STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at West Springfield	42 Prospect Avenue West Springfield, MA 01089

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 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** 42690 Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) Assessments were accurately coded for two Residents (#35, and #54) out of a total sample of 26 residents. Specifically, the facility failed to: 1. Accurately code that Resident #35 was no longer receiving an antibiotic (medication used to treat bacterial infections) medication. 2. Accurately code that Resident #54: -received Hospice (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) services. -utilized eyeglasses. Findings include: 1. Resident #35 was admitted to the facility in March 2024 with a diagnosis of Cellulitis (potentially serious bacterial infection of the skin) of the left lower limb. Review of the most recent MDS assessment dated [DATE], indicated that the Resident was currently taking an antibiotic. Review of the March 2024 through August 2024 Physician's orders indicated the Resident was prescribed the following antibiotic medications: -Cipro Oral Tablet 500 MG (Ciprofloxacin HCl) Give 500 milligrams (mg) by mouth, two times a day for Cellulitis until 3/22/24, start date 3/11/24 -Doxycycline Hyclate oral Tablet 100 MG (Doxycycline Hyclate) Give 100 mg by mouth, two times a day until 3/21/24 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2024
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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 8/5/24 at 12:23 P.M., the MDS Nurse said that Resident #35 was not currently receiving antibiotics, and was not receiving antibiotics at the time of the MDS assessment dated [DATE]. The MDS Nurse said that the MDS Assessment should not have been coded that the Resident was receiving an antibiotic, as the Cipro medication was completed on 3/22/24, and the Doxycycline medication was completed on 3/21/24. 42741 2. Resident #54 was admitted to the facility in May 2024, with diagnoses including Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), and Conversion Disorder (a condition where mental health issues disrupt how the brain works). Review of the Social Work Progress Note dated 5/17/24, indicated Resident #54 signed onto Hospice Services on 5/16/24. Review of the Admission/Readmission nursing assessment dated [DATE], indicated Resident #54 used eyeglasses. Review of the most recent comprehensive MDS assessment dated [DATE], indicated Resident #54 was not receiving Hospice Services and did not use eyeglasses. During an interview on 8/5/24 at 12:20 P.M., the MDS Nurse said the 5/20/24 MDS Assessment was coded inaccurately. The MDS Nurse further said Resident #54 was on Hospice Services and used eyeglasses. The MDS Nurse said the 5/20/24 MDS Assessment would need to be modified.

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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. 42741 Based on record review and interview, the facility failed to ensure a care plan was developed to address the medical needs for one Resident (#52) out of a total sample of 26 residents. Specifically, for Resident #52, the facility failed to ensure a care plan was developed that included necessary interventions and goals relative to the care of a pressure wound (injury to the skin and underlying tissue resulting from prolonged pressure or friction). Findings include: Resident #52 was admitted to the facility in February 2022, and had a diagnosis of a Stage Two (2) pressure wound (partial thickness wound with loss of skin presenting as an open shallow ulcer) to his/her coccyx (tail bone area). Review of the Nursing Admission/Readmission Nursing Assessment, Skin Integrity, dated 5/8/24, indicated Resident #52 had been readmitted to the facility following a hospitalization and he/she had a pressure wound to his/her coccyx. Review of the most recent comprehensive MDS Assessment, dated 6/20/24, indicated that Resident #52 had an unhealed pressure wound. Review of the corresponding Care Area Assessments (CAA - responses triggered by the MDS Assessment which indicated whether the facility will proceed to creating a specific care plan for the identified concern in question) indicated a care plan related to Resident #52's pressure wound should have been created. Review of the Resident's care plan indicated that no pressure wound care plan with pressure wound interventions and/or goals for the pressure wound had been created after the MDS Assessment completion on 6/20/24. Review of the Wound Physician Note, dated 8/5/24, indicated that the Resident was still being treated for a Stage 2 pressure wound to his/her coccyx. During an interview on 8/6/24 at 12:19 P.M., the Infection Preventionist (IP), who rounded (when the medical team visits a resident to review their status and care plan) with the Wound Physician, said when Resident #52 returned from the hospitalization , upon identification of the pressure wound, a care plan should have been developed addressing the interventions and goals for the pressure wound and this was not done.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44222 Based on record and policy review, and interview, the facility failed to conduct interdisciplinary care plan meetings after the Minimum Data Set (MDS) assessments were completed, and involve the Resident and/or Resident Representative in the care planning process for six Residents (#11, #1, #2, #23, #54, and #8), out of a total sample of 26 residents. Specifically, the facility failed to provide evidence of a care plan meeting being held, or that the Resident and/or Resident Representative had participated in the care planning process following the MDS assessments completed: 1. For Resident #11 on 5/20/24. 2. For Resident #1 on 3/25/24 and 6/25/24. 3. For Resident #2 on 12/22/23, 3/21/24 and 6/20/24. 4. For Resident #23 on 9/8/23, 12/1/23, 2/23/24, and 5/25/24. 5. For Resident #54 on 5/20/24 6. For Resident #8 on 8/10/23 and 2/28/24. Findings include: Review of the policy titled Comprehensive Care Plan, undated, included the following: --Our facility's Care Planning/Interdisciplinary Team (IDT) in coordination with the resident, his/her family or representative (sponsor), develops, and maintains a comprehensive care plan for each resident . -Members of the interdisciplinary team responsible for assisting the resident/representative with the development of a comprehensive care plan include but are not limited to: a. Resident/representative . -The Care Planning/Interdisciplinary Team along with the resident/representative is responsible for the review and updating of care plans: At least quarterly. Review of the facility policy titled Care Planning - Interdisciplinary Team (IDT), last revised 5/12/21 and reviewed May 2022, included the following: -The care plan is based on the resident's comprehensive assessment (and other assessments as appropriate) and is developed with the resident/representative with the Care/Planning Interdisciplinary Team. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are invited and encouraged to participate in the development of and revisions to the resident's care plan. 1. Resident #11 was admitted to the facility in May 2024, with diagnoses including Bipolar Disorder (a mental disorder characterized by periods of depression and periods of elevated mood) and Type 2 Diabetes (DM II - disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood). Review of the Resident's clinical record showed evidence that an MDS Assessment had been completed on 5/20/24, and the MDS assessment indicated that the Resident was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. Review of the Resident's clinical record did not provide any evidence of any involvement of the Resident and/or their Representative being involved in the care planning process or that a care plan meeting had been held following the MDS Assessment completed on 5/20/24. During an interview on 8/6/24 at 1:16 P.M., the MDS Nurse said that there had not been any care plan meetings held with the Resident and/or their Representative related to the development of the Resident's care plan since admission to the facility in May 2024. During an interview on 8/6/24 at 2:01 P.M., the Social Worker (SW) said that she was unable to provide any evidence of a care plan meeting being held or any involvement of the Resident and/or their Representative in the development of the care plan since the Resident's admission to the facility in May 2024. 50563 2. Resident #1 was admitted to the facility in April 2018, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD: a group of diseases of the lungs that cause airflow blockage and breathing-related problems), Type 2 Diabetes, Chronic Kidney Disease [CKD] Stage 4 (moderately to severely damaged kidneys causing them to no longer work as they should to filter waste from the blood), Chronic Heart Failure (CHF: a condition of the heart caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs), and Methicillin Resistant Staphylococcus Aureus (MRSA: strain of gram-positive bacteria resistant to several antibiotics, making it difficult to treat, which spreads through contact with infected individuals). Review of Resident #1's MDS Assessment, dated 6/25/24, indicated the Resident was moderately cognitively impaired as evidenced by a BIMS score of 9 out of 15. Review of Resident #1's MDS records indicated that MDS Assessments were completed on 3/25/24 and on 6/25/24. Review of Resident #1's clinical record indicated no evidence that a care plan meeting was held or that the Resident and/or their Representative were involved/offered to be involved in the review and revision of the Resident's care plan following the completion of MDS assessments on 3/25/24 and 6/25/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/24 at 2:01 P.M., the SW said she could not provide evidence that Resident #1 and/or their Representative were involved in/or offered involvement in the review and revision of the Resident's care plan following his/her scheduled MDS assessments on 3/25/24 and 6/25/24. 3. Resident #2 was admitted to the facility in November 2019, with diagnoses including Unspecified Cerebral Infarction (occurs when blood flow to the brain is blocked causing damage to the brain tissue), Vascular Dementia (a chronic condition that affects memory, thinking and behavior due to damage to the brain caused by restricted blood flow), and CKD Stage 2 (where the kidneys are still functioning well but there are signs of kidney damage). Review of Resident #2's MDS Assessment, dated 6/25/24, indicated the Resident was moderately cognitively impaired as evidenced by a BIMS score of 11 out of 15. Review of Resident #2's MDS records indicated that MDS Assessments were completed on 12/22/23, 3/21/24 and on 6/20/24. Review of Resident #2's clinical record indicated no evidence that a care plan meeting was held or that the Resident and/or their Representative were involved/offered to be involved in review and revision of the Resident's care plan following completion of MDS assessments on 12/22/23, 3/21/24 or 6/20/24. During an interview on 8/6/24 at 2:01 P.M., the SW said she could not provide evidence that Resident #2 and/or their Representative were involved in/or offered involvement in the review and revision of the Resident's care plan following his/her MDS assessments on 12/22/23, 3/21/24 or 6/20/24. 45435 4. Resident #23 was admitted to the facility in December 2023, with a diagnosis of Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy). Review of the MDS Assessment, dated 5/24/24, indicated that Resident #23 was severely cognitively impaired as evidenced by a BIMS score of 6 out of 15. Review of the Resident's clinical record indicated the following relative to MDS assessments: -assessment dated [DATE] was completed on 9/14/23. -assessment dated [DATE] was completed on 12/5/23. -assessment dated [DATE] was completed on 3/6/24. -assessment dated [DATE] was completed on 6/10/24. Review of Resident #23'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 9/8/23, 12/1/23, 2/23/24, and 5/25/24 MDS assessments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/2/24 at 3:30 P.M., the MDS Nurse said the process for care plan meeting scheduling is that the MDS Nurse provides a list of upcoming care plan meetings to the front desk staff, and the front desk staff send out notifications to the IDT (interdisciplinary team). The MDS Nurse further said that the Social Worker schedules and holds the care plan meetings. The MDS Nurse said she could not provide documented evidence that Resident #23's care plan meetings had been held with the IDT and the Resident/Resident Representative after the completion of the 9/8/23, 12/1/23, 2/23/24, and 5/25/24 assessments. During an interview on 8/6/24 at 8:15 A.M., the SW said she could provide no documented evidence that care plan meetings had been held for Resident #23 with the IDT and the Resident/Resident Representative after the completion of the 9/8/23, 12/1/23, 2/23/24, and 5/25/24 assessments. 42741 5. Resident #54 was admitted to the facility May 2024, with diagnoses including Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), Major Depressive Disorder, and Conversion Disorder (also known as functional neurological symptom disorder [FND], is a condition where mental health issues disrupt how your brain works). During an interview on 7/31/24 at 8:23 A.M., Resident #54 said he/she had been admitted a couple of months ago and he/she had not had any care plan meetings since he/she was admitted to the facility. Review of the most recent comprehensive MDS Assessment, dated 5/20/24, indicated Resident #54 had a BIMS score of 13 out of 15, indicating that he/she was cognitively intact. Review of Resident #54's medical record indicated no documentation that a care plan meeting had been held with the Resident and/or his/her Representative to review and revise Resident #54's plan of care following the most recent comprehensive assessment on 5/20/24. During an interview on 8/5/24 at 9:22 A.M., the SW said she was responsible for documenting when care plan meetings where held. The SW further said the documentation should include who attended the meeting, any concerns regarding care that were addressed during the meeting, and the resident's goals. During an interview on 8/5/24 at 1:23 P.M., the MDS Nurse said Resident #54 did not have a care plan meeting following his/her most recent comprehensive MDS Assessment which was the Resident's admission assessment. The MDS Nurse further said the facility had not been doing care plan meetings after admission assessments were completed and the care plan meeting should have been completed by Day 21 after the MDS admission assessment was completed. 50320 6. Resident #8 was admitted to the facility in April 2021, with diagnoses of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment) and Chronic Obstructive Pulmonary Disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS Assessment, dated 5/3/24, indicated the Resident was cognitively intact as evidenced by a BIMS score of 14 out of 15. During an interview on 7/31/24 at 10:41 A.M., the Resident said he/she does not remember being invited to or attending care plan meetings. Review of the Resident's clinical record indicated that MDS assessments had been completed on 8/10/23 and 2/28/24. Further review of Resident #8's clinical record did not indicate any evidence that the facility held a care plan meeting and/or involved the Resident and/or their Representative in reviewing the care plan after the MDS assessments were completed on 8/10/23 and 2/28/24. During an interview on 8/1/24 on 1:26 P.M., the MDS Nurse said she makes the list of care plan meeting dates and distributes them to the staff. The MDS Nurse said she completes the care plan meeting invitations and that the front desk secretary mails them to the appropriate person. The MDS Nurse further said the SW was responsible for planning and hosting the care plan meetings. During an interview on 8/2/24 at 8:39 A.M., the MDS Nurse said she could not find any evidence the IDT held a meeting or the Resident/ Resident Representative had participated in care plan meetings for the 8/10/23 and 2/28/24 Assessments. During an interview on 8/2/24 at 1:32 P.M., the SW said the MDS Nurse was responsible for making the list of residents who were due for care plans and sending the letters to Residents/Resident Representatives. The SW said she would then facilitate putting the meetings together with Residents/Representatives and hold the meetings. The SW said she did not use an attendance sheet when the care plan meeting was completed. the SW further said there was an additional SW who no longer works in the building, and was previously responsible for Resident #8's care plan meetings. The SW said since the previous SW left in September 2023, she was now responsible for planning the care plan meetings for all the residents in the facility. The SW said she does not have any evidence IDT care plan meetings were held for Resident #8 following the 8/10/23 and 2/28/24 Assessments.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42741 Based on interview, record review, and policy review the facility failed to maintain professional standards of practice to prevent the development and promote healing of pressure ulcers/skin injuries for one Resident (#83) out of a total sample of 26 residents. Specifically, for Resident #83 the facility failed to ensure: 1. that Physician's orders for care and treatment were in place to prevent worsening of a pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) identified at the time the Resident was admitted to the facility. 2. the completion of weekly wound assessments to monitor for improvement and/or deterioration of the wound. 3. that recommended lab work was obtained. Findings include: Review of the facility policy titled Pressure Ulcer Prevention, revised 12/22/22, indicated the following: -Wounds will have weekly assessment and documentation on each area until healed. Review of the facility policy titled Wound Care, undated, indicated the following: -Verify that there is Physician's orders for this procedure. -The following information should be recorded in the resident's medical record: >All Assessment data (i.e. wound bed color, size, drainage, etc) Resident #83 was admitted to the facility in July 2024, with diagnosis of a right tibia (long bone in the lower leg) fracture. During an interview on 7/31/24 at 9:45 A.M., the surveyor observed Resident #83 lying in bed and the Resident's spouse said Resident #83 had fallen and broken his/her leg. The Resident's spouse said he/she was put into a leg immobilizer (removable splint that keeps a person from bending their knee to allow for a leg fracture to heal) at his/her previous nursing home and the immobilizer had caused a pressure area on his/her outer right leg. Resident #83's spouse said they were concerned that the area had grown, and felt when Resident #83 was first admitted to the facility that the wound dressing was not being changed regularly. Review of the Weekly Skin Assessment, dated 7/3/24 at 7:30 P.M., indicated Resident #83 had a 5 centimeter (cm) by (x) 2 cm injury to his/her right leg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weekly Skin Assessment, dated 7/3/24 at 8:15 P.M., indicated Resident #83 had a large wound to the lower right leg that was red and open, and the Wound Physician had been notified. Further review of the Resident's medical record indicated no wound specific assessment had been completed when the wound on Resident #83's right leg was identified. Review of the most recent comprehensive Minimum Data Set (MDS) Assessment, dated 7/9/24, indicated Resident #83 had one unhealed pressure injury/ulcer. Review of the 7/8/24 Wound Physician Note indicated Resident #83 had: -an unstageable (due to necrosis [dead skin] of the right lateral [outside] calf) that measured 8 cm long x 3 cm wide and 0.1 cm deep. Further review of the 7/8/24 Wound Physician Note indicated the following treatment: -Calcium Alginate (a wound dressing used to absorb wound fluid), once daily and as needed (PRN). -Santyl (an ointment used to remove dead or damaged tissue), once daily and as needed (PRN). -Gauze roll, apply once daily and as needed (PRN). Review of the 7/8/24 Wound Physician Note also indicated a recommendation for a Prealbumin level to be drawn (lab work that assess whether a person is getting adequate nutrition in their diet). Review of the July 2024 Physician's orders from 7/3/24 through 7/9/24, indicated that no orders were in place for the care and treatment of Resident #83's wound on his/her right lower leg. Further review of the July 2024 Physician's orders indicated on 7/10/24, the orders for wound care as recommended by the Wound Physician on 7/8/24 were put into place. Further review of the Resident's medical record indicated no documentation that the facility was completing weekly wound assessments. During an interview on 8/5/24 at 8:06 A.M., the Director of Nursing (DON) said at the time Resident #83 was admitted to the facility the Resident's Primary Physician should have been consulted to obtain wound treatment orders for Resident #83's right leg wound until the Wound Physician could assess the Resident and that this was not done. The DON said recommendations for the treatment of the Resident's wound were not made until the Wound Physician saw him/her on 7/8/24. The DON further said the Wound Physician's orders should have been put into place immediately and this was not done until 7/10/24. The DON said the facility had a weekly Wound Assessment Form that should have been completed every week starting at admission when it was identified the Resident had a wound. The DON said the weekly Wound Assessment Form was not completed until the surveyor asked about the wound care for Resident #83. The DON said she would need to look into whether the lab work for the Prealbumin level was ordered per the Wound Physician's recommendation. At the time of survey exit on 8/6/24, the facility had not provided documentation that the recommended Prealbumin level had been obtained for Resident #83 as recommended by the Wound Physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42741 Based on observation, interview, record and policy review, the facility failed to provide care and services for the administration of supplemental Oxygen (O2), consistent with professional standards of practice for one Resident #272, out of a total sample of 26 residents. Specifically, for Resident #272, the facility failed to ensure that Physician orders were in place for the use of Oxygen and the care and services of oxygen equipment when the Resident had pulmonary diagnoses that required safe and appropriate Oxygen administration to prevent the occurrence of adverse events. Findings include: Review of the facility policy titled Oxygen Administration Policy and Procedure, reviewed 12/6/22, indicated the following: -Oxygen is administered by Licensed Nurses with a Physician's order. -Orders should specify the oxygen equipment and flow rate or concentration required as routine or as needed (PRN). Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates: -All oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with physicians' orders or inadequate instruction for oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2. -Equipment maintenance and supervision: >All oxygen delivery equipment should be checked at least once daily >Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. >should be serviced and maintained in accordance with the manufacturer specifications and consistent with all federal, state, and local laws and regulations. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bear Mountain at West Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE 42 Prospect Avenue West Springfield, MA 01089	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #272 was admitted to the facility in November 2021, with diagnoses including Chronic Respiratory Failure (a condition that occurs when the lungs cannot provide enough oxygen to the body or remove enough carbon dioxide from the body, identified with symptoms of trouble breathing and fatigue) and Chronic Obstructive Pulmonary Disease (COPD - a chronic lung disease that causes restricted airflow from the lungs and make it difficult to breathe). Review of the most recent Minimum Data Set (MDS) Assessment, dated 6/4/24, indicated Resident #272 had clear speech, was able to be understood, and understands. During an observation and interview on 7/31/24 at 8:30 A.M., the surveyor observed Resident #272 lying in bed and utilizing Oxygen via nasal cannula (tubing that supplies supplemental oxygen through the nose via nasal prongs). The surveyor observed that the Resident's oxygen concentrator (machine that delivers the supplemental oxygen) indicated the Resident was receiving O2 at 2 liters per minute (LPM - the flow rate of the oxygen). Resident #272 said he/she had been using O2 for a while and that his/her O2 should be set at 2 LPM. On 8/1/24 at 9:24 A.M., the surveyor observed Resident #272 lying in bed, utilizing O2 via nasal cannula and the oxygen concentrator was set at 3.5 LPM. Review of Resident #272's Physician's orders for July 2024 and August 2024, indicated no Physician's orders were in place for the administration of Oxygen and the care and services of oxygen equipment. Review of Resident #272's care plan titled Altered Respiratory Status/Difficulty Breathing due to COPD ., initiated 10/23/23, indicated the following intervention: -Oxygen Settings: O2 via nasal cannula as needed (PRN). Review of the most recent Physician's Visit Note, dated 7/1/24, indicated the following plan: -As needed (PRN) Oxygen During an observation and interview on 8/1/24 at 9:36 A.M., the surveyor and Nurse #3 observed Resident #272 lying in bed and utilizing Oxygen via nasal cannula set at 3.5 LPM. Nurse #3 said Resident #272's O2 should be set at 2 LPM. Nurse #3 reviewed Resident #272's Physician's orders and said Resident #272 did not have orders in place for the administration of Oxygen or for the care and services of the oxygen equipment. Nurse #3 said orders should have been put in place that included the administration of O2 and the liter flow, changing of oxygen tubing weekly, if titration (increasing or decreasing) of O2 was needed, and the goal of what Resident #272's oxygen saturation level (amount of O2 in the blood) should remain at.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45435 Based on interview, record and policy review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) were acted upon as required for one Resident (#23), of five applicable residents reviewed for unnecessary medications, out of a total sample of 26 residents. Specifically, the facility staff failed to act upon the Consultant Pharmacist recommendation dated 5/4/24, to include an evaluation date for a PRN (as needed) psychotropic (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medication. Findings include: Review of the facility policy titled Medication Regimen Review, undated, indicated the following: -The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. -The findings are phoned, faxed, or e-mailed within (24 hours) to the Director of Nurses (DON) or designee and are documented and stored with the other Consultant Pharmacist recommendation in the resident's active record. -Recommendations are acted upon and documented by the facility staff and/or the Prescriber. Resident #23 was admitted to the facility in December 2023, with a diagnosis of Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy). Review of the Physician's orders, dated August 2024, indicated the following: -Ativan (anti-anxiety medication) oral tablet 0.5 milligrams (mg), give 0.5 mg by mouth every six hours as needed (PRN) for anxiety/agitation, start date 4/19/24. Review of the Consultant Pharmacist recommendation, dated 5/4/24, indicated the following: -MD (Medical Doctor) Rec (recommendation): Please update this Resident's PRN Ativan order to include an evaluation date. Review of the July 2024 and August 2024 Medication Administration Records (MARs), indicated Resident #23 was administered the PRN Ativan 0.5 mg on the following dates/times: -7/5/24 at 8:12 A.M. -8/5/24 at 7:46 A.M. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident's Progress Notes indicated no documented evidence the Consultant Pharmacist recommendation dated 5/4/24, had been acted upon. During an interview on 8/6/24 at 10:21 A.M., the surveyor and the Regional Nurse reviewed the Physician's orders and the Consultant Pharmacist recommendation. The Regional Nurse said the Nurses should have requested a re-evaluation date or a stop date be added to the Ativan PRN order as required. During an interview on 8/6/24 at 10:30 A.M., the Director of Nursing (DON) said the process for Medication Regimen Review (MRR) is that the Consultant Pharmacist reviews the resident records monthly and sends her (the DON) an e-mail within a day or two with the recommendations. The DON said that she prints the recommendations and gives them to the Provider (Physician/ Nurse Practitioner [NP]), the Provider addresses the recommendation and returns the completed recommendation to the DON. The DON said she had reviewed her binder of Consultant Pharmacist recommendations and she did not have the completed recommendation for Resident #23 dated 5/4/24. The DON said this recommendation had not been acted upon and should have been.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 42741 Based on record review, and interview, the facility failed to ensure that Physician orders were in place prior to laboratory testing being conducted for two Residents (#52 and #59), out of a total applicable sample of three residents. Specifically, for Residents #52 and #59, the facility failed to ensure that a Physician's order for COVID-19 testing was in place prior to the Residents being tested for COVID-19. Findings include: Review of the facility policy titled Policy and Procedure: Testing for COVID-19, updated 3/31/23, indicated the following: -Resident testing will be performed per Medical Doctor (MD) order. 1. Resident #52 was admitted to the facility in February 2022, with a diagnosis of Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment, involves parts of the brain that control thought, memory, and language). Review of the facility's testing for COVID-19 line listing, undated, indicated Resident #52 was tested for COVID-19 every other day starting on 7/24/24 through 7/30/24, and then tested daily from 8/1/24 through 8/5/24. Review of Resident #52's July 2024 and August 2024 Physician's orders indicated there were no Physician's order for COVID-19 testing. 2. Resident #59 was admitted to the facility in March 2024, with a diagnosis of Unspecified Dementia (a mental disorder that occurs when someone has Dementia but does not have a specific diagnosis). Review of the facility testing for COVID-19 line listing, undated, indicated Resident #59 was tested for COVID-19 every other day starting on 7/24/24 through 7/30/24, and then tested daily from 8/1/24 through 8/6/24. Review of Resident #59's July 2024 and August 2024 Physician's orders indicated there were no Physician's order for COVID-19 testing. During an interview on 8/6/24 at 11:43 A.M., the Corporate Infection Control Nurse said Resident's #52 and #59 had been tested for COVID-19 in July 2024 and August 2024 and did not have a Physician's order in place for COVID-19 testing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50563 Based on observation, interview, and policy review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections within the facility on two units (Unit One and Unit Four) out of a total of four units. Specially, the facility failed to ensure: 1. On Unit One, that staff wore required Personal Protective Equipment (PPE-clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments) while caring for a resident on Enhanced Barrier Precautions (EBP), placing him/her at increased risk of infection. 2. On Unit Four, that a staff member wore a fit tested N95 mask appropriately. 3. On Unit Four, that staff correctly utilized and/or discarded/ disinfected the required PPE while caring for residents diagnosed with COVID-19 (a highly contagious respiratory infection) placing residents at risk of contracting the disease. 4. On Unit Four, that staff wore the required and appropriate PPE when assisting a COVID-19 positive resident. Findings include: Review of the Occupational Safety and Health Administration (OSHA) form, titled Seven Steps to Correctly Wear a Respirator at Work, OSHA 4015-05 2020, indicated the following: -Cover your mouth and nose with the respirator and make sure there are no gaps (e.g. facial hair, hair, and glasses) between your face and the respirator. Review of the facility policy titled Transmission Based Precautions (TBP) with PPE Grid for Covid 19 Endemic, revised January 2024, indicated but was not limited to: -Covid-19 Positive Residents - recommended Staff PPE: >Fit tested N95 respirator (mask). -In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be implemented for residents with active or colonized MDRO (Multi-Drug Resistant Organisms: bacteria that are resistant to antibiotic medications which treat bacterial infections) infections, those with indwelling devices, or chronic wounds. -In addition to wearing a gown as outlined for Standard Precautions, gowns are to be worn for high contact care activities (dressing, bathing, transferring, providing hygiene, changing linens, changing briefs/assisting with toileting), indwelling device care, wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control and Prevention (CDC) guidance titled Infection Control Guidance: SARS-CoV-2 (COVID-19), updated 6/24/24, included the following: -Health Care Personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). -All non-dedicated, non-disposable medical equipment used for that patient should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another patient. 1. On 8/6/24 at 9:46 A.M., the surveyor observed Certified Nurses Aide (CNA) #4 in a resident room on Unit One with a sign at the doorway indicating that the resident in the room was on EBP. The surveyor observed that CNA #4 was shaving the resident and wearing gloves but was not wearing a gown as required. During an interview on 8/6/24 at 12:03 P.M., the surveyor and CNA #4 reviewed the EBP signage at the resident's door. CNA #4 said the sign indicated a gown should be worn for high contact care which would include hygiene activities like shaving. CNA #4 further said she did not wear a gown for the care but should have worn a gown. 42741 2. On 7/31/24 at 8:42 A.M., the surveyor observed Certified Nurses Aide (CNA) #3 enter the room of a COVID-19 positive resident, located on Unit Four. The surveyor observed that CNA #3 was wearing a surgical mask underneath an N95 mask (a mask that reduces a wearers exposure to small aerosol particles and large droplet particles). During an interview on 7/31/24 at 8:45 A.M., following the observation, CNA #3 said she thought having the surgical mask on under the N95 mask would provide more protection and that she had not been educated that wearing a surgical mask under an N95 mask was not good practice. Review of the facility Employee Fit Test Log, undated, indicated CNA #3 was not fit tested (procedure used to ensure that an N95 mask is the correct size and properly fits the face of the person who wears it) until 8/4/24. During an interview on 8/6/24 at 10:33 A.M., with the Corporate Infection Control Nurse and the facility's Infection Preventionist (IP), the Corporate Infection Control Nurse said wearing a surgical mask under an N95 mask should not be done as it compromises the fit of the N95 mask. During an interview on 8/6/24 at 1:35 P.M., the Corporate Infection Control Nurse said CNA #3 had not been fit tested for the use of an N95 mask until 8/4/24 after the surveyor had brought the concern to the facility's attention. 37400 (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. On 7/31/24 on 9:14 A.M., the surveyor observed CNA #1 assisting a resident in their room with breakfast. The surveyor observed the signage posted outside of the resident's room indicated the following:

-that it was COVID-19 positive room.

-STOP. Isolation in addition to Standard Precautions.

-Staff and Providers MUST:

>clean hands when entering and exiting,

>gown- change between each resident,

>N 95 respirator,

>eye protection (goggles or face shield) and

>gloves-change between each resident.

The surveyor observed a bin containing N95 and surgical masks, gowns, gloves and eye protection was located outside of the resident's room but there was no disinfectant in the vicinity. The surveyor observed that CNA #1 was wearing a surgical mask (not an N95 mask), gown, and eye protection. CNA #1 was not wearing gloves as required. The surveyor observed that prior to exiting the room, CNA #1 disposed of her gown and removed her eye protection (goggles) and placed them in her shirt pocket. CNA #1 conducted hand hygiene and exited the room, without removing her surgical mask or disinfecting her eye protection.

During an interview on 7/31/24 at 9:33 A.M., CNA #1 said Resident #52 was positive for COVID-19 and staff were required to put on a gown, gloves, eye protection and an N95 mask prior to entering the room. CNA #1 said the gown and gloves should be removed upon exiting the room. CNA #1 said she should have worn an N95 mask and gloves but she did not. CNA #1 further said that reusable eye protection should be wiped down with bleach wipes upon exiting an Isolation Precautions room. CNA #1 said she did not disinfect her eye protection upon exiting the (COVID-19 positive) resident's room. The surveyor observed CNA #1 open the PPE bin located outside of the resident's room and CNA #1 said that N95 masks were available but she did not see bleach wipes.

4. On 8/1/24 at 9:03 A.M., the surveyor observed CNA #5 in the room of a COVID-19 positive resident during the breakfast meal. The surveyor observed the signage outside of the resident's room indicated that Isolation Precautions were in place. The surveyor observed that a bin was located outside of the resident's room and contained N95 masks, gowns, gloves, eye protection and surgical masks. The surveyor further observed that CNA #5 was wearing a gown and a surgical mask with an N95 mask over the surgical mask. The surveyor observed that CNA #5 was not wearing eye protection as required. During an interview at the time, the Minimum Data Set (MDS) Nurse, who was present during the observation, said CNA #5 was wearing two masks and should be wearing the N95 mask only. The MDS Nurse said CNA #5 did not have eye protection and should.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at 9:35 A.M., CNA #5 said she should have worn all of the required PPE for the COVID-19 positive resident which included eye protection, gown, gloves and the N95 mask, but thought because she was in the room briefly, she did not have to wear the required PPE. CNA #5 further said that she wore the surgical mask under the N95 mask because she thought this added another layer of protection.