STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225260	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Milford	20 Claflin Street Milford, MA 01757

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46562 Based on observations, interviews, and record review, for one Resident (#28) of 16 sampled residents, the facility failed to ensure his/her call light was accessible so he/she was able to call for assistance. Findings include: Review of the facility's policy titled Answering the Call Light, dated as revised September 2022, indicated but was not limited to: -Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. Resident #28 was admitted to the facility in November 2022 with the following diagnoses: cerebral infarction (stroke), hemiplegia (weakness or paralysis of one side of the body) affecting the right side and aphasia (defect or loss of the power of expression by speech, writing, or signs, or of comprehending spoken or written language, due to injury or disease of the brain). Review of the Minimum Data Set (MDS) assessment, dated 2/29/24, indicated Resident #28 had short and long-term memory problems as evidenced by staff interview. Further review of the MDS indicated Resident #28 had unclear speech, had limited range of motion on one side of his/her upper body, and was dependent on facility staff for self-care and mobility. On 4/29/24 at 9:25 A.M., the surveyor observed Resident #28 lying in bed with his/her call light on the floor on the left side of his/her bed and out of his/her reach. During an interview on 4/29/24 at 9:27 A.M., Certified Nursing Assistant (CNA) #1 said Resident #28 had a stroke and had paralysis of his/her right side and could not communicate verbally. The surveyor and CNA #1 observed the call light on the floor next to the Resident's bed and CNA #1 said the call light should be within reach and not on the floor. On 4/30/24 at 7:24 A.M., the surveyor observed Resident #28 lying in bed with the call light clipped to the top left corner of the mattress with the cord hanging down and the call light resting on the floor out of his/her reach. Resident #28 was pointing to his television and attempting to ask the surveyor for help. The surveyor made Nurse #1 aware that the Resident needed assistance and acknowledged the need to assist him/her. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 7:47 A.M., Nurse #1 said she had assisted Resident #28 and that he/she was all set. At 7:49 A.M., the surveyor returned to Resident #28's room and found the call light clipped to the top left corner of the mattress, hanging on the floor and out of his/her reach, in the same position previously observed. On 5/1/24 at 4:15 P.M., the surveyor observed Resident #28 lying in bed with the call light clipped to the top left side of the mattress with the cord hanging down and the call light resting on the floor out of his/her reach. The surveyor asked Resident #28 if he/she could reach the call light, and he/she was unable to do so. During an interview on 5/1/24 at 4:30 P.M., Nurse #4 said Resident #28 had a stroke and was unable to communicate verbally and could not use his/her right side. Nurse #4 said Resident #28 required staff assistance with bed mobility. Nurse #4 said the Resident's call light should always be within reach. The surveyor and Nurse #4 observed the call light on the floor and Nurse #4 said she had forgotten to put the call light within reach prior to leaving Resident #28's room. During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON) said the expectation was for call lights to be within reach at all times.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 34145 Based on interviews, policy review, and review of Resident Council Minutes, the facility failed to ensure that grievances brought forward through Resident Council from 9/21/23 through 3/29/24 were addressed and promptly resolved as required. Findings include: Review of the facility's policies titled Resident Council Policy and Procedure, last revised 4/2018, and the Grievance and Missing Items Policy and Procedure, last revised 4/2017, included but was not limited to: -The Grievance Officer is the Executive Director or the Director of Nursing, in their absence. -The Grievance Officer is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion; issue written grievances decision to the resident. -The facility must consider the views of a resident council and act promptly upon grievances and recommendations of the resident council concerning issues of resident care and life in the facility. -The facility must be able to demonstrate their response and rationale for their response. Review of the Resident Council Minutes, dated 9/21/23, indicated 13 residents participated in the meeting, and brought forward the following grievances: -One resident complained that staff do not come quick enough to assist him/her. -One resident complained that he/she is supposed to have two Flomax (medication), instead of one. Review of the Resident Council Minutes, dated 10/26/23, indicated nine residents participated in the meeting, and brought forward the following grievances: -One resident complained that he/she needs Citracal and ColEase (medications) everyday but is not receiving it. -One resident complained that he/she has a tear on her leg and that the dressing is not being changed every day and feels the nurses are not keeping an eye on those things. -One resident said he/she wants to know the rules about late night television and noise. -One resident complained that staff are putting his/her neighbor's briefs on the floor and not in bags. -One resident complained that he/she is not able to sleep at night due to his/her neighbors playing loud music and having the television on late at night. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Minutes, dated 11/24/23, indicated 16 residents participated in the meeting, and brought forward the following grievances: -One resident complained that the aides are not waking him/her up at 8:00 A.M. like they are supposed to. He/she said they have been waking him/her up around 10:00 A.M., which he/she dislikes. -One resident complained that his/her leg dressing is not getting changed daily like it's supposed to; only twice a week (repeated complaint from 10/23/23). Review of the Resident Council Minutes, dated 12/22/23, indicated 15 residents participated in the meeting, and brought forward the following grievances: -One resident complained that nursing staff should make rounds throughout their shifts. -Two residents voiced complaints during the meeting that were brought to the attention of the Director of Nursing (DON). -One resident requested to be toileted throughout the night so he/she doesn't wet the bed. Review of the Resident Council Minutes, dated 1/19/24, indicated 15 residents participated in the meeting, and brought forward the following grievances: -Four residents voiced complaints during the meeting that were brought forward to the attention of the DON. Review of the Resident Council Minutes, dated 2/23/24, indicated 13 residents participated in the meeting, and brought forward the following grievances: -One resident complained that he/she is being woken up too early (between 5:00 A.M. - 5:30 A.M.) for the nurses to take his/her blood pressure and temperature. -One of three residents' complaints that were voiced during the meeting that were brought forward to the attention of the DON were not addressed. Review of the Resident Council Minutes, dated 3/29/24, indicated 14 residents participated in the meeting, and brought forward the following grievances: -One resident requested to know how many pills he/she is supposed to take. -One resident complained that he/she doesn't want to be woken up at 6:00 A.M. (repeat complaint from 2/23/24). -One voiced complaints during the meeting that were brought forward to the attention of the DON. Review of the Grievance Book and Resident Council Book failed to indicate evidence that grievances brought forward through Resident Council were addressed and resolved. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24 at 1:00 P.M., the surveyor held a Resident Group meeting with eight residents in attendance. The surveyor reviewed grievances identified in the 9/21/23 through 3/29/24 Resident Council minutes as listed above. The residents said they are frustrated because when they ask about the issues they brought forward during each meeting, they are told they are working on it. They said some of these issues have been raised repeatedly during monthly Resident Council meetings, which are unresolved and continue to be a problem. During interviews on 4/30/24 at 2:20 P.M. and 3:10 P.M., the Activity Director said she coordinates the Resident Council Meetings and takes the meeting minutes. She said she is responsible for ensuring the grievance process is followed for grievances brought forward during Resident Council meetings. She said for each grievance, she completes an Interdisciplinary Communication Form and provides it to the appropriate department to address and keeps a copy of the responses in the binder. The Activity Director reviewed the Resident Council Binder and found three undated Interdisciplinary Communication Form responses for grievances identified during the 2/23/24 Resident Council Meeting; one of which was incomplete and unsigned by the department head. The Activity Director said the former DON (no longer employed by the facility as of March 2024) did not address or resolve any grievances brought forward for her department. During an interview with the Administrator and DON on 5/1/24 at 7:22 A.M., the Administrator said that he and the Social Worker work together as Grievance Officials for general grievances from residents and families and the Activity Director maintains the grievance book for grievances brought forward through the Resident Council. He said he oversees both grievance processes. The Administrator and DON reviewed the grievance book from Resident Council and said there was no follow-up to the residents' grievances. He said the goal is to address grievances immediately, but some things may take longer. The DON said grievances should be resolved at least before the next Resident Council Meeting. The Administrator said they need to develop a process to ensure grievances brought forward through Resident Council are addressed, documented, and resolved timely.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 46562 Based on Minimum Data Set (MDS) assessment review and staff interview, the facility failed to ensure an MDS assessment was completed timely as required for four Residents (#5, #12, #11, and #59), out of four records reviewed and 16 sampled residents. Specifically, the facility failed to ensure MDS discharge assessments were completed within the required timeframe. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3. 0 Manual Chapter 2: Assessments for the RAI, dated October 2023, indicated but was not limited to: -A Discharge Assessment when return is anticipated must be completed no later than 14 calendar days after the discharge date . Review of the facility's policy titled MDS Completion and Submission Timeframes, dated as revised July 2017, indicated but was not limited to: -Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes -Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. 1. Review of Resident #5's medical record indicated he/she was discharged from the facility on 2/28/24. Review of Resident #5's discharge MDS assessment indicated an assessment reference date (ARD) of 2/28/24, but the assessment had not been completed and therefore had not been transmitted. 2. Review of Resident #12's medical record indicated he/she was discharged from the facility on 1/18/24. Review of Resident #12's discharge MDS assessment indicated an assessment reference date (ARD) of 1/18/24, but the assessment had not been completed and therefore had not been transmitted. 3. Review of Resident #11's medical record indicated he/she was discharged from the facility on 12/19/23. Review of Resident #11's discharge MDS assessment indicated an assessment reference date (ARD) of 12/19/23, but the assessment had not been completed and therefore had not been transmitted. 4. Review of Resident #59's medical record indicated he/she was discharged from the facility on 11/21/23. Review of Resident #59's discharge MDS assessment indicated an assessment reference date (ARD) of 11/21/23, but the assessment had not been completed and therefore had not been transmitted. During a telephonic interview on 5/2/24 at 2:29 P.M., MDS Nurse #2 said she reviewed the medical records for Resident's #5, #12, #11, and #59 and the discharge MDS assessments had not been completed within 14 days of the discharge as required. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON) said the expectation was for MDS assessments to be completed and submitted as required.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on record review and interview, the facility failed to accurately complete the Minimum Data Set (MDS) assessment for four Residents (#47, #58, #22, and #46), out of 16 sampled residents. Specifically, the facility failed: 1. For Resident #47, to ensure falls were accurately coded on the MDS; 2. For Resident #58, to ensure falls were accurately coded on the MDS; 3. For Resident #22, to accurately code his/her hospice status on the MDS; and 4. For Resident #46, to accurately code a fall with fracture. Findings include: 1. Resident #47 was admitted to the facility in November 2022 with the following diagnoses: dementia and weakness. Review of Resident #47's medical record, including fall incident reports, indicated he/she had a fall on 1/25/24, 1/26/24, 3/3/24, 3/24/24, and 4/9/24. Review of the MDS assessment, dated 4/11/24, Section J, indicated Resident #47 had only one fall since the previous assessment on 1/18/24. During a telephonic interview on 5/2/24 at 2:29 P.M., MDS Nurse #2 said she reviewed the medical record for Resident #47 and said the MDS, dated [DATE], had not accurately reflected the Resident's number of falls. 2. Resident #58 was admitted to the facility in January 2024 with the following diagnoses: weakness and repeated falls. Review of Resident #58's medical record, including fall incident reports, indicated he/she had a fall while in the facility on 4/4/24. Review of the MDS assessment, dated 4/4/24, Section J, indicated Resident #58 had no falls since admission/re-entry. During a telephonic interview on 5/2/24 at 2:29 P.M., MDS Nurse #2 said she reviewed the medical record for Resident #58 and said the MDS, dated [DATE], had not accurately reflected the Resident's fall status. 3. Resident #22 was admitted to the facility in July 2021 with the following diagnoses: dementia and weakness. Review of Resident #22's medical record indicated he/she had been admitted to hospice on 12/6/23. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the MDS assessment, dated 3/7/24, Section O, failed to indicate he/she had received hospice services. During a telephonic interview on 5/2/24 at 2:29 P.M., MDS Nurse #2 said she reviewed the medical record for Resident #22 and said the MDS, dated [DATE], had not accurately reflected the Resident's hospice status. 48695 4. Resident #46 was admitted to the facility in January 2021 with diagnoses of dementia and multiple fractures of the pelvis. Resident #46 was hospitalized in February after a fall and returned to the facility in March 2024, with diagnoses of right lateral rib fracture. Review of the MDS assessment, dated 3/11/24, Section J, failed to indicate Resident #46 had a fall with major injury. During a telephonic interview on 5/2/24 at 2:02 P.M., MDS Nurse #2 said the MDS, dated [DATE], should have been coded as a fall with fracture but was not. During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON) said the expectation was for MDS assessments to accurately reflect the residents' status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48695 Based on observations, interviews, policy review, and records reviewed, for three Residents (#14, #22, and #51), out of 16 sampled residents, the facility failed to develop and implement comprehensive care plans to reflect the individual needs of the residents. Specifically, the facility failed: 1. For Resident #14, to develop and implement a care plan for an indwelling Foley catheter (tube placed in the body to drain and collect urine from the bladder); 2. For Resident #22, to develop and implement a care plan for an indwelling Foley catheter; and 3. For Resident #51, failed to a. develop a comprehensive care plan for self-administration of finger stick blood sugar testing (FSBS), and b. develop a comprehensive care plan for an implantable cardiac device. Findings Include: Review of the facility's policy titled Care Planning- Comprehensive, last revised May 2017, indicated but not limited to: -An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. -Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. Each resident comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; e. Reflect treatment goals, timetables, and that objectives are measurable; f. Identify the professional services that are responsible for each element of care; and i. Reflect currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. 1. Resident #14 was admitted to the facility in March 2024 with diagnoses including hypertensive urgency, cognitive communication deficit, and urinary retention. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/5/24, indicated that Resident #14 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Review of Resident #14's May 2024 Physician's Orders indicated but was not limited to: -Foley Cath (Indwelling Catheter) care every shift (4/26/24) -Document Foley Cath output every shift (4/26/24) Further review of Resident #14's medical record indicated his/her indwelling catheter was inserted on 4/11/24. Review of Resident #14's care plans failed to indicate that a care plan for the indwelling catheter had been developed. During an interview on 5/2/24 at 12:31 P.M., Nurse #5 said residents who have an indwelling catheter should have a care plan which includes care of the indwelling catheter. Nurse #5 and the surveyor reviewed Resident #14's care plans. Nurse #5 said Resident #14 did not have a care plan for an indwelling catheter but should. During an interview on 5/2/24 at 5:07 P.M., the Director of Nursing (DON) said the expectation for a resident with an indwelling catheter was to have a care plan. The DON said Resident #14 did not have an indwelling catheter care plan but should have had one. 46562 2. Resident #22 was admitted to the facility in January 2024 with diagnoses including dementia. Review of the MDS assessment, dated 3/7/24, indicated that Resident #22 had short and long-term memory problems as evidenced by staff interview. Review of Resident #22's May 2024 Physician's Orders indicated but was not limited to: -Foley Catheter care every shift, dated 4/16/24 Further review of Resident #22's medical record indicated his/her indwelling catheter was inserted on 4/15/24. Review of Resident #22's care plans failed to indicate a care plan for the indwelling catheter had been developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/24 at 12:33 P.M., Nurse #4 said, when a resident's plan of care changes, the care plans should be implemented and/or updated. During an interview on 5/2/24 at 3:32 P.M., Nurse #3 said Resident #22 had an indwelling catheter related to hospice recommendations. Nurse #3 reviewed the medical record and said there was no care plan for the indwelling catheter. During an interview on 5/2/24 at 5:07 P.M., the DON said the expectation for a resident with an indwelling catheter was to have a care plan. The DON said Resident #22 did not have an indwelling catheter care plan but should have had one. 34145 3. Resident #51 was admitted to the facility in October 2022 with diagnoses including atrial fibrillation (a quivering or irregular heartbeat) and diabetes mellitus type 2. Review of the most recent MDS assessment, dated 3/14/24, indicated Resident #51 was cognitively intact as evidenced by a BIMS score of 15 out of 15, has diabetes mellitus, and receives insulin injections daily. During an interview on 4/29/24 at 10:17 A.M., Resident #51 said he/she is diabetic and showed the surveyor a small black box that he/she said contained supplies to test blood sugar. The Resident said he/she tests his/her blood sugar, then goes out to the nursing station so they know what the number is and administer insulin coverage if needed. The surveyor observed a small electronic device on a table. The Resident said it is a monitor for an implanted device to monitor his/her atrial fibrillation. He/she said if he/she goes into atrial fibrillation, a signal is sent to the monitor, and it is then sent to his/her cardiologist. a. Review of the medical record included, but was not limited to the following Physician's order: -Humalog (antidiabetic insulin) 100 units/1 milliliter (mL) solution per sliding scale, subcutaneous before meals and at hour of sleep (HS) (2/10/23): -fingerstick blood sugar (FSBS) 0 - 149=no coverage -FSBS 150 - 199=give 2 units -FSBS 200 - 249=give 4 units -FSBS 250 - 299=give 6 units -FSBS 300 - 349=give 8 units -FSBS 350 - 399=give 10 units -FSBS above 400=give 12 units, then re-evaluate in one week (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 11:40 A.M., the surveyor observed Resident #51 walk out of his/her room and approach Nurse #2 at the medication cart. The Resident told the nurse that he/she had just checked his/her blood sugar and the value was 150. Nurse #2 said the Resident checks his/her own blood sugar levels and tells nursing the results. On 5/1/24 at 4:56 P.M., the surveyor observed Resident # 51 poke his/her finger, place a drop of blood onto a test strip (strip of material containing chemicals that react to certain substances) and insert it into the glucometer (used to measure how much glucose (a type of sugar) is in the blood). Review of comprehensive care plans included, but was not limited to: -Problem: Diabetes Mellitus, Alteration in Metabolic Function (10/20/22) -Interventions: Medication as ordered; Observe for signs and symptoms of hypo/hyperglycemia; Monitor blood sugar as ordered -Goals: Resident will be free from signs and symptoms of hypo/hyperglycemia daily through next review (goal date: 6/24/24) Further review of interdisciplinary care plans failed to indicate a care plan was developed for Resident #51's self-administration of FSBS testing before meals and at HS. b. Review of the medical record indicated a 3/8/23 consultation note from the Resident's Cardiologist. The note indicated Resident #51 had an implantable loop recorder (ILR: used for continuous electrocardiographic monitoring) inserted on 4/20/21. Review of comprehensive care plans failed to indicate a care plan had been developed for the use of an ILR device to monitor the Resident's atrial fibrillation. During an interview on 5/1/24 at 9:52 A.M., Nurse #2 said Resident #51 has an implanted cardiac device that transmits information to his/her cardiologist. The Nurse reviewed the Resident's medical record and said a care plan had not been developed for the use of the cardiac device and monitoring system. During an interview on 5/1/24 at 12:10 P.M., the Director of Nursing (DON) reviewed the medical record and said a care plan had not been developed for the Resident to self-administer FSBS testing and for the Resident's ILR device and monitoring system.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Milford	20 Claflin Street Milford, MA 01757

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on record review, observation, interview, and policy review, the facility failed to follow professional standards for five Residents (#46, #27, #62, #17, and #51), out of a total sample of 16 residents. Specifically, the facility failed: 1. For Resident #46, to transcribe a physician's order for a gradual dose reduction (GDR, the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for Haloperidol (antipsychotic medication); 2. For Resident #27, a. to transcribe a physician's order for a GDR for Olanzapine (antipsychotic medication), and b. to follow a physician's order to re-evaluate a GDR for Olanzapine; 3. For Resident #62, to follow manufacturer's instructions for administering Metamucil (used to treat constipation); 4. For Resident #17, to follow a physician's order to obtain pathology results following surgical intervention to treat osteomyelitis in the Resident's right great toe; and 5. For Resident #51, to obtain a physician's order for the Resident to self-administer finger stick blood sugar (FSBS) testing. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #46 was admitted to the facility in January 2021 with diagnoses of major depressive disorder, brief psychotic disorder, and dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) assessment, dated 4/15/24, indicated that Resident #46 had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. Further review of the MDS indicated Resident #46 was receiving an antipsychotic medication on a regular basis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #46's Psychiatric Nurse Practitioner's (NP) follow up note, dated 4/9/24, indicated a recommendation to decrease Haldol (Haloperidol) from 1 milligram (mg) PO (by mouth) BID (twice daily) to 0. 5mg PO AM and continue with PM dose x (for) 14 days. Review of Resident #46's Physician's Progress Note, dated 4/10/24, indicated he agreed with the psychiatric NP's recommendations and planned to decrease Haldol from 1 mg by mouth twice a day to 0.5 mg by mouth in a.m. (morning). Continue with p.m. dose x 14 days. Review of Resident #46's May 2024 Physician's Orders indicated but was not limited to: - Haloperidol 1 mg by mouth daily (12/8/22) - Haloperidol 1 mg every evening (2/18/23) Review of Resident #46's Medication Administration Record (MAR) for March, April, and May 2024 indicated he/she received Haloperidol per physician's orders. During an interview on 5/2/24 at 12:21 P.M., Nurse #3 said the physician reviewed the psychiatric recommendations and then he would either write an order for a medication change or he would give a telephone/verbal order for a medication change. During an interview on 5/2/24 at 12:27 P.M., Social Worker #1 said the Psychiatric NP provided recommendations on a visit summary report. Social Worker #1 said she would highlight all recommendations on the visit summary report and leave them in the Physician/NP communication book to be reviewed and/or approved. During a telephonic interview on 5/2/24 at 2:04 P.M., Physician #1 said he reviewed the Physician/NP communication book with each visit and initialed and dated any recommendations he agreed with. Physician #1 said the facility staff then transcribed and implemented the orders into the resident record. Physician #1 said, on 4/10/24, he reviewed the Psychiatric NP recommendation dated 4/9/24 and signed and initialed the visit summary report. Physician #1 said the expectation was for the nurse to initiate the order. During an interview on 5/2/24 at 2:22 P.M., Nurse #4 said the Physician reviewed the Physician/NP communication book and initialed and dated any recommendations he agreed with on the Psychiatric NP visit summary report and then the nurse working that day would write the orders. Nurse #4 and the surveyor reviewed the Physician/NP communication book which indicated that on 4/10/24 the physician had initialed and signed the 4/9/24 Psychiatric NP recommendations to decrease Resident #46's Haloperidol. Nurse #4 said a telephone order for the change in Haloperidol should have been written but it was not. During an interview on 5/2/24 at 5:07 P.M., the Director of Nursing (DON) said the nurse that was on when the Physician signed the recommendation should have written a telephone order for the medication change but the nurse did not. 2a. Resident #27 was admitted to the facility in September 2023 with diagnoses of bipolar and dementia with agitation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #27's MDS assessment, dated 2/20/24, indicated that Resident #27 was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident #27 was receiving an antipsychotic medication on a regular basis. Review of Resident #27's Psychiatric Nurse Practitioner's (NP) follow up note, dated 4/9/24, indicated a recommendation to decrease HS (bedtime) Zyprexa (Olanzapine) from 10 mg to 7.5mg x 14 days. Review of Resident #27's Physician's Progress Note, dated 4/10/24, indicated he agreed with the Psychiatric NP's recommendations and planned to decrease bedtime Zyprexa from 10 mg to 7.5 mg x 14 days. Review of Resident #27's May Physician's Orders indicated but was not limited to: - Olanzapine 10 mg by mouth every night at 8 P.M., 9/19/24-5/2/24 - Olanzapine 7.5 mg by mouth every night at 8 P.M., 5/2/24 Review of Resident #27's MAR for March, April, and May 2024 indicated he/she received Olanzapine per physician's orders. During an interview on 5/2/24 at 12:21 P.M., Nurse #3 said the physician reviewed the psychiatric recommendations and then he would either write an order for a medication change or he would give a telephone/verbal order for a medication change. During an interview on 5/2/24 at 12:27 P.M., Social Worker #1 said the Psychiatric NP provided recommendations on a visit summary report. Social Worker #1 said she would highlight all recommendations on the visit summary report and leave them in the Physician/NP communication book to be reviewed and/or approved. During a telephonic interview on 5/2/24 at 2:04 P.M., Physician #1 said he reviewed the Physician/NP communication book with each visit and initialed and dated any recommendations he agreed with. Physician #1 said the facility staff then transcribed and implemented the orders into the resident record. Physician #1 said, on 4/10/24, he reviewed the Psychiatric NP recommendation, dated 4/9/24, and signed and initialed the visit summary report. Physician #1 said the expectation was for the nurse to initiate the order. During an interview on 5/2/24 at 2:22 P.M., Nurse #4 said the Physician reviewed the Physician/NP communication book and initialed and dated any recommendations he agreed with on the Psychiatric NP visit summary report and then the nurse working that day would write the orders. Nurse #4 and the surveyor reviewed the Physician/NP communication book which indicated that on 4/10/24 the physician had initialed and signed the 4/9/24 Psychiatric NP recommendations to decrease Resident #27's Olanzapine. Nurse #4 said a telephone order for the change in Olanzapine should have been written but it was not. During an interview on 5/2/24 at 5:07 P.M., the DON said the nurse that was on when the Physician signed the recommendation should have written a telephone order for the medication change but the nurse did not. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. Review of Resident #27's April Physician's Orders indicated but was not limited to: - Olanzapine 10 mg by mouth every night at 8 P.M., 9/19/23-5/2/24 - Olanzapine 5 mg by mouth every day at 1 P.M., 9/19/23 - 4/2/24 - Olanzapine 2.5 mg by mouth every day at 1 P.M., 4/2/24 - 4/17/24 Review of the medical record indicated that Resident #27 had a new order from the Physician on 4/2/24 to: -D/c (discontinue) 1 P.M. Zyprexa 5 mg dose. -Start Zyprexa 2.5 mg PO daily at 1 P.M. Continue Zyprexa 10 mg PO daily at 8 P.M. Re-eval (Re-evaluate) 14 days. Further review of the medical record indicated that the Zyprexa was discontinued on 4/17/24 and failed to indicate that the medication was re-evaluated. During an interview on 5/2/24 at 2:22 P.M., Nurse #4 said the medication should have been put in the Physician/NP communication book for the Physician or NP to re-evaluate the medication and whether or not to continue the medication or discontinue it, but it was not. Nurse #4 said the medication had just dropped off (stopped) after 14 days. During a telephonic interview on 5/2/24 at 2:04 P.M., Physician #1 said the expectation was for the nurses to put the need for a medication to be re-evaluated into the Physician/NP communication book for him, the NP, or another Physician to re-evaluate the medication. Physician #1 reviewed his notes and said the Zyprexa was not re-evaluated as ordered but should have been. 3. Resident #62 was admitted to the facility in August 2023 with diagnoses of hemiplegia and hemiparesis following other cerebrovascular disease affecting the left non-dominant side. On 5/1/24 at 9:00 A.M., the surveyor observed Nurse #3 administer 1 teaspoon of Metamucil in 5 ounces of water to Resident #62. Review of Resident #62's May 2024 Physician's Orders indicated but was not limited to: - Metamucil Clear and Natural powder 1 tea spoon (sic) oral every day at 9 A.M. daily. Mix with water or juice (9/13/23) Review of the manufacturer's recommendations for Metamucil said to fill glass with at least 8 ounces of water. During an interview on 5/1/24 at 10:00 A.M., Nurse #3 said she mixed Resident #62's Metamucil with 5 ounces of water instead of 8 ounces because she only had 5-ounce cups but should have mixed it with 8 ounces. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/24 at 10:45 A.M., the DON said the expectation was for the Metamucil to have been mixed in 8 ounces of fluid per manufacturer's recommendations. 34145 4. Resident #17 was admitted to the facility in May 2022 with diagnoses including diabetes mellitus, end stage renal disease, and peripheral vascular disease. Review of the most recent MDS assessment, dated 4/4/24, indicated Resident #17 had severe cognitive impairment as evidenced by a BIMS score of 6 out of 15, and had one stage 2 pressure ulcer (an injury that breaks down the skin and underlying tissue). Review of the medical record indicated the Resident had a chronic venous ulcer and cellulitis of the right great toe. On 4/14/24, Resident #17 had a stat (urgent) x-ray (imaging study that takes pictures of bones and soft tissues) of the right great toe which indicated the Resident had developed osteomyelitis (a serious infection of the bone). The Resident was sent to the hospital for evaluation and returned to the facility on [DATE] following a partial amputation of his/her right great toe. Review of the medical record indicated a Physician's Interim Order, dated and signed by the Physician on 4/22/24: 1st toe osteomyelitis (call Pathology). Please follow up on final pathology/microbiology results of intraoperative bone margin to make sure it is clear of infection not requiring further antibiotics. Further review of the entire medical record failed to indicate facility staff called Pathology to obtain microbiology results as ordered by the Physician. During a telephone interview on 5/2/24 at 2:43 P.M., Physician #1 said that he had not heard any follow-up with Resident #17's pathology results. He said he was in the facility on 4/22/24 and remembered writing the order and directing the nurse on the unit to call the pathology department to get the pathology results to determine if the Resident would require antibiotic treatment. He said his expectation is that the nurse should have followed the order to obtain the pathology reports. During an interview on 5/2/24 at 3:05 P.M., Nurse #5 reviewed Resident #17's medical record and said he could not find any documentation that anyone followed up with pathology. He said if someone did follow-up, it would be documented in the progress notes. During an interview on 5/2/24 at 3:15 P.M., the Director of Nursing (DON) was unable to find any documentation that anyone followed up with the pathology department to obtain Resident #17's pathology results. She said she would call the pathology department at the hospital to get the results. During a subsequent interview on 5/2/24 at 3:56 P.M., the DON said she called the pathology department and requested a copy of the pathology report. She provided the survey team with a copy of the pathology report, dated 4/17/24 and a faxed date stamp of 5/2/24, 10 days after the Physician wrote the order to obtain results. The results indicated the Resident's right great toe was clear for infection margins. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #51 was admitted to the facility in October 2022 with diagnoses including diabetes mellitus type 2. Review of the most recent MDS assessment, dated 3/14/24, indicated Resident #51 was cognitively intact as evidenced by a BIMS score of 15 out of 15, has diabetes mellitus, and receives insulin injections daily. During an interview on 4/29/24 at 10:17 A.M., Resident #51 said he/she is diabetic and showed the surveyor a small black box that he/she said contained supplies to test blood sugar. The Resident said he/she tests his/her blood sugar, then goes out to the nursing station so they know what the number is and administer insulin coverage if needed. Review of the medical record included but was not limited to the following Physician's Order: -Humalog (antidiabetic insulin) 100 units/1 milliliter (mL) solution per sliding scale, subcutaneous before meals and at hour of sleep (HS) (2/10/23): -FSBS 0 - 149=no coverage -FSBS 150 - 199=give 2 units -FSBS 200 - 249=give 4 units -FSBS 250 - 299=give 6 units -FSBS 300 - 349=give 8 units -FSBS 350 - 399=give 10 units -FSBS above 400=give 12 units, then re-evaluate in one week The Physician's orders failed to include an order for the Resident to self-administer FSBS testing. On 5/1/24 at 11:40 A.M., the surveyor observed Resident #51 walk out of his/her room and approach Nurse #2 at the medication cart. The Resident told the nurse that he/she had just checked his/her blood sugar and the value was 150. During an interview on 5/1/24 at 11:41 A.M., Nurse #2 said the Resident checks his/her own blood sugar levels and tells nursing the results. During an interview on 5/1/24 at 11:45 A.M., Resident #51 said no one has come in to assess him/her for their ability to conduct FSBS testing. During an interview on 5/1/24 at 12:10 P.M., the Director of Nursing (DON) said she is aware Resident #51 takes his/her own blood sugars. She said she does not know if the Resident has been assessed to self-administer finger stick blood sugar testing or if there is a physician's order to do so. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 4:56 P.M., the surveyor observed Resident #51 poke his/her finger, place a drop of blood onto a test strip (strip of material containing chemicals that react to certain substances) and insert it into the glucometer (used to measure how much glucose (a type of sugar) is in the blood). During an interview on 5/2/24 at 1:22 P.M., the DON said that she reviewed Resident #51's medical record and said an assessment had not been conducted and there was no physician's order for the Resident to self-administer FSBS.

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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. 46562 Based on record review and staff interview, for one Resident (#66), of three closed records reviewed, the facility failed to document the recapitulation of the Resident's stay that included his/her course of illness/treatment. Findings include: Resident #66 was admitted to the facility in January 2024 with the following diagnoses: partial amputation of left great toe. Review of the medical record indicated Resident #66 was discharged home on 1/31/24. Review of the discharge paperwork, titled Discharge Plan, indicated the following information in the Summary of Stay and Discharge Observations sections were left blank: -Admission diagnosis -Summary of Course of Stay -Final Diagnosis -Lab, X-ray, Skin Condition, Pain, etc. -Comments During an interview on 5/2/24 at 3:28 P.M., Social Worker #1 said the facility utilized a paper packet for discharge. Social Worker #1 said each department was responsible for completing a section of the discharge paperwork. During an interview on 5/2/24 at 3:32 P.M., Nurse #3 said when a resident was discharged home the nurse completing the discharge reviews the paperwork, provides education and reviews medications and discharge instructions with the resident. Nurse #3 said every department has a section of the discharge paperwork to complete and that usually the night shift nurse completed the nursing section. During an interview on 5/2/24 at 5:08 P.M., the Director of Nurses (DON) said the discharge paperwork is started when the discharge date was set and all departments complete a section. The DON and the surveyor reviewed Resident #66's discharge paperwork and the DON said the summary section should have been completed and the paperwork should have included a recapitulation/summary of his/her stay.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34145 Based on record review and interviews, the facility failed to promote and manage the delivery of safe nursing care in accordance with accepted Standards of Nursing Practice for one Resident (#26), out of a total sample of 16 residents. Specifically, the facility failed to ensure a dietary aide did not move a resident off the floor and into a wheelchair after the Resident sustained an unwitnessed fall with a head strike, prior to having a nurse assess the Resident. Findings include: Review of the facility's Falls Policy & Procedure, last reviewed 12/2023, included but was not limited to: -The resident is to be left as found, and not moved, until the nurse has completed an assessment. Resident #26 was admitted to the facility in July 2017 and had diagnoses including malignant brain tumor and epilepsy. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/14/24, indicated Resident #26 was unable to complete the Brief Interview for Mental Status (BIMS) assessment, had short and long-term memory problems, and severely impaired cognitive skills. Review of Nursing Progress notes, dated 4/25/24, indicated Resident #26 fell from his/her wheelchair in the unit dining room and hit his/her left forehead on the floor. The Resident complained of pain to the left forehead, was administered pain medication, and was sent to the hospital for evaluation. The Resident returned from the hospital with imaging results indicating no injuries were sustained as a result of the fall. Review of the Incident Report indicated Resident #26 had an unwitnessed fall out of his/her wheelchair in the unit dayroom at 10:00 A.M., was put back in his/her wheelchair, assessed, complained of head pain and sent to the hospital for evaluation. Review of a statement from Nurse #7 indicated the Resident was found on the floor and put back into his/her chair. Review of a statement from Certified Nurses Assistant (CNA) #4 indicated she was assisting another resident and did not witness the fall. There were no other statements as part of the 4/25/24 fall investigation. Review of the staffing schedule for 4/25/24 indicated CNA #2 and CNA #5 were working on Resident #26's unit at the time of the fall. During an interview on 5/1/24 at 1:40 P.M., CNA #4 said she worked the day Resident #26 fell out of his/her wheelchair in the dining room. She said she was helping another resident and did not see the Resident on the floor or assist him/her back into the wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/24 at 1:57 P.M., CNA #2 said he worked the day Resident #26 fell out of his/her chair in the unit dining room. He said he was working with another resident at the time of the fall and did not see him/her on the floor and did not assist in getting the Resident back into the wheelchair. During an interview on 5/2/24 at 10:15 A.M., CNA #5 said she worked the day Resident #26 fell out of his/her chair in the unit dining room and hit his/her head on the floor. She said she fed him/her breakfast and the Resident remained in the dining room. She said Dietary Staff #1 found the Resident on the floor, picked him/her up and put the Resident back in the wheelchair. She said you are not supposed to move anyone that falls on the floor, but Dietary Staff #1 didn't know that. During an interview with Dietary Staff #1 in the presence of the Food Service Manager on 5/2/24 at 1:10 P.M. , Dietary Staff #1 said on 4/25/24, he was coming off the elevator on the 2nd floor and heard Resident #26 shouting for help. He said he saw the Resident on the floor in the dining room, saw that there were no staff around, so he went over to the Resident and lifted him/her up and placed him/her back into their wheelchair. He said right after that, he saw a CNA walking toward him and he told her to get the nurse. He said he did not know he was not supposed to move a resident. During an interview on 5/2/24 at 1:22 P.M., the Director of Nursing (DON) said she was not aware the Resident was moved back into his/her wheelchair before being assessed by the nurse. She said the Resident should have been assessed by a nurse before being moved.

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Blaire House of Milford	20 Claflin Street Milford, MA 01757

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48695 Based on observation, interview, and record review, for one Resident (#14), of 16 sampled residents, the facility failed to provide indwelling catheter (a flexible tube inserted into the bladder to drain urine outside of the body) care consistent with professional standards related to infection control prevention. Specifically, the facility failed to maintain/secure the Resident's Foley catheter drainage bag away from contaminated surfaces. Findings include: Review of Centers for Disease Control and Prevention's Guidelines for Prevention of Catheter-Associated Urinary Tract Infections, page last reviewed November 2015, indicated but was not limited to: - Do not rest the catheter bag on the floor. Review of the facility's policy titled Catheter Care, Urinary, last revised September 2014, indicated but was not limited to: - Purpose: The purpose of this procedure is to prevent catheter associated urinary tract infections. - General Guidelines: Infection Control 2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor. Resident #14 was admitted to the facility in March 2024 with diagnoses including hypertensive urgency, cognitive communication deficit, and urinary retention. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/5/24, indicated that Resident #14 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Review of Resident #14's May 2024 Physician's Orders indicated but was not limited to: - Foley Cath (Indwelling Catheter) care every shift (4/26/24) - Document Foley Cath output every shift (4/26/24) Further review of Resident #14's medical record indicated his/her indwelling catheter was inserted on 4/11/24. On 5/1/24, at the following times, the surveyor observed Resident #14's indwelling catheter drainage bag: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9:29 A.M., lying on the floor not in a privacy bag. -10:29 A.M., lying on the floor not in a privacy bag. -12:09 P.M., lying on the floor in a black privacy bag. During an interview with observation on 5/1/24 at 12:37 P.M., Certified Nursing Assistant (CNA) #2 said indwelling catheter drainage bags should be hanging on the bed. The surveyor and CNA #2 observed the indwelling catheter bag lying in a privacy bag on the floor. CNA # 2 said the indwelling catheter bag should not be on the floor and should be hanging from the bed frame. During an interview on 5/1/24 at 12:39 P.M., Nurse # 2 said indwelling catheter drainage bags should be in a privacy bag attached to a non-movable part of the bed and should not be on the floor. During an interview on 5/1/24 at 3:32 P.M., the Director of Nursing (DON) said the expectation is that catheter drainage bags are kept in a privacy bag and off the floor.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48695 Based on records reviewed and interviews, the facility failed to ensure for one Resident (#27), out of a total sample of 16 residents, that each Resident's drug regimen was free from unnecessary psychotropic medications. Specifically, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS) assessment (a clinical outcome checklist completed by a healthcare provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body) was completed timely in accordance with standards of practice. Findings include: Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to: - The AIMS is administered every three to six months to monitor the patient for the development of TD (tardive dyskinesia, is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292174/) Review of the facility's policy titled Antipsychotic Medication Use, last revised 2016, failed to indicate intervals at which an AIMS should be conducted. Resident #27 was admitted to the facility in September 2023 with diagnoses that included bipolar disorder and dementia with agitation. Review of Resident #27's Minimum Data Set (MDS) assessment, dated 2/20/24, indicated that the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS indicated Resident #27 was receiving an antipsychotic medication on a regular basis. Review of Resident #27's Physician's Orders indicated but was not limited to: - Olanzapine (anti-psychotic) 5 milligrams (mg) by mouth every day at 1 P.M., 9/19/23-4/2/24 - Olanzapine 5 mg by mouth every day at 8 A.M., 9/19/23-3/22/24 - Olanzapine 10 mg by mouth every night at 8 P.M., 9/19/24-5/2/24 - Olanzapine 2.5 mg by mouth every day at 9 A.M., 3/22/24-3/29/22 - Olanzapine 2.5 mg by mouth every day at 1 P.M., 4/2/24 - 4/17/24 - Olanzapine 7.5 mg by mouth every night at 8 P.M., 5/2/24 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's Medication Administration Record (MAR) for March, April, and May indicated he/she received Olanzapine per physician's orders. Review of Resident #27's Practitioner Notes/Psychiatric Follow-ups, dated 3/19/24 and 4/9/24, indicated an AIMS assessment had last been completed 9/25/23. During an interview on 5/2/24 at 5:07 P.M., the Director of Nursing (DON) said the expectation was for the Psychiatric Practitioner to complete an AIMS assessment every six months. During an interview on 5/2/24 at 5:55 P.M., the DON said the AIMS assessment for Resident #27 had not been completed every six months as expected.

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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. 48695 Based on observation, interview, and policy review, the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner as required. Specifically, the facility failed to ensure all medication and treatment carts were locked when unattended and unsupervised on three of three units in the facility. Findings include: Review of the facility's policy titled Storage and Expiration Dating of Medications, Biologicals, last revised 8/7/23, indicated but was not limited to: -Applicability: This Policy 5.3 sets forth for the procedures relating to the storage and expiration dates of medications, biologicals . -Procedures: 3. General Storage Procedures: -3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. The surveyor observed the following medication/treatment carts: - 4/29/24 at 8:14 A.M., East unit medication cart unlocked and unattended parked in front of the nurses' station. -4/29/24 at 9:36 A.M., Sub-acute treatment cart unlocked and unattended parked along the wall between nurses' station and dining area; two residents were in the dining area. -4/30/24 at 7:51 A.M., Sub-acute treatment cart unlocked and unattended parked along the wall between nurses' station and dining area; two residents in the dining area. -4/30/24 at 8:21 A.M., [NAME] Unit medication cart unlocked and unattended in front of the nurses' station. -4/30/24 at 8:35 A.M., [NAME] Unit medication cart unattended and locked, but with bottom drawer ajar with medication cards visible and accessible. -4/30/24 at 12:05 P.M., Sub-acute treatment cart unlocked and unattended parked along the wall between nurses' station and dining area; two residents in the dining area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/01/24 at 8:44 A.M., Sub-acute treatment cart unlocked and unattended parked along the wall between nurses' station and dining area; one resident in the dining area. -5/01/24 at 12:12 P.M., [NAME] Unit medication cart unlocked and unattended parked at nurses' station. During an interview on 5/01/24 at 10:33 A.M., Nurse #4 said the treatment cart should be locked when unattended or unsupervised. During an interview on 5/1/24 at 12:21 P.M., Nurse #3 said the medication cart should not have been left unlocked while unattended and she should have locked it before walking away. During an interview on 5/1/24 at 3:32 P.M., the Director of Nursing (DON) said the expectation was for all medication and treatment carts to be locked when unattended.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 34145 Based on document review and interview, the facility failed to fully inform all residents of their right to not sign a binding arbitration agreement upon admission. Findings include: Review of the facility's Resident and Facility Arbitration Agreement, last revised 2/2022, indicated but was not limited to the following: It is understood and agreed by (the Facility) and (Resident, or Resident's Authorized Representative, hereinafter collectively the Resident) that any legal dispute, controversy, demand or claim (herein collectively referred to as claim or claims) that arises out of or relates to the Resident Admission Agreement or any services or health care provided by the Facility to the Resident, shall be resolved exclusively by binding arbitration to be conducted at a pace agreed upon by the parties, or in the absence of such agreement, the Facility, in accordance with the American Arbitration Association (AAA) Alternative Dispute Resolution Services Rules of Procedure for Arbitration which are hereby incorporated into the agreement, and not by lawsuit or resort to court process except to the extent that applicable state or federal law provides for judicial review of arbitration proceedings or the judicial enforcement of arbitration awards. The parties understand and agree that by entering this Arbitration Agreement they are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury. The Resident understands that (1) he/she has the right to seek legal counsel concerning this agreement, (2) the execution of this Agreement is not a precondition to the furnishing of services to the Resident by the Facility, and (3) this Arbitration Agreement may be rescinded by written notice to the Facility from the Resident within 30 days of signature. If not rescinded within 30 days, this Arbitration Agreement shall remain in effect for all care and services subsequently rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility. The undersigned certifies that he/she has read this Arbitration Agreement and that it has been fully explained to him/her, that he/she understands its contents, and has received a copy of the provision and that he/she is the Resident, or a person duly authorized by the Resident, which shall include a Responsible Party, Health Care Proxy, Power of Attorney, or Legal Guardian, or otherwise to execute this agreement and accept its terms. During the entrance conference on 4/29/24 at 8:05 A.M., the Administrator said every Resident in the facility has signed the binding arbitration agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/2/24 at 8:55 A.M., the Business Office Manager (BOM) said the arbitration agreements are part of the admission packet and are reviewed with residents and/or their representatives. She said in 2023, they started asking all residents/representatives to sign the arbitration agreement and added by hand the words Accept and Decline with a line next to it. She said the reason they started having everyone sign it is because admissions staff were being questioned why residents were not signing the agreement, and she needed to prove to management that the agreements were being explained to the residents/representatives. During an interview with the Administrator and BOM on 5/2/24 at 11:23 A.M., they provided the survey team with copies of nine signed arbitration agreements for active residents, and 57 signed arbitration agreements for discharged residents all with the handwritten word Declined circled. The Administrator and BOM reviewed the arbitration agreement with the surveyor and said the agreement is confusing because it states that the resident/representatives sign to indicate they understand the agreement but also that they agree to enter into the agreement. They said they did not realize that, although the word Declined was circled on the form, by signing the agreement, the resident/representative was legally entering into the agreement. The Administrator and BOM said they need to come up with a process to track that arbitration agreements are reviewed with every residents/representative whether or not they want to enter into the agreement.

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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. 46562 Based on observation, interview, and record review for one Resident (#16), of 16 sampled residents, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, for Resident #16, the facility failed to ensure transmission-based precautions (TBP) were implemented per physician's order for contact precautions. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 8/1/23, indicated but was not limited to: -Contact Precautions are one type of Transmission-Based Precaution that are used when pathogen transmission is not completely interrupted by Standard Precautions alone. Contact Precautions are intended to prevent transmission of infectious agents, like MDROs, that are spread by direct or indirect contact with the resident or the resident's environment. -Contact Precautions require the use of gown and gloves on every entry into a resident's room. Review of the CDC Transmission-Based Precautions, last updated January 2016, indicated but not limited to: -Contact Precautions: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning (putting on) PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. Resident #16 was admitted to the facility in November 2023 with the following diagnoses: sepsis and infection with Multi-Drug Resistant Organisms (MDRO). Review of Resident #16's current Physician's Orders indicated but was not limited to: -MDRO: contact precautions to urine and coccyx every shift, dated 4/23/24 -Vancomycin Resistant Enterococcus (VRE): contact precautions to coccyx every shift, dated 4/23/24 The surveyor observed an enhanced barrier precautions sign posted on the door entrance of Resident #16's room on: -4/29/24 at 8:33 A.M. -4/30/24 at 11:20 A.M. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/1/24 at 4:26 P.M. -5/2/24 at 8:01 A.M. Further review of the facility posted enhanced barrier precations sign indicated but was not limited to: -Everyone must: -Clean their hands, including before entering and when leaving the room Providers and Staff must: -Wear gloves and a gown for the following High-Contact Resident Care Activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing On 5/1/24 at 4:26 P.M., the surveyor observed an enhanced barrier precaution sign posted on Resident #16's doorway. Nurse #4 was in the room and was observed applying skin prep and repositioning Resident #16 in bed. Nurse #16 was not wearing a gown. During an interview on 5/1/24 at 4:30 P.M., Nurse #4 said Resident #16 was on contact precautions related to an infection in his/her wound. Nurse #4 said she did not need to wear a gown unless she was going near his/her wound on his/her coccyx. Nurse #4 said because the Resident was on contact precautions due to an infection in the wound she did not need a gown if she was only giving medication, helping reposition and or touching the Resident's feet. Nurse #4 and the surveyor reviewed the sign posted outside of the door and Nurse #4 could not provide an answer as to why an enhanced barrier precaution sign was posted and not a contact precaution sign. Nurse #4 was unable to tell the surveyor the difference between enhanced barrier precautions and contact precautions. During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON) said Resident #16 had MDROs and should have had a contact precaution sign posted outside of his/her room and not an enhanced barrier precaution sign because the two were not the same. The DON said staff should have worn a gown and gloves when in the room with Resident #16 related per policy for contact precautions.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on record review, policy review, and interview, for one Resident (#46), of five residents reviewed, the facility failed to provide the pneumococcal vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations and facility policy. Specifically, for Resident #46, the facility failed to ensure that pneumococcal vaccinations were administered after consent was obtained. Findings include: Review of the facility's policy titled Pneumococcal Vaccine, dated as revised October 2023, indicated but was not limited to: -Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series -Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the CDC website Pneumococcal Vaccine Timing for Adults greater than or equal to [AGE] years (cdc.gov), dated 3/15/23, indicated but was not limited to the following: -For adults 65 and over who has had Pneumococcal Conjugate Vaccine 13 (PCV13) and it has been one year or greater since the last Pneumococcal Vaccination, then the patient and the vaccine provider may choose to administer the 20-Valent Pneumococcal Conjugate Vaccine (PCV20) or Pneumococcal polysaccharide vaccine (PPSV) 23. Resident #46 was admitted to the facility in January 2021 with the following diagnoses: diabetes mellitus and dementia. Review of Resident #46's medical record indicated: -consent to receive the pneumococcal vaccination was obtained on 8/25/21 (Resident #46 was [AGE] years old when the consent was signed) Review of Resident #46's vaccination administration record from Massachusetts Immunization Information System (MIIS) indicated Resident #46 received the PCV 13 vaccination on 12/31/20. During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON), who was also the Infection Prevention Nurse, said when the facility administered a vaccine, she recorded it in MIIS. The DON and surveyor reviewed the medical record for Resident #46. The DON said Resident #46 was eligible for the pneumococcal vaccine any time after 12/31/2021, and had signed consent for it, however there was no documented evidence that it had been administered.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on record review, policy review, and interview for one Resident (#63), of five sampled residents, the facility failed to provide education, assess for eligibility, and offer COVID-19 vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations and facility policy. Findings include: Review of Centers for Disease Control and Prevention (CDC) guidance titled Stay Up to Date with COVID-19 Vaccines, revised January 2024, indicated but was not limited to the following: -People aged [AGE] years and older who got COVID-19 vaccines before September 12, 2023, should get one updated Pfizer-BioNTech, Moderna, or Novavax COVID-19 vaccine. Resident #63 was admitted to the facility in January 2024 and was [AGE] years old at that time. Review of Resident #63's medical record indicated: -Consent to receive the COVID-19 vaccination was obtained on 1/28/24. Review of Resident #63's vaccination administration record from the Massachusetts Immunization Information System (MIIS), indicated he/she had received COVID vaccinations on 2/12/21, 3/12/21, and 10/13/22. Further review of the MIIS indicated Resident #63 was eligible for an updated COVID-19 vaccine as indicated in CDC guidance. During an interview on 5/2/24 at 1:09 P.M., the Director of Nurses (DON), who was also the Infection Prevention Nurse, said when the facility administered a vaccine, she recorded it in MIIS. The DON and surveyor reviewed the medication record for Resident #63 and the DON said Resident #63 had signed consent to receive an updated COVID-19 vaccination in January but there was no documented evidence that it was administered.