Director told her that Resident #1 wasn't eating and refused his/her antipsychotic medication. The Guardian said that during the telephone conversation, she told the Admission Director that if Resident #1 had to be transferred to the hospital, he/she should be transferred to the closest hospital (around 10 miles away.) The Guardian said that the Admission Director told her that it would be a disservice to Resident #1 and unfair to the closer hospital to send Resident #1 there, and, if Resident #1 needed to be transferred to the hospital, the Facility leadership staff thought he/she should go back to the Hospital that referred him/her to the Facility (which was 60 miles away.) The Guardian provided the Surveyor with an email, dated 3/12/24, to the Facility Unit Secretary, which indicated the Guardian's request that, in the event of a transfer to the hospital, Resident #1 be transferred to the closest hospital and not the Hospital which referred him/her to the Facility. The Guardian said that a short while after her conversation with the Admission Director, the Hospital ED notified her that Resident #1 was in the ED (of the Hospital 60 miles away from the Facility.) The Guardian said that the Facility had not told her when Resident #1 was transferred to the Hospital ED. During telephone interviews on: -3/25/24 at 1:13 P.M. with the Hospital Director of Regulatory Affairs, and, -3/26/24 at 3:50 P.M. and with Hospital Case Manager and Hospital Social Worker, they said the following: on 3/12/24, Resident #1 presented to their ED, alone, with several bags of personal belongings, Resident #1 was brought to the ED by a wheelchair van, that the ED had not been prepared for or expecting Resident #1's arrival, when the Facility was contacted about Resident #1, Facility staff informed the ED that Resident #1 was not permitted to return to the Facility, they said Resident #1 did not need to be in the Hospital and had no where to go. The Guardian said that on 3/12/24 the Hospital ED called her and notified her that Resident #1 was in the ED and the Facility refused to permit Resident #1 to return. The Surveyor asked the Physician about Resident #1's discharge from the Facility to the Hospital ED and he said he had not given the Facility an order to discharge Resident #1. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Surveyor asked the Physician about the Facility's ability to meet Resident #1's needs. The Physician said that it would be difficult for the Facility to claim an inability to meet Resident #1's needs when they had admitted him/her with those needs a week prior and had cared for him/her for a week. During an interview on 3/25/24 at 11:00 A.M., with the Administrator and the Director of Nursing, they said the following: when Resident #1 was referred to the Facility by the Hospital, Hospital leadership told them that Resident #1 could return to the Hospital if his/her admission to the Facility was unsuccessful, the Facility did not develop a discharge plan for Resident #1 given their understanding that he/she could return to the Hospital, and the Facility discharged Resident #1 to the Hospital ED when they decided that the Facility could not meet Resident #1's needs. On 3/27/24, the Facility faxed the Surveyor a copy of Resident #1's Discharge Note. The Note, written by the Physician and dated 3/12/24, indicated that he/she received a phone call from the Unit Manager stating that Resident #1 was not eating, was behavioral and was refusing to care for his/her hygiene. The Note indicated the Physician agreed to transfer Resident #1 to the emergency department for further evaluation. Review of the Discharge Note provided to the Surveyor by the Facility indicated there was no documentation to support the Facility having developed a post-discharge plan of care for Resident #1, with Resident #1's participation and/or his/her Guardian, or having obtained a physician order for discharge, as required.

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1) for whom the Facility initiated a discharge, the Facility failed to ensure completion of a discharge summary that included a recapitulation of the Resident #1's stay, course of illness/treatment or therapy, final summary of his/her status and a post-discharge plan of care developed with the participation of Resident #1 and the Guardian, as required. Findings include: The Facility Discharge/Transfer Process Policy, dated as revised 10/2022, indicated that that Facility interdisciplinary team and the physician would regularly review a resident's potential for discharge and/or need to transfer to an alternate setting. The Policy indicated that a physician order was required to discharge a resident in non-emergent cases. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed a legal Guardian for Resident #1 during April 2023. The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating and hygiene and was continent of bowel and bladder. Review of the Progress Note, dated 3/12/24 at 12:41 P.M. and written by the Unit Manager, indicated Resident #1 refused care, refused to eat any Facility food and a physician order was obtained by nursing staff to transfer Resident #1 to the Hospital for further evaluation. During a telephone interview on 3/26/24 at 3:27 P.M., the Physician said that on 3/12/24, he received a call from the Unit Manager about Resident #1. The Physician said that the Unit Manager told him that Resident #1 was out of control, wasn't caring for his/herself, wasn't eating, was agitated, uncooperative, was not accepting his/her medication and defecated in his/her room. The Physician said that he gave an order to transfer Resident #1 to the emergency department for an evaluation. The Physician said that he had not given an order for Resident #1 to be discharged . During an interview on 3/25/24 at 11:00 A.M. with the Administrator and Director of Nursing, they said the Facility discharged Resident #1 to the Hospital Emergency Department on 3/12/24. On 3/27/24, the Facility faxed the Surveyor a copy of Resident #1's Discharge Note. The Note, written by the Physician and dated 3/12/24, indicated that he received a phone call from the Unit Manager stating that Resident #1 was not eating was behavioral and was refusing to care for his/her hygiene. The Note indicated the Physician agreed to transfer Resident #1 to the emergency department for further evaluation. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Discharge Note provided to the Surveyor by the Facility indicated there was no documentation to support the Facility's discharge summary included a recapitulation of the Resident #1's stay, course of illness/treatment or therapy, a final summary of Resident #1's status or a post-discharge plan of care developed with the participation of Resident #1 and Guardian, as required.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1) whose diagnoses included severe Obsessive Compulsive Disorder (OCD, OCD is a mental disorder that affects a person's brain and behavior which causes excessive thoughts that lead to repetitive behaviors and often centers on themes such as a fear of germs and commonly causes food aversion) the Facility failed to ensure Resident #1 received and was provided appropriate Behavioral Health services that addressed and met his/her mental health needs. Findings include: The Facility Behavioral Health Services Policy, dated as revised 10/2022, indicated the Facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the resident's assessment and plan of care. The Facility Psychiatric Services Policy, dated as reviewed 1/2023, indicated that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem and for the resident to receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. The Procedure indicated that the referral process would be assessed and set up by the Interdisciplinary Team, including the primary care physician and a written order for the referral obtained. The Facility Assessment, dated as updated 12/05/23 and reviewed by the Quality Assurance Committee on 1/25/24, indicated that Facility accepted residents with psychiatric/mood disorders such as psychosis, impaired cognition, mental disorder, depression, Bipolar disorder, schizophrenia, post-traumatic stress disorder, anxiety disorder and behavior that needs interventions. The Facility Assessment indicated the Facility provided services which include the following: managing the medical and medication-related issues causing psychiatric symptoms and behavior; identifying and implementing interventions to help support individuals with issues such as dealing with anxiety; the care of someone with cognitive impairment, and, the care of individuals with depression, trauma/PTSD and other psychiatric diagnoses. The Facility Assessment identified resources to provide competent support and care to residents which included social workers, mental health social workers and behavioral and mental health providers. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. The Record indicated the court appointed legal a Guardian for Resident #1 during April 2023. (continued on next page)

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F 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The Admission Minimum Data Set (MDS) Assessment, dated 3/12/24, indicated Resident #1's mental status was moderately impaired and he/she refused care daily. The MDS indicated Resident #1 was independent with eating, hygiene and was continent of bowel and bladder.

Review of Resident #1's Referral to the Facility from the Hospital indicated that Resident #1 had OCD, delusional disorder/psychosis and multiple extended hospitalization s for inability to care for him/herself. The Referral indicated that due to Resident #1's OCD/germophobia Resident #1 had been unwilling to use bathrooms and would instead urinate/defecate on public floors and him/herself. The Referral indicated Resident #1 had hoarding tendencies. The Referral indicated Resident #1 had severe malnutrition in the context of social/environmental/behavioral circumstances.

The National Institute of Mental Health indicates OCD is a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts (obsessions), engages in repetitive behaviors (compulsions), or both. People with OCD have time-consuming symptoms that can cause significant distress or interfere with daily life. Common obsessions include fear of germs or contamination and aggressive thoughts toward others or oneself. Common compulsions include excessive cleaning or handwashing. People with OCD generally can't control their obsessions or compulsions and experience significant problems in daily life due to these thoughts or behaviors.

The Mayo Clinic indicates OCD treatment includes talk therapy and/or medications. OCD symptoms include compulsive behavior, agitation, compulsive hoarding, hypervigilance, impulsivity, meaningless repetition of own words, repetitive movements, ritualistic behavior, social isolation, persistent repetition of words or actions, anxiety, apprehension, guilt, or panic, depression, fear, repeatedly going over thoughts, food aversion and/or nightmares

During interviews on:

- 3/25/24 at 11:00 A.M. with the Director of Nursing and the Administrator,

- 3/25/24 at 12:00 P.M. with the Admission Director, and,

- 3/25/24 at 2:15 P.M. with the Regional [NAME] President of Business Development, they said the following: the Hospital contacted the Facility and asked them to screen Resident #1 during February 2024, that Resident #1 had severe OCD and had been hospitalized for more than 100 days, Resident #1 required placement at a long-term care facility in a private room; Resident #1 had a court-appointed guardian, and Resident #1 had been referred to several other long-term care facilities, but not accepted.

The Director of Nursing and the Administrator said that the hospital told them that Resident #1 had been seen by psychiatry twice per week while in the Hospital.

The Admission Director said that once the Facility arranged a private room for Resident #1, his/her admission was scheduled for early March 2024.

During a telephone interview on 3/28/24 at 2:37 P.M., the Guardian said that she met with Resident #1 and the Admission Director at the Facility and completed Resident #1's admission documents.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Admission Documents indicated that on 3/06/24, Resident #1's Guardian consented for him/her to receive services at the Facility from the consultant Psychiatric Service which included assessment, service plan development and course of treatment. Review of Resident #1's Care Plan related to diagnosis of OCD requiring use of antipsychotic medication, dated as initiated 3/07/24, indicated a goal for resident was to have no evidence of behavior problems and Plan interventions included the following: administer medications as ordered; monitor/document side effects and effectiveness of medications; anticipate and meet Resident #1's needs; explain all procedures before starting, and, allow Resident #1 X minutes to adjust to change. Review of Resident #1's Progress Notes indicated the following: - on 3/06/24, Resident #1 stated he/she would only eat kosher food from a package that had not been handled by staff and he/she refused dinner; - on 3/07/24, Resident #1 requested kosher meals and refused vital signs; - on 3/08/24, Resident #1 refused his/her antipsychotic medication; - on 3/09/24, Resident #1 refused his/her antipsychotic medication and stated he/she did not take drugs and refused to be weighed; - on 3/10/23, Resident #1 refused his/her antipsychotic medication, and, - on 3/11/24, Resident #1 was defensive, focused on germs and obtaining prepackaged, kosher food and was unable to take in explanation and reasoning due to her overwhelming beliefs related to OCD/germophobia, and, Resident #1 refused his/her antipsychotic medication. During interviews on: - 3/25/24 at 2:45 P.M. with the Unit Manager, - 3/26/24 at 12:15 P.M. by telephone with the Unit Secretary, - 3/26/24 at 3:05 P.M. by telephone with Nurse #1, -3/28/24 at 1:08 P.M. by telephone with Nurse #2, - 3/27/24 at 2:40 P.M. by telephone with CNA #1, - 3/28/24 at 1:17 P.M. by telephone with CNA #2, and, -3/28/24 at 1:35 P.M. by telephone with CNA #3, they said the following: Resident #1 wanted to be left alone and not bothered while at they Facility. The Unit Manager, Nurse #1 and Nurse #2 said Resident #1 refused medication and vital signs assessment. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Unit Manager, Nurse #1, Nurse #2, the Unit Secretary, CNA #1 and CNA #2 said Resident #1 refused his/her meal trays and asked for prepackaged, kosher foods instead. The Unit Manager said Resident #1 asked to keep unrefrigerated milk at his/her bedside and for alcohol wipes to clean off the outside shells of hard-boiled eggs before eating them. The Unit Manager, the Unit Secretary and Nurse #2 said Resident #1 washed his/her hands excessively and requested alcohol wipes for cleaning. CNA #1 said Resident #1 wore gloves whenever he/she left his/her room. The Unit Manager, Nurse #1, Nurse #2, CNA #1 and CNA #2 said Resident #1 refused care and refused to change his/her clothes. The Unit Manager and Nurse #1 said Resident #1 would only allow staff members in his/her room if they removed their shoes. The Unit Manager said Resident #1 urinated on the floor in his/her room. Nurse #1 said Resident #1 urinated in his/her bed. They said Resident #1 would not allow staff members to change the bed linen or clean the room. CNA #2 said that although Resident #1's room was in need of housekeeping, including mopping the floor and removal of trash, he/she would not allow staff members in the room. During telephone interviews on: - 3/28/24 at 11:34 A.M. with Licensed Mental Health Counselor (Clinician #1), - 3/28/24 at 4:35 P.M. with Licensed Independent Clinical Social Worker (Clinician #2), and, - 3/29/24 at 8:10 A.M. with the Psychiatric Nurse Practitioner (Clinician #3), they said the following: They worked for the Psychiatric Service that contracted with the Facility to provide consultation and mental health services to Facility residents. They said they were in the Facility during Resident #1's stay at the Facility (Clinician #2 on 3/06/24, Clinician #1 on 3/07/24 and Clinician #3 on 3/08/24.) They said that they were also available by telephone to consult with the Facility about residents or to visit residents as needed in emergencies. They said that the Facility had not referred Resident #1 to the Psychiatric Service or contacted them about him/her while he/she was a resident. During an interview on 3/25/24 at 12:45 P.M., the Licensed Social Work Associate (LSWA) said that she faxed a referral to the Psychiatric Service on 3/11/24 and she said she did not know why the referral had not been sent sooner. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing and Administrator said that the Facility discharged Resident #1 to the Hospital emergency department on 3/12/24, twenty-four hours after the LSWA referred Resident #1 to the Psychiatric Service. The Director of Nursing said that the Facility considered referring Resident #1 the Psychiatric Service sooner and, by the time they got around to it, Resident #1 was already discharged .

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), the Facility failed to ensure they maintained compliance with regulation 258 CMR 20.00 relating to Professional Standards for social workers when, between 3/06/24 and 3/12/24, the Licensed Social Work Associate (LSWA) documented four Progress Notes in Resident #1's electronic health record (EHR) using the name (and therefore credentials) of the Licensed Independent Certified Social Worker (LICSW) Findings include: The Facility Social Worker Job Description indicates the social worker assumes the lead role in the delivery of psychological, financial, religious and physical needs of the resident, family members and significant others and assures resident's needs are met in accordance with policy and procedures of the facility. The Facility Charting and Documentation Policy, dated as revised 1/2023, indicated that all services provided to residents, or any changes in the resident's medical or mental condition are documented in the resident's medical record and should include the signature and title of the individual documenting. Review of a Written Statement, dated 3/25/24, indicated that the LSWA and LICSW worked for a Social Work Staffing Agency contracted by the Facility and were assigned to work at the Facility. The Statement indicated the LSWA was assigned to provide social services to residents at the Facility and the LICSW was assigned to provide weekly supervision to the LSWA. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. Review of Resident #1's Progress Notes indicated there were four social service Notes written between 3/11/24 and 3/12/24 (two on each date.) The Notes were dated and signed by the LICSW. During an interview on 3/25/24 at 12:45 P.M., the LSWA said that she provided the services described in the Progress Notes in Resident #1's clinical record on 3/11/24 and 3/12/24. During a telephone interview on 3/26/24 at 11:15 A.M., the Chief Executive Officer of the Social Work Staffing Agency said that she spoke to the LSWA on 3/25/24 and the LSWA told her that she had been documenting notes in Resident #1's EHR using the LICSW's username and password. The Chief Executive Officer said that the LICSW had not worked in the Facility during Resident #1's seven day stay and would not have been able to provide the services documented in the notes in Resident #1's EHR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adviniacare at Northbridge	85 Beaumont Drive Northbridge, MA 01534

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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/24 at 11:00 A.M., the Administrator said that she was not aware that the LSWA was documenting in Resident #1's EHR using the LICSW's username and password

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2024
NAME OF PROVIDER OR SUPPLIER Adviniacare at Northbridge		STREET ADDRESS, CITY, STATE, ZIP CODE 85 Beaumont Drive Northbridge, MA 01534	

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 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. 15203 Based on interviews and records reviewed, for one of three sampled Residents (Resident #1), the Facility failed to ensure they maintained accurate and complete medical records related to social services, when documentation for services provided by a staff member for social services in Resident #1's electronic health record (EHR) was signed under another contracted staff member's name and professional credentials. Findings include: The Facility Charting and Documentation Policy, dated as revised 1/2023, indicated that all services provided to residents, or any changes in the resident's medical or mental condition are documented in the resident's medical record. The Procedure indicated entries may be recorded only by licensed personnel and should include the signature and title of the individual documenting. Review of Resident #1's medical record indicated that he/she was admitted to the Facility during March 2024 and his/her diagnoses included obsessive compulsive personality disorder, adult failure to thrive, delusional disorder and unspecified psychosis. Review of Resident #1's Progress Notes indicated four social service Notes were written on 3/11/24 and 3/12/24 (two on each date.) The Notes were dated and signed by the Licensed Independent Certified Social Worker (LICSW.) During an interview on 3/25/24 at 12:45 P.M., the Licensed Social Work Associate (LSWA) said that she provided and documented the services described in the Progress Notes in Resident #1's clinical record on 3/11/24 and 3/12/24. During a telephone interview on 3/26/24 at 11:15 A.M., the Chief Executive Officer of the Social Work Staffing Agency said that she spoke to the LSWA on 3/25/24 and the LSWA told her that she had been documenting notes in Resident #1's EHR using the LICSW's username and password. The Chief Executive Officer said that the LICSW had not worked in the Facility during Resident #1's seven day stay and would not have been able to provide the social services or document the notes in Resident #1's EHR. During an interview on 3/25/24 at 11:00 A.M., the Administrator said that she was not aware that the LSWA was documenting in Resident #1's EHR using the LICSW's username and password .