STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225250	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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 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. 42741 Based on observation, interview, and policy review the facility failed to maintain a clean and homelike environment for one Resident (#11) on one Unit (#1) out of three units observed. Specifically, for Resident #11 who resided on Unit #1 the facility failed to ensure that the Resident's window covering was maintained in a clean manner. Findings include: Review of the facility policy titled Environmental Services Guidelines, dated September 2011, indicated the following: -Cleaning of walls, curtains, blinds, etc. will be completed when dust/soil is visible. On 5/9/24 at 10:20 A.M., the surveyor observed multiple areas of dried dark brown material and a large stain on Resident #11's window covering. During an interview at the time, Resident #11 said his/her window covering was dirty and he/she would like to have it cleaned or replaced. Resident #11 further said that he/she had not seen anyone clean the window covering recently and he/she was unsure what the spots and large stain were from. On 5/13/24 at 8:31 A.M., the surveyor observed that Resident 11's window covering remained with multiple areas of dried dark brown material and a large stain. During an observation and interview on 5/14/24 at 3:36 P.M., the surveyor and the Housekeeping Director observed Resident #11's window covering that remained with multiple spots of dried dark brown material and a large stain. The Housekeeping Director said the Resident's window covering should be wiped down regularly and if it could not be cleaned, housekeeping should have asked to have the window covering removed and replaced. The Housekeeping Director further said no one had informed him of the large stain on the window covering and he had window coverings readily available in the facility, that once staff noticed the window covering was visibly dirty a new window covering should have been requested.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37400 Based on observation, interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) Assessments for two Residents (#60 and #21), out of a total sample of 25 residents. Specifically, the facility failed to ensure the MDS Assessment was accurately coded relative to: 1. For Resident #60, the use of hypoglycemic medications (medications that reduce blood sugar [glucose]), antianxiety medication (used to treat feelings of fear, dread, uneasiness that may occur as a reaction to stress) and that the Resident was on dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). 2. For Resident #21, the administration of antipsychotic (used to treat symptoms of psychosis which include hallucinations, delusions and Dementia), antibiotic (used to treat bacterial infections), antianxiety and hypoglycemic medications. Findings include: 1. Resident #60 was admitted to the facility in October 2022, with diagnoses including End Stage Renal Disease (ESRD: medical condition in which the kidneys cease to function on a permanent basis), Psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality), Anxiety (reaction to stress that can cause fear, dread, and uneasiness), Type 2 Diabetes (inability for the body to regulate blood glucose levels in the blood) and dependence of renal dialysis. a. Review of the December 2023 Physician's orders indicated: -Insulin Lispro Kwikpen 100 Units(U)/1 milliliter (ml), 5 units with meals and 5 units at 6:00 A.M., and 5 units with lunch and dinner, initiated 2/13/23 -Insulin Glargine Pen 100 IU/1 ml solution, 16 units at 6:00 A.M., 16 units at 8:00 A.M. and 16 units at 8:00 P. M. -Clonazepam (antianxiety medication) 0.5 milligrams (mg) daily, initiated 12/28/23 -Dialysis on Mondays, Wednesdays, and Fridays, initiated 11/14/22 -Monitor the Dialysis shunt (surgically created connection between an artery and vein that provides access to the bloodstream for dialysis) every shift, bruit and thrill (sounds that can be heard or felt near a dialysis site and indicates that the site is working), initiated 11/14/22 Review of the December 2023 Medication Administration Record (MAR) indicated the Clonazepam, and the Insulin was administered as ordered and that the dialysis site and bruit and thrill were monitored as ordered. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment dated [DATE], indicated Resident #60 received Insulin (type of hypoglycemic medication) for 7 days. Further review of the MDS Assessment did not indicate that the Resident was on hypoglycemic and antianxiety medications or received dialysis during the assessment period. b. Review of the March 2024 Physician's orders indicated: -Dialysis on Mondays, Wednesdays, and Fridays, initiated 11/14/22 -Monitor the Dialysis shunt every shift, bruit and thrill, initiated 11/14/22 Review of the March 2024 MAR indicated the dialysis site, and the bruit and thrill were monitored as ordered. Review of the MDS assessment dated [DATE], indicated Resident #60 was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15 and was not receiving dialysis during the assessment period. On 5/9/24 at 9:00 A.M., the surveyor observed the Resident seated at the edge of the bed eating breakfast. During an interview, Resident #60 said that he/she had been receiving dialysis three times weekly on Mondays, Wednesdays and Fridays, had been on dialysis for a long time and has had no issues with the treatments. During an interview on 5/14/24 at 2:32 P.M., MDS Nurse #1 said that Resident #60's MDS Assessments dated 12/30/23 and 3/31/24 were reviewed and were inaccurate. Nurse #1 said the identified miscoded areas relative to the use of hypoglycemic medications, antianxiety medication, and that the Resident was not receiving dialysis were an oversight and modifications were made to the assessments. 2. Resident #21 was admitted to the facility in April 2021 with diagnoses including Adjustment Disorder with mixed Anxiety and Depressed Mood, Psychotic Disorder with delusions, Type 1 Diabetes (condition in which the body is unable to regulate blood sugar levels) and Schizophrenia (a serious mental disorder that interferes with a person's ability to think clearly, manage emotions, make decisions and relate to others). a. Review of the December 2023 Physician's orders indicated: -Augmentin (antibiotic) 500 mg-125 mg orally twice daily for a urinary tract infection (UTI), initiated 12/8/23 and discontinued 12/22/23 -Aripiprazole (antipsychotic) 15 mg daily, initiated 7/20/21 -Novolog Insulin 100 U/1 ml solution, per sliding scale (varies the dose of Insulin based on blood glucose [sugar] levels) before meals , initiated 7/12/23 -Novolog Insulin 100 U/1 ml solution, 6 units before meals, initiated 7/12/23 -Levemir Insulin 100 U/1 ml solution, 24 units at 8:00 P.M., initiated 6/1/22 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the December 2023 MAR indicated the Augmentin, Aripiprazole, and scheduled Insulin medications were administered as ordered. Further review of the December 2023 MAR indicated no documented evidence that an antianxiety medication was administered. Review of the MDS assessment dated [DATE], indicated Resident #21 received 7 days of Insulin and an antianxiety medication, and did not indicate that he/she received an antipsychotic, antibiotic or was on a hypoglycemic medication during the assessment period. b. Review of the March 2024 Physician's orders indicated Valium (antianxiety medication) 2 mg every 8 hours was initiated on 3/15/24. Review of the MDS assessment dated [DATE], indicated Resident #21 received antianxiety medication during the assessment period. Review of the March 2024 MAR indicated the Valium was not administered (was held) until 3/16/24. During an interview on 5/14/24 at 5:21 P.M., MDS Nurse #1 said he reviewed Resident #21's MDS Assessments dated 12/14/23 and 3/15/24, and the MDS Assessments were miscoded relative to the administration of an antipsychotic, antibiotic, antianxiety and hypoglycemic medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on record review and interview, the facility failed to ensure that two Residents (#109 and #82) and/or their Representative, out of a total sample of 25 residents, were included in the comprehensive care planning process. Specifically, the facility failed to: 1. For Resident #109, schedule Care Plan meetings as required, and facilitate participation by the Resident and/or Representative in the care planning process. 2. For Resident #82, ensure that a Care Plan conference was held, and the Resident and/or Resident Representative was involved in the care planning process after the completion of two MDS Assessments. Findings include: Review of the facility policy titled Care Planning, revised on 10/28/22, indicated the following: -A letter will be sent to each resident or resident representative inviting them to the meeting. -Attendance: CP (Care Plan) Coordinator (Social Worker) oversees the meeting, Unit Manager, Activities Staff, Dietary, CNA (Certified Nurse ' s Aide) Rehabilitation Staff as indicated. -During the care plan meeting, IDT (interdisciplinary team) member will summarize their care plan goals and interventions with the IDT and resident/resident representative. -The resident/resident representative's input and changes to any part of the plan of care will be updated by the appropriate IDT member 1. Resident #109 was admitted to the facility in September 2023, with diagnoses including malnutrition, COPD (a chronic lung disease that causes obstructed airflow and breathing problems) and Respiratory Failure (a serious condition that makes it difficult to breathe on your own. Develops when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively intact as evidenced by a BIMS (Brief Interview for Mental Status) score of 13 out of 15. During an interview on 5/9/24 at 10:39 A.M., Resident #109 said that he/she had meetings with outside community support for discharge planning that included the facility Social Worker (SW). Resident #109 said he/she could not recall participating in Care Plan meetings that included the IDT. Review of the medical record and UDA's (User Defined Assessments) indicated no documented evidence of care plan meetings since the Resident's admission in September 2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24 at 1:44 P.M., Social Worker (SW) #1 said that Care Plan meetings are held typically every 92 days, unless there is a significant change. SW #1 said that meetings are held with the resident and/or their representative and the IDT (which can include social services, rehabilitation services, nursing, dietary and activities) to review the Resident's care plan and to talk about progress, discharge planning or any concerns the Resident might have. SW #1 said the Care Plan meeting is documented under the UDA titled Care Plan Meeting. SW #1 further said that if the assessments are not documented in the computer under the UDA then the meeting did not occur. SW #1 said that the Care Plan meetings most likely did not occur and that it may have been an oversight by the facility staff. During a follow-up interview on 5/14/24 at 2:09 P.M., SW #1 said that after talking with the MDS Nurse it appeared that the Resident should have had three Care Plan meetings and did not as required. SW #1 additionally said that the Resident was not on any Care Plan meetings schedules and should have been. 42741 2. Resident #82 was admitted to the facility in October 2023, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), Polymyalgia Rheumatica (an inflammatory disorder causing muscle pain and stiffness), Atherosclerotic Heart Disease (damage or disease in the hearts major blood vessels), and Peripheral Vascular Disease (a circulatory condition where the blood vessels narrow and reduce blood flow to the limbs). Review of the Minimum Data Set (MDS) Assessment indicated the Resident had quarterly or comprehensive MDS Assessments completed with Assessment Reference Dates (ARD - date used as a specific end point of a look back period in the MDS Assessment process) of 11/2/23 and 2/2/24. Review of the Resident's medical record indicated no documentation that a Care Plan conference was held or the Resident and/or Resident Representative was involved in the care planning process after the completion of the 11/2/23 and 2/2/24 MDS Assessments. During an interview on 5/13/24 at 8:27 A.M., Nurse #4 said Care Plan conferences are held after the MDS Assessment is completed. The surveyor and Nurse #4 reviewed Resident #82's medical record and Nurse #4 said she was unable to locate any documentation a Care Plan conference had been held following the completion of the 11/2/23 and 2/2/24 MDS Assessments. Nurse #4 further said the Care Plan Meeting documentation should include who was invited to the meeting, who attended the meeting, and what changes were made to a resident's care plan. During an interview on 5/14/24 at 10:13 A.M., the Corporate Quality Assurance Nurse said Care Plan conferences should be held following the completion of the MDS Assessments. The Corporate Quality Assurance Nurse further said she was unable to locate any documentation to show Care Plan conferences were held for Resident #82 following the completion of the 11/2/23 and 2/2/24 MDS Assessments. She said documentation should be placed in the chart indicating who attended the conference and what was discussed at the care plan conference, but it did not appear this was done.

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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. 50563 Based on observation, interview, record and policy review, the facility failed to provide care in accordance with professional standards of practice for one Resident (#18), out of a total sample of 25 residents, with a Peripherally Inserted Central Catheter (PICC: a thin, soft tube that is inserted into a vein in the arm, for long-term antibiotics, nutrition, medications, and blood draws. The PICC is a type of CVAD [Central Vascular Access Device] catheter) placing Resident #18 at risk for undiagnosed infiltration (when fluid or medication given by an intravenous device exits the vein and enters the soft tissues) and/or deep vein thrombosis (DVT: a blood clot in a deep vein). Specifically, the facility staff failed to: -appropriately monitor the PICC device and discontinue use when external catheter length measurements varied from the admission insertion measurements. -complete external catheter length and arm circumference measurements as ordered. -notify the Provider timely when changes in external catheter length and arm circumference measurements were identified. Findings include: Resident #18 was admitted to the facility in January 2024, with the following diagnoses: Osteomyelitis of the right femur (inflammation of the thigh bone or bone marrow due to infection), paraplegia (chronic condition that involves the partial or complete loss of muscle function and feeling in the lower half of the body, including both legs) and Stage 4 pressure ulcers of the right and left buttock (full thickness tissue loss with exposed bone, tendon or muscle. Slough [is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture] or eschar [dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color] may be present on some parts of the wound bed). Review of the facility policy titled Central Vascular Access Device (CVAD): Dressing Changes, dated 7/1/18, included but was not limited to: -measurement of external catheter length upon admission/insertion of the PICC and with every dressing change. -measurement of upper arm circumference, 3 inches above insertion site or other location determined by insertion or admission Nurse, upon admission/insertion of the PICC and with every dressing change. -If the measurements are different, notify the Practitioner (Physician/Nurse Practitioner [NP]/ Physician Assistant [PA]) Nurse to discuss clinical plan. According to Lippincott Nursing Procedures - 9th Edition (2023), to ensure the PICC line has not migrated (moved out of the appropriate location for safe use): (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Nurse should measure the external length of the catheter during dressing changes. -Additionally, the Nurse should measure the arm circumference above the PICC insertion site when clinically indicated to monitor for the presence of edema (swelling) and DVT. Review of Resident #18's Physician orders from March 2024 to May 2024 indicated, but was not limited to, the following: -Intravenous (IV: medication administered through a catheter, such as the PICC, for stronger/quicker effect) antibiotic (medication given to treat infection), Cefepime 2 grams (gm) every 12 hours for treatment of Osteomyelitis and Stage 4 pressure ulcer of the right buttock, initated 3/5/24 and discontinued on 4/16/24. -Intravenous antibiotic Cefepime 2 gm every 12 hours for treatment of Osteomyelitis and Stage 4 pressure ulcer of the right buttock, initiated 4/16/24 and discontinued on 5/14/24. -PICC dressing change every 7 days, measure external catheter length and arm circumference at 3 inches above insertion site with each dressing change. Admission external catheter length of 0 cm (centimeters) and arm circumference of 32 cm, initiated 3/7/24 and discontinued 5/2/24. -PICC dressing change every Thursday, measure external catheter length and arm circumference at 3 inches above insertion site with each dressing change. Admission external catheter length of 0 cm and arm circumference of 32 cm, initiated 5/2/24. Review of PICC Insertion Report titled Record for IV Nurse dated 3/6/24, indicated the measurement of Resident #18 PICC's external catheter was 0 cm at time of insertion and the arm circumference that was measured 10 cm (3.9 inches) above the insertion site was 32 cm at time of insertion. Review of Resident #18's PICC care plan dated 1/31/24 and revised on 3/8/24, included the following interventions: -1/31/24: monitor for signs/symptoms of catheter and infusion related complications. -1/31/24: change dressing per policy, specific catheter type. -1/31/24: measure external catheter length, and upper arm circumference per policy and notify Prescriber (Physician/NP/PA) if change noted from previous measurements. Review of the March 2024 Treatment Administration Record (TAR) indicated scheduled PICC dressing changes were due on 3/12/24, 3/19/24 and 3/26/24. Further review of the March 2024 TAR indicated no Pro Re Nata (PRN: as needed) documentation for unscheduled dressing changes. Review of the PICC dressing change documentation on the scheduled TAR change dates indicated: -3/12/24: M was documented with no attached note in the TAR Documentation Report indicating what M meant. No measurements were documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/19/24: held (not done), with attached note in TAR Documentation Report that indicated the dressing change was held due to the dressing being changed on 3/14/24 and change was not due until 3/21/24. No measurements were documented. -3/26/24: held, with attached note in TAR Documentation Report that indicated held due to dressing change was performed by the Wound Nurse. No measurements were documented. Review of the April 2024 TAR indicated weekly PICC dressing changes were due on 4/2/24, 4/9/24, 4/16/24, 4/23/24 and 4/30/24. Further review of the April 2024 TAR PRN PICC dressing documentation review indicated no documentation of unscheduled dressing changes. Review of the PICC dressing change documentation on the scheduled TAR change dates indicated: -4/2/24: M with no attached note in TAR Documentation Report that indicated what M meant. No measurements were documented. -4/9/24: M with no attached note in TAR Documentation Report that indicated what M meant. No measurements were documented. -4/16/24: held, with attached note in TAR Documentation Report that indicated the dressing was completed by the Wound Nurse. No measurements were documented. -4/23/24: held, with attached note in TAR Documentation Report that indicated completed by a different Nurse. No measurements were documented. -4/30/24: held, with attached note in TAR Documentation Report that indicated the Charge Nurse was to complete the dressing change. No measurements were documented. Review of May 2024 TAR indicated weekly PICC dressing changes were due on 5/2/24 and 5/9/24. Further review of May 2024 TAR PRN PICC dressing documentation indicated no unscheduled dressing change documentation. Review of the PICC dressing change documentation on the scheduled TAR change dates indicated: -5/2/24: dressing completed. Measurements included 13 cm external catheter length (+13 cm change from the time of insertion) and 38 cm arm circumference (+6 cm change from the time of insertion). Note attached in the TAR Documentation Report indicated dressing changed with no issues. -5/9/24: dressing completed. Measurements included 11 cm external catheter length (+11 cm change from the time of insertion) and 44 cm arm circumference (+20 cm change from the time of insertion). No attached note in the TAR Documentation Report. Review of the Nursing Progress Notes from March 2024 to May 2024 addressing PICC dressing changes, external catheter length and arm circumference measurements and/or notification to Provider of changes to measurements indicated the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/14/24 at 9:59 P.M.: PICC dressing changed. External catheter length 0 cm and arm circumference 42 cm (+10 cm change from the time of insertion). -4/5/24 at 2:36 P.M.: PICC dressing changed by Unit Manager (UM) this shift. No measurements documented. -5/9/24 at 3:22 P.M.: PICC line dressing changed with no issues. External catheter length of 12.5 cm (+12.5 cm change from the time of insertion) and 38 cm circumference measured at 2 inches above the insertion site (+6 cm change from the time of insertion). During an interview on 5/14/24 at 9:45 A.M., Nurse #2 said if there was a change identified when performing a PICC dressing change, the Nurse would notify the Provider for orders. During an interview on 5/14/24 at 1:32 P.M., UM #2 said during a dressing change measurement would be obtained for the external catheter length and arm circumference and if there was variation in the measurements from the admission insertion measurements, that the Provider would be notified right away. UM #2 said that the expectation would be the PICC would not be used until orders from the Provider were obtained as the changed measurements place Resident #18 at risk for having infiltration and/or the catheter no longer being in the correct place for use. When the surveyor asked about the documentation process, UM #2 said if the Charge Nurse completed the dressing change, the expectation would be for the Nurse on the medication cart to document the dressing change as held, and note who completed the treatment. UM #2 said the Charge Nurse would then document the dressing change in a nursing progress note. The surveyor and UM #2 reviewed the 5/2/24 and 5/9/24 dressing change documentation on the Resident's TAR, and UM #2 said the measurements were different than the measurements obtained on the PICC insertion date. UM #2 said if those were the measurements obtained, the Nurse should not use the PICC without contacting the Provider for additional instructions. On 5/14/24 at 2:15 P.M., the surveyor observed UM #2 measure the external catheter length of Resident #18's PICC and the external catheter measurement obtained was 1.5 cm (+1.5 cm change from the time of insertion). UM #2 said that she would go speak with the Nurse Practitioner (NP) to obtain orders due to the measurement of 1.5 cm external catheter length being longer than the insertion length of 0 cm.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, record review, and interview, the facility failed to provide proper treatment and care for good foot health for one Resident (#226) out of a total sample of 25 residents. Specifically, for Resident #226, the facility staff failed to assess, and assist with completing and submitting the necessary podiatry consent form to facilitate timely podiatry services to address the Resident's long toenails. Findings include: Review of the facility policy titled Consulting Services, Podiatry/Dental/Optometry/Audiology approved on 12/22/16, indicated that residents/resident representative are provided information about consulting services upon admission and at any time when need arises. Resident #226 was admitted to the facility in April 2024 with diagnoses including localized edema (a disorder that causes swelling in a specific area of the body due to a buildup of fluid) and peripheral edema (swelling in the arms, legs, ankles, feet and hands caused by fluid retention in the tissues). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was mildly cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. Review of the Resident's medical 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) had been invoked (put into effect by a Physician) on 4/29/24. On 5/9/24 at 11:15 A.M., the surveyor observed that the Resident was wearing flip flop sandals and his/her toenails were long, thick and slightly yellow. Resident #226 said that his/her toenails were uncomfortable and depending on what shoes he/she had on they sometimes hurt. Resident #226 said that he/she was unsure of who to contact to help get his/her toenails cut. Review of the Request for Services for the company contracted to provide podiatry services, indicated that the form was incomplete. Further review of the Request for Services form indicated no disciplines was selected, including podiatry services, and the signature area was blank. During an interview on 5/15/24 at 9:55 A.M., Nurse #5 said that she often completed paperwork when a new admission came into the facility and that the contracted service consent form was reviewed upon admission with the resident and/or their representative/HCP. Nurse #5 pulled up the contracted service consent form on the computer and found that the Resident's name and date of birth were completed, but no services were selected and the form was not signed. Nurse #5 said it appeared that the services provided by the contracted company had not been reviewed with the Resident or his/her Representative but should have been. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 10:22 A.M., Social Worker (SW) #1 said that the contracted company consent form was completed upon admission and faxed to the contracted company so that the consents were on file when a resident requested or required any of the services offered. SW #1 said that the Unit Manager (UM), SW and Director of Nurses (DON) are provided a list of residents that are to be seen by the contracted company through email. SW #1 said that the UM, SW and DON can also make a referral. SW #1 said she was not aware of Resident #226 receiving any services through the contracted company. During an interview and observation on 5/15/24 at 10:54 A.M., Nurse #3 said that she looks at feet and toenails when completing weekly skin checks. Nurse #3 said that Resident #226's toenails were long, and that she noticed it when he/she was admitted but the long toenails had not been addressed at this point. The surveyor and Nurse #3 observed Resident #226's toenails and Nurse #3 said his/her toenails were long, but thought she might be able to cut the toenails herself, except for one nail that was too thick. Nurse #3 said that she could also follow-up to ensure the Resident will be seen by a Podiatrist through the contracted company.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#35) out of a total sample of 25 residents, was provided with an environment that was free from accidental hazards. Specifically, for Resident #35, the facility failed to implement the appropriate size bed side rails and maintain the bed in the lowest position after the Resident sustained a fall and injury, as preventative measures for further falls and injuries. Findings include: Review of the facility policy titled Care Planning, revised on 10/28/22, indicated the following: -All MD (Medical Doctor) orders .are considered a part of the care plan. Resident #35 was admitted to the facility in March 2024, with a new diagnosis of above the knee amputation (AKA -surgically cutting off the limb) of the right leg. Review of the Fall Care Plan initiated on 3/26/24, indicated the Resident was at risk for falls due to a change in mobility/gait status post right AKA and deconditioning (physiological change following a period of inactivity, bedrest or sedentary lifestyle). Review of a Nurses Progress note dated 4/4/24 (late entry for 4/3/24), indicated the following: -CNA (Certified Nurses Aide) came out of another resident's room when they heard someone yelling help me and Resident #35 was seen hanging off the side of the bed. -Resident #35 was kneeling on the floor and had his/her hands on the bed rail. -Resident #35 said he/she was lying on their side when the air mattress shifted his/her weight, and he/she slipped out of the bed and caught him/herself on the bedrail and landed on his/her left leg. -Amputation site had been hit; two stitches popped open resulting in light bleeding. -Skin tear on the left lower abdomen. Review of the incident report completed on 4/3/24 due to an unwitnessed fall/near fall out of bed indicated the following: -Resident was lying on their side after patient care, waiting for wound care to be completed. -Environmental factors included: air mattress, no side rail. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Active Orders Report indicated a Physician order for quarter (1/4) side rail on bilateral (both) side(s) of bed with a start date of 3/25/24. Review of the UDA (User Defined Assessment) section titled Side Rail assessment dated [DATE], indicated 1/4 bed side rails right upper and [right] lower. During a telephone interview on 5/14/24 at 9:25 A.M., CNA #1 said that the Resident was on an air mattress with the hand bar side rails in the locked position. CNA #1 said immediately after the (fall) incident, the new intervention was to install the longer bed side rails, also known as 1/4 bed side rails. During an interview on 5/14/24 at 10:33 A.M., the surveyor and Unit Manager (UM) #1 reviewed the Physician orders, the admission side rail assessment, and the comprehensive care plan for Resident #35. UM #1 said that the nursing staff had completed a side rail assessment upon the Resident's admission that indicated right upper and [right] lower 1/4 bed side rails were appropriate at this time. UM #1 said that was a documentation error and that it should have indicated right and left upper 1/4 bed side rails were appropriate at this time. UM #1 said that per the Physician orders and the side rail assessment, 1/4 bed side rails should have been in place upon admission and at the time of the Resident's fall on 4/3/24. UM #1 said that based on the information she had, the small hand positioning bars were in place rather than the required 1/4 bed side rails. The surveyor and UM #1 reviewed the updated care plan which indicated a new intervention on 4/5/24 to add 1/4 bed side rails to the bed, indicating that the 1/4 bed side rails had previously not been installed on the Resident's bed at the time of the fall that occurred on 4/3/24, as required per the Resident's care plan. Review of the Falls Care Plan initiated on 3/26/24 and updated on 4/5/24, after Resident #35 experienced a fall out of bed on 4/3/24, indicated to keep the bed in the lowest position at all times. On 5/13/24 at 10:40 A.M., the surveyor observed Resident #35 to be seated in bed with the head of the bed elevated, watching television. The surveyor further observed that the bed was not set to the lowest position. On 5/15/24 at 10:03 A.M., the surveyor observed Resident #35 lying in bed with the bed not set in the lowest position. During an interview immediately following the observation on 5/15/24 at 10:03 A.M., the surveyor and CNA #2 reviewed the Kardex (a documentation system that enables Nurses to write, organize, and easily reference key patient information that shapes their nursing care plan and is utilized by the CNA's when providing care) and CNA #2 said that per the Kardex the Resident's bed should be in the lowest position as an intervention for fall safety. The surveyor and CNA #2 walked to the Resident's room and observed that the bed was not in the lowest position as indicated in the Resident's care plan. CNA #2 said that the bed was not in the lowest position and that it should be much lower than the position it was found, per the Resident's plan of care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45435 Based on observation, interview, record and policy review, the facility failed to provide nutritional care and services for two Residents (#63 and #84), out of a total sample of 25 residents. Specifically, the facility staff failed to: 1. For Resident #63, provide a nutritional supplement when the Resident was identified as being at nutritional risk due to a resolving hip fracture. 2. For Resident #84, provide an increase in a nutritional supplement as indicated for added calories, protein and hydration support from once to twice daily. Findings include: Review of the facility's policy titled Nutrition Management, dated 6/6/22, indicated the following: -Review dietitian's recommendations. Obtain orders per recommendation. -Review dietitian's progress notes to identify ongoing progress and recommendations. 1. Resident #63 was admitted to the facility in June 2022, with diagnoses including Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment), and a fracture of the neck of the right femur (hip fracture) sustained in April 2024. Review of the Minimum Data Set (MDS) Assessment, dated 4/24/24 indicated the following: -Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of 15 total possible points. -Resident was dependent on staff for eating. -Resident had a fracture related to a fall in the past six months. -Resident had recent surgery requiring active skilled nursing facility (SNF) care. -Resident had repair of fracture of pelvis, hip, leg, knee or ankle. Review of the Readmission, Initial Nutritional History Assessment, dated 4/30/24 indicated the following: -Resident did not take supplements. -Resident had a resolving fractured right hip. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident was at nutritional risk due to experiencing or having the potential for unplanned weight loss, skin breakdown, and delayed wound healing. -The Dietitian made a recommendation for House supplement 237 milliliters (ml) twice a day. Review of the Physician's orders, dated 4/30/24 through 5/15/24 indicated the following: -Diet-House regular, regular texture, thin liquids. -HS (hour of sleep) substantial snack. Further review of the Physician's orders indicated no evidence of a Physician's order for the House supplement as recommended by the Dietitian on 4/30/24. Review of the Medication Administration Record (MAR) dated 4/30/24 through 5/14/24, indicated no evidence that a House supplement had been administered to Resident #63 as recommended by the Dietitian. During an interview on 5/14/24 at 1:53 P.M., Unit Manager (UM) #3 said when the Dietitian has a recommendation for a resident, it is communicated through an e-mail to the UM, the Director of Nurses (DON), and the Nurse Practitioner (NP). UM #3 said it was her responsibility to review the recommendation with the NP and obtain an order for the recommendation. UM #3 said she checks her e-mail every day and did not recall receiving an e-mail regarding Resident #63. UM #3 checked her e-mails and provided the surveyor with a recommendation for Resident #63, from the Dietitian, that was dated 4/30/24, and requesting to implement House supplement 237 ml twice a day. UM #3 said that she had been having computer problems and must have missed the recommendation. 2. Resident #84 was admitted to the facility in August 2023, with the diagnosis of Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy resulting in too much sugar in the blood). Review of the MDS Assessment, dated 2/1/24, indicated the following: -Resident had intact cognitive functioning as evidenced by a score of 15 out of a possible 15 points on the BIMS. -Resident required set-up and clean up assistance for eating. -Resident had malnutrition (a lack of proper nutrition caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). -Resident had weight loss of 5% or more in the last month or 10% or more in the last six months (defined as significant weight loss), and was not on a Physician prescribed weight loss program. Review of the Dietitian Progress Note dated 2/13/24, indicated the following: -Resident #84 continued to present at nutritional risk. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Weight 162.9 pounds indicated a questionable significant weight loss x 180 days. -Weight loss was attributed to the use of different scales and resolving edema. -The Dietitian made a recommendation for the Boost Glucose Control (nutritional supplement) to be increased to twice a day for added calorie/protein and hydration support. Review of the May 2024 Physician's orders indicated the following: -Diet - HCC (Diabetic diet), regular texture, thin liquids -Boost Glucose Control Chocolate, eight ounces daily at 10:00 A.M. Review of the Resident's MAR dated 2/13/24 through 5/9/24 indicated Resident #84 had been administered Boost Glucose Control Chocolate, eight ounces, daily at 10:00 A.M. During an interview on 5/10/24 at 10:53 A.M., the Registered Dietitian (RD) said that her process when she has a recommendation for a Resident is that she sends the recommendation via e-mail to the UM, the DON, and the NP. The RD said the recommendation to increase the Boost Glucose supplement from once a day to twice a day for Resident #84 was not sent to the UM, DON and the NP and the recommendation was never implemented. Review of the Dietitian Progress Note dated 5/10/24 at 11:27 A.M., indicated the following: -Resident was supplemented with Boost Glucose at 237 ml every day and was consuming 100%. -When the RD asked the Resident about the supplement and if he/she would like a second one, the Resident said he/she would like to have the supplement increased.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on record and policy review, and review of the facility assessment, the facility failed to ensure that annual performance appraisals were completed every 12 months and regular in-service education was provided based on the outcome of the performance appraisals for four Certified Nurses Aides (CNAs) out of a sample of five CNAs. Specifically, the facility failed to ensure that expectations, individual performance, and training requirements were communicated to CNA #3, CNA #4, CNA #5 and CNA #6 through the annual performance appraisal process as required. Findings include: Review of the Facility assessment dated [DATE] indicated: -The facility uses competency-based job descriptions, -a competency-based assessment process for the nursing department and annual performance appraisals to identify the training the staff needs to receive and accompanying plan. Review of the facility policy titled Performance Review indicated: -The facility will attempt to maintain a performance appraisal system that is administered at the completion of one's introductory period and at least once a year to every employee. -The performance appraisal will be used as a tool to assess one's performance and for such things as determining changes that may be appropriate to one's job, setting goals/expectations for the coming year, providing for an opportunity to receive feedback from employees about their job, and determining one's fitness for continued employment. Review of the facility personnel files for CNA #3, #4, #5, and #6 indicated the following: -CNA #3: date of hire 9/3/10, last performance appraisal was completed on 10/18/19. -CNA #4: date of hire 5/13/20, indicated no evidence that an annual performance appraisal had ever been completed. -CNA #5: date of hire 5/28/18, indicated no evidence that an annual performance appraisal had ever been completed. -CNA #6: date of hire 10/7/21, indicated no evidence that an annual performance appraisal had ever been completed. During an interview on 5/14/24 at 8:33 A.M., the Staff Development Coordinator (SDC) said she was not responsible for the staff's annual performance reviews and said she thought the Unit Managers (UMs) completed the annual performance reviews. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/24 at 9:05 A.M., the Director of Nurses (DON) said annual performance appraisals/ reviews were not completed consistently. The DON further said the process was for the Human Resource (HR) department to notify the UMs which employees were due for their annual performance appraisal, and it was the UMs responsibility to complete the performance appraisal and review with the employee annually. During an interview on 5/14/24 at 4:37 P.M., CNA #7 said she started working at the facility in 2018 and could not remember if she had ever received an annual performance appraisal. During an interview on 5/14/24 at 5:05 P.M., CNA #8 said she has worked at the facility for more than nine years, and used to have yearly performance appraisals with the UM, however it has been more than two years since she last had a performance appraisal. During an interview on 5/14/24 at 5:16 P.M., CNA #9 said the UMs used to do performance appraisals with the staff, but he could not recall the last time he had a performance appraisal. During an interview on 5/15/24 at 8:30 A.M., CNA #4 said she did not recall ever having had an annual performance appraisal. During an interview on 5/15/24 at 8:37 A.M., CNA #6 said she did not recall the last time she had received an annual performance appraisal. During an interview on 5/15/24 at 8:48 A.M., Nurse #4, who had previously worked as a UM at the facility said UMs, or the employee's direct supervisor were supposed to be notified by HR as to which employees were due to have performance appraisals completed. Nurse #4 said this should be done annually on the employee's anniversary date and the performance appraisals were to be reviewed by the manager with the employee. During an interview on 5/15/24 at 9:10 A.M., UM #2 said the annual performance appraisal process begins with HR providing a list of staff members that were due to be completed to the UMs. UM #2 said the UMs then complete the performance appraisal forms and review the data with the employee at which point the UM and the employee discuss the results, questions, and concerns. UM #2 said this process should be completed annually and the performance appraisals were to be retained in the employee's permanent personnel file. UM #2 further said the last performance appraisal she completed was for a Nurse over a year ago, she had never completed a performance evaluation for a CNA, and had not been notified by HR of any employees due for their annual performance appraisals in over a year. During an interview on 5/15/24 at 11:21 A.M., the DON said the facility did not have a consistent HR person in the building, therefore the annual performance appraisals had not been completed annually as required. During a follow-up interview on 5/15/24 at 1:56 A.M., the SDC said that while she ensured CNAs completed their required annual 12 hours of education, the education provided was not directly related to the results of the annual performance appraisals as she did not have access to that information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50563 Based on observation, interview and policy review, the facility failed to ensure that medications were labeled in accordance with professional standards to include an expiration date on two (#2 and #4) out of three observed medication carts, and on two units (Unit 1 and Unit 2) out of three observed units. Specifically, the facility failed to ensure that an ophthalmic (relating to the eye and its diseases) medication was appropriately labeled to indicate the bottle open date and/or discard date according to manufacturer's guidelines and prevent the administration of outdated medications that could result in contamination and infections for facility residents. Findings include: According to the National Library of Medicine (2022): https://www.ncbi.nlm.nih.gov/books/NBK540978/#:~:text=Latanoprost%20is%20a%20colorless%2C%20isotonic,46%20%C2%B0F)%20for%20storage, once Xalatan Ophthalmic Drops (generic name Latanoprost: eye drops used to treat high pressure in the eye) is opened, it may be stored at room temperature for 6 weeks. Review of the facility policy titled Medication Storage Information, undated, indicated: -opened Xalatan Ophthalmic Drops should be stored at room temperature and have an expiration date of 6 weeks after opening. On 5/14/24 at 11:54 A.M., the surveyor observed and Nurse #8 observed medication cart #2 on Unit 1. The surveyor and Nurse #8 observed one bottle of Xalatan Ophthalmic Drops in the medication cart drawer that was undated and did not indicate when the medication bottle was opened or when to discard the medication. During an interview at the time, Nurse #8 said the bottle of Xalatan Ophthalmic Drops should be dated when opened. Nurse #8 further said that he would discard the medication bottle when the bottle was empty, or when the Physician's order for the administration of the medication was completed. On 5/15/24 at 1:01 P.M., the surveyor and Nurse #9 observed medication cart #4 on Unit 2. The surveyor and Nurse #9 observed one bottle of Xalatan Ophthalmic Drops in the medication cart drawer without a date that indicated when the bottle was opened or when to discard the medication. During an interview at the time, Nurse #9 said that she was unsure how to know when to discard the medication bottle and would find out. Nurse #9 left and returned and said that the DON said eye drops did not have to be dated when opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 1:38 P.M., the surveyor and Director of Nurses (DON) reviewed the undated facility policy titled Medication Storage Information. The DON said the policy indicates that Xalatan Ophthalmic Drops should be discarded 6 weeks after opened. The DON said she could not provide an answer as to how Nurses would know when to discard the two undated bottles of Xalatan Ophthalmic Drops. The DON said the bottles of Xalatan Ophthalmic Drops should labeled when opened to indicate either the date opened or the discard date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45435 Based on interview and record review, the facility failed to maintain complete and accurate medical records for three Residents (#8, #21 and #60) out of a total sample of 25 residents. Specifically, the facility staff failed to: 1. For Resident #8, ensure accurate documentation relative to the units of Insulin (medication used to manage blood sugar levels) administered per the sliding scale for each of the readings requiring sliding scale coverage. 2. For Resident #21, accurately administer and document the base and sliding scale units of Insulin as ordered by the Physician. 3. For Resident #60, accurately document the bruit and thrill (sounds that can be heard or felt near a dialysis site and indicate that the site is working) assessment of the dialysis access site. Findings include: Review of the facility's policy titled, Diabetic Management Protocol, dated, April 2018, indicated the following: -Document all scheduled insulin/oral hypoglycemic medication on Medication Administration Record (MAR). -Document all sliding scale insulin medication on Diabetic Monitoring Flow Sheet. 1. Resident #8 was admitted to the facility in March 2013, with a diagnosis of Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy resulting in too much sugar in the blood). Review of the May 2024 Physician's orders indicated the following: -Insulin Glargine (long-acting insulin used to treat high blood sugar) 18 units subcutaneously (under the skin) at 8:00 P.M. -Insulin Lispro- (fast acting insulin used to control high blood sugar) 5 units base and sliding scale before meals, scheduled for 7:30 A.M., 11:30 A.M., and 4:30 P.M. -Check blood glucose before meals, scheduled for 7:30 A.M., 11:30 A.M., and 4:30 P.M. Insulin Lispro sliding scale: Below 80 mg/dl (milligrams per deciliter) mealtimes base= - (minus)2 units (continued on next page)

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	225250	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Commons Nursing & Rehabilitation Center	Christian Hill Road Great Barrington, MA 01230

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	80-149 mealtime base = 0 units 150-199 mealtime base = +1 unit 200-249 mealtimes base = +2 units 250-299 mealtime base = +3 units 300-349 mealtime base = +4 units 350 mealtime base = +5 units -Give mealtime Insulin after meal has been eaten. Review of the Medication MAR, dated 5/1/25 through 5/14/24, indicated the following: -the Resident received Insulin Glargine 18 units daily at 8:00 P.M. -the Resident received Insulin Lispro 5 units daily at 7:30 A.M., 11:30 A.M., and 4:30 P.M. Further review of the MAR showed no indication of what dose, if any Lispro Insulin was given as ordered per the sliding scale requirements for the following blood sugar readings: -At 7:30 A.M., the Resident's blood glucose readings were the following: -5/5/24 - 298 -5/6/24 -183 -5/7/24 - 241 -5/8/24 - 287 -5/10/24 - 263 -5/13/24 - 80 -5/14/24 - 245 -At 11:30 A.M., the Resident's blood glucose readings were the following: -5/1/24 - 261 -5/2/24 - 410 -5/3/24 - 249 -5/5/24 - 355 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/9/24 - 285 -5/10/24 - 263 -5/11/24 - 241 -5/12/24 - 305 -5/13/24 - 265 -5/14/24 - 215 -At 4:30 P.M., the Resident's blood glucose readings were the following: -5/1/24 - 346 -5/2/24 - 272 -5/3/24 -154 -5/4/24 -189 -5/6/23 - 232 -5/6/23 -179 -5/8/24 - 206 -5/9/24 - 350 -5/10/24 - 311 -5/11/24 -159 -5/12/24 - 254 -5/14/24 - 256 Review of the Nurses Progress Notes, dated 5/1/24 through 5/14/24, showed no documented evidence of the number of units of Insulin that were administered per the sliding scale for each of the readings requiring sliding scale coverage. A Diabetic Monitoring Flow Sheet was not provided for Resident #8. During an interview on 5/15/24 at 9:31 A.M., the Corporate Quality Assurance Nurse said she was unable to provide documented evidence of the number of units of Lispro Insulin that was administered as ordered per the sliding scale for Resident #8. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/24 at 11:30 A.M., Nurse #7 said that the Insulin orders were confusing because some of the orders indicated to administer the Insulin before meals, after the blood glucose was tested , and another order indicated to administer the Insulin after the meal was eaten. When the surveyor asked Nurse #7 if she was able to see what dose of sliding scale Insulin the Resident had received on the past several days in the electronic MAR, Nurse #7 scrolled through the order history and said there was no documentation of what dose was administered. Nurse #7 said that the only documentation indicated base dose plus sliding scale, but that there was no indication of the number of units of Insulin given. Nurse #7 further said that the Insulin orders for the Resident were confusing to her and that she was a travel Nurse and did not want to say too much. 37400 2. Resident #21 was admitted to the facility in April 2021 with a diagnosis including Type 1 Diabetes (condition in which the body is unable to regulate blood sugar [glucose] levels within the blood). Review of the May 2024 Physician's orders included the following: -Novolog Insulin 100 U/1 milliliter (ml) solution .6 units before meals, initiated 7/12/23 -Novolog Insulin 100 U/1 ml solution . per sliding scale before meals . 0-149 (blood sugar reading) = 0 units 150-199 = 1 unit 200-249 = 2 units 250-299 = 4 units 300-349 = 6 units 350-399 = 8 units 400-449 = 10 units 450 or over = 12 units -contact the Physician greater than 500, initiated 7/12/23 Review of the May 2024 Medication Administration Record (MAR) indicated the following: -Novolog Insulin, 6 units before meals was documented as administered daily -Novolog Insulin, per sliding scale, was documented as administered: -5/3/24 at 4:30 P.M., Blood Sugar = 326; the documentation indicated that 12 units of Insulin were administered, and 6 units were indicated per the sliding scale order (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/4/24 at 7:30 A.M., Blood Sugar = 207; the documentation indicated that 8 units of Insulin were administered, and 2 units were indicated per the sliding scale order -5/4/24 at 11:30 A.M., Blood Sugar =320; the documentation indicated that 13 units of Insulin were administered, and 6 units were indicated per the sliding scale order -5/5/24 at 7:30 A.M., Blood Sugar =89; the documentation indicated that 6 units of Insulin were administered, and 0 units were indicated per the sliding scale -5/5/24 at 11:30 A.M., Blood Sugar =223; the documentation indicated that 8 units of Insulin were administered, and 2 units were indicated per the sliding scale -5/7/24 at 11:30 A.M., Blood Sugar =223; the documentation indicated NA and 2 units were indicated per the sliding scale -5/9/24 at 7:30 A.M., Blood Sugar = 220; the documentation indicated that 7 units of Insulin were administered, and 2 units should have been administered per the sliding scale -5/9/24 at 11:30 A.M., Blood Sugar = 247; the documentation indicated that 9 units of Insulin were administered, and 2 units should have been administered per the sliding scale During an interview on 5/15/24 at 10:46 A.M., Nurse #6 said the 6 units of scheduled Insulin that Resident #21 receives are signed off as administered under that specific Insulin order and the amount of Insulin given per the sliding scale should be documented under the sliding scale order. The surveyor and Nurse #6 reviewed the May 2024 MAR and Nurse #6 said that she does not understand why the amounts of sliding scale Insulin on certain days did not match the sliding scale orders to be administered. Nurse #6 further said that the scheduled doses and the amount per the sliding scale should not be added together and documented under the sliding scale order as they are separate orders. During an interview on 5/15/24 at 10:53 A.M., Unit Manager (UM) #2 said that the dosage of Insulin administered per the sliding scale should be the amount documented under that specific Insulin order for Resident #21 and should not include the scheduled doses of Insulin. UM #2 said the schedule doses are documented under those specific Insulin orders. 3. Resident #60 was admitted to the facility in October 2022 with diagnoses including End Stage Renal Disease (ESRD: medical condition in which the kidneys cease to function on a permanent basis), dependence of renal dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) and presence of arteriovenous fistula (AV fistula: connection between an artery and vein to provide access for dialysis). Review of the May 2024 Physician's orders included the following: -Dialysis right arm shunt (AV fistula) monitoring bruit and thrill every shift, initiated 4/11/24 Review of the May 2024 Medication Administration Record (MAR) indicated an order to monitor the dialysis right arm shunt for bruit and thrill every shift and indicated an N (no presence of) on the following dates/times: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Shift 1 (7:00 A.M. to 3:00 P.M.) on 5/3, 5/8, 5/9 and 5/12/24 -Shift 2 (3:00 P.M. to 11:00 P.M.) on 5/4, 5/7, 5/8, and 5/10/24 -Shift 3 (11:00 P.M. to 7:00 A.M.) on 5/4, 5/5, 5/11, and 5/12/24 On 5/14/24 at 2:06 P.M., the surveyor and Nurse #2 reviewed Resident #60's May 2024 MAR relative to the documentation of the bruit and thrill. Nurse #2, who regularly works at the facility and with Resident #60, said the Resident's bruit and thrill are monitored every shift to ensure that the dialysis site was functioning. Nurse #2 said if the bruit and the thrill were not present, then the Nurse should call the Physician and the Resident's dialysis clinic for instructions. Nurse #2 reviewed the documentation and said that there have been no issues with the Resident's right arm shunt, that the Resident has been going to dialysis three times weekly as scheduled and there have been no complications. During an interview on 5/14/24 at 2:25 P.M., UM #2 said she has cared for Resident #60 frequently and there had never been any issues with his/her right arm dialysis shunt site. UM #2 reviewed the documentation relative to the bruit and thrill for May 2024 and said that the documentation was inaccurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on observation, interview, record and policy review, the facility failed to maintain an infection prevention and control program designed to help prevent the potential transmission of communicable diseases and infections within the facility for one Resident (#112) out of a total sample of 25 residents. Specifically, the facility staff failed to clean and disinfect multi-use equipment after use on a resident prior to using the same equipment on Resident #112 who was at high risk for infection. Findings include: Review of the facility policy titled Procedure for Isolation: Initiation of Isolation Precautions dated 4/11/22 indicated but was not limited to: -If supplies go into the room, it must not be used for any other resident until it is cleaned and disinfected. -The blood pressure cuff may be cleaned with the healthcare system approved disinfectant product per the manufacturer's instructions. Review of the facility policy titled Enhanced Barrier Precautions (EBP: a type of precautions initiated to help prevent a resident who is at high risk for infection from contracting facility acquired infections), dated 1/10/23, indicated but was not limited to the following: -Enhanced Barrier Precautions expand the use of Personal Protective Equipment (PPE) and refer to the use of gown and gloves during high-contact care that provide opportunities to transfer Multi-Drug Resistant Organisms (MDROs: infection causing bacteria that have become resistant to antibiotics and are easily transmitted to others) -Nursing home residents with wounds and indwelling medical devices (device that enters the body providing an entry point for MDROs and other organisms) Resident #112 was admitted in December 2023 with the following diagnoses: Sepsis (the body's widespread and life threatening response to an infection), End Stage Renal Disease dependent on renal dialysis (ESRD: a permanent condition where the kidneys stop functioning and requires filtering of the blood regularly[dialysis] to remove the toxins the kidneys no longer cannot remove) and Obstructive Uropathy (the back up of urine into one or both kidneys due to a structural or functional obstruction in the urinary tract). Review of Resident #112's May 2023 Physician's orders indicated the following: -Enhanced Barrier Precautions due to an Indwelling Urinary Catheter (a tube inserted into the bladder to assist with draining of urine), initiated 4/19/24. On 5/15/24 at 8:30 A.M., during a medication administration the surveyor observed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #1 taking the blood pressure of a resident in room [ROOM NUMBER] and then without cleaning or disinfecting the blood pressure cuff (device used to obtain the blood pressure) place the cuff into her scrubs (uniform) pocket. -Nurse #1 completed the medication administration for the resident in room [ROOM NUMBER] and exited the room and returned to the medication cart located in the hallway with the blood pressure cuff still in her pocket. -Nurse #1 was then observed to proceed down the hall to Resident #112's room which had an EBP sign attached to the door frame. -Nurse #1 was observed preparing medications for administration, performed hand hygiene appropriately, donned (put on) a gown (over the top of her scrubs where the soiled blood pressure cuff remained in her pocket) and gloves and entered Resident #112's room. -Nurse #1 was observed to assess the Resident, which included obtaining a blood pressure, for which she reached under her gown and removed the blood pressure cuff from her pocket, and then applied it to Resident #112's arm without cleaning/disinfecting the blood pressure cuff before use. During an interview immediately following the medication administration observation on 5/15/24, Nurse #1 said that she should not have used the blood pressure cuff that was used on another resident and stored in her uniform pocket on Resident #112, without first cleaning and disinfecting the blood pressure cuff. During an interview on 5/15/24 at 9:42 A.M. the Infection Control Nurse (IC Nurse) said the expectation would be to sanitize the blood pressure cuff after use before using it on another resident. The IC Nurse said Nurse #1 also should have notified the IC Nurse that there was no dedicated blood pressure cuff for Resident #112 since he/she was on EBP. The IC Nurse said relative to cleaning and disinfecting equipment, she would refer staff to the portions of the Procedure for Isolation: Initiation of Isolation Precautions policy that discuss cleaning and disinfecting equipment for cleaning and disinfecting policy and procedures.